Addressing the adverse consequences of disability on health status in rural settings

Sir,

Disability refers to a combination of impairments, constraints in performing work, and restrictions in involvement, which often results due to the close

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319
interplay between an individual’s health status and their environment (intrinsic/extrinsic/social).[1] People with disabilities are one of the most marginalized sections across the world, predominantly because more than by their bodies, they are disabled by the community.[2] In fact, excess of 1 billion people have one or another form of disability, whereas close to 110–190 million adults have major limitations in performing their routine activities.[3] In addition, these estimates are supposed to rise further owing to the increase in life expectancy and acquisition of lifestyle diseases.[1,3]

It is very important to acknowledge that people with disabilities have very high unmet needs, as most of the health promotion and other preventive package of services are never targeted toward them.[1] In fact, people with disability from different age groups have to encounter varied forms of health services deprivations (viz., adolescents with disability are deprived of sexual and reproductive health needs, adults with disability are deprived of routine screening measures or regular health interventions, etc.).[3] Further, many secondary conditions (such as bed sores, and infections.), comorbid conditions (such as onset of diabetes in schizophrenia patients), age-related conditions, adoption of high-risk behaviors (viz., substance abuse, poor lifestyle measures), and higher rates of premature deaths have been reported among people with disabilities.[3] All these conditions are both foreseeable and therefore preventable, provided the stakeholders are willing to make a difference.[1,3,4]

Moreover, especially in developing nations and rural settings, people with disability are exposed to different kinds of barriers, which in combination prevent them from availing health care services.[2] These include affordability, transport constraints, nonexistence of the desired services in some geographical regions, presence of isolated services in a health establishment (not complete package – ideal case), physical constraints (viz., uneven access to health centers, inability to use available medical equipments, no signage boards, questionable restroom facilities, no access to parking slots, etc.), and untrained or ill-sensitized health professionals to meet the needs of people with disabilities.[1,2,5]

To significantly improve the health outcomes among people with disability, there is a great need to address the existing shortcomings to ensure that health services are quality assured, affordable, and delivered within the existing framework of resources.[1‑5] Nevertheless, as the health needs of people with disability are not limited to health sector alone, cooperation is required from all the stakeholders.[1,5] The primary intervention is to assess the existing policies and services so that deficient areas can be identified and corrective strategies can be planned to expand the range of benefits to all those who are in need.[3] In addition, measures to facilitate access to health care services by neutralizing physical barriers, sensitization of the health professionals about the special needs of the people with disability, their motivation for self-care, encourage community-based rehabilitation in heterogeneous settings, and conduct large-scale research work pertaining to the needs, barriers, and health outcomes for people with disabilities can also provide enough support.[1‑5]

However, none of the above measures can provide sustainable results, unless continued financial support is extended at all levels.[1,3]

To conclude, acknowledging the global magnitude of disability, extensive resource constraints in rural settings, and serious violation of human rights, the need of the hour is to ensure that national governments, voluntary health agencies, health sector, and people with disability along with their families should work in a coordinated manner to minimize the adverse outcome of the disability.

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Sir,

Magnetic resonance imaging (MRI) of brain plays a key role in supporting the diagnosis of Wilson’s disease. Classical radiological findings such as symmetrical gray matter (basal ganglia and thalamus) hyperintensities on T2-weighted MRI sequence are well known. At the same time, atypical MRI signs such as “Face of the giant Panda” and “Trident Pons sign” have been reported in some cases. However, the complete spectrum of common along with atypical MRI signs is rarely reported in a single case in medical literature. This case displays the entire range of MRI changes in Wilson’s disease.

A 23-year-old boy presented with history of dystonic posturing of his extremities for the past 2 years. He also had drooling of saliva and slurred speech for the same duration. There was no history of seizures or cognitive decline. The symptoms were insidious in onset and progressively worsened over the duration of illness. On general examination, the patient had facial muscles dystonia producing a characteristic “risus sardonicus” facies. Besides, he had severe hypokinetic dysarthria and was detected to be positive for “Kayser–Fleischer” (K-F) ring on torchlight which was further confirmed on slit lamp examination. Neurological examination revealed dystonic posturing of extremities along with cogwheel rigidity. Rest of the systemic examination did not reveal any abnormality. On investigating the case, patient’s MRI of the brain showed symmetrical hyperintensities in basal ganglia and thalamus and asymmetrical subcortical white matter hyperintensities on T2-weighted imaging sequence [Figure 1a and b].

MRI was also remarkable in revealing classical changes in midbrain indicative of the “Face of giant panda” along with central pontine myelinolysis (CPM)-like changes in pons, appearing as a “Bisected pons” [Figure 1c and d]. Considering MRI features and K-F ring suggestive of Wilson’s disease, patient’s further investigations were directed accordingly. Serum ceruloplasmin level was