EXIOMM 2016

NORTH

10th June 2016 at Srinagar, Jammu & Kashmir

"EXIOMM 2016":

"EXIOMM 2016" was held at Srinagar, Jammu & Kashmir, India under the banner of Asian Society of Continuing Medical Education.

The sole objective of the CME was to update the knowledge of Cardiologist, Diabetologist and General Practitioner on Management and complication of Hypertension and Anti Diabetic treatment with cardiology perspective.

The Introductory speech was given by Asian Society. He emphasized the main role played by Asian Society of Continuing Medical Education and how important it is to spread the knowledge known to select few to the practicing Doctors at large.

The CME was attended by 16 Doctors all round India.

Date: 10th June 2016.

Places and Venues:

- Srinagar, Jammu & Kashmir

Total Participants: 16

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Moderator:

- **Dr Upendra Kaul**

Speaker's Name (s):

- **Dr. Peeyush Jain**
- **Dr. Vijay Kher**
- **Dr. Sujatha Jha**

TOPICS –

1) Rosuvastatin in intermediate risk patients - Lessons from HOPE 3

2) Challenges of Controlling Hypertension in CKD patients-case based discussion

3) Hypertension control - BP Target to get maximum protection? ACEi or ARB as a treatment choice?

4) Insulin Requiring Diabetics vs Non Insulin requiring Diabetics. How to minimize vascular complications?

5) Panel Discussion on: Optimal Management of Diabetic Hypertensive.

Summary of talk:

Rosuvastatin is the most effective statin at lowering LDL – C and produces significant increased in HDL – C, Treatment with rosuvastatin at a dose of 10 mg per day resulted in a significantly lower risk of cardiovascular events.

Antihypertensive agents may have a role in the treatment of CKD and HTN. Agents that target the renin-angiotensinaldosterone system (RAAS), such as angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs), are generally considered first-line antihypertensive therapy for this patient population.

Control of hypertension in CKD requires a collaborative network among patients, primary care providers, endocrinologists, and nephrolgists. Careful blood pressure measurement, a multiple risk factor modification strategy, and

persistent and judicious RAAS blockade in combination with diuretics and add-ons should result in good blood pressure control in a majority of patients. Engaging patients and their families through HBP, lifestyle modification, and collaboration with clinic nurses, advanced practice nurses, and clinical pharmacists will facilitate success, thereby reducing the extraordinarily high CVD risk burden of DKD and retarding progression to kidney failure.

The use of ACE inhibitors and ARBs in HTN, HF, and other special populations. Overall, it has been noted that ACE inhibitors and ARBs appear to have an additional benefit beyond just the blood pressure-lowering effect. When compared to each other in head-to-head, ACE inhibitors and ARBs generally appear to demonstrate no difference in primary outcomes. With regard to side effect profiles, ARBs do tend to be better tolerated than ACE inhibitors. While ACE inhibitors and ARBs may increase initial medical costs, over time they may prove to be very cost-effective. Generally, either ACE inhibitors or ARBs may be selected in the treatment of HTN or HF, and the deciding factor may be largely patient-specific.

Hypertension occurs twice as commonly in diabetics than in comparable nondiabetics. Patients with both disorders have a markedly higher risk for premature microvascular and macrovascular complications. Aggressive control of blood pressure (BP) reduces both micro- and macrovascular complications. In diabetic hypertensives, angiotensin converting enzyme inhibitors (ACEIs) are the first line in management of hypertension, and can be replaced by angiotensin II receptor blockers (ARBs) if patients are intolerant of them. Recent studies suggest ARBs to be on par with ACEI in reducing both macro- and microvascular risks. Thiazides can also be used as first line drugs, but are better used along with ACEI/ARBs. Beta-blockers [especially if the patient has coronary artery disease] and calcium channel blockers are used as second line add-on drugs.

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SNAPSHOTS