SRI BALAJI VIDYAPEETH (SBV)
(Deemed to be University)
U/S 3 of UGC Act 1956
Puducherry-607402

This document contains the details of the

Value added program in Protocol Writing,

conducted by the Medical Education Unit, Mahatma Gandhi Medical College & Research Institute, Sri Balaji Vidyapeeth, Deemed to be University.

(This document is attested from pages 1- 54)

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Pillaiyarkuppam, Pondicherry-607 402.

NAAC 2020

Criteria 1

Metrix 1.3 : Curriculum Enrichment

1.3.2

Index Page

Details of **Value added program in Protocol Writing**

Links to documents (Click on the links to navigate to the page)

1. Link to Prospectus
2. Circular
3. Course content
4. Sample Certificate
5. Enrolled List of students

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SBV/VAC committee/2016 **16.05.2016**

To

The Heads of Institutions.

SBV constituent Colleges.

Respected Sir /Madam.

As per the Strategic perspective plan prepared by the Value-added course committee, the following courses have been planned to be conducted as a part of Curriculum Enrichment for the year 2016-2017 by the institute as listed below.

Sl.No.	Course	Institution
1	CReAMS - Clinical Research and Audit by Medical Students	Mahatma Gandhi Medical College and Research Institute, Puducherry.
2	Value added program in Protocol Writing	Mahatma Gandhi Medical College and Research Institute, Puducherry.
3	PG orientation course on Teaching Learning methods	Sri Sathya Sai Medical College and Research Institute, Chennai
4	Certificate course on Research Methodology	Kasturba Gandhi Nursing College, Puducherry.

Kindy nominate a course co-ordinator for each course, who will prepare the syllabi and the conduct the BOS for the same before **28.05.2016**.

Dr. Kripa Angeline,

Member secretary

Copy to:

- The Registrar, SBV.
- IQAC, SBV.
- The Dean, MGMCR.
- The Principal, IGIDS.

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Office of the Dean/Acad./2016/293 16.05.2016

CIRCULAR

Value added committee (VAC) of Sri Balaji Vidyapeeth has decided to initiate following courses for the year 2016-2017 as listed below. In this regards, Medical Education Unit, MGMCRI, is directed to nominate course co-ordinators, who will prepare the syllabi and submit the same before 27.05.2016 to undersign.

S. No.	Course	Department
1	CReAMS - Clinical Research and Audit by Medical Students	Medical Education Unit, MGMCRI, Puducherry.
2	Value added program in Protocol Writing	Medical Education Unit, MGMCRI, Puducherry.

DEAN

DEAN
Mahatma Gandhi Medical College & Research Institute
Pondicherry - 607 402.

Copy to: The Coordinator, VAC Committee
The Dean PG Studies & Research / ADHS / MS/VP (Curriculum)/VP (Students)

Copy submitted to: The Vice-Chancellor/ Chancellor for kind information

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MEDICAL EDUCATION UNIT

Mahatma Gandhi Medical College and Research Institute
Pillaiyarkuppam, Puducherry - 607402.
(Sri Balaji Vidyapeeth Deemed University)

Date 26.05.2016

From

The Coordinator
Medical Education Unit
MGMCRI, Puducherry.

To
The Dean
MGMCRI, Puducherry

Dear Sir,

Sub: Nomination course co-ordinator-Regarding.

Ref: Circular Office of the Dean/VAC/2016/1 Dt.15.05.2016

Hereby , following faculty are nominated as coordinator for PG orientation course on Teaching Learning methods, who will be coordinating in conducting the course on behalf of Medical Education Unit ,MGMCRI, Puducherry.

Sl.No.	Course	Faculty
1	CReAMS - Clinical Research and Audit by Medical Students	Dr. Abhijit Boratne
2	Value added program in Protocol Writing	Dr. Seetesh Ghose

Seal with signature

Co-Ordinator
Medical Education Unit
Mahatma Gandhi Medical College
& Research Institute
Pillaiyarkuppam, Pondicherry-607 402

Enclosed: The syllabi on

- CReAMS - Clinical Research and Audit by Medical Students
- Value added program in Protocol Writing

Copy to: The VAC,SBV

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MEDICAL EDUCATION UNIT

Mahatma Gandhi Medical College and Research Institute
Pillaiyarkuppam, Puducherry - 607402.
(Sri Balaji Vidyapeeth Deemed University)

MEU/PG/13/2016

02.08.2016

Circular

Sub: Value added program in Protocol Writing,

Value added program in Protocol Writing, for Final year postgraduates, will be held from **8th to** 12th August 2016 from 1.30 to4.30 PM at Medical Education Unit(College Block annexe). Heads of the departments are requested to intimate the same and ask them to be present at the venue by 1.15 pm every day without fail. Attendance of the final year postgraduates will be taken during the workshop. Cooperation of the heads of the departments is expected.

Dr.Seetesh Ghose
Co-ordinator, MEU

Prof. M. Ravishankar
Dean & Chairman, MEU

Copy to: - The Chairman, SBECPT

The Chancellor, SBV, Vice Chancellor, SBV, Dean-Research, Postgraduate Studies & AHS,SBV, Dean Administration, Medical Superintendent, Additional Director Health Services, All HOD'S Clinical Para-Clinical, Pre - Clinical

*** Kindly bring your own laptop with backup power, Master chart (Excel sheet) and Zetero standalone software (free download)**

This document is attested from pages 1 to 59.

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MEDICAL EDUCATION UNIT

Mahatma Gandhi Medical College and Research Institute
Pillaiyarkuppam, Puducherry - 607402.
A unit of Sri Balaji Vidyapeeth

Program for the final year postgraduates on "Value added program in Protocol Writing,

S. No	Time	Topic	Faculty
		Registration 01.15 to 01.30 pm	
		Day 1, 8th August 2016	
1	01.30 to 02.00 pm	Introduction, How to get started with the dissertation	Dr. N.Ananthakrishnan
2	02.00 to 02.30 pm	Writing Aims and Objectives, Material and Methods	Dr. A.R. Srinivasan
3	02.30 to 04.30 pm	*Cleaning data, preparing master chart, analysis, generating tables and figures	Dr. G. Ezhumalai & Mr.Lokesh Maran
		Daily evaluation &Tea	
		Day 2, 9th August 2016	
4	01.30 to 03.30 pm	Writing review of literature and references	Dr. Sivaprakash
5	03.30 to 04.30 pm	Writing Observations and results	Dr. R. Ramesh
		Daily evaluation &Tea	
		Day 3, 10th August 2016	
6	01.30 to 02.15 pm	Group tasks and plenary on writing Observation and results	Dr. R. Ramesh
7	02.15 to 02.45 pm	Writing Discussion	Dr. D.Gunasekaran
8	02.45 to 04.30 pm	Group work and plenary on discussion	Dr. D.Gunasekaran
		Daily evaluation &Tea	
		Day 4, 11th August 2016	
9	01.30 to 02.00 pm	Writing introduction	Dr. Partha Nandi
10	02.00 to 03.15 pm	Group task and plenary on introduction	Dr. Partha Nandi
11	03.15 to 04.30 pm	Writing Abstract	Dr. Seetesh Ghose
		Daily evaluation &Tea	
		Day 5, 12th August 2016	
12	01.30 to 02.30 pm	Writing Acknowledgements, Formatting and Layout of Dissertations, certificate, plagiarism check and uploading	Dr. Jagan Mohan
13	02.30 to 03.00 pm	The final check	Dr. N.Ananthakrishnan
14	03.00 to 04.00 pm	Converting Dissertation into Journal Article	Dr. Sukanto Sarkar
15	04.00 to 04.30 pm	Daily / Program Evaluation & Tea	

Note : 2hrs of self study /day to complete the assignments and to prepare for the next session

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CH

Sl. No.	Contents	Task
1	Table No. and Title	
2	Column headings	
3	Serial No. for rows / Row headings	
4	Units	
5	Species & No. ("n" of subjects/animals)	
6	Drugs name & doses, route	
7	Asterisks to indicate significance	
8	Foot notes	
a	The values (Mean ± SD)	
b	P values / df (degrees of freedom)	
c	Expansion of abbreviations if any	
9	Important derived data	
	Characteristics:	
1	Lines	
2	Alignment – horizontal & vertical	
3	Uniformity	
4	Precision	
5	Simplicity	
6	Clarity	

CHECK LIST FOR FIGURES

Sl. No.	Contents	Task
a.	Figure No. and title	
b.	X and Y axes graduated?	
c.	X and Y axes titled?	
d.	Axes have their units mentioned (if appropriate)?	
e.	Different groups indicated with different markers?	
	SDs or SEs represented (graphically)?	
f.	Legend	
(i)	"n" – number of subjects?	
(ii)	Summary statistics (mean, mode or median)	
(iii)	Inferential statistics (p value)	
(iv)	Any other info	
g.	Is the figure clean, simple and easy to understand?	

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Use this	For
1. Line diagram	Showing time course of an event
2. Bar chart	Presenting comparative data
3. Pie chart	Illustrating the division of the whole into segments
4. Histogram	Presenting frequency distribution of quantitative date
5. Scattergram	Pointing out relationships or association between two variables.

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GROUP TASK 3: FOR GROUPS E & F

GIVEN TIME: 30 MINUTES

TASK TO BE DONE: READ THE FOLLOWING STUDY,AND WRITE THE DISCUSSION

School Absenteeism Among Children and its Correlates

Introduction:

School absenteeism has been studied in detail in relation to various social and physical causes (1, 2). School absenteeism has been linked to maternal education, residence, and specific illnesses like asthma, headache, abdominal pain, etc (3-7). However, role of social pressures like poverty, part-time jobs etc. has not been explored. Identification of such problems may help in predicting children at higher risk of absenting themselves and hence ensuring timely preventive interventions. But, there is paucity of literature comprehensively assessing the various factors leading to school absenteeism. So, we conducted this study to assess the magnitude of school absenteeism and to study its correlates.

Methods

A cross-sectional, school based study was conducted in three government schools in South Delhi. The absenteeism was studied over a 6 month period from July to December 2006. Total of 704 children, of both sexes in the age group 10-15 years were registered as the participants.

At enrolment, information on socio-demographic profile of the students was collected. It included age, sex, class, education and occupation of the parents, their family structure and income. The socio-economic status was calculated as per the Revised Kuppuswami's Scale for determining socio-economic status of urban families (2001).

A pre-designed questionnaire was administered to ascertain the duration of absence and the causes for absenteeism, medical and non-medical. Participants were assured of confidentiality and were inquired about school truancy and various phobias of schools, teachers and subjects. The causes of absenteeism were also ascertained by school records, leave applications and one month's recall by the students. Students, teachers and parents were interviewed whenever needed.

For the purpose of this study, significant school absenteeism is defined as "absent for more than 2 days per month (i.e. 12 days in the 6 month study period).
Data were analyzed using Stata 9.1 software.

Results

A total of 704 students were registered of which 332 (47.16%) were boys. The average absenteeism per

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child was 10.2%. Only 9 children did not miss a single school day.
336 (47.8%) children had significant absenteeism.

Table I

Relationship of Socio-demographic Factors with Significant School Absenteeism

Factors	Total number in each group	Children with significant Absenteeism
Sex*		
Male	332	208 (61.9%)
Female	372	128 (38.1%)
Age group*		
< 14	441	250 (74.4%)
> 14	263	86 (25.6%)
Standard*		
6	132	92 (27.4%)
7	224	122 (36.3%)
8	180	68 (20.2%)
9	168	54 (16.1%)
Birth order*		
1	165	42 (12.5%)
2	276	133 (39.6%)
3	140	83 (24.7%)
4	81	40 (11.9%)
5	42	38 (11.3%)
Mother's education*		
<5 standard	277	180 (53.6%)
>5 standard	427	156 (46.4%)
Father's education*		
<8 standard	206	124 (36.9%)
>8 standard	498	212 (63.1%)
Residence		
City	227	107 (31.8%)
Urban slum	477	229 (68.2%)
Occupation		
Unskilled	62	48 (14.3%)
Semi skilled	114	81 (24.1%)
Skilled	178	83 (24.7%)
Clerk/Shop	273	112 (33.3%)
Semi Professional	77	12 (3.6%)

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GROUP TASK 1

Key references pertaining to a topic are listed below, in random order. Salient findings/conclusions from each reference are also provided. Please integrate, synthesize & summarize these findings into a coherent & brief single-paragraph review. Please follow the ICMJE/Vancouver style for in-text citations. Please include a list of references at the end of the paragraph, in the appropriate sequence.

Note: Entire citations need not be reproduced in the list of references. Serial number, name of first author & year of publication would be sufficient for the purpose of this group task.

Topic: Diabetes & depression
Research theme: Co-existence of diabetes & depression, & the impact of depression on diabetes

Reference: Campayo A, Gomez-Biel CH, Lobo A. Diabetes and depression. Curr Psychiatry Rep 2011; 13(1):26-30.
Key findings/conclusions:
- Increased risks of prevalent depression and incident depression among diabetic patients have been reported in community studies.
- Even more consistent is the finding supporting psychosomatic hypotheses regarding the increased risk of diabetes among depressed patients.

Reference: Bowser DM, Utz S, Glick D, Harmon R. A systematic review of the relationship of diabetes mellitus, depression, and missed appointments in a low-income uninsured population. Arch Psychiatr Nurs 2010; 24(5):317-329.
Key findings/conclusions:
- Individuals with diabetes have an increased incidence of depression across socioeconomic and racial groups.
- The cost and burden of diabetes are greatly increased among individuals with both diabetes and depression versus diabetes alone.

Reference: Egede LE, Ellis C. Diabetes and depression: global perspectives. Diabetes Res Clin Pract 2010; 87(3):302-312.
Key findings/conclusions:
- Coexisting depression in people with diabetes is associated with decreased adherence to treatment, poor metabolic control, higher complication rates, decreased quality of life, increased healthcare use and cost, increased disability and lost productivity, and increased risk of death.

Reference: Schram MT, Baan CA, Pouwer F. Depression and quality of life in patients with diabetes: a systematic review from the European depression in diabetes (EDID) research consortium. Curr Diabetes Rev 2009; 5(2):112-119.
Key findings/conclusions:
- Diabetic individuals with depressive symptoms had a severely lower diabetes-specific quality of life.
- Increased awareness and monitoring for depression is needed within different diabetes care settings.

Reference: Gonzalez JS, Peyrot M, McCarl LA, Collins EM, Serpa L, Mimiaga MJ et al. Depression and diabetes treatment nonadherence: a meta-analysis. Diabetes Care 2008; 31(12):2398-2403.
Key findings/conclusions:
- There exists a significant association between depression and treatment non-adherence in patients with diabetes.

Reference: Mezuk B, Eaton WW, Albrecht S, Golden SH. Depression and type 2 diabetes over the lifespan: a meta-analysis. Diabetes Care 2008; 31(12):2383-2390.
Key findings/conclusions:
- Depression is associated with a 60% increased risk of type 2 diabetes.
- Type 2 diabetes is associated with increased risk of depression.

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GROUP TASK 2

The dissertation topic of Dr. A, a postgraduate student, is - ***"A study of the clinical significance of depression in patients of myocardial infarction"***. Dr. A submits a draft of the review of literature of her dissertation to Prof. X, her dissertation guide. An extract from Dr. A's literature review is provided here. Please analyze the literature review strategy followed by Dr. A, and give your comments.

Note: Your comments should focus on the review method (i.e. the way in which the review has been written/presented), & NOT on the subject matter & specific details of the content.

Frasure-Smith et al[1] conducted a study to assess gender differences in the impact of depression on 1-year cardiac mortality in patients hospitalized for an acute myocardial infarction (MI) Depression in hospital after MI is a significant predictor of 1-year cardiac mortality for women as well as for men, and its impact is largely independent of other post-MI risks.

Lauzon et al[2] prospectively evaluated patients admitted to 5 tertiary care and 5 community hospitals and followed them for 1 year to measure the prevalence and prognostic impact of depressive symptoms after acute myocardial infarction. Depressive symptoms are common after acute myocardial infarction and are associated with a slight increase in risk of in-hospital catheterization and angiography and readmission because of cardiac complications. Death was infrequent, with no statistically significant difference between the 2 groups.

In a study by Strik et al[3], depression appeared to be a predictor of increased health care consumption, but not of major cardiac events such as cardiac death and recurrent infarction in first myocardial infarction (MI) patients up to 6 years post-MI. In contrast to depression, symptoms of anxiety do predict cardiac mortality and recurrent MI in patients following first MI independently of other risk factors of cardiac mortality. Recognition of risk factors for post-MI depression may help the cardiologist to identify patients at risk for depression. Examples of such risk factors are, according to our studies, complications during admission, such as arrhythmic disorders and recurrent angina pectoris, and prescription of benzodiazepines.

In a study by Spijkerman et al[4], four hundred ninety-four MI patients were screened for depression. Patients with depression were compared with patients without on cardiovascular events (fatal or nonfatal) during an average follow-up of 2.5 years. Demographic characteristics and cardiac risk factors were controlled for. It was found that depression was associated with the occurrence of cardiovascular events in both univariate [hazard ratio (HR), 1.84; 95% confidence interval, 1.24-2.72] and multivariate analysis (HR, 1.56; 1.02-2.38). Depression still has an independent impact on cardiac prognosis after MI, but this influence is smaller than found in early studies. Improvements in general care for MI and better recognition and treatment of post-MI depression may have decreased the impact of depression on prognosis.

References

1. Frasure-Smith N, Lesperance F, Juneau M, Talajic M, Bourassa MG. Gender, depression, and one-year prognosis after myocardial infarction. Psychosom Med 1999; 61(1):26-37.
2. Lauzon C, Beck CA, Huynh T, Dion D, Racine N, Carignan S et al. Depression and prognosis following hospital admission because of acute myocardial infarction. CMAJ 2003; 168(5):547-552.
3. Strik JJ, van Praag HM, Honig A. [Depression after first myocardial infarction. A prospective study on incidence, prognosis, risk factors and treatment]. Tijdschr Gerontol Geriatr 2003; 34(3):104-112.
4. Spijkerman TA, van den Brink RH, May JF, Winter JB, van Melle JP, de JP et al. Decreased impact of post-myocardial infarction depression on cardiac prognosis? J Psychosom Res 2006; 61(4):493-499.

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GROUP TASK 3

The dissertation topic of Dr. B, a postgraduate student, is - ***"A study of physical symptoms in depressive disorders"***. Dr. B submits a draft of the review of literature of his dissertation to Prof. Y, his dissertation guide. The introductory paragraph of Dr. B's literature review thus reads as follows:

According to Henningsen et al[1], medically unexplained symptoms of pain and bodily dysfunction are the single most prevalent class of symptoms in primary care. They also have a high prevalence in specialist care and are responsible for a significant proportion of disability in the workforce. They are a defining feature of the different functional somatic syndromes within somatic medicine and of the somatoform disorders within psychiatry. Patients with medically unexplained physical symptoms have been shown to have increased rates of depression and anxiety. This correlation has not yet been reviewed systematically, and several possible explanations exist. The association might signify a reactive increase of depression and anxiety in patients suffering from chronic bodily symptoms.

Dr. B has provided the reference corresponding to this paragraph in his list of references, as follows:

1. Henningsen P, Zimmermann T, Sattel H. Medically unexplained physical symptoms, anxiety, and depression: A meta-analytic review. Psychosomatic Medicine 2003;65:528-33.

Prof. Y is impressed by this paragraph & acquires the article by Henningsen et al. He finds the following introductory paragraph in the article:

Medically unexplained symptoms of pain and bodily dysfunction are the single most prevalent class of symptoms in primary care. They also have a high prevalence in specialist care and are responsible for a significant proportion of disability in the workforce (1–3). They are a defining feature of the different functional somatic syndromes within somatic medicine and of the somatoform disorders within psychiatry. Patients with medically unexplained physical symptoms have been shown to have increased rates of depression and anxiety (3–5). This correlation has not yet been reviewed systematically, and several possible explanations exist. The association might signify a reactive increase of depression and anxiety in patients suffering from chronic bodily symptoms (6).

Prof. Y looks at the list of references provided at the end of the article, & finds that the references corresponding to this paragraph have been listed by Henningsen et al as follows:

1. Kroenke K, Spitzer RL, Williams JBW, Linzer M, Hahn SR, deGruy FV III, Brody D. Physical symptoms in primary care: predictors of psychiatric disorders and functional impairment. Arch Fam Med 1994;3:774 –9.
2. Reid S, Wessely S, Crayford T, Hotopf M. Medically unexplained symptoms in frequent attenders of secondary health care: retrospective cohort study. BMJ 2001;322:767–70.
3. Bass C, Peveler R, House A. Somatoform disorders: severe psychiatric illnesses neglected by psychiatrists. Br J Psychiatry 2001;179:11– 4.
4. Katon W, Sullivan M, Walker E. Medical symptoms without identified pathology: relationship to psychiatric disorders, childhood and adult trauma, and personality traits. Ann Intern Med 2001;134:917–25.
5. Von Korff M, Simon G. The relationship between pain and depression. Br J Psychiatry Suppl 1996;(30):101– 8.
6. Nielson WR, Merskey H. Psychosocial aspects of fibromyalgia. Curr Pain Headache Rep 2001;5:330 –7.

Please analyze the citing/referencing strategy implemented by Dr. B in his review, and give your comments.

Note: Your comments should focus on the citing/referencing method (i.e. the way in which references have been handled), & NOT on the subject matter & specific details of the content.

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GROUP TASK 4

The dissertation topic of Dr. C, a postgraduate student, is - ***"A study of the role of music therapy in perioperative scenarios"***. Dr. C submits a draft of the review of literature of her dissertation to Prof. Z, her dissertation guide. An extract from Dr. C's literature review is provided here, along with the corresponding list of references. Please analyze the citing/referencing strategy implemented by Dr. C in her review, and give your comments.

Note: Your comments should focus on the citing/referencing method (i.e. the way in which in-text citations & the list of references have been presented), & NOT on the subject matter & specific details of the content.

Several researchers have studied the role of music in the control of patients' anxiety in perioperative scenarios. Music can reduce the anxiety and stress of patients in the surgical holding area.[1] Augustin and Hains[2] demonstrated that music can be more beneficial than preoperative instruction alone in reducing ambulatory surgery patients' preoperative anxiety. Patients who listened to their choice of music before surgery in addition to receiving preoperative instruction had significantly lower heart rates than patients in the control group who received only preoperative instruction.

In a controlled study (Haun et al. 2001), it was observed that music produced a significant reduction in anxiety and respiratory rates of women awaiting breast biopsy. A recent study (Wang et al. 2002) evaluated the role of music in the management of preoperative anxiety through a randomized, controlled study. Patients who listened to music before surgery reported lower levels of state anxiety. A recent randomized controlled trial (Cooke et al. 2005) demonstrated that exposure to music resulted in a statistically significant reduction of preoperative anxiety in patients undergoing day surgery.

Patients who listened to their choice of music during surgery with local anesthesia experience significantly lower anxiety levels, heart rates, and blood pressure than patients who did not listen to music.

Allred et al[7] studied the effect of music on postoperative pain and anxiety following total knee arthroplasty. The music group's decrease in pain and anxiety was not significantly different from the comparison rest group's decrease in pain or anxiety. However, statistical findings within groups indicated that the sample had a statistically significant decrease in pain and anxiety over time. In a systematic review of 42 randomized controlled trials of the effects of music interventions in perioperative settings[8], it was observed that music intervention had positive effects on reducing patients' anxiety and pain in approximately half of the reviewed studies.

References

1. Winter MJ, Paskin S, Baker T. Music reduces stress and anxiety of patients in the surgical holding area. Journal of Post Anesth Nurs 1994;9:340-343.
2. Augustin, P. & Hains, A.A. 1996. Effect of music on ambulatory surgery patients' preoperative anxiety. AORN J 1996;63:750,753-758.
3. Haun, Mainous, Looney. Effect of music on anxiety of women awaiting breast biopsy. Behav Med 2001;27:127-132.
4. Wang, S.M., Kulkarni, L., Dolev, J., & Kain, Z.N. 2002. Music and preoperative anxiety: a randomized, controlled study. Anesth Analg;94:1489-94.
5. Cooke M, Chaboyer, Schluter, Hiratos M. The effect of music on preoperative anxiety in day surgery. J Adv Nurs 2005;52:47-55.
6. Mok E, Wong KY. Effects of music on patient anxiety. AORN J;77:396-6, 409.
7. Allred, K.D., Byers, J.F., & Sole, M.L. 2010. The effect of music on postoperative pain and anxiety. Pain Manag Nurs.
8. Nilsson U. The anxiety- and pain-reducing effects of music interventions: a systematic review. AORN J 2008;87:780-807.

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GROUP TASK 5

The dissertation topic of Dr. X, a postgraduate student, is - ***"A study of physical symptoms in depressive disorders"***. Dr. X is in the process of writing the Review of Literature for his dissertation. Dr. X is behind schedule & needs to submit a draft of his dissertation to his guide within two days. While conducting a literature search, he had retrieved the following reference:

Henningsen P, Zimmermann T, Sattel H. Medically Unexplained Physical Symptoms, Anxiety, and Depression: A Meta-Analytic Review. Psychosomatic Medicine 2003;65:528-33.

Dr. X finds that the introductory paragraph of this reference article is highly relevant to his dissertation topic. He extracts the entire introductory paragraph verbatim, along with six citations, & inserts it into his literature review. He hasn't made an attempt to search for and retrieve the six references that the paragraph is based on, but lists all six in his own list of references at the end of the dissertation. The introductory paragraph of Dr. X's literature review thus reads as follows:

Medically unexplained symptoms of pain and bodily dysfunction are the single most prevalent class of symptoms in primary care. They also have a high prevalence in specialist care and are responsible for a significant proportion of disability in the workforce (1–3). They are a defining feature of the different functional somatic syndromes within somatic medicine and of the somatoform disorders within psychiatry. Patients with medically unexplained physical symptoms have been shown to have increased rates of depression and anxiety (3–5). This correlation has not yet been reviewed systematically, and several possible explanations exist. The association might signify a reactive increase of depression and anxiety in patients suffering from chronic bodily symptoms (6).

References

1) Kroenke K, Spitzer RL, Williams JBW, Linzer M, Hahn SR, deGruy FV III, Brody D. Physical symptoms in primary care: predictors of psychiatric disorders and functional impairment. Arch Fam Med 1994;3:774 –9.
2) Reid S, Wessely S, Crayford T, Hotopf M. Medically unexplained symptoms in frequent attenders of secondary health care: retrospective cohort study. BMJ 2001;322:767–70.
3) Bass C, Peveler R, House A. Somatoform disorders: severe psychiatric illnesses neglected by psychiatrists. Br J Psychiatry 2001;179:11– 4.
4) Katon W, Sullivan M, Walker E. Medical symptoms without identified pathology: relationship to psychiatric disorders, childhood and adult trauma, and personality traits. Ann Intern Med 2001;134:917–25.
5) Von Korff M, Simon G. The relationship between pain and depression. Br J Psychiatry Suppl 1996;(30):101– 8.
6) Nielson WR, Merskey H. Psychosocial aspects of fibromyalgia. Curr Pain Headache Rep 2001;5:330 –7.

Please analyze the strategy followed by Dr. X, and give your comments. *Your comments should focus on the review strategy, & NOT on the subject matter & specific details of the content.*

GROUP TASK 6

An excerpt from a reference article (*Cameron, O.G., 2009. Visceral brain-body information transfer. Neuroimage 47, 787–794)* is given below. Please convert the in-text citations & the list of references into the Vancouver format.

Discovery of connections between the brain and the immune system is more recent than for the endocrine system, but there is now a great deal of evidence that immune function affects the CNS and vice versa (Tracey, 2002; Glaser and Kiecolt-Glaser, 2005). It has been suggested that the normal inflammatory response is usually localized, but that under some circumstances a broader reaction occurs including involvement of the CNS (Tracey, 2002). Data supporting afferent connections are substantial, such as receptor binding in the hypothalamus and in numerous other brain regions (Haas and Schauenstein, 1997).

References

Glaser, R., Kiecolt-Glaser, J.K., 2005. Stress-induced immune dysfunction: implications for health. Nat. Rev. Immunol. 5, 243–251.

Haas, H.S., Schauenstein, K., 1997. Neuroimmunomodulation via limbic structures - the neuroanatomy of psychoimmunology. Prog. Neurobiol. 51, 195–222.

Tracey, K.J., 2002. The inflammatory reflex. Nature 420, 853–859.

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GROUP TASK 7

The dissertation topic of Dr. X, a postgraduate student, is - **"A study of the prevalence of ocular diseases among patients with alcohol dependence"**. The dissertation is nearing completion. Dr. X has submitted the first draft of his Review of Literature to his guide & co-guide. His review includes *several pages containing theoretical aspects of alcohol dependence & the toxic effects of alcohol on the eye, & a few pages that summarize the findings/conclusions of 40 relevant studies*. The guide & co-guide scrutinize the review carefully & inform Dr. X that his Review of Literature does not provide sufficient points/arguments supporting the need for this study, & does not adequately justify the selection of this topic for his dissertation. Dr. X approaches you for some advice & help. You have seen neither his review nor the references. Keeping his topic in mind, please list a few **salient general principles** that Dr. X has to follow while correcting/rewriting the Review of Literature, in order to ensure that the review explains & justifies the need for this study. In other words, list the specific review strategies that will enable a reader to understand why Dr. X thinks that it is necessary to take up such a topic for research.

GROUP TASK 8

Dr. Y, a final year postgraduate student in a busy clinical speciality, is currently writing the Review of Literature for her dissertation. She has been collecting references since her first year of PG training. However, *she has not used reference management software such as Zotero or Reference Manager to store & organize her references*. She has conducted several PubMed searches online using various search strategies. Unfortunately, she hasn't created a PubMed account & has not saved any of her searches within PubMed. She has stored several PubMed webpages containing relevant abstracts as HTML documents in her computer. In some cases, she has copied abstracts from PubMed & pasted them into a Microsoft Word document. Fortunately, most of the abstracts contain PMID numbers. She has been manually inserting in-text citations in the Harvard style (author-year) **without** using reference management software. Her list of references continues to grow, since her guide & co-guide have been requesting her to keep adding the most recent references. She is also required to repeatedly edit the review. Besides, she feels overwhelmed by the prospect of preparing the list of references. The process is becoming increasingly cumbersome, tedious & unmanageable, & the dissertation submission deadline is just 2 months away.

Dr. Y is eager to simplify & expedite the process, & wants to know whether it would be feasible and beneficial to start using reference management software *at this stage* of her dissertation. She also needs to know HOW this can be achieved. Please analyze the scenario and list simple & practical options for Dr. Y.

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Family size*		
<4	158	63 (18.8%)
5	227	80 (23.8%)
6	115	67 (19.9%)
7	107	61 (18.25%)
8	97	65 (19.3%)
Family income/mo (Rs.)*		
£6,10	84	78 (23.2%)
6,101-10,160	97	92 (27.4%)
10,161-15,280	115	104 (30.9%)
>15,281	408	62 (18.5%)

***P <0.01.**

Male sex, increasing birth border and family size, lower parental education and income were identified to be associated with significant school absenteeism (***Table* I**). Causes responsible for their school absenteeism, as reported by the students are listed in ***Table* II**.

Table II

Causes of School Absenteeism Reported by Students

Cause	Absentees n = 336	Others n = 368	P value
Part-time job	72 (21.4%)	0 (0%)	<0.001
Illness	182 (54.2%)	187 (50.8%)	0.37
Chronic illness	51 (15.2%)	14 (3.8%)	<0.001
Perception of ill health	150 (44.64%)	129 (35.1%)	<0.001
Family function	162 (48.2%)	115 (31.2%)	<0.001
Family illness	103 (30.6%)	62 (16.85%)	<0.001
Family problem	141(42%)	36 (9.8%)	<0.001
School phobia	159 (47.32%)	82 (22.3%)	<0.001
School truancy	59 (17.6%)	2 (0.5%)	<0.001
School load	167 (49.7%)	121(32.9%)	<0.001

References:

2. Besculides M, Heffernan R, Mostashari F, Weiss D. Evaluation of school absenteeism data for early outbreak detection, New York City. BMC Public Health 2005; 5: 105. {percentage of children with school absenteeism in different schools range from 7.3% to 17.8%. Adolescent children were more likely to remain absent compared to younger children}

8. Awasthi S, Sharma A. Survey of school health and absenteeism in Lucknow. Indian Pediatr 2004; 41: 518. {Prevalence of school absenteeism is 4.7%. Male children are more likely to remain absent from

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school}

11. Ananthakrishnan S, Nalini P. School absenteeism in a rural area in Tamil Nadu. Indian Pediatr 2002; 39: 847-850.{ Of children with school absenteeism, 50.2% were males and 49.8% were females. School absenteeism is more common in younger children}

12. Kaplan BA, Mascie Taylor CG, Boldsen J. Birth order and health status in a British national sample. J Biosoc Sci 1992; 24: 25-33. (In first born child, school absenteeism is seen in 8%, in second order birth it is 12% and in 3rd order it is 22.4%)

13. Rumberger RW. Dropping out of high school: the influence of race, sex, and family background. Am Educ Res J 1983; 20: 199-220.{75% of children with school absenteeism were from poor families and 80% of mothers were uneducated}

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GROUP TASK 1: FOR GROUPS A & B

GIVEN TIME: 30 MINUTES

TASK TO BE DONE: READ THE FOLLOWING STUDY, AND WRITE THE DISCUSSION

Iron Deficiency as a Risk Factor for Simple Febrile Seizures– *A Case Control Study*

Introduction:

Febrile seizures are the commonest cause of seizures in children, occurring in 2-5% of children [1]. Iron deficiency is the commonest micronutrient deficiency worldwide, and is a preventable and treatable condition [7]. Iron is needed for brain energy metabolism, for metabolism of neurotransmitters and for myelination. Thus, iron deficiency may alter the seizure threshold of a child [8, 9]. Iron deficiency is postulated as a risk factor for febrile seizures in children [10, 11]. We, therefore, studied the association between iron deficiency and simple febrile seizures.

Methods

This case control study was done in the Department of Pediatrics, in a tertiary care Hospital during January 2011 to December 2011. Cases were children of age group 6 months to 3 years presenting with simple febrile seizures to the Pediatrics Emergency Department and wards of the hospital during the study period. Diagnostic criteria for simple febrile seizures was based on AAP Clinical Practice Guidelines (2); those who did not satisfy AAP criteria and those who were on iron supplements were excluded. Consecutive cases were selected for the study and concurrent controls were selected from the same setting and included febrile children of age group 6 months to 3 years who presented with short duration fever (<3 days) but without seizures. Cases and controls were selected in 1:1 ratio.

After informed consent, detailed history was elicited and physical examination was done. Iron deficiency was diagnosed by hemoglobin , serum ferritin, serum iron and red cell width distribution ratio (RDW), based on WHO recommended standard values [7]. Other variables

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studied are sex, socioeconomic status and protein energy malnutrition (IAP classification).

Sample size was calculated using standard procedure and analysis was done using SPSS version 11.

Results:

Criteria	Cases (n=154)	Controls (n=154)	P value
Female	71(46.15%)	81(52.6%)	0.254
Social Class 4	115(74.7%)	109(70.8%)	0.443
Iron deficiency	98 (63.6%)	38 (24.7%)	0.001
Malnutrition	62 (40.3%)	52(33.8%)	0.238
Rural / urban	69 (44.8%)	83 (55.2%)	0.234

154 cases and 154 controls were included in the study. The average age of cases and controls was 17.5±8.81 and 17.6±8.54 months, respectively. Iron deficiency is found to be significantly associated with simple febrile seizures (***Table*** I). Variables Malnutrition (p value 0.238), socio-economic status (p value 0.443) and sex of the child (p value 0.254) were found to be insignificant. No difference between rural and urban children (p value 0.234). All children who had reduced HB also had reduced serum iron and ferritin levels in their blood.

Discussion:

References

12. Pisacane A, Roland P, Sansone R, Impagliazzo N, Coppola A, D' Appuzo A. Iron Deficiency anaemia and febrile convulsions: A case control study. BMJ. 1996;313:343
{age group studied: 6 months to 3 years; iron status was measured based on Hb and serum iron. Iron deficiency anemia in controls was 10 % and in cases 50%}

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13. Dawn SH, Jonatan T, Jerome Y, Don S. The association between iron deficiency and febrile seizures in childhood. Clin Pediatr. 2009;48:420-6.
{iron status was measured based on Hb and serum iron. Febrile seizures was 1.83 times more likely in iron deficient children aged 3 months to 5 years}

14. Daud AS, Batieha A, Ekteish A, Gharaibeh N, Ajlouni S, Hijazi S. Iron status: a possible risk factor for first febrile seizures. Epilepsia. 2002;43:740-3.
{Iron status was assessed based on the serum ferritin levels only. The mean serum ferritin level in the cases was 29.5 mcg/L, and in the controls 53.5 mcg/L}

15. Rajwanti KV, Praveen GD, Swati K, Ghosh K. Iron deficiency as a risk factor for first febrile seizure. Indian Pediatr. 2010;47:437-9.
{Both Hb and serum ferritin were studied in this study. The mean serum ferritin level in children with first febrile seizures (31.9±31.0 mcg/L) and in controls (53.9±56.5 mcg/L) (P=0.003). Mean hemoglobin value of cases (9.4±1.2 g/dL) and controls (9.5±1.0 g/dL) (P=0.7)}. This study was done in Mumbai}

16. Rao S. Assessment of iron status; ICMR .
{Serum ferritin is the early indicator of iron deficiency in the body; changes in serum iron and Hb occurs much later}

17. Kanth et al. Nutritional status in upper socioeconomic status:
{50% of children <5 years belonging to India's upper most economic group have less Hb values}.

18. Nutritional status of Indian children. NFHS survey III.
{iron deficiency in rural community of India is 74% and urban community of India 66 % in children < 3 years}

19. Kumar et al. Utility of serum ferritin in diagnosing iron status. Acta Hematologica 1998.
{Serum ferritin is an acute phase reactant and can rise in any infection and inflammation.}

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(WRITING INTRODUCTION) GROUP TASK – I

Randomised, clinically controlled trial of intensive geriatric rehabilitation in patients with hip fracture: subgroup analysis of patients with dementia

The number of demented patients with hip fracture is increasing as the population ages. In Finland, the prevalence of moderate to severe dementia in people aged 65 years and over is 6.7 per 1000.[1] Alzheimer-type dementia has been reported to increase the risk of hip fractures, with an odds ratio of 6.9.[2] Dementia was the main contributor to the development of functional dependence and decline in a community based study of residents older than 74 years in the Kungsholmen project, Sweden.[3] Dementia has also been associated with less favourable outcome of rehabilitation after hip fracture.[4–12] However, selected cognitively impaired patients with hip fracture were as likely as mentally normal patients to return to the community in a specialised geriatric inpatient rehabilitation programme.[13]

This study aimed to determine the effect of intensive geriatric rehabilitation after surgery for hip fracture in elderly patients. As a preplanned part of this trial, we studied whether cognitively impaired patients can benefit from geriatric assessment and intensive rehabilitation.

Q. Give your Comment

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(WRITING INTRODUCTION)GROUP TASK - II

Randomised, clinically controlled trial of intensive geriatric rehabilitation in patients with hip fracture: subgroup analysis of patients with dementia

Earlier studies provide conflicting results on the benefits of geriatric assessment and treatment in rehabilitation hospitals for elderly patients with hip fractures.[14] A meta-analysis suggested that geriatric assessment programmes with intensive long term management can improve survival and function in older people.[15] No randomised studies have been published on the impact of geriatric rehabilitation on demented patients with hip fracture.

Over the past decade, the median length of stay in orthopaedic wards for patients with hip fracture in central Finland healthcare district has fallen from 19 to five days, and 81% of the patients are now referred to local health centre hospitals for rehabilitation after surgery.[16] Patients in local hospitals owned by local communities are treated by general practitioners. Local hospitals usually have physiotherapists, but other resources for rehabilitation vary from hospital to hospital. About half of the patients in these hospitals are in long term institutional care. In the United States the mean length of hospital stay decreased from 21.9 to 12.6 days between 1981 and 1986.[17] Shorter stays were associated with less inpatient treatment and an increase in placement in long term nursing home. [17] [18]

This study aimed to determine the effect of intensive geriatric rehabilitation after surgery for hip fracture in elderly patients. As a preplanned part of this trial, we studied whether cognitively impaired patients can benefit from geriatric assessment and intensive rehabilitation.

Q. Give your Comment

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(WRITING INTRODUCTION)GROUP TASK – III

Routine vaccinations and child survival: follow up study in Guinea-Bissau, West Africa

Measles vaccine is strongly associated with better childhood survival in developing countries. [1 2] Since this effect cannot be explained by the specific prevention of measles, [1 3 4] standard measles vaccine may be associated with a non-specific beneficial activation of the immune system.[1] This effect would be observed only in areas with high mortality.[5] Similar studies of BCG, polio, and diphtheria, tetanus, and pertussis vaccines have not been carried out in countries with a high mortality.

Worldwide, BCG is the most widely used vaccine and has been recommended for tuberculosis control in developing countries for more than 40 years. The protection provided by BCG is controversial as it has variable efficacy in different settings. [6 7]Routine vaccinations with diphtheria, tetanus, and pertussis vaccine and polio vaccine provide good protection against the specific diseases. The recommended schedule is based on studies of seroconversion and protection and on assumed feasibility of the schedule.[8] The effect of these vaccines has been assumed to be proportionate to the impact of the specific infections.

Guinea-Bissau in West Africa is one of the world's poorest countries. It has the sixth highest childhood mortality according to Unicef estimates.[9] Since the early 1990s we have followed a representative cohort of 10 000 mothers and their children from the rural areas of Guinea-Bissau. Because the survival of recipients of routine vaccines has not been investigated in areas with high mortality, we examined the association between vaccination and survival in rural Guinea-Bissau.

Q. Give your Comment

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(WRITING INTRODUCTION)GROUP TASK - IV

Randomised trials of secondary prevention programmes in coronary heart disease: systematic review

Disease management programmes are increasingly advocated as a means of improving management of and outcomes for patients with coronary heart disease.[3–5] Disease management has been defined as "a combination of patient education, provider use of practice guidelines, appropriate consultation, and supplies of drugs and ancillary services."[3] Although the specific elements of these programmes vary across different settings and disease states, great enthusiasm exists for coronary heart disease management programmes that use multidisciplinary teams and specialised clinics dedicated to the prevention of death or of recurrent myocardial infarction.[4]

Despite this enthusiasm the effectiveness of these programmes in reducing morbidity and mortality is largely unknown. Many reviews have shown that cardiac rehabilitation programmes improve outcomes in survivors of myocardial infarction,[6–8] but these conclusions are based largely on eight trials that tested exercise programmes of varying intensity. Only two of the trials included in these reviews evaluated disease management approaches, and neither of these trials found a benefit from the intervention. Most subsequent studies of multidisciplinary disease management programmes have been uncontrolled before-after case series, and the results of the few randomised trials that have been done are far from conclusive owing to inadequate power. In the absence of a conclusive trial, the data should be examined in a systematic way in an attempt to draw valid conclusions. ***

Q. Give your Comments

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Kish method and interviewed. A total of 300 spouses were also selected by systematic random numbers and interviewed.

Q. Give your comments

(WRITING INTRODUCTION)GROUP TASK – VII

Alcohol Use and STI among men in India: Evidences from a national household survey

IJCM

Studies on alcohol use behavior have drawn greater attention of social scientists and public health researchers in the recent past due to its hypothesized association with sexually transmitted infections (STI). The consistent relationship of alcoholism with risky sexual behavior as well as with STIs has been established by several studies in different parts of the world. [1],[2],[3],[4] In India, a survey of female sex workers (FSWs) and their clients conducted in 2006 by the National AIDS Control Organization (NACO) revealed that about 46% of the FSWs and 78% of the clients ever consumed alcohol. Of these, 11% of FSWs and 17% of clients consumed alcohol regularly before sex. [5] Another study conducted among long-distance truck drivers in the country found that truckers who consumed alcohol were about 2.7 times more likely to frequent FSWs than their counterparts. [6] Consumption of alcoholic beverages is shown to be associated with risky sexual behavior as well as with STI/HIV among clients of FSWs in Mumbai. [7] A study done among migrant FSWs as well as migrant male workers in 14 districts of four high HIV prevalent states in India concluded that more than half of the FSWs and their clients consumed alcohol prior to sex and alcohol use was independently associated with unprotected sex. [8] Alcohol use has also been concluded as an independent cofactor for HIV risk behavior among those being treated for psychiatric disease [9] as well as those addicted to injecting drug use. [10]

Alcohol consumption can enhance risky behavior in numerous ways, e.g., leading to more sexual partners, difficulty in remembering to use a condom, or being unable to use it correctly. Also, it may promote a social environment in which unprotected sex is more likely to occur. [7],[11]

The STI prevalence is found to be higher among those men who consume alcohol than their counterpart irrespective of their sociodemographic status. Though no information on risky sexual behavior has been collected in the survey, the increased STI prevalence among those

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who consume alcohol in the study is suggestive of the risky sexual practices under influence of alcohol among men in the country. The findings corroborate earlier small-scale studies carried out in low socioeconomic communities of Mumbai, which have shown a significant association between frequency, quantity, and types of alcoholic drinks with risky sexual behavior and presence of STIs among adult men. [12],[13] *It may be noted that the present study has not analyzed separately the viral and bacterial STIs because of small number of observations for each type of STI. Hence, in spite of such limitations as above about the availability of data to construct the pathways through which alcohol mediate with increased STI prevalence, the present study provides observed evidences that alcohol use is critically positively associated with the risk of acquiring STI even among so called low-risk general men in the country. This clearly suggests that prevention programmes need to recognize that alcohol use is likely to influence the ability to practice safer sex and hence there is a need to integrate alcohol risk reduction into STI/HIV prevention programmes in the country.*

The foregoing studies have investigated the possible associations between alcohol use and risk of acquiring STI including HIV among high-risk population including FSWs, clients, long distance truck drivers, migrant male workers, and injecting drug users. [5],[6],[7],[8],[10] Little is known about correlates of alcohol consumption and its association with STI/HIV among general adult men in the country. [12],[13] It is in this light, the present paper has attempted to examine sociodemographic determinants of alcohol use and its association with the prevalence of STIs as measured by biological tests among adult men in India. It has used a nationally representative large-scale household sample survey to examine the associations.

Q. Comments on the above

(WRITING INTRODUCTION)GROUP TASK – VIII

Dengue Incidence in Urban and Rural Cambodia: Results from Population-Based Active Fever Surveillance, 2006–2008

Dengue remains a major public health problem in tropical and sub-tropical countries despite aggressive efforts to control the mosquito vector [1]–[3]. Every year, an estimated 50–100 million cases of dengue fever occur and 250,000 to 500,000 cases of the more severe form, dengue hemorrhagic fever (DHF), are reported depending on epidemic activity [4]. However, the true incidence of dengue fever is not known in most disease endemic countries. Several dengue vaccine candidates have been developed and are currently being tested in clinical trials [5], [6]. Accurate estimates of dengue disease burden based on robust estimates of disease incidence will become an

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important factor in the public-health decision making process for endemic countries regarding the use of a safe and effective vaccine [7], [8].

In Cambodia (estimated population: 14.4 million), dengue is highly endemic and affects mainly children [9]. However, due to limited resources, the National Dengue Control Program (NDCP), which manages the national dengue reporting system, only accepts reports of clinically diagnosed cases who are <16 years of age and have been hospitalized [9]–[11]. As a result, national incidence data is thought to substantially underestimate the actual incidence of dengue since most patients are not hospitalized [11], [12]. Secondly, inherent to the NDCP case definition, the burden of dengue in late adolescence is unknown.

Historically, dengue has been considered a predominantly urban disease of tropical countries [1], probably because many early studies of dengue epidemiology were performed in urban settings and observations that annual increases in mild and severe disease incidence usually emanate from urban centers [1], [13]–[15]. However, while a high incidence of disease has been reported from rural and urban areas [16]–[18], to our knowledge no studies have compared dengue incidence in contiguous rural and urban settings.

Cambodia's national data have indicated high dengue incidences in both rural and urban districts [9]. To make a robust estimate of the actual incidence of symptomatic dengue virus (DENV) infection (i.e. dengue disease burden) in children and adolescents living in rural and urban areas of Cambodia and to describe other aspects of the epidemiology of dengue, we conducted active, community-based fever surveillance combined with diagnostic testing for DENV infection in the largest province in Cambodia during 2006–2008.

*Active, community-based fever surveillance was conducted in Kampong Cham (KC) province from 2006–2008 mostly during May–November, which is the rainy season and associated with increased vector activity. KC has the largest population in Cambodia and is located 120–180 km east of Phnom Penh. The provincial capital, KC town, has a population of approximately 90,000 (**Figure 1**) and a provincial hospital which has served as a sentinel site for NDCP dengue surveillance. We selected a convenience sample of villages from two rural districts located within ~60 km radius of KC town and three districts within the KC town urban area. The population density within the urban area was estimated at ~1900 persons/km^2 and ~450 persons/km^2 within the rural villages.*

Q. Comment on the above Introduction.

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(WRITING INTRODUCTION)GROUP TASK – V

Mass drug administration coverage evaluation survey for lymphatic Filariasis in Bagalkot and Gulbarga districts

Lymphatic filariasis (LF) is one of the important public health and socioeconomic problem faced by many developing countries in the world.[1] It is endemic in 83 countries and territories, with more than a billion people at risk of infection. Nearly 120 million people are affected worldwide of whom about 40 million are incapacitated and disfigured by the disease. It is one of the world's leading causes of permanent and long-term disability with an estimated 5.1 million disability adjusted life years (DALYs) are lost due to this disease. [2],[3]

The 5 th MDA campaign in the eight LF endemic districts of Karnataka state was held on November 11, 2008, followed by mopping up activities on two successive days. A combination of single dose of DEC and albendazole tablets was distributed to the eligible population of the districts by drug distributors. The entire implementation of the programme was supervised by concerned district malaria officer and chief medical officer at the regional office for health and family welfare.

Q. Give your comment

(WRITING INTRODUCTION)GROUP TASK – VI

An epidemiological study of mental disorders at Pune, Maharashtra

The WHO Global Burden of Disease study estimates that mental and addictive disorders are among the most burdensome in the world, and their burden will increase over the next few decades. The mental and behavioral disorders account for about 12% of the global burden of diseases. By 2020, it is likely to increase to 15%. [1] Depression, alcohol use disorders, schizophrenia and bipolar disorders constitute the top 10

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conditions contributing to the global burden of disease among the age group of 15-44 years. Mental and behavioral disorders are present, in about 10% of the adult population, at any given point of time. [2] However, these estimates and projections are based largely on literature review rather than cross-national epidemiological surveys.

In India, little is known about the extent, severity and unmet need of treatment of mental disorders. Few studies on the epidemiology of mental disorders have focused on prevalence at their isolated sites. The metaanalysis of available Indian studies carried out by Reddy and Chandrasekhar [3] revealed the overall prevalence of mental disorders as 5.8% among the population. A review analysis of 15 epidemiological studies by Ganguli [4] on the prevalence of mental disorders in India estimated the national prevalence of all mental disorders as 70.5 per 1000 in the rural and 73 per 1000 in the urban population. Most of the Indian studies had limitations of properly selected study population based on scientifically valid sampling techniques, and selected the study population based on convenience due to availability of existing resources. Thus, there was a need to carry out rigorously implemented general population surveys to assess the prevalence of mental disorders among the urban population at Pune, Maharashtra.

The study was undertaken to estimate the lifetime and 12-month prevalence rates of specific mental disorders (as per ICD-10 of WHO-1992 edition) among the urban population, sociodemographic correlates of mental disorders and to assess the service utilization in individuals with mental disorders. The study attempted to form a basis for formulating the mental health need of the community to address unmet care.

The study was conducted at Pune city of Maharashtra state. The catchment population in the study covered the urban population of Pune city, about 25,13,776 based on the year 2001 census data, residing in Pune Municipal Corporation with an area of 146.14 sq km. Administratively, the Pune Municipal Corporation is divided into four subdivision levels. There are 48 Prabhags (Khands) divided into 161 wards and 4269 census enumeration blocks. Data listing was obtained from the census office from recent census of 2001 data. All 161 wards and 4269 census enumeration blocks were included in the sampling frame. Each census enumeration block of Pune city, composed of about 43-207 households, was utilized for sampling purpose, adopting a stratified multistage systemic sampling scheme with probability proportion to size (PPS) measures, [2] *which ensured an equal probability for every eligible individual in the target population to be selected in the sample. A minimum sample size of 3000 respondents, including 300 spouses, were planned (assuming the prevalence rate of mental disorders of 7% with 95% confidential level, deviation of 2 and keeping in mind the minimum drop out/nonresponse of 20%). All the blocks were serially numbered from 1 to 4269, of which 100 census enumeration blocks were selected by systematic sampling fractions. A sample fraction of 42.7 was obtained by dividing 4269 by 100. From the first random number, every 42.7 th blocks were sampled. Location of each block sampled was traced back to ward location. From each census enumeration block sampled, 27 households were selected by computer-generated random numbers. From each household, one eligible individual was selected by the*

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GROUP TASKs

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Introduction (Handout)

Why did I do this study?

1. One paragraph of introduction to the subject

- It is always better to begin with a background -historical and theoretical
- To describe the problem statement in the World..... Nation..... State.... & District level
- Short notes what researches say
- Can write some theoretical part on the subjects from the Reference Text Book also

2. One or two paragraphs of the lacunae in current knowledge / or controversies

- tells particularly about the deficiency of adequate knowledge about the subjects or
- Very less studies have been conducted in this particular subject / field and that's why....
- Controversies of knowledge about the subject; drugs dosage, duration; adverse effect etc.

3. Therefore this study was done with the intention of ..... STATING THE AIMS OF THE STUDY

NB: LET INTRODUCTION BE THE LAST WRITING EXERCISE:

- Experts insist on taking up dissertation introduction writing at the end of the dissertation.
- Such a step ensures the quality and completeness of a dissertation introduction.
- An introduction provides a complete overview, which can only be reached after having completed the dissertation.
- Though the objectives are clear in the beginning, the success and limitations of the research methodology used can only be identified after analysis.

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GROUP 1

Task – 1

Choose a figure/chart appropriate for the situations/data given below and draw the figure using Excel.

Situation and Data

12,453 subjects in a city were interviewed for addiction to drugs and the following data were obtained:

Category	No.
No addiction	2375
Opiates	1284
Cocaine	3456
Amphetamine	2478
Cannabis	2312
Hypnotics	548

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Task 2

The given below is the first paragraph of the Result section of an article.Comment.

Results

Serum Triglycerides, Cholesterol, LDL, VLDL concentration in renal failure patients were found to be significantly high compared with control group ($p<0.001$). Serum HDL and albumin concentration in renal failure patients were found to be significantly lower compared with control group ($p<0.001$). The result demonstrated significant ($p < 0.001$) elevation in serum Cholesterol, Triglyceride, LDL-Cholesterol, VLDL concentration in renal failure patients when compared with those of the control group, while HDL- Cholesterol,

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Task 3

Observe the Table given below ad give your comment and suggestion to improve the Table.

and decrease the flow of blood. These

S.No.	Serum Lipid Profile	Male	Female	p Value
1	Cholesterol (mg/dl)	238.05 ± 63.20	229.08 ± 58.00	Non significant
2	Triglycerides (mg/dl)	168.76 ± 81.38	203.03 ± 75.38	Non significant
3	HDL cholesterol (mg/dl)	39.82 ± 9.32	40.86 ± 9.29	Non significant
4	LDL cholesterol (mg/dl)	159.12 ± 59.23	144.58 ± 56.78	Non significant
5	Albumin (g/dl)	3.93 ± 0.68	3.98 ± 0.58	Non significant

Table.2: Effect of Sex on Serum Lipid Profile and Albumin Concentration in Renal Failure Patients

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Group 2

Task – 1

Choose a figure/chart appropriate for the situations/data given below and draw the figure using Excel.

Situation and data

Blood sugar and endogenous insulin levels were measured in 10 diabetic subjects to find out the relationship.

The following data were obtained:

Insulin in IU	Blood sugar in mg%
20	282
29	246
34	193
25	256
39	180
10	404
18	264
6	502
24	250
33	201

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Task 3

The given below is the first paragraph of the Result section of an article. Comment.

Results

Liver Function Tests:

Table No. 1 shows Mean & SD values of Total Bilirubin, ALT, AST, ALP, GGT and Albumin in both control group and test group with the p values.

Total Bilirubin : The normal range of Serum total Bilirubin in pregnant women is 0.20 ± 1.0 mg/dl . Table 1 shows the means value of total bilirubin in controls is 0.7 ± 0.12 and in test group is 0.83 ± 0.16 . There was no much difference found in the Total Bilirubin levels in both control group and test group.

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Group 3

Task – 1

Choose from the list a figure appropriate for the situations/data given below and draw the figure using Excel. The data are given in the CD.

Blood samples were taken at the following timings after oral administration of 1g of paracetamol in 10 volunteers. The samples were analysed for concentration.

Min	Mean Conc. In mcg	SEM
15	21.5	3.9
30	49.6	4.3
60	85.3	5.2
120	92.4	4.7
180	68.3	4.4
240	44.8	7.2
300	19.7	2.7

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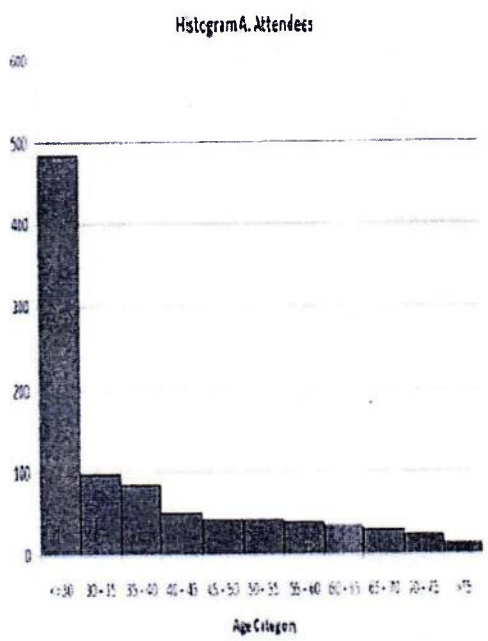
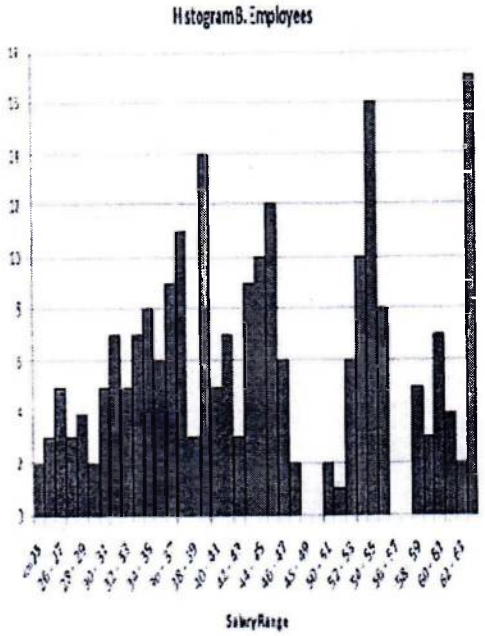
Task 2

5.4. Figure 5.14 shows two histograms. Histogram A represents the ages of people attending a recent event: histogram B represents the salary ranges of employees at a company. Each of these histograms could be improved in order to provide a better picture of the underlying data. For each, explain why the given histogram is less-than-ideal, and explain what you would do to improve it. In other words, how would you go about making a better histogram?





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Task 3

Give your comments and suggestions to improve the table given below:

Parameters	Control group	Test group	p Value
	MEAN ± SD	MEAN ± SD	
Total Bilirubin	0.70 ± 0.12	0.83 ± 0.16	>0.05
ALT	22.48 ± 4.29	27.2 ± 4.4	>0.05
AST	20 ± 2.82	45.64 ± 4.8	<0.001
ALP	136 ± 9.81	228 ± 15.6	<0.01
GGT	13.8 ± 2.39	45.68 ± 4.7	<0.01
Albumin	3.03 ± 0.34	3.29 ± 0.39	>0.05

TABLE 1: The Mean ± SD Values of Total Bilirubin, ALT, AST, ALP, GGT & Albumin

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Group 4

Task – 1

Choose from the list a figure appropriate for the situations/data given below and draw the figure using Excel. The data are given in the CD.

Situation and data

The diastolic blood pressure levels were analysed in 3 different age groups of 6 volunteers each after iv administration of 1 ml of saline and 5 mg hypoten (new drug)

Mean diastolic BP in different age groups

Drugs	16-30	35-50	60-80
Control	15	21.5	3.9
Before saline	30	49.6	4.3
After saline	60	85.3	5.2
Before hypoten	120	92.4	4.7
After hypotem	180	68.3	4.4

Drugs	Age Group		
	16-30	35-50	60-80
Before Saline	70	75	90
After Saline	85	95	100
Before Hypotonic	100	110	140
After Hypotonic	70	80	100

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Task2

Which graph would you recommend to convey the data in the given table in a more effective way.

Table3: Comparison of lipid profile between obese and non-obese males.

Variables	Means		T- test (df=58)	P value
	Obese	Non-obese		
TC (mg/dl)	188.5 ± 33.26	152.73 ± 22.5	-4.866	0.000*
TAGs (mg/dl)	177.57± 67.41	108 ± 18.70	-5.373	0.000*
HDL (mg/dl)	34.35 ± 8.95	44.03 ± 11.00	3.738	0.000*
LDL(mg/dl)	112 ± 47.33	96.73 ± 26.48	-1.618	0.1111
HDL/LDL RATIO	0.3± 0.11	0.4 ± 0.36	2.542	0.0011*

*indicates p<0.05 P<0.001(*) was the level of highly significance

Denotes measurement of levels in serum

TC—Total cholesterol TAGs – Triacylglycerols

HDL—High Density lipoprotein LDL—Low Density lipoprotein

A detailed lipid profile was undertaken in obese and non-obese and the results are summarized in Table 3. The results suggest that the levels of total cholesterol, TAGs and HDL were quite significant. The HDL/LDL ratio was also significant.

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Group 5

Task – 1

Choose a figure/chart appropriate for the situations/data given below and draw the figure using Excel.

Situation and data

The heights of adult subjects were measured and the following data were obtained:

Height category in cm	No. of subjects falling in the category
100-110	2
110-120	32
120-130	56
130-140	101
140-150	223
150-160	454
160-170	287
170-180	132
180-190	61
190-200	27
200-210	1

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Task 3

Comment on the given table and suggest how the table can be improved?

Table 4: Correlation of insulin resistance and insulin with cardiometabolic risk factors

Parameters	Insulin	Insulin resistance (HOMA-IR)
BMI	0.81**	0.78**
WHR (waist-hip ratio)	0.93**	0.84**
TAG	0.15	0.14
HDL	0.26*	0.26*
Mean arterial BP	0.75**	0.74**
Waist circumference (WC)	0.49*	0.46*

** Correlation is significant at the $p < 0.01$ level (2-tailed).
* Correlation is significant at the $p < 0.05$ level (2-tailed).

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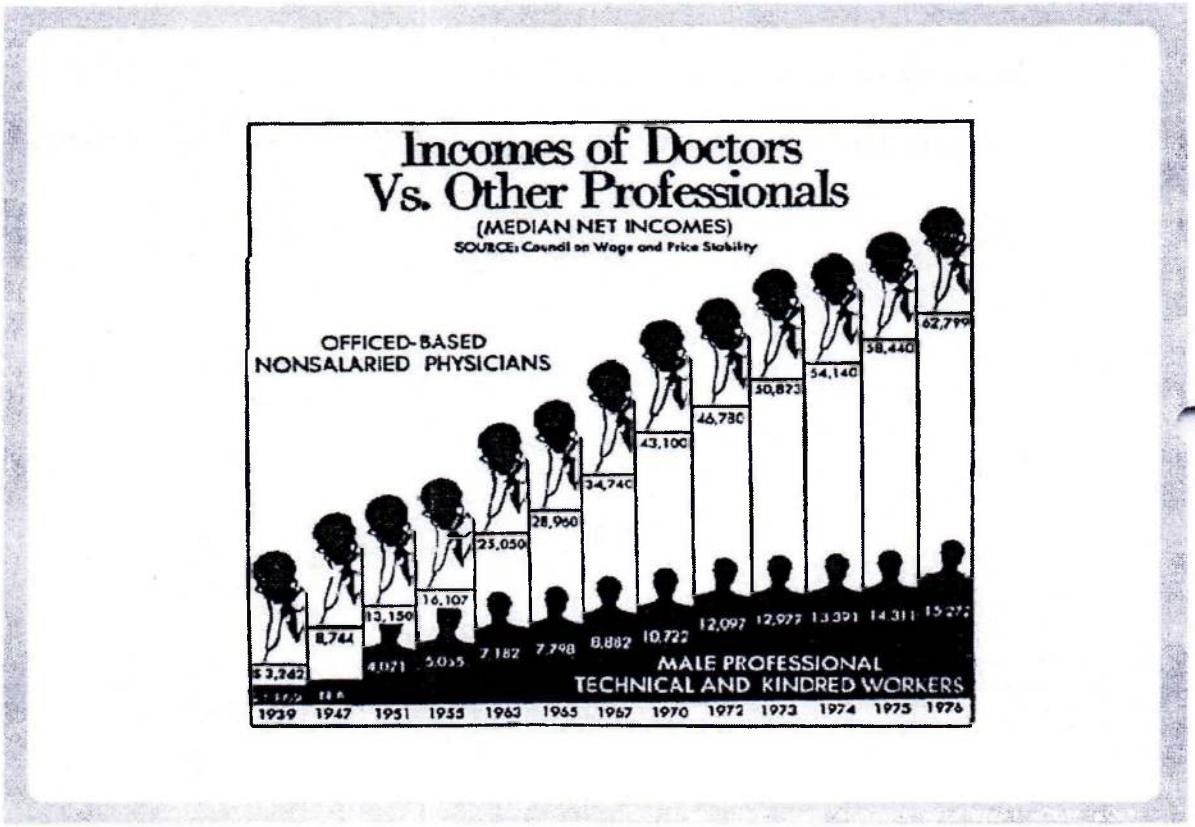
Task 2

Survey report of Income of Doctors Vs other professionals is depicted below as a graph. Comment and give your suggestion to improve the graph.



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Task 3

Comment and give suggestions to improve the table given below:

S.No.	Serum Lipid Profile	Control	Patients	p Value
		Mean ± SD	Mean ± SD	
1	Cholesterol (mg/dl)	175.26 ± 23.78	228.13 ± 57.31	< 0.001
2	Triglycerides (mg/dl)	176.12 ± 23.84	188.41 ± 79.16	< 0.001
3	HDL cholesterol (mg/dl)	52.84 ± 9.46	38.98 ± 9.12	< 0.001
4	LDL cholesterol (mg/dl)	94.28 ± 28.32	152.96 ± 58.32	< 0.001

Table.1: Serum Lipid Profile and Albumin Concentration in Renal Patients and Control group.

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Group 6

Task – 1

Choose a figure/chart appropriate for the situations/data given below and draw the figure using Excel.

Situation and data

Blood sugar and endogenous insulin levels were measured in 10 diabetic subjects to find out the relationship.

The following data were obtained:

Blood glucose in mg%	Blood cholesterol in mg%
220	282
229	246
134	193
225	256
339	180
110	404
118	264
326	502
224	250
133	201

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Task 2

Comment on the Table given below and give your suggestions to improve the graph

TABLE 1: Comparison of anthropometric and biochemical parameters of cardiometabolic risk factors among obese versus healthy non-obese adolescents.

Parameter	Control	Case
Plasma insulin	7.5 ±2.03	14.9 ±3.37**
Body mass index	19.5 ±2.57	27.7 ±2.40**
Waist circumference	25.5 ±1.98	31.4 ±3.1**
Fasting blood glucose	86 ±7.61	100 ± 9.81**
triacylglycerol	98±51.43	125±59.5**
High desnsity lipoprotein	47.73±10.93	47.0±15.55
HOMA-IR	1.51 ± 0.912	3.36 ±0.15**

*p<0.05- significant
**p<0.01- highly significant

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Task 3

Comment on the graph given below and give your suggestions to improve it.

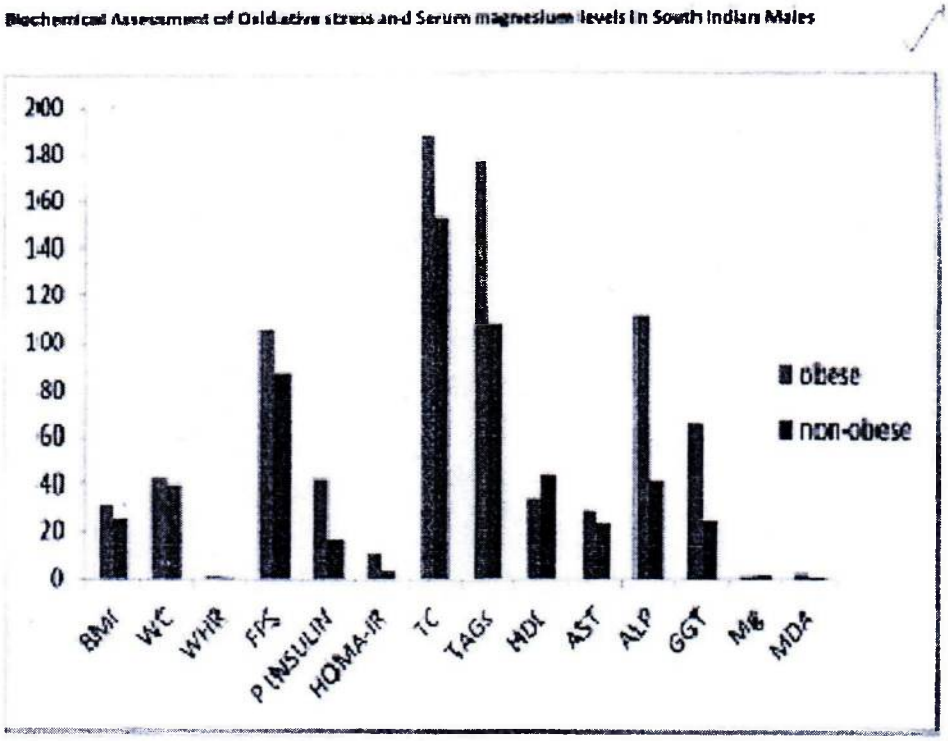

Figure 3: Anthropometric measurements with key biochemical parameters in obese and non-obese males

BMI- Body Mass Index **WC**- Waist Circumference **Mg**- Magnesium

WHR- Waist Hip Ratio **MDA**- Malondialdehyde **TAG**- Triacylglycerol

HOMA-IR- Homeostatic Model of Assessment –Insulin Resistance

Fig. 3 summarizes the key biochemical findings in association with anthropometric measurements. The results indicate that all the three indices of obesity viz; BMI, WC and WHR were very much significant which associates well with hypomagnesaemia, increased oxidative stress, Dyslipidemia and Insulin resistance

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MEDICAL EDUCATION UNIT

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MGMCRI

Co-Ordinator
Medical Education Unit

SAMPLE

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6	1401021004	RAMSESH MANOHAR. R.	Anaesthesiology	
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18	1401101001	SURYARAM .A	General Surgery	
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27	1401091002	PRIYADHARSHINI .K	General Medicine	
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29	1401091010	RISHI RAJHANS	General Medicine	
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40	1401131004	ASHWIN SEGI	Ophthalmology	
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43	1401131005	VIKRAM	Ophthalmology	
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45	1401141001	REGUVARAN. N.J	Orthopaedics	
46	1401141003	SHAMIM AHMED	Othopaedics	
47	1401151002	AIJAS MOIDU	Paediatrics	
48	1401151001	AJAY PRAKAASH .T.R	Paediatrics	
49	1401151003	SRIDHAR SANGAIAH	Paediatrics	
50	1401151004	SUMATHI SRI .R	Paediatrics	
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52	1401161003	PRIYA R.	Pathology	
53	1401161001	RAJA VIGNESHWARI .N	Pathology	
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59	1401201001	GAURAV BALPANDE	Radiology	
60	1401201003	GREESHMA Y.	Radiology	
61	1401201004	SEKHAR REDDY J.	Radiology	
62	1401201006	VANJAVAKA NAVYA SINDHU	Radiology	
63	1401201005	VASHISHTA MOHIT NARESH REKHA	Radiology	

CH 1501151003 Dr. Prasanna Venkatesh Pediatrics

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Value added course on Protocol Writing

32	1401091007	VIJESH ANAND L.A.	General Medicine	
33	1401121006	FATHIMA SHAHEEN. A	OB &GY	
34	1401121004	GISI SEBASTIAN	OB &GY	
35	1401121002	KABANI . M.S	OB &GY	
36	1401121003	LAKSHMI PRIYA . R	OB &GY	
37	1401121005	NEMAKALLU SARALA REDDY	OB & GY	
38	1401121001	SWATHY SRINIVASAN	OB & GY	
39	1401131002	ANUGRAHA .B	Ophthalmology	
40	1401131004	ASHWIN SEGI	Ophthalmology	
41	1401131003	LAISHRAM MEMOTA.	Ophthalmology	
42	1401131001	PRASANNA VENKATESH. R	Ophthalmology	
43	1401131005	VIKRAM	Ophthalmology	
44	1401141002	CHITARTH . R	Othopaedics	
45	1401141001	REGUVARAN. N.J	Orthopaedics	
46	1401141003	SHAMIM AHMED	Othopaedics	
47	1401151002	AIJAS MOIDU	Paediatrics	
48	1401151001	AJAY PRAKAASH .T.R	Paediatrics	
49	1401151003	SRIDHAR SANGAIAH	Paediatrics	
50	1401151004	SUMATHI SRI .R	Paediatrics	
51	1401161002	ANUSHA MULKA	Pathology	
52	1401161003	PRIYA R.	Pathology	
53	1401161001	RAJA VIGNESHWARI .N	Pathology	
54	1401191002	CHARANYA .T	Psychiatry	
55	1401191001	KARTHIK BALAKRISHNAN	Psychiatry	
56	1401211002	MOHAMMED WASHID. K.M.	Pulmonary Med.	
57	1401211001	PARIVENTAAN S	Pulmonary Med.	
58	1401201002	BRINDA. K.V.	Radiology	
59	1401201001	GAURAV BALPANDE	Radiology	
60	1401201003	GREESHMA Y.	Radiology	
61	1401201004	SEKHAR REDDY J.	Radiology	
62	1401201006	VANJAVAKA NAVYA SINDHU	Radiology	
63	1401201005	VASHISHTA MOHIT NARESH REKHA	Radiology	

34 - 1401151006 Praveen Venkatesh Pediatrics

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MEDICAL EDUCATION UNIT

Mahatma Gandhi Medical College and Research Institute
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(Sri Balaji Vidyapeeth Deemed University)

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Sl.No.	UIN No	NAME OF THE STUDENT		Signature
1	1401021001	ANTO SAHAYA PRIYANKA .A	Anaesthesiology	
2	1401021002	ARJUN ASHOK	Anaesthesiology	
3	1401021003	FERNAZ BASHA, M	Anaesthesiology	
4	1401021005	MOHAMMED HANIFER M.H.	Anaesthesiology	
5	1401021006	PRAJITH K. R.	Anaesthesiology	
6	1401021004	RAMSESH MANOHAR. R.	Anaesthesiology	
7	1401061004	BEN EASOW GEORGE	DVL	
8	1401061003	BHANU PRIYA, T.	DVL	
9	1401061001	DHARANI .D	DVL	
10	1401061002	GIRLLY KURIAN	DVL	
11	1401071001	KAVIN KUMAR .M.P	ENT	
12	1401071002	SRUTHI NARAYANAM	ENT	
13	1401101003	ANILKUMAR.G	General Surgery	
14	1401101006	BALAVIGNESH R	General Surgery	
15	1401101010	GAUTHAM G.	General Surgery	
16	1401101002	ROHITH KUMAR .R	General Surgery	
17	1401101007	SADHAN KUMAR CHEEKURI	General Surgery	
18	1401101001	SURYARAM .A	General Surgery	
19	1401101004	SUSHRUT SUBHASH CHAVAN	General Surgery	
20	1401101005	VELURU ROHAN	General Surgery	
21	1401101009	VIJAY G.	General Surgery	
22	1401101008	YASH PRADEEP VAIDYA	General Surgery	
23	1401091001	ABHINAV PRASHANTH .G	General Medicine	
24	1401091009	ABHISHEK C.	General Medicine	
25	1401091004	ASHWIN .T	General Medicine	
26	1401091005	NIRMALA.S	General Medicine	
27	1401091002	PRIYADHARSHINI .K	General Medicine	
28	1401091003	RAMYALAKSHMI. R	General Medicine	
29	1401091010	RISHI RAJHANS	General Medicine	
30	1401091008	SIVAJI PATIBANDLA	General Medicine	
31	1411091006	TIWARI SHASHA NK RAKESH	General Medicine	

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(Note: The highlighted students were not certified)