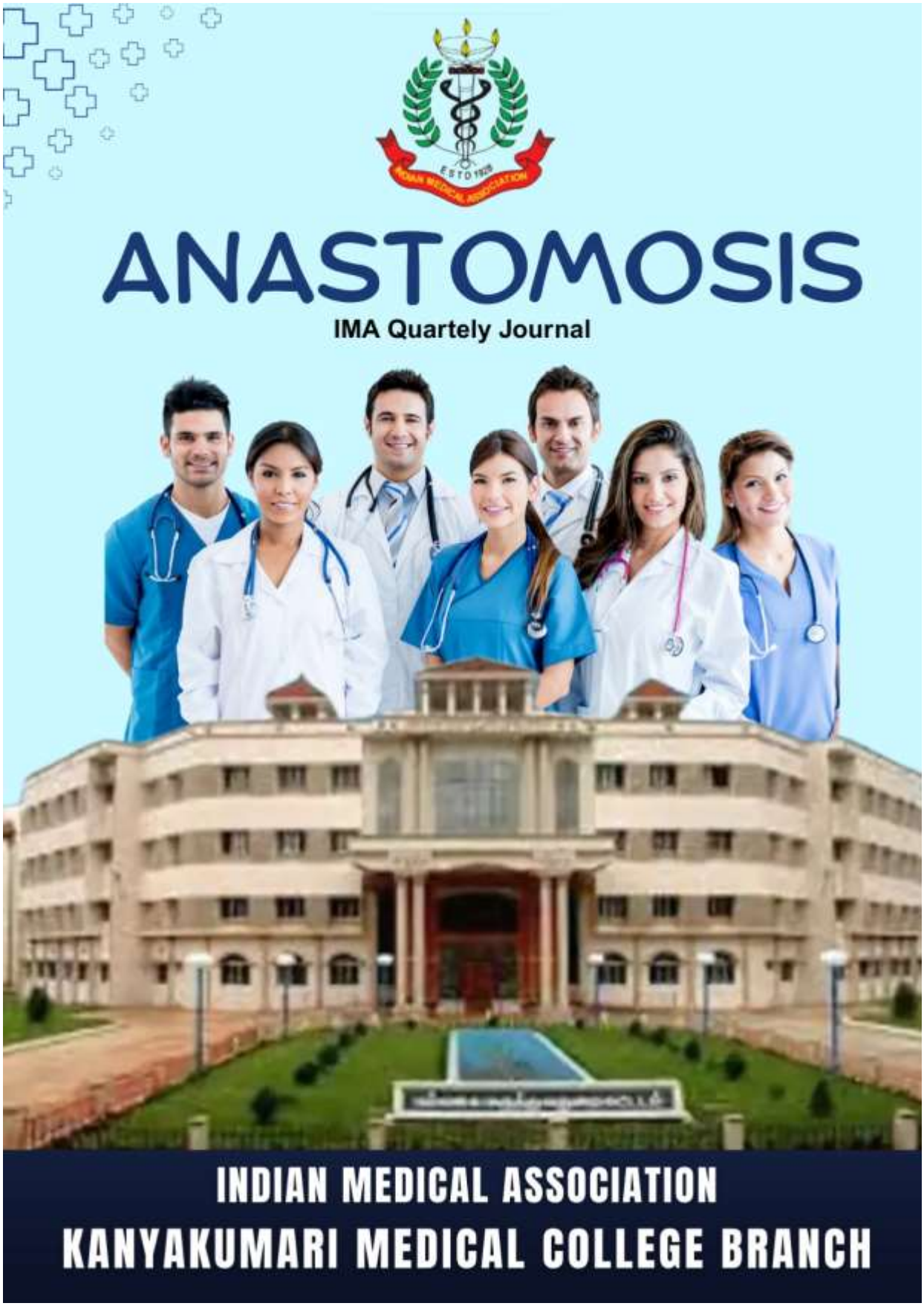
ANASTOMOSIS
IMA Quartely Journal
INDIAN MEDICAL ASSOCIATION
KANYAKUMARI MEDICAL COLLEGE BRANCH

ANASTOMOSIS: THE IMA QUARTERLY JOURNAL

Released by

INDIAN MEDICAL COLLEGE ASSOCIATION

KANYAKUMARI MEDICAL COLLEGE BRANCH

Registered under Tamil Nadu Society Registration Act ,1975 - 95/2023

DAS Quarters, Additional Building,

Kanyakumari Medical College

Asaripallam, Nagercoil

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PREFACE

Indian Medical Association (IMA) Kanyakumari Government Medical College Branch, takes immense pleasure to present this edition of our Chronicle. This publication marks a significant milestone in the journey of IMA – KMC since its inspection, showcasing the collective achievements of our branch and highlighting our commitment to medical education, research, and the unity of our medical fraternity.

This Chronicle serves as a platform to celebrate our accomplishments over the past 9 years. This edition compiled the history of the evaluation of IMA – KMC branch, Executive members, List of Successors, highlights and mile stones of the KMC through its variety of activities to the medical community and society. The articles, research papers, and case studies that cover a wide range of medical specialties, reflecting the expertise and interests of our members are also discussed in this chronicle.

Furthermore, we are thrilled to announce the launch of our new website [website address] the digital platform which will serve as a valuable resource for our members, providing easy access to information about our activities, upcoming events, and important announcements and circulars. It will also facilitate communication and collaboration among our members and medical students, further strengthening our bonds as a united medical community.

The prime focus of our branch is “Upliftment of Medical Students”. We believe in nurturing the next generation medical professionals and providing them with the support and guidance

needed to excel. Research is another cornerstone of our activities. We recognize the importance of research in advancing medical knowledge and improving patient outcomes. This Chronicle showcases the research endeavours of our members, highlighting their contributions to the field of medicine. We encourage all members to actively engage in research and contribute to the growing body of medical knowledge.

We extend our sincere gratitude to the team, the contributors, and all those who have made this Chronicle possible. We hope that this publication will serve as a valuable resource for our members and inspire us all to continue striving for excellence in medical practice, research, and education.

EVOLUTION OF THE IMA – KANYAKUMARI MEDICAL COLLEGE BRANCH

The Indian Medical Association (IMA) is the largest representative body of modern medicine doctors in India, serving as a powerful organisation for both medical professionals and the broader community's health and wellbeing.

The Indian Medical Association (IMA) Tamil Nadu is a voluntary organization that represents the diverse range of modern allopathic medicine and its specialties across the state. Founded in 1940 by a group of visionary doctors, IMA Tamil Nadu has grown to have a presence in every town, fostering a strong network of medical professionals.

The Indian Medical Association - Kanyakumari Government Medical College branch (IMA - KMC) was established on July 10, 2016, as the fourth IMA branch in the Kanyakumari District by the tireless commitment and remarkable contributions of Dr. S.Muthu Kumar, Dr.A.Muralidharan and Dr.AJS.Pravin with a dual mission to uphold the dignity of the medical profession and enhance the quality of medical services for the people of Kanyakumari district, in collaboration with the Government Medical College, Kanyakumari. Since its inception, IMA – KMC has been actively engaged in mentoring younger members, advocating for doctors' rights, knowledge Sharing and upliftment of medical Education, community service and outreach, governance and decision-making. With a strong membership of 103 lifetime members, IMA - KMC plays a significant role in representing the organization in various forums, such as conferences, seminars, lectures, workshops, training programs participating in state and national governing bodies and in decision-making processes within the organization. With the Selfless devotion and exemplary efforts of the present executive committee the Indian Medical Association - Kanyakumari Government Medical College branch (IMA - KMC) was registered under the Tamil Nadu Societies Registration Act,1975 with No. SRG/ Kaniyakumari/95/2023.

INDIAN MEDICAL ASSOCIATION

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KANYAKUMARI GOVERNMENT MEDICAL COLLEGE BRANCH

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Dr.G.ARUL VENKADESH
Secretary

Dr.D.C. JERALD BOSE
Finance Secretary

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Member - State Council

Dr. RAJASEKAR N
Member - Central Council

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Vice President

Dr T SUSITHA
Women's Wing Chairman

Dr M K RAKESH
Blood Donation & Organ Donation

Dr JAYARAM KOSALRAM
Scientific Committee

INDIAN MEDICAL ASSOCIATION

KANYAKUMARI GOVERNMENT MEDICAL COLLEGE BRANCH

List of Successors of Office Bearers

PRESIDENT

Year	Name
2016 - 2017	Dr. Narayanan Srinivasan
2017 - 2020	Dr. AJS. Pravin
2020 - till date	Dr. S. Muthu Kumar

SECRETARY

Year	Name
2016 - 2017	Dr. Jefferson
2017 - 2019	Dr. A. Muralidharan
2019 - 2020	Dr. Amalan Christhudhas
2020 - 2021	Dr. Geolin Mithun
2021 - till date	Dr. G. Arul Venkadesh

FINANCE SECRETARY

Year	Name
2016 - 2019	Dr. Amalan Christhudhas
2019 - 2020	Dr. Muthamil Silambu
2020 - 2023	Dr. P. Ram Praveen
2023 - till date	Dr. D.C. Jerald Bose

COMMONWEALTH MEDICAL ASSOCIATION

INTERNATIONAL DEPARTMENT
BMA House
Tavistock Square
London WC1H 9JP
United Kingdom

President : Prof. Dr. J.A. JAYALAL (India)
Email : lapsurgeon2001@yahoo.co.in
Phone : +91 94431 60026

General Secretary : Dr. K. MUGAMBI JOY (Kenya)
Email : dr.mugambijoy@gmail.com
Phone : +254721310018

27.06.2025

Ref: CMA/2025/99/Admin

Dear Colleagues and Members,

I hope this message finds you in great health and high spirits. As the President of the Commonwealth Medical Association and a proud member of the Indian Medical Association (IMA), I am honored to share a few words with you in this quarterly edition.

The IMA unit functioning within the Kanyakumari Medical College campus is a remarkable example of dedication and commitment to both academic excellence and social welfare. Through our monthly academic meetings and various outreach programs, we are fostering not only knowledge but also leadership skills among our faculty and students. This unit plays an essential role in mentoring the next generation of medical professionals, instilling in them the values of integrity, compassion, and service.

As the largest professional body in the country, IMA is tirelessly working to restore professional competence, social relevance, ethical uprightness, and legal protection for our esteemed faculty and members. It is crucial for us to maintain a strong connection with our state and national headquarters, ensuring that each member feels valued, accomplished, and supported both professionally and personally.

As we celebrate a significant milestone—the centenary of the IMA, which began its journey in 1928—I am excited to share that the IMA headquarters has commenced the construction of an impressive Centenary Building Complex at its existing location. This ambitious project aims to encourage the participation of all 400,000 members of the IMA. I am reaching out to you as a member of the building committee, inviting your contributions of a minimum of ₹1,000 to support this important initiative for our century-old organization.

I also extend warm greetings from the Commonwealth countries, emphasizing the shared commitment we all have to the noble profession of medicine.

Thank you for your continued support and engagement. Together, let us strive to make our IMA unit stronger and more impactful for the benefit of our community and profession.

Warm regards

Prof. Dr. J. A. Jayalal
President, Commonwealth Medical Association UK
Professor of Surgery & HOD, Kanyakumari Government Medical College
National President, IMA (2021)

THIRAVIAM CLINIC

85/Old 54 – 56, Asambu Road
Vadasery, Nagarcoil
Phone : 04652 294029
Mobile : 7449094029

Dr. M.Thiraviam Mohan
Child Specialist
Reg Number : 52267

Dear Members of IMA Kanyakumari Medical College Branch,

"It is truly inspiring to see Anastomosis -IMA Quarterly Journal Of kanyakumari Medical college Branch, which continue as a vibrant reflection of our collective medical journey..."

It reflects the intellectual spirit, professional achievements, and compassionate service of our esteemed fraternity.

I am confident that this magazine will serve as a vibrant platform for sharing knowledge, experiences, and innovations across generations of dedicated medical professionals in all specialties.

Let us remain united in purpose, steadfast in service, and ever inspired to uphold the values of ethics, empathy, and excellence that define our noble profession.

Warm regards,
Dr. M.Thiraviam Mohan
Past Vice President IMA South Zone 2023
Candidate for the post of Honorary Secretary IMA TNSB (2026-2027)

PRAVIN
SKIN, LASER & COSMETIC CENTRE
Dr. A.J.S. PRAVIN MD DD
Reg. No. 41553
Chief Consultant

Dr. AVINASH PRAVIN MD DVL
Reg. No. 120863
Consultant Skin, Laser & Cosmetic Surgeon

"Adv. Dharmaraj Complex",
49 Court Road,
Nagercoil - 629 001.
K.K. Dist, Tamil Nadu.
Phone: 04652 233515 / 228450

27 | 2 | 2025

Greetings

I Professor Dr.A.J.S.Pravin M.D.,D.D past president of IMA KGMC 2017- 2020 wish the President, Secretary and the core team of IMA, KGMC the very best in all the academic, social and humanitarian activities. This IMA was started in 14th July 2016 with the dedicated efforts of Dr.Muthukumar, Dr.Muralidharan, Dr.Narayana Sreenivasan and many others. The purpose of the IMA was to foster the academic activities especially Government medical college and other hospitals. It has fulfilled the long felt need of young aspiring medicos, post graduates and upcoming medical professionals. IMA KGMC started the first medical student using at KGMC in 2019 and has performed many academic CMEs, meetings and agitations especially against NMC NEET, violence against medical professionals and social causes – Jallikattu. I once again wish IMA KGMC the very best in the future endeavors under dynamic leadership of Professor Dr.Muthukumar, Secretary Dr.G.Arul Venkatesh and others.

Dr. A.J.S. PRAVIN, M.D.,D.D.,
Reg. No. 41553
PRAVIN SKIN LASER & COSMETIC CENTRE
49 COURT ROAD
NAGERCOIL - 629 001
KANYAKUMARI DIST., TAMILNADU

INDIAN MEDICAL ASSOCIATION

Kanyakumari Medical College Branch

இந்திய மருத்துவ சங்கம்

கன்னியாகுமாரி மருத்துவ கல்லூரி கிளை

Registered under Tamilnadu Society Registration Act ,1975 - 95/2023

Association Head Quarter: IMA House, Indraprastha Marg, New Delhi – 110002

President	Secretary	Finance Secretary
Dr.S.Muthu Kumar, M.D.,	Dr.G.Arul Venkadesh,M.D.,	Dr.D C Jerald Bose,M.D.,
70100 05799	9791765579	8903705644

Dr. S.Muthukumar
President
IMA – KMC Branch

"Wherever the art of medicine is loved,
there is also a love of humanity."

– Hippocrates

These profound words from the father of medicine resonate deeply with our mission at the Indian Medical Association (IMA) - Kanyakumari Medical College (KMC). As we continue to propel the Indian Medical Association (IMA) - Kanyakumari Medical College (KMC) to new heights, I would like to extend my sincerest gratitude to our dedicated Secretaries for their tireless efforts. The IMA Chronicle serves as a vital link between clinical practices and academic activities within our esteemed institution.

KMC has established itself as a premier healthcare organization, boasting a team of highly skilled super specialists and a broad spectrum of state-of-the-art technologies. I am delighted to see our members sharing their expertise and knowledge through this platform.

As President, it is heartening to witness the IMA Chronicle become a reality, thanks to the relentless hard work of our Secretaries, Dr.Arul Venkadesh, Dr.Geolin Mithun, Dr.Ram Praveen and Dr.Jerald Bose and the unwavering support of our cofounders Dr.AJS Pravin and Dr.Muralitharan, and the active participation of our members. Together, we are elevating the IMA to unprecedented levels.

Secretary Office:DAS quarters,Additional building,Kanyakumari Medical College, Asaripallam,Nagercoil.

INDIAN MEDICAL ASSOCIATION

Kanyakumari Medical College Branch

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70100 05799	9791765579	8903705644

Dr. G.Arul Venkadesh

Secretary
IMA – KMC Branch

"Not all Angels have Wings, some have Stethoscopes." These words eloquently capture the essence of our medical community's selfless service. I'm delighted to extend my warmest greetings to each of you on the launch of our Chronicle, a milestone that showcases the vibrant spirit of the Indian Medical Association - Kanyakumari Medical College Branch.

The Indian Medical Association (IMA), founded in 1928, is a premier organization of doctors in India, boasting over 300,000 members who strive to promote medical science and maintain the dignity of the medical profession. Our Tamil Nadu State Branch, headquartered in Chennai, caters to the specific needs and concerns of doctors across the state.

As a local chapter, the Kanyakumari Medical College Branch was established on July 10, 2016, and operates under the Tamil Nadu State Branch and IMA. We're dedicated to promoting medical excellence, research, community service, and the welfare of doctors and patients in the Kanyakumari region, fostering a strong network of medical professionals in collaboration with Kanyakumari Medical College.

This Chronicle and our newly launched website are the culmination of a long-held dream by our executive members. I'm delighted to see this vision become a reality. Our Chronicle features outstanding contributions from our members, including innovative research articles, impactful outreach programs, and notable milestones. We're proud to highlight the recognition and accolades received by our esteemed members.

I'm grateful to Dr. Muthukumar, our President, for the opportunity to serve as Secretary. During my tenure, we've taken significant steps to register our branch under the Tamil Nadu Societies Registration Act of 1975. I'd also like to thank our past and present office bearers, friends, colleagues, and each of you for your tireless efforts and support in making our branch a beacon of excellence.

Special thanks go to our editorial team, contributors, and designers who've worked tirelessly to bring out this Chronicle. Once again, I congratulate each of you on this remarkable achievement and look forward to your continued support in our future endeavors.

Secretary Office:DAS quarters,Additional building,Kanyakumari Medical College, Asaripallam,Nagercoil.

INDIAN MEDICAL ASSOCIATION

Kanyakumari Medical College Branch

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70100 05799	9791765579	8903705644

Dr. D.C.Jerald Bose

Finance Secretary

IMA – KMC Branch

We are pleased to present this edition brought to you by the Indian Medical Association Kanyakumari Government Medical College Branch. As healthcare professionals, staying updated on the latest medical knowledge and advancements is crucial for delivering exceptional patient care. Our Mission: IMA KGMC is committed to promoting the highest standards of medical practice and patient care. Through initiatives like medical camps and awareness programs, we strive to make a positive impact on the healthcare landscape. In this edition, you'll find Insightful articles on cutting-edge medical research and advancements, Expert opinions from renowned healthcare professionals, Updates on the latest medical developments and breakthroughs.

The IMA KGMC is dedicated to supporting the ongoing education and professional development of healthcare professionals. We believe that this publication will be a valuable resource for our members and the broader medical community. We wish the IMA KGMC branch continued success and growth, and we strive to become the best IMA branch in the country. May this publication contribute to the ongoing improvement of healthcare in KGMC and beyond.

I'm deeply grateful to the President, Secretary and Lifetime members for their invaluable support and contributions to the IMA KMC branch. Their dedication has been instrumental in shaping the branch's past successes and future achievements. The collective efforts of these individuals have Fostered a spirit of collaboration and excellence, driven initiatives that benefit the medical community, Enhanced the branch's reputation and impact. Thank you to all who have contributed to the IMA KMC branch's growth and success. Your tireless efforts are truly appreciated.

Secretary Office:DAS quarters,Additional building,Kanyakumari Medical College, Asaripallam,Nagercoil.

INDIAN MEDICAL ASSOCIATION – KMC BRANCH

LIST OF MEMBERS

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2	Dr. RAMESH KUMAR T.	9486961681
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55	Dr. ASHITHA ABDUL WAHIB	9486960303
56	Dr. GAYATHRI SHYLAJAKUMARAN THAMPI	7598405646
57	Dr. SAIRAMAKRISHNA. O	9908080010
58	Dr. KARTHICK SUBASH S	9444350053
59	Dr. AYISHA SHEERIN	7598138840
60	Dr. MURALIDHARAN A	9444321248

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64	Dr. SUDHA M	9443365947
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91	Dr. PON SHANKAR ANANDARAJA	9488062790
92	Dr. AISWARYA SUYAMBULINGAM	8903678674

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95	Dr. MALATHI.M	9965981739
96	Dr. MOHAN MURUGESAN	8489156745
97	Dr. SREELEKSHMI.S.H.	8547665879
98	Dr. ASHWIN CYRIL EMPEROR E	7598538896
99	Dr. DEVIKA V L	7448873330
100	Dr. KATHIRAVAN M	7904960166
101	Dr. KIRUBANANTH	8675722156
102	Dr. KUMARAVEL K	8754103776
103	Dr. MOHAN N	9597910895
104	Dr. NISANTH M	8056072476
105	Dr. THIYANESWARAN S	8760632945
106	Dr. VARADHARAJ M	6382578841
107	Dr. ANBU M	9843866682
108	Dr. ANEES BINU J	9487657903
109	Dr. PRAVEEN MANOHARAN	
110	Dr. GOWTHIN D	9894818335
111	Dr. VIDYACHAL RAVINDRA	9080632562
112	Dr. BENIL V	9442872870
113	Dr. CILI V A	9443108419
114	Dr JAYARAM KOSALRAM	97871 75404
115	Dr THANALAKSHMI	95856 09277
116	Dr NIKESH	89036 19355
117	Dr ABISHEKA	75988 54765
118	Dr RAKESH	99440 60809
119	Dr. SIVANESAN P.	9626398570

REDUCING THE INCIDENCE OF FNHTR BY USING LEUKOREDUCED BLOOD AND BLOOD PRODUCTS

Dr.M.K.Rakesh MD.,
Department of Transfusion Medicine

ABSTRACT

Removal of leucocytes from various blood products has been shown to minimize Febrile nonhemolytic transfusion reactions, HLA alloimmunization, platelet refractoriness in multitransfused patients and prevention of transmission of leukotropic viruses such as EBV and CMV. Rapidly growing size of hemato-oncological patients who require multiple transfusion of blood and blood components during the course of their management pose a great challenge to transfusion services for providing them red cell and platelet antigen matched products in alloimmunized subjects. Hence, removal of leucocytes below a certain threshold level of ≤ 5×10^6 in a blood component certainly helps in prevention of alloimmunization and associated risks in those patients. In this modern era, the best Leucoreduction can be achieved with the help of 3rd and 4th generation leukofilters, both in the laboratory and bed side, and state of the art apheresis devices. The present article briefly reviews the current literature for pros and cons of leucofilteration and its scope of implementation in the cost constrained settings.

HISTORY

The concept of removal of leukocytes from the blood was introduced by Fleming, as early as 1920. Fleming used a cotton wool plug in a bent glass tube with a constricted limb. Blood was placed above the cotton wool and forced through it with the help of a teat. It was later realized that this model closely resembled the structure of modern depth filters. The work on leucofilteration got a boost subsequent to the accidental observation by Swank in 1961, while working on a blood viscosity model, wherein, on microscopic examination, he found that very high pressure was required to force 2-10 days old acid-citrate-dextrose (ACD)stored blood through a microfilter, as aggregates of platelets and leukocytes clogged the filter passes. Later, in the 1980s, advancement in

technology led to the development of the first generation cellulose acetate filters, with a leukocyte removal efficiency of 98 percent. Although clinically acceptable results were achieved, they had two major limitations. First, they appeared to activate complement C3, with subsequent vasoconstriction and increased capillary permeability. Second, the efficacy of leukocyte removal was strongly dependent on the flow across the filter, so the overall filtration process was slow. The new generation filters with rapid flow and excellent leukocyte removal are discussed later in the text.

CASE REPORT

An 8-year-old female child who was diagnosed as **Pyruvate kinase deficiency** at 2months of age and her blood group is **B RH** positive. She was in need of transfusion every month after diagnosis and during the course of transfusion, she developed adverse transfusion reactions like Allergic reaction and Febrile non hemolytic transfusion reaction for which the transfusion reaction workup was done and the results were such that there is no agglutination of antigen and antibody, there is no pretransfusion error, there is no delay in transfusion and storage and there is no hemolysis also. So, the further transfusion was planned to transfuse coombs cross matched O Rh negative compatible red cells for which she developed again an episode of allergic and febrile reaction. Since, she is in need of transfusion every month for maintaining normal physiology to ameliorate anaemia, we planned for Leukoreduced red blood cell for further transfusion for which there was no allergic and febrile reaction even after subsequent transfusion. She was transfused with more than 18 leuckoreduced blood products with success.

DISCUSSION

Blood transfusion is a fundamental therapy in numerous pathological conditions. Chronic Blood transfusion dependent diseases like Pyruvate kinase Deficiency, Thalassemia, and Sickle cell Anemia are in need of regular transfusion to lead a normal life. Even though, HSCT is the final most appropriate treatment for hemato-oncological patients, Blood transfusion plays

an important role in conservative treatment. Regrettably, many clinical reports describe adverse transfusion's drawbacks due to non leukoreduced red blood cells. So, by using leuckofilter, leukoreduced blood component transfusion plays an important role in reducing transfusion reactions, morbity and unnecessary hospital stay for longer period during post transfusion.

DISEASE BACKGROUND

Pyruvate kinase deficiency (PKD) is the most common enzyme-related glycolytic defect that results in red cell hemolysis. Red blood cell (RBC) metabolism hinges on glycolysis. Pyruvate kinase (PK) enzyme is a key to this process. PK converts phosphoenolpyruvate to pyruvate. In PKD, cellular energy efficiency and longevity decrease. Young RBCs are most affected in PKD. PKD is a lifelong chronic hemolytic anaemia with a wide spectrum of symptoms and manifestations. Given the significant risk of complications that can arise over a patient's lifetime, monitoring is critical. Currently, supportive care includes transfusions, splenectomy, and chelation therapy. PK activators and gene therapy offer innovative disease-directed approaches which may transform the clinical phenotype of patients in the future. Given the potential future treatment possibilities for PKD, careful thought is needed to determine the optimal management strategies in individual patients[4]

CONCLUSION

The current generation of leukofilters could achieve 4 log reductions in leukocyte content. The availability of leukocyte removal (leukoreduction) techniques for blood components is associated with a considerable improvement in various clinical outcomes which includes a reduction in the frequency and severity of febrile transfusion reactions, reduced cytomegalovirus transfusion-transmission risk, the reduced incidence of alloimmune platelet refractoriness, will prevent HLA alloimmunization as well as reducing the overall risk of both recipient mortality and organ dysfunction. So, transfusing Leuckoreduced Blood component is ideal for patients with Chronic Blood transfusion dependent diseases and for Haemato oncological patient, who are in need of HSCT.

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LESSONS FROM A TRAGEDY: FATAL SYSTEMIC POISONING FOLLOWING ACCIDENTAL PARAQUAT DERMAL CONTACT

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INTRODUCTION

Paraquat (1,1'-dimethyl-4,4'-bipyridylium dichloride) is a widely used herbicide recognized for its high toxicity. It is commonly utilized around the globe to manage weed growth in agricultural settings, especially in crops like cotton, soybeans, and corn. While it plays a significant role in farming, paraquat is infamous for its potential to cause fatal poisoning. There have been numerous reports of accidental or intentional ingestion, and because of its deadly effects on the lungs, kidneys, and other essential organs, it is considered one of the most hazardous substances when swallowed or inhaled.

The mechanism of paraquat toxicity mainly involves the buildup of the chemical in the lungs, resulting in severe oxidative damage and inflammation, which can lead to acute respiratory distress syndrome (ARDS) and multi-organ failure. The mortality rate associated with paraquat exposure is notably high, even with low quantity ingestions. Prompt identification, supportive care, and targeted treatments can enhance the outcomes of those who are affected. This case report discusses the clinical features and diagnostic challenges that we encountered in this case of percutaneous paraquat poisoning in a patient who presented with severe respiratory distress and multi-organ dysfunction syndrome.

CASE REPORT

A 42-year-old male, who works as a foreman for the electricity board, was admitted to the intensive care unit (ICU) due to gradually worsening breathlessness over the past five days. His symptoms had escalated significantly in the last 24 hours before admission, and he reported no history of fever, cough, or sputum production. Additionally, he had an ulcer on his scrotum and left inner thigh that had been present for about ten days. The patient also had a history of chronic alcohol use, with his last drink taken around 15 days before his admission.

While receiving in ICU, the patient was in severe respiratory distress. He was dyspnoeic, tachypnoeic, and exhibited labored breathing. Arterial blood gas (ABG) analysis revealed respiratory alkalosis (pH 7.54) with hypoxic respiratory failure, as evident from low pO2 of 49 mm Hg, a decreased pCO2 of 25.9 mm Hg, and a bicarbonate level of 22.1 mmol/L. Chest X-ray revealed bilateral heterogeneous infiltrates, and hence provisionally diagnosed as a case of Severe Acute Respiratory Distress Syndrome (ARDS).

Figure 1:

Chest XRay taken at the time of admission

Figure 2:

Chest XRay taken on Day 3 of hospitalization

Despite initial treatment with nasal oxygen therapy with NRBM, the patient did not improve, and he could not tolerate non-invasive ventilation (NIV). Consequently, endotracheal intubation was done and mechanical ventilation was started. Routine lab investigations revealed Leucocytosis of 30,700/cu.mm, with Neutrophilic predominance (92% neutrophils, 4% lymphocytes, and 4% eosinophils), indicating a potential infection. Furthermore, renal function was impaired, with elevated urea levels (82 mg/dL) and creatinine (1.8 mg/dL), along

with hyponatremia, as evidenced by a serum sodium of 119 mEq/L. However, liver function tests were normal. The patient's C-reactive protein (CRP) was elevated at 22.4 mg/L, and procalcitonin levels were also high, suggesting Sepsis with Multi-Organ Dysfunction Syndrome (MODS).

MANAGEMENT AND DIAGNOSIS

Based on the initial presentation, the patient was started on broad-spectrum intravenous antibiotics (MEROPENEM and DOXYCYCLINE), along with IV Steroids and other supportive treatments, including intravenous fluids and electrolyte corrections. CT scan of the chest showed consolidation with air bronchograms in the bilateral basal lung fields, diffuse ground-glass opacities, thickening of the interlobular septa, reticulations, and bronchiectatic changes. These findings were indicative of interstitial lung disease, along with bilateral minimal pleural effusion. CT scan of the abdomen was taken to exclude any other underlying issues and revealed mild ascites and a left renal cortical cyst, but no other significant abnormalities were found in the abdomen.

Figure 3: CT Film (Lung Window) of the patient

As there was no clinical improvement with initial treatment, the patient was started on IV Antifungal therapy with VORICONAZOLE and Antiviral therapy with OSELTAMIVIR. Sputum collected from endotracheal aspirates was tested for acid-fast bacilli (AFB) and returned negative for tuberculosis, while the CBNAAT (Cartridge-Based Nucleic Acid Amplification Test) also showed no

positive results. Additionally, SARS-CoV-2 PCR, antigen, and IgM/IgG tests were all negative, effectively ruling out COVID-19 as a cause of the patient's respiratory symptoms. Sputum Culture and Sensitivity did not yield any pathogen growth.

As the patient's condition continued to deteriorate and no infectious organisms were found, our clinical team explored alternative diagnostic methods to uncover the reason behind the patient's worsening clinical status. During a thorough review of the patient's history, his wife recalled seeing a greenish stain on the patient's pants in the left thigh area about 20 days before his admission. This detail turned out to be vital in refining the diagnosis. The stain was traced back to an accidental spill of pesticide, which the patient had encountered while trying to open the container. Upon investigating further, the pesticide was found to be PARAQUAT. He had unintentionally spilled PARAQUAT on his clothes, and there were no immediate symptoms after the exposure. However, the later development of respiratory distress and subsequent organ dysfunction raised concerns that led to the diagnosis of percutaneous paraquat poisoning.

Figure 4: Scrotal and left thigh contact ulcer

DISCUSSION

Paraquat is a highly toxic herbicide that can cause severe pulmonary toxicity following ingestion, inhalation, or skin exposure. Its toxicity arises from its ability to undergo redox cycling, leading to the generation of reactive oxygen species (ROS), which induce cellular oxidative damage. Once absorbed, paraquat primarily accumulates in the lungs, where it causes direct injury to alveolar epithelial cells, leading to inflammation, fibrosis, and eventual respiratory failure. In severe cases, the damage progresses to ARDS, requiring mechanical ventilation and intensive care.

The initial signs of paraquat poisoning can be quite vague, with symptoms that may vary from mild stomach discomfort, oral ulcers to more serious complications like pulmonary edema. The defining feature of paraquat toxicity is its swift advancement to acute respiratory distress syndrome (ARDS) and multi-organ failure, which can result in death within days to weeks following exposure. Early detection and supportive care are crucial for improving outcomes, which may involve low oxygen therapy, corticosteroids, and medications aimed at reducing oxidative stress, although there is currently no specific antidote for paraquat poisoning.

In this case, the patient exhibited severe hypoxia and signs of ARDS, which, combined with laboratory results indicating infection and multi-organ dysfunction, initially led the clinical team to suspect an infectious cause. The delayed recognition of paraquat exposure highlights the necessity of obtaining a comprehensive history, particularly in cases of unexplained respiratory failure and multi-organ involvement.

The treatment for paraquat poisoning is mainly supportive. If paraquat ingestion or exposure is suspected, patients should be promptly decontaminated, which includes removing contaminated clothing and administering activated charcoal if ingestion occurred within a few hours. While various agents like antioxidants (e.g., N-acetylcysteine, glutathione) have been tested, none have shown definitive effectiveness in enhancing survival.

CONCLUSION

This case underscores the necessity of maintaining a high level of suspicion for paraquat poisoning in patients who show signs of acute respiratory distress and multi-organ dysfunction. Although the initial symptoms appeared to align with an infectious cause, a detailed investigation into the patient's background revealed paraquat exposure as the probable reason for his condition. Prompt recognition and supportive care are vital in treating paraquat poisoning, as the situation can quickly escalate to life-threatening organ failure if not managed properly.

Healthcare providers should be alert to potential environmental exposures, like pesticides, in patients with unexplained symptoms, particularly in agricultural or industrial environments. Additionally, a comprehensive clinical history that includes any contact with toxic substances is crucial for making a swift diagnosis and informing treatment strategies in these intricate cases.


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DOUBLE-FACE BUCCAL MUCOSAL GRAFT SUBSTITUTION URETHROPLASTY – A NOVEL TECHNIQUE FOR OBLITERATIVE BULBAR URETHRAL STRICTURES – CASE REPORT

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INTRODUCTION

The current trend in the management of bulbar urethral strictures is non-transection, minimal urethral mobilization, and substitution of the urethra. Substitution bulbar urethroplasty can be performed using a dorsal or ventral approach, depending on the length, extent, and calibre of the stricture. Combined dorsal and ventral on-lay augmentation urethroplasty technique was described by Palminteri et al. for bulbar urethral reconstruction. In this paper, we present our report of the double-face Buccal Mucosal graft urethroplasty technique for near-obliterative bulbar urethral strictures and short-term outcomes of this technique.

CASE REPORT

A 54 years male, a known case of head injury with history of urethral catheterisation presented with severe Lower urinary tract symptoms on September 2023 and on evaluation was found to have an obliterative mid bulbar urethral stricture on ascending urethrogram (AUG). Supra pubic cystostomy was done and he was on regular follow up. On November 2023, he was re-evaluated with ascending urethrogram showing a completely obliterative mid bulbar stricture of length 3 cm. (Fig 1)

He was admitted and double face buccal mucosal graft substitution urethroplasty was done on November 2023. Urethral catheter was removed on end of December 2023. Repeat AUG revealed a normal Caliber urethra at the site of anastomosis. (Fig 2) Supra pubic cystostomy was removed on first week of January 2024. Patient is now voiding well and he is on regular follow up.

Fig. 1 - Before Surgery AUG

Fig. 2 – After surgery AUG

SURGICAL TECHNIQUE

The double- face BMG urethroplasty can be performed in two ways, either dorsal on-lay with ventral inlay or ventral on-lay with dorsal inlay technique. Near- obliterative bulbar strictures are the main indications of double-face graft urethroplasty. In our case we did dorsal on-lay with ventral in-lay. (Fig. 3 - 10)

The operative procedure was performed with the patient under general anaesthesia with nasotracheal intubation. The patient is placed in the exaggerated lithotomy position. Urethroscopy was performed with a 6-Fr ureteroscope to assess the urethral strictures, Caliber. A 0.032 guide wire was placed to enable the identification of the urethral lumen during the procedure. A 16Fr urinary catheter is inserted, identifying the distal end of the segment affected by stenosis. A longitudinal mid line incision is made in the perineum. The left & dorsal surfaces of the urethra are dissected, with the right border maintained, as proposed by Kulkarni et al. A longitudinal incision is made along the midline of the dorsal wall of the urethra affected by stenosis, extending up to 1cm beyond the area of stenosis, preserving the spongy tissue.

The unhealthy mucosa is excised on the already exposed ventral urethra. A small patch of buccal graft is inserted ventrally and quilted with delicate sutures. On the dorsal aspect a long buccal graft is quilted on the corpora. The anastomosis is then performed over a 14 size silicone urethral catheter.

Fig 3 – Stricture area exposed

Fig 4 – proximal caliberation

Fig 5 – Distal caliberation

Fig 6 – BMG harvested

Fig 7 – Ventral graft quilted

Fig 8 – Dorsal

Fig 9 – Catheter inserted

Fig 10 – Urethral Closure Completed

A BRIEF DESCRIPTION OF RELEVANT ANATOMY

Anterior urethra is divided anatomically into 2 parts, namely penile and bulbar urethra. The bulbar urethra lies between penoscrotal junction and membranous urethra, which includes external urethral sphincter. The bulbar urethra is divided also into proximal, middle and distal bulbar urethra. The proximal and middle bulbar urethral parts are unique in terms of spongious tissue, which is more developed in these regions. These proximal and middle parts of the bulbar urethra are covered by the bulbospongio-cavernosus muscle, which is divided into 2 parts, and the proximal 2/3 of the muscle surrounds the urethra. We know from the anatomical studies that this proximal portion aids in the ejaculation, and also in the evacuation of last few drops of urine. The distal 1/3 parts of bulbospongio-cavernosus muscle surrounds the corpora cavernosa at the base of the penis. This distal muscle is known to compresses the deep dorsal vein of the penis to aid in erection. We approach the dorsal surface of urethra by one of two ways. The first one is by incising bulbospongiosous muscle in midline ventrally with circumferential mobilization of the urethra. The second is by one-sided dissection, sparing the bulbospongiosous muscle and limiting the muscle division only to the distal bulbocavernosus muscle, which is a muscle preserving approach.

DISCUSSION

Urethral stricture differs according to its aetiology, extent, site, depth and density. All these factors are relevant to the management of this pathology, determining the most appropriate approach in each case. The use of urethral dilatation, internal urethrotomy and primary reconstruction are treatment options, however, there are limitations when the stenosis is complex and extensive. In such cases, the use of flaps and grafts has been proposed. These can be of different origins, including lingual mucosa, labial mucosa, postauricular mucosa, etc.

Buccal mucosa graft (BMG) was first described for urethral reconstruction by Humby in 1941. It has become an ideal urethral substitute because of ease of harvest, surgical handling characteristics, hairlessness, compatibility in a wet

environment, and its early ingrowth and graft survival. Because of these unique characteristics, buccal mucosa has endeared itself to the realm of reconstructive urology. Standard bulbar urethroplasties using buccal grafts should have a lifetime success rate approaching 92%.

In 1996, Morey et al. described ventral on-lay oral mucosa urethroplasty and proposed an improvement to the technique used to harvest buccal mucosa using two teams working simultaneously. Two years later, Barbagli et al. described the application of a dorsal on-lay graft with preservation of the ventral surface. Asopa et al. also described the use of a dorsal on-lay graft. More recently, dorsal grafts have been used in less extensive dissections of the urethra, as described by Kulkarni et al. In selected patients, double Face urethroplasty has also been used for more severe forms of stenosis, with little or no lumen for this purpose. Several variations in techniques have been used. Palminteri et al. described a technique in which a combined dorsal plus ventral double buccal mucosa graft was used in the urethra. Despite encouraging results, there are two disadvantages with that technique. The first is the need for two incisions in the urethra, one ventral and the other dorsal. The second disadvantage is that the ventral graft has little support for its fixation, since it is not fixed to the corpus spongiosum. The technique described here offers the considerable advantage of increasing the lumen, both in the dorsal and ventral parts, using only a urethral incision on the dorsal surface.

CONCLUSION

Double-face urethroplasty is indicated for near-obliterative strictures. A double-face urethroplasty with buccal mucosa using a longitudinal urethral incision preserving the corpus spongiosum and inlay graft proved a viable option, with good results in the postoperative follow-up.

THE GROWING NEED FOR BIOMEDICAL WASTE MANAGEMENT IN HOSPITALS

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Abstract

Biomedical waste (BMW) remains as a threat to the medical personnels and community. Adequate knowledge and good practice towards BMW are mandatory for different cadres in health care sector dealing with medical wastes. Every healthcare facility (HCF) should have a designated flow of BMW management. Segregation is the crucial step and if done properly ensures that all the remaining steps are done effectively. More focus is needed in record maintenance and reporting of BMW. Regular inspection and periodic audits of BMW are to be implemented in waste generating facilities. Hospitals should ensure proper implementation of guidelines by forming a Committee for BMW management.

Key words

Biomedical waste, Biohazard, Health care facility

Introduction

BMW is "'any waste, which is generated during the diagnosis, treatment or immunization of human beings or animals, or in research activities pertaining thereto, or in the production or testing of biologicals"[1]. BMW are infectious wastes which can be either liquid or solid in nature. The demand for rapid and quality health care attracts more wastes due to improved diagnostic procedures. The common sources of production are clinics, diagnostic laboratories, nursing houses, hospitals and health camps.

Adequate knowledge and good practice towards BMW are mandatory for different cadres in health care sector. Various health hazards are associated with mishandling of these wastes. About 40 pathogens are documented to be

transmitted and the predominant ones are HIV, Hepatitis B and C viruses[2]. Pollution of air, water and soil can occur due to poor BMW activities. So utmost care is needed at all levels, while handling and disposing them.

Biomedical waste rules

The Ministry of Environment, Forest and Climate change has formulated BMW management rules in 2016. These rules are done amendments in 2018 and 2019. The apex body which monitors the BMW activities is Central Pollution Control Board (CPCB) in India. The State Pollution control boards of respective state regulate, monitor and report the BMW activities to CPCB. Every HCF should have a designated flow of BMW management and their own sewage treatment plant (STP).

The Indian scenario

The average BMW produced per bed is about 1.5-2 kg daily in India. Our country generates 484 tonnes per day from 168869 HCFs. There are 198 Common BMW treatment facilities (CBMWTF) in use and 28 are under construction. The number of HCFs using CBMWTFs are 131837 and approximately 21870 HCFs have their own treatment facilities on-site[3].

Classes of biomedical waste

Among the total waste generated in hospitals, 85% is general (non-hazardous) waste, and the remaining 15% is hazardous. BMW includes masks, gloves, body parts, sharps, broken ampoules, soiled cotton, discarded linen, expired drugs, vaccines, laboratory wastes, urinary bags, chemicals, cytotoxic and radioactive materials. The BMW produced in hospitals is classified into four major classes. They are the non-plastic infectious wastes (yellow), the plastic recyclable items (red), sharps and metals (white) and broken glasses and metallic body implants (blue) (Figure 1). All the BMW bags and containers should have the logos of biohazard and cytotoxic hazard on them (Figure 2).

Figure 1-Colour coded bins for biomedical waste[4]

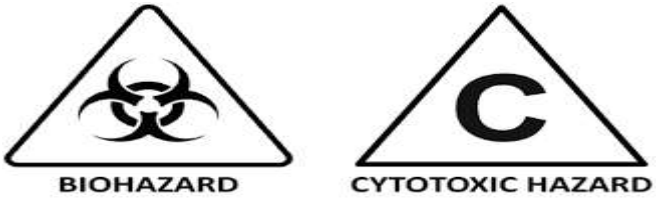

Figure 2. Logos of biohazard and cytotoxic hazard

Steps

The four main steps in BMW management are

1.Segregation

2.Storage

3.Transport

4.Disposal

Segregation

BMW is a potential source of infection. Segregation is the crucial step and if done properly ensures that all the remaining steps are done effectively. Health care workers have to be mindful while doing this step. A single wrong mistake nullifies the entire effort of appropriate disposal[5]. For example, disposing a plastic syringe in yellow bag instead of red one leads to liberation of toxic fumes during incineration. Only three fourths of the capacity of the bags are to be filled. Adequate number of bins should be placed at appropriate waste generating units[5]. All the laboratory liquid waste is to be pretreated either by autoclaving or 1-2% hypochlorite.

Storage

The properly labelled and segregated waste from various areas of hospital is transported by trained workers to common storage area. These workers during transport should wear gowns, masks, heavy duty gloves and gumboots. The common storage area should be safe, well-ventilated, easy to clean with good drainage system and remote from general public. It should display biohazard sign and have compartments to store different categories of wastes temporarily. This area should be sheltered from water, wind, rodents, insects and animals.

Transport

The BMW from central storage area after proper weighing are transported in designated closed vehicle which has a tracker system. The waste reaches the CBMWTF where all wastes are treated and safely disposed within 48 hours of generation time. The treatment methods are Incineration, Autoclaving, Microwaving, Plasma Pyrolysis and Shredding. Any waste which couldn't be reused or recycled are disposed by Deep burial, Sharp pits and Encapsulation.

The principle of BMW management is based on 3Rs- Reduce (decreasing the production of waste), Reuse (if feasible), and Recycle (Plastics). The energy obtained during disposal is used for generating electricity and also as compost for soil.

Challenges

Non-adherence of BMW rules is a major failure. There is always demand for human resources and infrastructure for handling and storing the wastes respectively. Poor segregation practices by few health care workers adds to the menace. The safety measures for BMW workers are often inadequate. There is always risk of hospital associated infections and environmental hazards due to mishandling. Inaccurate data maintenance and poor documentation of BMW also fuels the problem. There is a deficiency in knowledge, attitude and practice on medical wastes among health professionals. Among doctors, the knowledge

about BMW is desirable (82%) while its of lower percentages in other cadres. Nurses score more in practice (83%) compared to other cadres.[6]

Solutions

Hospitals should ensure proper implementation of guidelines by forming a Committee for BMW management. Following right approach towards onsite segregation of wastes should be insisted consistently. Logos of biohazard should be displayed on the plastic bags and containers. The BMW should not be stored more than 24 hours after generation. More focus is needed in record maintenance and reporting, at all levels starting from site of generation to common storage area. Dedicated trolley or vehicle is needed for safe transport of wastes from wards to the common storage area of hospital. Strict monitoring of BMW is to be done as per Standard Operating Procedures (SOP). Raising the awareness among health care workers by Information, Education and Communication (IEC) strategies. Regular inspection and periodic audits of BMW are to be implemented in waste generating facilities.

Conclusion

BMW remains as a threat to the medical personnel and community. Adequate infrastructure with dedicated health care workers with right approach helps in effective BMW management. Commitment and support from Government helps in creating a sustained impact. An eco-friendly environment could be derived by collaborating easy approaches and strict monitoring measures.

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CASE REPORT: LUMBAR SYMPATHETIC BLOCK FOR PERIPHERAL VASCULAR DISEASE (PVD)

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ABSTRACT

Peripheral Vascular Disease (PVD) is a debilitating condition characterized by reduced blood flow to the lower extremities, often leading to pain, ulceration, and impaired mobility. While surgical interventions such as angioplasty or bypass are potions, minimally invasive Interventional pain procedures like Lumbar sympathetic block (LSB) is an effective intervention aimed at improving circulation and alleviating pain. We present a case of a 50-year-old male with PVD who underwent an LSB for symptom relief. The procedure demonstrated significant improvement in pain levels and circulation, highlighting the role of LSB as a therapeutic option in PVD management.

Introduction

PVD, often secondary to atherosclerosis, results in ischemic pain, claudication, and non-healing ulcers. Sympathetic nerve blockade has been explored as a method to enhance blood flow and relieve ischemic symptoms. Lumbar sympathetic block interrupts the sympathetic supply to the lower limbs, leading to vasodilation and improved perfusion. Here, we report a case where LSB was performed for severe PVD-related pain, demonstrating its efficacy in symptomatic relief.

Case Report

A 50-year-old male patient came with Chief Complaints of Left lower limb pain for 2 weeks. Pain characteristics - Intermittent claudication pain in both legs with difficulty in walking due to pain, Able to walk for only short distance. He

also complaints of Rest pain in the left lower limb. NRS score – 9/10. He was a chronic smoker and alcoholic with no comorbidities. On General physical examination, Skin discoloration present on the affected limb (fig 1) & left leg Peripheral pulse reduced. Ankle-Brachial Index (ABI) was 0.8 (suggestive of PVD) & Ultrasound Findings: Suggestive of arterial insufficiency. Patient was started on Heparin 5000U IV QID with Aspirin and for pain patient was receiving Paracetamol, Brufen and Amitriptyline. Despite these measures patient complained of pain with NRS 7/10. So, Planned for Lumbar Sympathetic Block.

After obtaining informed consent and pre procedure workout, patient was prepared for the procedure with standard NPO guidelines on the day of procedure. Procedure Details: With proper ASA monitoring and a secure IV line patient was positioned in a prone and the procedure was performed under fluoroscopic guidance. Under ASP WITH 22 G 12 cm Quincke needle left lumbar sympathetic block done with 8 ml of 1 % xylocard,0.125% Bupivacaine and 20 mg Triamcinolone at L3 level after obtaining desired contrast spread in AP and lateral view (Fig 2,3). Vital signs were stable throughout the procedure. No sensory or motor deficits post-procedure

Outcome and Follow-up

- Immediate post-procedure improvement in pain score NRS – 2/10
- Increased skin temperature indicating improved circulation
- No complications observed
- The patient was discharged with instructions for wound care, lifestyle modifications, and medication (Gabapentin 300 mg, antiplatelets, and vasodilators).
- Follow-up after 2 weeks showed sustained relief of symptoms. NRS 1/10

Discussion

PVD is a progressive vascular disorder that significantly impairs quality of life. While surgical interventions such as angioplasty or bypass are options, conservative and interventional pain management techniques like LSB play a crucial role in symptomatic relief. LSB leads to vasodilation by blocking the

sympathetic nervous system, thereby improving peripheral circulation. This case highlights the efficacy of LSB as a minimally invasive, yet effective, option for pain management and circulation enhancement in PVD patients.

Conclusion

Lumbar sympathetic block is a viable and effective intervention for PVD-related pain. This case reinforces its role in multimodal pain management, especially in patients with contraindications for surgical interventions. Further studies and long-term follow-ups are needed to establish its role in disease progression and quality of life improvement.

Fig 1 Skin Discoloration

Fig 2:Dye spread in AP image

Fig 3 -Dye spread in lateral image


Emglyza-10/25
Emglyza-Met 500/1000
Javlis-5
Javlis-DUO 5/25
Javlis-M 2.5/500 2.5/1000
Javlis-M 5/500
GLYZANDA-M0.5 M1 M2
GLYZANDA-MV 1mg 2mg
Telaze-20/40
Telaze-H
Telaze-CT40
Telaze-MT25/MT50
Cilnilet 5 10 20
Cilnilet-T
PalmiStar
UPSIRON
MERZENDA PLUS
SignoPraz-20/D
AMARIX
Pharmaceuticals


Dear Doctors,
Kindly extend your valuable Rx Support for.....
Levion
Pulmolar
Acebrophylline &
N-Acetylcysteine Tablets
LAPROCIN 10g
Mupirocin Ointment IP 2.0%w/w
Xovigut-HS
Pre & Probiotic Capsules
Zovibion 5G
Softgels
Omega3 Fatty Acid, Green Tea Extract,
Ginkgo Biloba Extract, Ginseng Extract, Grape
Seed Extract, Multimineral, Multivitamin
with Antioxidants & Trace Element
Soft Gelatin Capsules

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Start investing 1lakh in a SIP @ 12% returns

·First 1.6 Crores takes 8 long years

·Second 1.6 Crores takes only half the time, at 4 years!

·Third 1.6 Crores takes 3 years!

·Fourth 1.6 Crores takes just 2 years!

Unlock the power of compounding and achieve financial milestones faster.

An SIP approach without much fuss,

- Start SIP of ₹1,00,000 per month for 12 years in an index fund

-Assuming 12% CAGR, corpus after 12 years will be 4 Crores

Your mindset determines your financial success. The right mindset will turn ₹1

lakh into ₹4 Crores. Consistency is far superior than Timing the market. Running

an SIP for next 10 years will outperform most of the strategies that involve timing

the market.

Consistency is the Key.

Investor have to be like a man standing with a spear next to a stream. Most of the

time he is doing nothing. When a fat juicy salmon swims by, the man spears it.

Then he goes back to doing nothing. It may be six months before the next salmon

goes by.

Charlie Munger says most of the time we have to do nothing and stay quite.

Inaction is the key to be a successful investor

Happy Investing days Ahead

Disclaimer: This newsletter is purely is on purely financial awareness and

educational purpose. Strictly not a recommendation

1Lakh to 4 Crore Magic

About myself

I am Dr .S. Jefferson Roy MBBS DA a practicing Anaesthesiologist in Kanniyakumari District. What I do I preach and educate is the strategy behind the newsletter. Kindly make good use of it.I aim at reaching out to a million doctors in India about achieving financial freedom .I dont run any financial services.

IMA ACTIVITIES

S.No	Year	Month	Theme	Guest of Honor
1	2023	January	Multidisciplinary management of low backache	**Dr Ramkumar** Neurosurgeon KGMC - Kanyakumari
2	2023	February	Emergency trends in vascular surgery	**Dr.K.Rajesh** Vascular Surgeon KGMC - Kanyakumari
3	2023	March	Outreach activities Village adoption Elandhayadivilai	**Dr.M.Thiraviam Mohan** IMA TNSB Vice President South Zone ALL members of IMA – KMC Branch
4	2023	March	Black day black badge protest against Right to health bill in Rajasthan	All Members of IMA - KMC Branch
5	2023	June	Outreach activities Village adoption Melmidalam	All members of IMA – KMC Branch
6	2023	June	ARDS beyond Mechanical Ventilation	**Dr Ajmal Abdul Karim** Consultant Critical Care KIMS - Health, Trivandram
7	2023	July	Is snoring a disease	**Dr Joseph Pratheeban** **Consultant Pulmonologist**
8	2023	July	Doctor's Day Celebration	**Dr.Prince Sreekumar Pius** Dean KGMC - Kanyakumari
9	2023	August	Combination therapy in uncontrolled T2DM	**Dr.Jayaram Kosalaram** Consultant Physician KGMC - Kanyakumari

10	2023	September	Outreach activities Medical Camp Puthukudierupu	**All members of IMA – KMC Branch**
11	2023	October	Art Competition World Anatomy Day	**Prof Dr Anitha Department of Anatomy, KGMCH**
12	2023	October	Acute stroke management-An update	**Dr Krishnasree** Associate Consultant Neurology KIMS - Health, Trivandram
13	2024	January	Awareness on Eye Care	**Dr.AJS.Pravin** RI District Chairman
14	2024	February	CME on Oncological imaging via PET & SPPECT	**Dr.J.Balasubramaniyan** Chief Transplant & Interventional Nephrologist
15				
16			Current Scenario Approach to Pancytopenia : Focus on Aplastic Anemia	**Dr.Arshad Raja** Associate Consultant Kauvery Hospital Alwarpet
17				
18	2024	July	Doctor's Day Celebration	All members of IMA- KMC Branch
19	2024	September	Unravelling novelties of Modern management in Chronic Pancreatitis	**Dr.Johnson MariaAntony** Senior Consultant Department of Gasteroentrologist KMC, Kanyakumari

20	2024	September	Blood Donation Camp Chembaruthivilai	**Dr M K Rakesh MD** IMA – KMC Branch
21	2024	October	Blood Donation Camp KMC - Kanyakumari	**Dr M K Rakesh MD** IMA – KMC Branch
22	2024	November	Metabolic Dysfunction Associated Steatotic Liver Disease & Diabetes recent Concepts	**Dr.Joel Franklin F** Joel's Diabetes Thyroid & Hormone Clinic Nagercoil
23	2025	January	Demystifying Sepsis Management	**Dr.C.Ayyapan** Consultant & ICU Head Apollo Speciality Hospital Madurai

GLIMPSES OF IMA


ரோட்டரி கிளப் ஆப் நாகர்கோவில் BLOSSOMS
இந்திய மருத்துவ சங்கம்
C.S.I சந்தையடி சபை


Indian Medical Associa
Trivandram
for the
CELEBRATION


INDIAN MEDICAL ASSOCIATION
Kanyakumari Medical College Branch
Cordially invite you for the Monthly
CME PROGRAM


மருத்துவம்

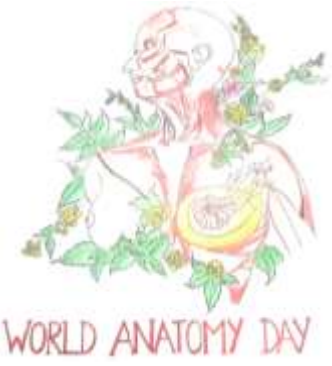

PRAVIN ADVANCED
SKIN, LASER & COSMETIC CENTRE

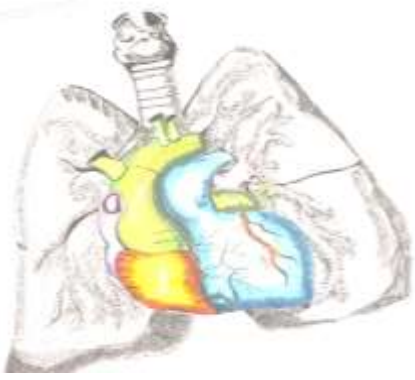

INDIAN MEDICAL ASSOCIATION
CME PROGRAM

57 | IMA – Kanyakumari Medical College Branch

Greetings by the Office Bearers to the Members of IMA

ANATOMY ART COMPETITIONS


WORLD ANATOMY DAY



MEGA BLOOD DONATION CAMP

On March 5, 2025, the Indian Medical Association (IMA) Kanyakumari Medical College (KMC) Branch organized a mega blood donation camp in collaboration with Kanyakumari Medical College, IMA Medical Students Network, and the Red Ribbon Club. The event was held in the examination hall of Kanyakumari Medical College Hospital (KMCH). Prof. Dr. V. Ramalakshmi, Dean, inaugurated the camp, while Dr. K.U. Suresh Balan, Vice Principal, Dr. Y. Kingsley Jeba Singh, Medical Superintendent, Dr. Joseph Sen, RMO, Dr. Vijayalakshmi Mohandas, ARMO, and Dr. Renimol, ARMO, felicitated the event. The camp received overwhelming support from IMA President Dr. Muthukumar, Dr. Arul Venkadesh, Secretary and other IMA members. A total of 220 blood units were collected, marking the highest collection among all camps conducted by KGMCH in Kanyakumari district to date. The success of the camp was attributed to the active participation and coordination of undergraduate and postgraduate students, Vice Principal, Heads of Departments, Professors, and Assistant Professors of Kanyakumari Medical College. Dr.M.K.Rakesh, District Blood Transfusion Medical officer convened the Mega Medical Camp in a grand manner.

AWARDS & RECOGNITION

LIFE TIME ACHIEVEMENT AWARD

Dr.M.MUTHU SHENBAGAM
Professor & HOD of Emergency Medicine

Dr.P.JOHN CHRISTOPHER
Professor & HOD of Medicine

Dr.EDWARD JOHNSON
Professor and Hod of Anaesthesiology

Dr.EDWIN EMPEROR
Professor and Hod of Plastic Surgery

BEST PERFOMANCE AWARD - 2023

S.NO	Name	Designation
1	Prof Dr Anitha	Professor and HOD of Anatomy
2	Dr Padma kumar	Department of Nephrology
3	Dr Selvakumar	Deprtment of Urology
4	Dr T Ramesh Kumar	Deprtment of Neonatology
5	Dr Sam Anbu Sahayam	Deprtment of Pharmacology
6	Dr T Susitha	Deprtment of Microbiology

BEST PERFOMANCE AWARD - 2024

S.NO	Name	Designation
1	Dr.M.Balabharathi	Assistant Professor of Radiology
2	Dr.Oxy T.S. Dharsini	Plastic Surgery
3	Dr.V.Breetha	Assistant Professor of OG
4	Dr.J.Rosebell	Assistant Professor of Anesthesia
5	Dr.M.K.Rakesh	Assistant Professor of Immunohaematology
6	Dr.Mohan Murugesan	Assistant Professor of Pathology
7	Dr.R.Balaji	Medical Officer, ISRO
8	Dr.P.Ram Praveen	First Year PG
9	Dr.M.Mohamed Jasir	First Year PG
10	Dr.Hari Krishnan	First Year PG

TEACHERS DAY AWARD - 2024		
1	Dr.V.Anitha	Department of Anatomy
2	Dr.D.Jude Anselm Shyras	Department of ENT
3	Dr.G.M.Niban	Department of Neurosurgery
4	Dr.Sri Vidya	Deprtment of General Medicine
5	Dr.R.Beena	Department of Opthalmology
6	Dr.Jayaram Kosalram	Deprtment of General Medicine
7	Dr.J.Merceline Alice Pon Jeba	Department of pediatrics
8	Dr.R.Keerthana	Department of Pharmacology
9	Dr.J.Jeya Deepana	Department of Microbiology

1. Organize Continuing Medical Education (CME) programs

2. Provide a platform for young medical graduates to showcase their research work, share knowledge, and learn from experts in the field.

3. Community Health Initiatives

4. Mentorship Programs

5. Collaborate with Local Healthcare Institutions

6. Advocate for Healthcare Policy Changes

7. Host Medical Conferences and Workshops

8. Develop a Member Support System

9. Promote Research and Innovation

10. Foster Interdisciplinary Collaboration

11. Develop a Public Health Awareness Program

"KANYAKUMARI - A TREASURE TROVE OF NATURAL BEAUTY AND CULTURAL HERITAGE"

Kanyakumari located at the southernmost tip of the Indian subcontinent, Kanyakumari District is a gifted area, rich in natural beauty, cultural significance, and historical landmarks. Formed on November 1, 1956, the district was once the "Granary" of the erstwhile Travancore State. Kanyakumari, also known as Cape Comorin, is a coastal town surrounded by the sea on three sides. The town boasts a scenic coastline with beautiful beaches, making it a popular tourist destination. Kanyakumari has a rich cultural heritage, with a blend of Tamil, Kerala, and Christian influences. The town is known for its vibrant festivals, including the Chithra Pournami festival. The Thiruvalluvar Statue: A Symbol of Cultural Heritage

The Thiruvalluvar Statue, located on a small island near Kanyakumari, is a magnificent monument dedicated to the renowned Tamil poet and philosopher Thiruvalluvar. The statue stands tall at an impressive height of 133 feet, including the pedestal, and is steeped in symbolism, representing the 38 chapters of virtue, 95 chapters of wealth and love, and the three-level platform, Atharapeedam. The Thiruvalluvar Statue is an awe-inspiring monument that showcases the rich cultural heritage of Tamil Nadu, making Kanyakumari District a must-visit destination for anyone interested in exploring the natural beauty, cultural significance, and historical landmarks of India.