



The 521st CME of IMA Chennai Kodambakkam Branch was held on 28th June 2026 at 2:00 PM at Aaditya Hotel, Vadapalani, Chennai.

Tamil Thai Vazhthu, IMA Prayers, Flag Salute was performed in accordance with IMA protocol. The meeting was called to order by President Dr. Nirmala Ponnambalam. Our Secretary Dr. Shahul Hameed and Finance Secretary Dr.Vamsi Krishna conducted the meeting.

Around 90 members attended the CME, and one TNMC Credit Hour was awarded to the participating members.

LIFETIME ACHIEVEMENT AWARD



Dr. S. ASOKAN, MBBS, MS

An alumnus of Stanley Medical College, Dr S Asokan is a distinguished surgeon with 40+ years in healthcare leadership, he served 21 years in Tamil Nadu Government hospitals before becoming Senior Consultant Surgeon at Vijaya Hospitals for two decades. He was Vice Chairman at Velammal Medical College and currently leads GEM Hospital, Chennai as Director-CEO.

Beyond surgery, he has shaped policy as President of the Tamilnadu Assistant Surgeons Association, Co-Convenor of CII TN's Healthcare Panel, and Senate Member at Dr Ambedkar Law University.

His contributions are recognized with Best Doctor Award from Dr. M.G.R. Medical University and Lifetime Achievement Awards from Saveetha University and IMA Madurai.

A Life Member of the Indian Medical Association, Chennai Kodambakkam branch.

We, the President and members of the Indian Medical Association Chennai Kodambakkam branch feel proud to honor a Doyen in Medical Field.

CME PROGRAMME

1. IMA PRAYER AND FLAG SALUTATION - Dr. M.I.Shahul Hameed
2. Diabetes Continuum in India : The Power of Dual Agonism
Dr Adlyne Reena Solomon
3. Neuroprotection in NICU - Dr Arun Kumar
Consultant Infectious Disease, SIMS Vadapalani.
4. The Curious Case Files of Pulmonary Medicine
Dr R Naveen Vennilavan
Consultant, Kauvery Hospital. Alwarpet.
5. My Professional Journey - Dr S Asokan
(Life Time Achievement Awardee)
6. Laproscopy and Robotics Surgery in Urology
Dr R Manikandan
Senior Consultant Nephrologist, SRM PRIME
7. Liver Transplantation through Clinical Cases
Dr Magnus Jayaraj, Lead Transplant Surgeon
GEM Hospital, Chennai
8. Interventional Radiology: Minimally Invasive Solutions for
Everyday Clinical Practice - Dr Shoban Haridoss
Apollo Speciality Hospital
9. Dr A Karunagaran Endowment Oration
Topic : Epidemiology and Prevention of Arthropod-Borne
Infections
Speaker: Dr L Kannan, Prof. of Community Medicine, SRMC.
10. Medical Quiz - Dr C R Padma

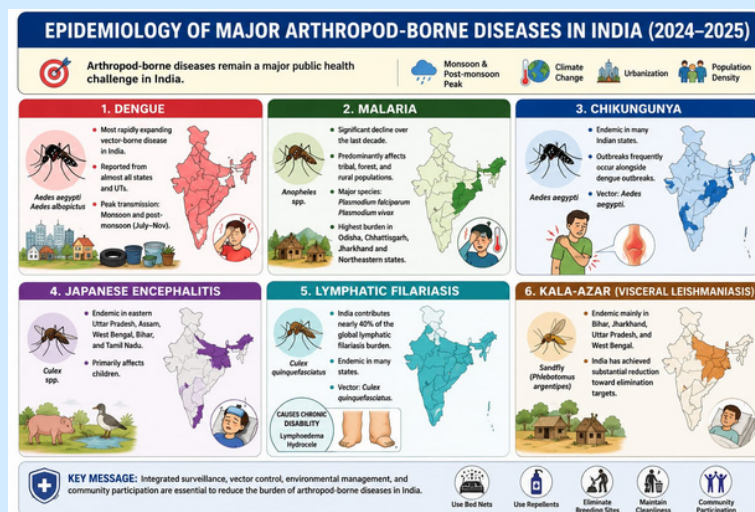
AN OVERVIEW OF THE PRESENTATION IS GIVEN BELOW.

Epidemiology and Prevention of Arthropod-Borne Infections

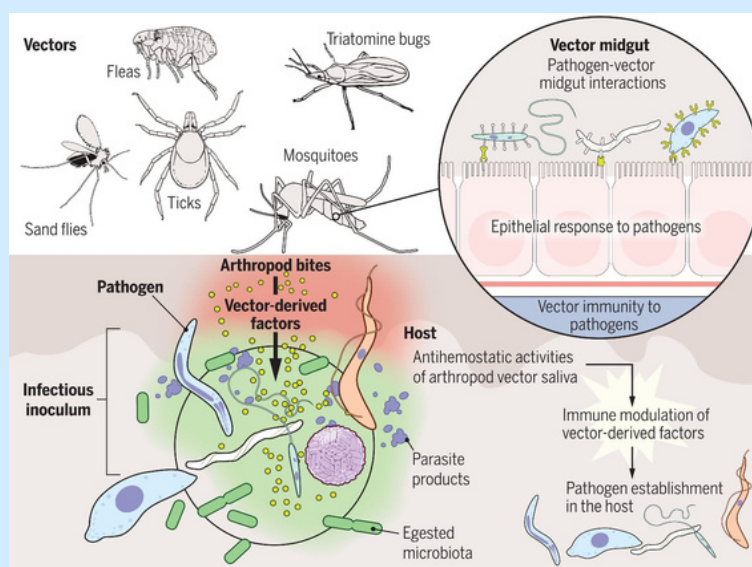
Dr. L. Kannan, Professor of Community Medicine, SRMC presented on the topic: Epidemiology and prevention of Arthropod borne infection.

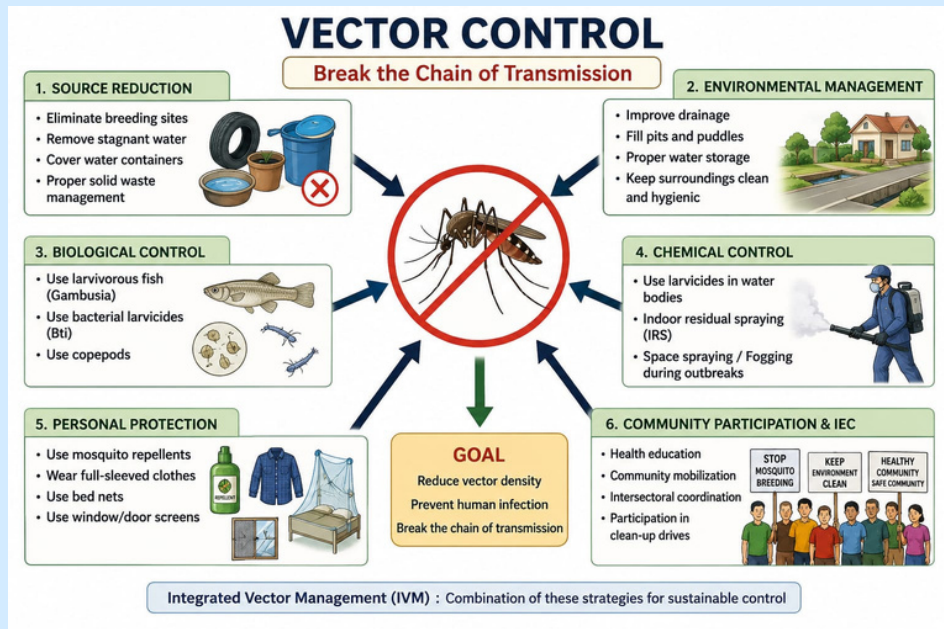
The description of presentation based on,

Global burden: Vector-borne diseases cause 17% of global infectious disease and 700,000+ deaths/year; malaria alone accounts for 263 million cases and nearly 608,000 deaths worldwide; India reports 500,000+ cases annually (most common are dengue and malaria).



Vectors & diseases : The main vectors are mosquitoes (*Aedes*, *Anopheles*, *Culex*), ticks, mites, fleas, and lice as vectors for diseases like malaria, dengue, chikungunya, Zika, filariasis, Japanese encephalitis, plague, and typhus.





Transmission: Direct/mechanical/biological transmission modes, with examples (e.g., malaria via Anopheles, filariasis via Culex). **Clinical description :** Detailed description of disease-by-disease breakdown of causative agents, vectors, clinical features, and management/treatment for major infections (malaria, dengue, chikungunya, Zika, filariasis, JE, leishmaniasis, plague, typhus).

Prevention/Control : Three-pronged approach — vector control (IRS, insecticide nets, biological/genetic control), host protection (PPE, early treatment), and environmental management (source reduction, sanitation).

Programs : India's National Centre for Vector Borne Diseases Control (NCVBDC, est. 2003) organizational structure and objectives.

Key takeaways : Climate change, urbanization, and insecticide resistance are growing threats; Integrated Vector Management (IVM) and community participation are essential for control of many Arthropod borne diseases.

Neuroprotection in the NICU: Moving from Survival to Intact Survival

By Dr. Arun Kumar Sundaram, SIMS Hospital

Advances in antenatal and neonatal care have significantly improved survival among preterm infants. The next priority for neonatal intensive care is not survival alone, but intact survival: ensuring that infants leave the NICU with the strongest possible foundation for long-term neurological and neurodevelopmental health.

Preterm birth disrupts a critical period of third-trimester brain growth, when the central nervous system undergoes rapid maturation. Because preterm brain injury is multifactorial, neuroprotection must be approached as a continuum of care that begins before birth, continues through delivery and stabilization, and extends throughout the NICU stay.

A Continuum of Evidence-Based Care:

Before birth: Antenatal care provides some of the earliest and most powerful opportunities for neuroprotection. Antenatal steroids remain a cornerstone intervention, with benefits that include reductions in perinatal mortality, neonatal mortality, respiratory distress syndrome, intraventricular hemorrhage, and childhood developmental delay. Magnesium sulphate also plays an important role by reducing the risk of cerebral palsy. Timely antenatal transfer to an appropriate center, along with careful management of chorioamnionitis and preterm premature rupture of membranes, further supports safer outcomes for high-risk pregnancies.

At birth and early after birth: stabilizing the brain

Neuroprotection continues in the delivery room and early postnatal period. Deferred umbilical cord clamping supports physiological transition at birth and is increasingly recognized as part of brain-protective care.

In the NICU, caffeine, widely used for apnea of prematurity, has also emerged as an important neuroprotective therapy, with follow-up evidence showing benefits in motor and developmental outcomes.

Avoiding fluctuations in blood pressure, temperature and Co2 is important in prevention of intraventricular hemorrhage which is common in the first 72 hours of life.

During intensive care: reducing neurological risk.

Within the NICU, acute neurological threats require prompt recognition and consistent prevention strategies. Seizures in preterm infants are associated with risk factors such as chorioamnionitis, severe intraventricular hemorrhage, periventricular leukomalacia, necrotizing enterocolitis, sepsis, and meningitis, and may contribute to poor neurodevelopmental outcomes. Sepsis prevention is an essential component of neuroprotection, supported by standardized central-line care bundles, antimicrobial stewardship, early enteral feeding with breast milk, cautious use of postnatal steroids, and meticulous hand hygiene.

Developmental Care as Neuroprotection

Developmental and family-centered care are central to modern neonatal neuroprotection. Kangaroo Mother Care is associated with improved cognitive, language, and motor outcomes, higher later IQ, and greater gray matter volume. Beyond its clinical value, KMC strengthens parental participation and should begin early and be delivered consistently whenever feasible.

Other supportive practices also contribute to a brain-protective environment. Sleep protection, optimized nutrition, pain management, skin protection, and neurosensory care help reduce stress and support neurodevelopment. Practical measures include minimal handling, comfort positioning, clustering procedures, noise control, cycled lighting, and attention to the developmental sequence of tactile, vestibular, gustatory-olfactory, auditory, and visual inputs.

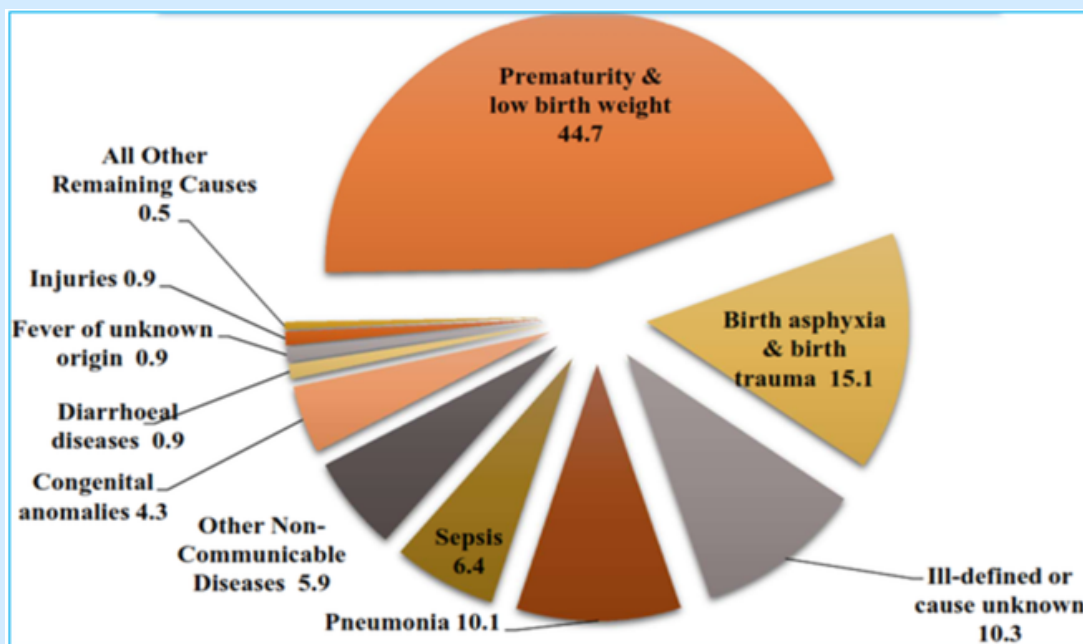
Future Directions:

Emerging therapies such as erythropoietin, melatonin, and stem cells represent promising directions in pharmacological neuroprotection. Their potential mechanisms include anti-apoptotic, anti-inflammatory, antioxidant, and neural-repair effects. However, these approaches remain areas of ongoing investigation, and current practice should continue to prioritize reliable delivery of proven interventions.

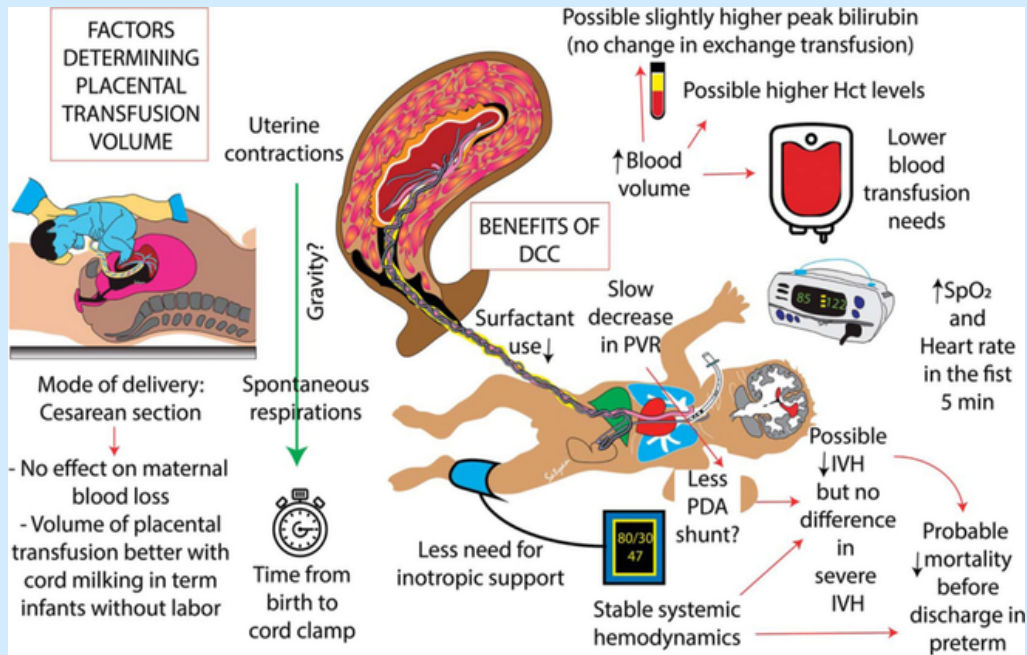
Building a Brain-Protective NICU:

Neuroprotection is not a single intervention, but a coordinated care philosophy. From antenatal steroids and magnesium sulphate to deferred cord clamping, caffeine, seizure and sepsis prevention, developmental care, and family engagement, every step should contribute to a standardized brain-protective pathway. For every NICU, the goal should be to embed these practices into routine care bundles so that preterm infants are supported not only to survive, but to thrive.

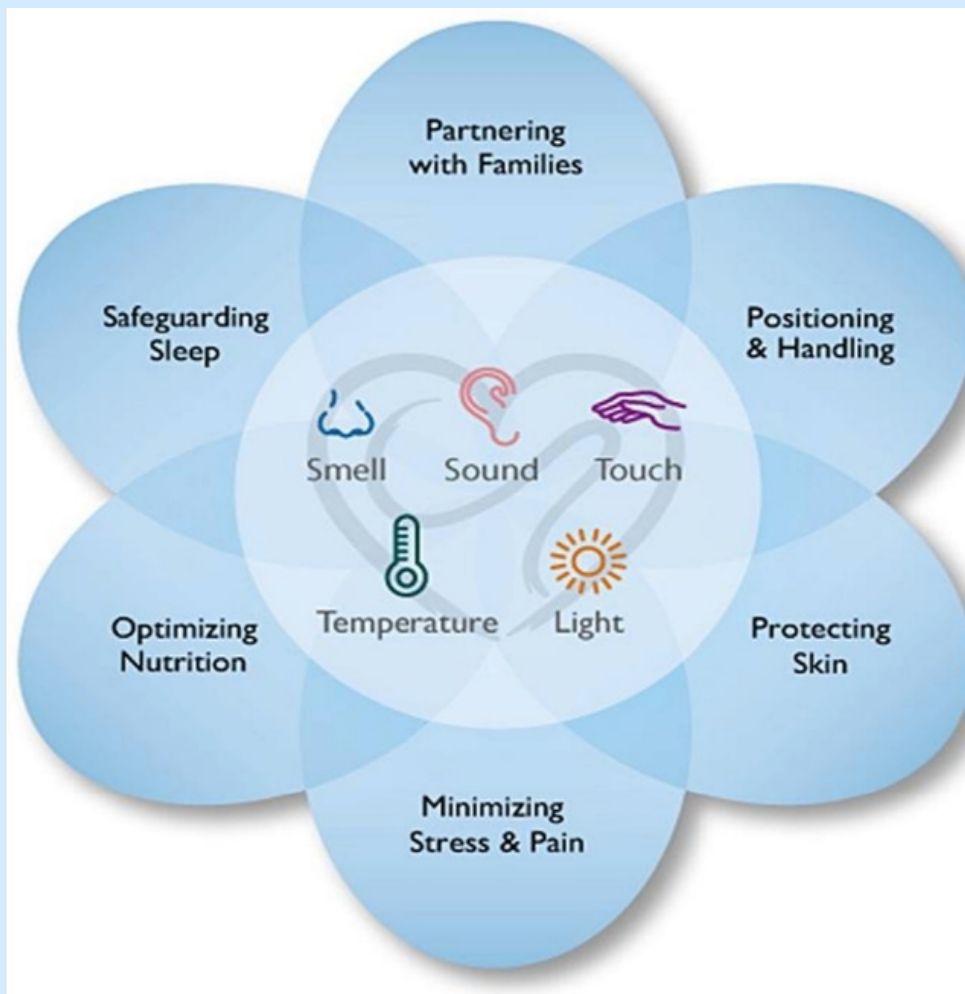
Neonatal mortality in India



Benefits of delayed cord clamping



Neonatal integrative developmental care model



Interventional Radiology: The Future of Minimally Invasive Care

Dr. Shoban Haridass MD, DNB, DM

Interventional Radiology (IR) replaces traditional surgery with image-guided micro-procedures. Doctors insert thin tubes called catheters, or small needles, through pinhole incisions in the skin. Using real-time X-rays (fluoroscopy), CT scans, MRIs, or ultrasounds, the radiologist navigates these instruments through blood vessels or organ pathways to fix the problem directly at the source.

1. Minimal Trauma and Local Anesthesia

No Scalpels: Incisions are typically less than 3 millimeters wide, requiring only a small bandage, not stitches.

Conscious Sedation: Patients remain awake but relaxed. This avoids the grogginess, nausea, and breathing tube risks of general anesthesia.

2. Shorter Hospital Stays and Economics

Outpatient Dominance: Up to 70-80% of IR procedures allow patients to go home within hours.

Cost Efficiency: Eliminating operating room fees and multi-day hospital stays significantly lowers medical bills.

3. Rapid Recovery Timeline

Days vs. Months: Open surgeries often require 6 to 12 weeks of recovery. IR patients generally resume light activities within 24 to 48 hours.

Low Impact: No deep muscle tissue cuts mean the body spends less energy healing the incision site.

4. Safety Profile

Low Infection Rates: Smaller entry points offer bacteria almost no access to internal organs.

Precision Control: Real-time imaging ensures tools avoid damaging nearby healthy nerves, tissues, and blood vessels.

Medical Applications:

1. Vascular Care: Angioplasty and Stents: Balloon catheters expand narrowed arteries in the legs or heart, and metal mesh tubes (stents) keep them open.

IVC Filters: Placing a tiny umbrella-like filter in the inferior vena cava to catch blood clots before they reach the lungs.

2. Interventional Oncology (Cancer Care)

TACE (Transarterial Chemoembolization): Tiny beads loaded with chemotherapy are injected straight into the hepatic artery feeding a liver tumor, trapping the drug inside the cancer cells.

Y90 Radioembolization: Injecting millions of microscopic radioactive beads into tumor-feeding vessels to destroy cancer from the inside out.

3. Neurovascular (Brain and Spine)

Mechanical Thrombectomy: For ischemic strokes, a stent-retriever tool enters the groin, travels to the brain, and grabs the clot to instantly restore blood flow.

Vertebroplasty: Injecting medical-grade bone cement into fractured vertebrae to instantly relieve severe back pain.

4. Specialized Health Issues

Uterine Fibroid Embolization (UFE): For women suffering from heavy bleeding, microscopic particles block the blood supply to fibroid tumors, causing them to shrink and die.

Varicocele Embolization: Treating male infertility and pain by closing off enlarged veins in the scrotum.

Why Early Referral and Collaboration Matter The Critical Window (Early Referral)

Preserving Options: If a vascular or oncology condition is caught early, IR can treat it before open surgery becomes the only viable lifesaving choice.

Preventing Damage: For strokes or internal bleeding, every minute saved by an immediate IR referral preserves brain tissue and prevents organ failure.

The Multidisciplinary Team

Tumor Boards: Interventional radiologists sit with oncologists, surgeons, and pathologists to debate the best sequence of therapy for cancer patients.

Coordinated Care: A cardiologist might identify a blocked leg artery, but work with an IR specialist to open it, ensuring the patient benefits from the combined expertise of both fields.



“Did You Know”

Fat is exhaled: When patients lose weight, over 80% of the metabolized fat mass is converted into carbon dioxide and leaves the body through the lungs.

Stomach auto-digestion protection: The human stomach lining completely replaces itself every 3 to 4 days to prevent the highly acidic gastric juices from digesting the organ itself.

High-velocity reflexes: A cough exits the respiratory tract at speeds up to 100 km/h, while a sneeze can exceed 166 km/h.

Extreme placental endocrine output: By the end of a third-trimester pregnancy, the placenta produces more estrogen in a single day than a non-pregnant woman's ovaries produce in roughly three years

Liver Transplantation through Clinical Cases

Dr Magnus Jayaraj, Lead Transplant Surgeon

The logic of liver transplantation:

The liver disease is irreversible

Expected survival without transplant < survival with transplant

Quality of life is unacceptably compromised

The patient is a suitable surgical and psychosocial candidate

01 Chronic Liver Disease (CLD): Timing & Optimization

MELD Score 14-16 Threshold: The Model for End-Stage Liver Disease (MELD) score predicts 3-month mortality. At a score of 14-16, the survival benefit of receiving a new liver begins to outweigh the surgical risks of the transplant itself.

The "Planned" Transplant: Emergency transplants on decompensated, critically ill patients carry high complication rates. Referring a patient while they are still stable allows the surgical and medical teams to optimize their nutritional status, manage portal hypertension, and plan elective surgery.

Surgical Fitness: Patients referred early have better cardiac, renal, and physical reserve (less sarcopenia/muscle wasting). This high physiological reserve allows them to tolerate the intense stress of a major transplant surgery and recover faster.

Lower Mortality: Early referral minimizes the time a patient spends in the "high-risk zone" where unexpected, fatal complications (like variceal bleeding or spontaneous bacterial peritonitis) can occur while waiting for an organ.

02 Hepatocellular Carcinoma (HCC): Tumor Biology & Bridging Bridge Therapy: Local-regional therapies (LRT) like chemoembolization or ablation are used to "bridge" patients.

This prevents the tumor from growing beyond acceptable transplant criteria (e.g., Milan Criteria) while they wait on the transplant list.

LDLT vs. Tumor Biology: Living Donor Liver Transplantation (LDLT) allows the surgery to be scheduled immediately once a matching donor is found. This eliminates the "race against time" inherent to deceased donor lists, where a patient might drop off the list because their tumor grows too large while waiting.

Earn the Transplant" via TACE: Response to Transarterial Chemoembolization (TACE) serves as a dynamic test of tumor aggressiveness. If a tumor responds well to TACE, it indicates a favorable, less aggressive tumor biology. If it progresses rapidly despite TACE, the systemic recurrence risk post-transplant is too high, making the patient a poor candidate.

AFP Trajectory: Alpha-Fetoprotein (AFP) is a tumor marker. Rather than looking at a single static number, clinicians track the trajectory (the trend over time). A rising AFP trajectory signals aggressive disease and a high risk of vascular invasion, even if imaging looks stable.

03 Acute-on-Chronic Liver Failure (ACLF): Rapid Stabilization

PLEX as a Bridge: Plasma Exchange (PLEX) removes large volumes of the patient's plasma and replaces it with fresh frozen plasma. This clears systemic inflammatory cytokines, endotoxins, and ammonia, temporarily stabilizing the patient's organs until a liver becomes available.

Documentation and Parallel Workups: ACLF patients can deteriorate into multi-organ failure within days. Waiting to finish one test before starting the next (sequential workup) takes too long. Teams must run cardiac, infectious, and financial clearances in parallel. Accurate clinical documentation is vital to justify high MELD exception points to transplant boards quickly.

The Flexible 6-Month Rule: Historically, patients with alcohol-associated liver disease required 6 months of documented sobriety before listing. In acute, life-threatening presentations of ACLF (like severe alcoholic hepatitis), centers increasingly waive this absolute rule if the patient has a strong support system and a low risk of recidivism.

Psychosocial Evaluation: Because medical criteria are compressed in ACLF, the psychosocial assessment becomes the ultimate gatekeeper. The team must verify that the patient has a reliable support network to manage complex, lifelong post-transplant medications and follow-ups.

04 Acute Liver Failure (ALF): Neurological Emergency

King's College Criteria: This is a validated medical scoring tool used to predict which ALF patients will die without a transplant. It uses specific markers (like pH, creatinine, INR, and encephalopathy grade) depending on whether the liver failure was caused by acetaminophen (paracetamol) toxicity or other factors.

Listing Urgency: In ALF, a previously healthy liver fails rapidly over days or weeks. Patients must be listed with the highest priority (Status 1A) immediately, because their clinical window is extremely narrow.

Brain at Risk: When the liver fails completely, toxic metabolites—especially ammonia—build up in the blood. This causes severe brain swelling (cerebral edema). Every hour of delay increases intracranial pressure.

The Point of No Return: A failing liver can be replaced with a donor organ, and it will function immediately. However, if cerebral edema progresses to transtentorial herniation (where the brain stem is compressed through the base of the skull), the patient becomes brain-dead. At that stage, a transplant is useless.

05 ABO-Incompatible Transplants (ABOi): Overcoming Immunological Barriers

Protocol Challenge:

Transplanting an organ from a donor with an incompatible blood type (e.g., Type A donor into a Type O recipient) normally triggers a hyperacute rejection because the recipient's natural antibodies will immediately attack the donor liver's blood vessels.

Desensitization Protocol:

To make an ABOi transplant safe, the recipient undergoes a strict pre-conditioning regimen:

Rituximab: A monoclonal antibody that destroys B-cells, preventing them from producing new anti-donor blood-type antibodies.

Plasmapheresis:

A plasma washout process that physically filters out the existing antibodies already circulating in the recipient's blood.

Clinical Viability:

Once the antibody levels (titers) are driven down to a safe threshold, the transplant can proceed. This protocol is crucial in urgent situations where a living donor is available but blood-type matched organs are nowhere to be found



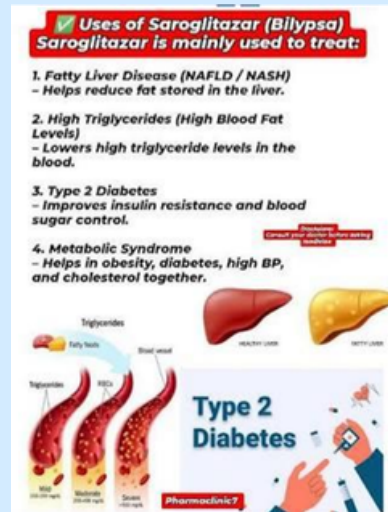
MEDICAL QUIZ

BY Dr C.R. Padhma

QUESTION NO.1

What is the drug of choice for fatty liver disease ?

Saroglitazar



QUESTION NO.2

This patient has c/o loss of weight ,increased appetite ,loose stools, tremors, palpitation and fever.

Grave's disease

T3 □ increased

T4 □ increased

TSH □ below normal

Elevated TRAb

(Thyrotropin receptor antibodies)



QUESTION 3

What are the food or food habits that leads to anemia?

Tea and Coffee (Tannins and Polyphenols)

Milk and diary products (Cheese , yogurt compete with iron absorption)

Whole grain cereals and legumes (Contains phytates)

Oxalate rich foods (Spinach , Nuts and chocolates)

QUESTION NO 4

What Anti – diabetic drug should be avoided in Diabetic patients with UTI ?

SGLT2 Inhibitors(Glifozins) – Dapaglifozin / Empaglifozin

QUESTION NO.5

Is BMI an accurate indicator of Obesity?

BMI SCREENING TEST

DOESN'T DIFFERENTIATE FAT/ BODY WATER /BONE

LOWER BMI ASSOCIATED WITH CVD IN ASIAN POPULATION

DISTRIBUTION OF FAT CANNOT BE DETERMINED

ACCURATE TESTS:

WAIST CIRCUMFERENCE

DEXA SCAN

BIOELECTRICAL IMPEDANCE

QUESTION NO.6

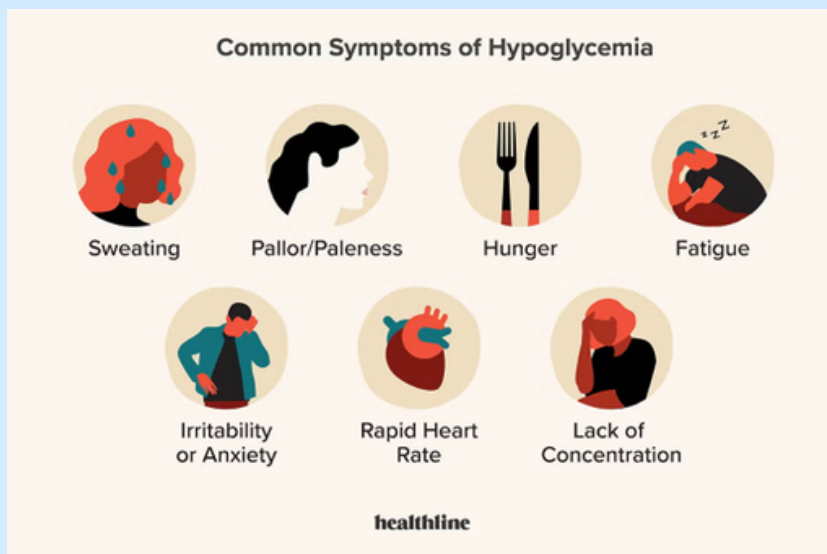
What is hypoglycemia unawareness ?

Lack of symptoms

Repeated low blood sugars

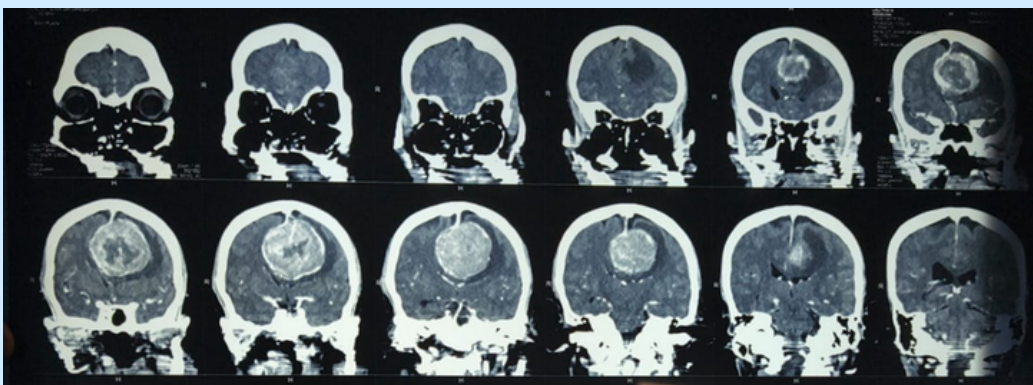
Common in patients on Propranolol / Metoprolol / Anti - depressants

It can lead to confusion , LOC , Seizures



QUESTION NO 7

Where does this Intra cranial lesion arise from ?



Meningioma arising from the Falx cerebri

QUESTION NO.8

What is most common electrolyte imbalance in the elderly ?

HYPONATREMIA

Low sodium intake

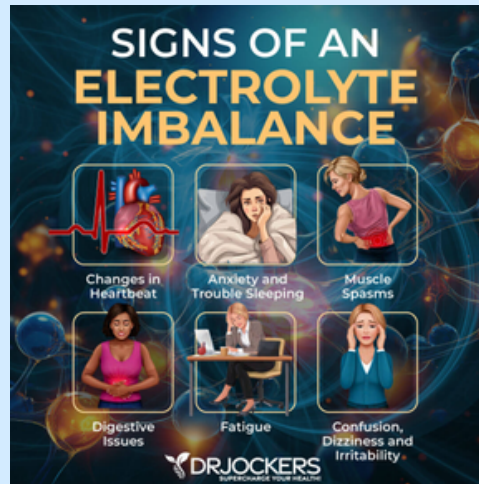
Poor intake

Diuretics

Polypharmacy

Decline in Renal function/
cognitive decline

Not always CVA



QUESTION NO.9

This French doctor's name is associated with

Crystals in asthmatic sputum

Cerebral artery and aneurysm

Peripheral neuropathy

Neuropathic joints

Biliary triad



Jean – Martin Charcot

QUESTION NO.10



This patient was admitted for Urinary symptoms , incidentally her Alkaline Phosphatase levels were high and this is her X-ray Skull

PAGET'S DISEASE



“Did You Know”

Malignancy-induced pregnancy tests: Human chorionic gonadotropin (hCG) can be secreted by testicular germ cell tumors, causing male patients with these tumors to test positive on a standard urine pregnancy test.

Flash photography leukocoria: A white pupillary reflex (leukocoria) captured instead of a normal "red-eye" in standard flash photography can indicate life-threatening pediatric retinoblastoma.

Atypical geriatric presentations: Elderly or diabetic patients experiencing an acute myocardial infarction or acute appendicitis frequently lack typical symptoms like crushing chest pain or localized right lower quadrant pain

AI IN PATIENT CARE: A BOON OR A BANE

To understand this, let's first recapitulate the history of medicine. From the very ancient times to the present day, medicine has evolved leaps and bounds and especially since the last 100 years, tremendous changes and advancements have taken place in various fields of medicine. But it was always a physician / doctor oriented practice till very recent past. The physicians used to apply their clinical knowledge and experience in diagnosing and treating the patients. Some stalwarts in medicine have contributed by doing extensive research in a particular field and have proposed and invented newer ways and medications for the treatment. There was tons of human efforts lasting days to years in treatment of the patients. This is very much understandable to the human brain to think about all those events retrospectively.

In the last few decades, the computers have entered into almost all fields of life and likewise medical practice. The computers have made our life easier by various ways

- 1.Reducing paperwork – the use of a physical paper has come down significantly, thereby creating lots of physical space
2. Data storage – patient data and medical records can be stored for indefinite period of time safely and can be retrieved within few minutes from any part of the world and also without much strain.
3. Clarity of prescriptions – a computer printout of the prescriptions can be very much legible and help the pharmacist and the patient to follow the advice very comfortably.

4. Data interpretation – all the entered data can be interpreted very easily with the help of computers helping the researchers to come to a conclusion more accurately

5. Communication – with the advent of telemedicine, a patient in the remote parts of the world can converse with the specialist in the most advanced hospital in a tier 3 city, thereby giving the patient an option of the best possible treatment.

The new kid on the block is Artificial Intelligence. This software is the new normal and many countries and hospitals are already in the verge of launching in their centres. In addition to the above mentioned advantages, AI can be of help in many other ways:

1. Diagnosis

a. AI can read 1000s of images in a few seconds and tell a diagnosis – this is esp useful in radiology where microfractures and very small nodules can be mistakenly overlooked.

b. The human eye can miss some findings at places esp in studying slides in pathology and microbiology. AI can study many cross sectional images and slides in a few minutes and suggest a diagnosis

c. Disease prediction – AI can study reports and its pattern and can predict a future medical event like cardiac arrest or sepsis hours before the symptoms manifest. It can predict the onset of cancers in many cases months before the actual cellular changes occur in the body.

2. Fetching data

a. AI can access data from all over the world and assimilate them to come to a diagnosis.

The disease trend of a particular diagnosis can be studied and compared with the data from all over the world thereby enabling the physician to diagnose faster and more accurately.

b. The physician can compile the data and can discuss with his peers all over the world and this can help the patient get the best possible treatment.

3. Saves time

- a. AI, with its automated algorithms can help save time by automating many “boring” works of the physician, thereby giving time for them to think about the treatment.
- b. The administrative problems of the physician can be unburdened and this can prevent a burn out of the doctor.
- c. AI can point out / correct any errors made inadvertently by the doctor, and this helps in carrying out the patient care properly and also avoiding any legal complications which can end the career of a doctor.

4. Personalised treatment - AI is the engine behind precision medicine. Practitioners now have access to clinical decision support tools that synthesize a patient's entire medical history, genomic profile, and real-time data from wearable devices. Instead of a "one-size-fits-all" treatment plan, a physician can use AI to predict how a specific patient might respond to a particular chemotherapy or identify individuals at high risk for sepsis up to 48 hours before clinical symptoms appear. This transition from reactive to proactive care is perhaps the greatest professional satisfaction for a physician –the ability to prevent a crisis before it occurs.

Any new technology, with its added advantages, also has its disadvantages

1. Information overload - AI works without rest and gives information to the doctors which can be overwhelming at times because of overload of data which needs to be interpreted.
2. Constant alerting - AI can point out errors very efficiently and always. This can interfere with the working of the doctor and they tend to have the so called - Alert fatigue
3. Loss of professional identity - when a doctor disagrees with AI, the hospital, public and the judiciary tend to stand with algorithm generated treatment models rather than clinical and experiential acumen. This can be looked at in 2 ways: - -
A doctor with vast experience can be held liable for not following AI.

So doctors tend to follow the algorithm rather than think on their own. On the contrary, a doctor with limited experience tend to take more risky and sick patients for treatment with his reliance on the algorithm which may lead to some complications and fatalities.

4. Lack of explanation – AI can predict the illnesses much before its onset. But many times, it cannot explain why. This leads to false information and there develops a crisis of trust between the doctors and the patients.

5. AI works on very complex algorithms which a doctor with no computer knowledge can understand. The doctors are not able to correct any error and thereby the output is not as per the doctor's thinking rather its actually what the software thinks.

6. Legal liabilities – according to the law, the doctor is primarily responsible for the diagnosis and the treatment of the patient. There is no clear guidelines on the interpretation of the suggestions of the AI and the doctor acting on it. Rather they are held responsible for following his experience rather than an algorithm generated protocol.

7. Possibility of self medication – Since there is so much information which is so easily available, the patients do research in “Whatsapp University” and discuss the symptoms with “Dr. Google” rather than consulting the doctor. This leads to delay in diagnosis and possibility of self medication which can complicate the illness and increasing the chances of a negative outcome even after treatment.

8. Defensive practice – the patients consult the doctor after their research online and present to the doctor with a “diagnosis”. Some of them have so much research done that the clinical knowledge is questioned and this can lead to a defensive practice rather than actual treatment of the disease.

9. Misinformation – due to its information overload, the patient cannot actually read about their condition but rather they are exposed to tons of irrelevant information which is sometimes misleading

10. Lacking knowledge about AI's capacity – The wings of AI is growing day by day. And this can make a very powerful tool capable of self thinking and self sustainance. This can potentially control the health care of the future and this can take the power of treatment away from the doctors.

11. There are lots of hidden costs in implementing AI into medical practice. The cost of the software, maintaining it, data security and ways it can be misused. This leads to creating new job profiles / add new roles to the existing ones and sometimes it can be financially draining to adopt this new technology.

12. Newer documentation strain – We have recently heard about a patient who files a medico legal case against a doctor by uploading the discharge summary into AI and to find errors in it and the AI had done it. It has also helped the patient to write a petition citing those errors. This leads to newer problems as the doctors now not only need to write the discharge summaries but also need to cross verify the same with AI. This drains the doctors' time and money to do the same.

Conclusion

AI is a boon for the health care with a potential bane

AI should be used at places where its advantages are clearly established and not at all places where it can be used. The doctors should have control over the software and it should be Explainable AI. The AI should assist the doctors and not the patients. The goal of AI should be not to replace the doctors rather to assist them in removing the unnecessary tasks which are carried out by them, so that they can get more time for history taking, clinical examination and diagnosis and finally be more human.

There should also be robust governance and legal guidelines for the use of AI so that it protects the rights of the doctors and the patients. The successful practitioner of the future is the one who uses AI for its computational speed but relies on their own experience, empathy and ethics to guide the final hand in patient care.

By
Dr.S.S.K.SANDEEP
Winner



“Did You Know”

The solitary bone: The hyoid bone in the anterior neck is the only bone in the entire human body that does not articulate with any other bone.

End-to-end vascular network: The combined network of arteries, veins, and capillaries in an adult human stretches across more than 60,000 miles.

The "ABC" abdominal priority: Even when evaluating a chief complaint of acute abdominal pain, the initial assessment must prioritize the Airway, Breathing, and Circulation (ABC) to catch critical vascular emergencies like a ruptured abdominal aortic aneurysm.

Microbial outnumbering: The human body hosts trillions of microbes, with the average human umbilical region (belly button) alone harboring at least 67 distinct bacterial species

IMA Chennai Kodambakkam branch Photo Gallery



IMA Chennai Kodambakkam branch Photo Gallery



IMA DOCTOR'S DAY AWARD

IMA FSS MEET, VELLORE

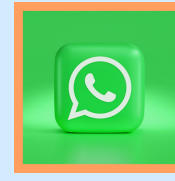


DOCSTAR AWARD



TRAILBLAZER AWARD





Dr. K.K.Perumal

Clinical Pearls

Direct Oral Anticoagulants (DOACs) in Primary & Secondary Prevention of Thrombotic Events

♦ DOACs are now the preferred oral anticoagulants for most patients with non-valvular atrial fibrillation (AF) and venous thromboembolism (VTE) because of predictable pharmacokinetics, fewer drug interactions, and lower intracranial bleeding than warfarin.

♦ DO NOT use DOACs in:

Mechanical prosthetic heart valves

Moderate-to-severe rheumatic mitral stenosis

Triple-positive antiphospholipid syndrome (APS)

Warfarin remains the standard in these situations.

♦ Apixaban emerges as the preferred DOAC for acute VTE, with lower clinically relevant bleeding than rivaroxaban while maintaining similar efficacy.

♦ For unprovoked or recurrent VTE, extended or lifelong anticoagulation should be considered after balancing bleeding risk, with periodic reassessment.

♦ Reduced-dose Apixaban (2.5 mg BID)* is an evidence-based option for extended VTE prevention, offering efficacy comparable to the standard dose with less major bleeding.

♦ In CKD, Apixaban has the strongest evidence, including selected patients with advanced CKD/dialysis; dabigatran should be avoided in dialysis because of predominant renal clearance.

- ♦ In chronic liver disease:

Child-Pugh A: All DOACs are generally acceptable.

Child-Pugh B: Avoid rivaroxaban.

Child-Pugh C: DOACs are not recommended.

- ♦ Apixaban is preferred in frail elderly patients because it consistently demonstrates a lower bleeding risk across frailty categories.

- ♦ In morbid obesity (BMI ≥ 40 kg/m²), apixaban and rivaroxaban remain acceptable options; Evidence is less robust for dabigatran and edoxaban.

- ♦ Patients receiving DOACs should undergo regular review of renal function, hepatic function, bleeding risk, drug interactions, affordability, and adherence—bleeding scores should guide follow-up, not deny anticoagulation.

Take-Home Message

Choose the right DOAC for the right patient—not just the right indication.

Patient factors such as renal function, liver disease, frailty, obesity, prior bleeding, cancer, and valve status are now central to individualized anticoagulation decisions.





CEA Registration & Renewals



The IMA State Council meeting in Chennai on 14.06.2026 addressed key issues around TN Clinical Establishments Act (TNCEA) registration and renewal. Speakers included Dr. Meenakshi Sundari, JD DMS, and TVK MLA Dr. M. Sudhakar, Katpadi.

Deadlines & Process

- Last date for first-time registration, including already functioning but unregistered clinics, is ***31.07.2026***. One-month extension granted.
- New user-friendly CEA portal will launch by ***01.08.2026***.
- If you applied earlier and got no response, or your renewal is pending for months, reapply now or wait for the new site.
- Renewal link activates in your original account 3 months before expiry. Flat renewal fee: ***Rs. 5,000*** for all establishments.

Documents Required

- Clinics < 3000 sq ft: Upload rental/property tax proof + 1 MB video of premises.
- Clinics > 3000 sq ft: Additional certifications will be listed on the new site.
- < 50 beds: Self-certify via signed 1 MB video, download renewal certificate.
- > 51 beds: Upload annexures and stakeholder certifications.
- PCB: One-time registration if no waste generated; full certification if waste is generated.

Important Notes

- Registration validity is tied to accreditation date.
- Non-registered establishments by August 2026 risk being classified as quackery institutions and face possible sealing.

Register immediately if you haven't yet.

IMA Chennai Kodambakkam branch Activities



MEMBER'S DIRECTORY



This is to inform our esteemed Members that the Executive Committee of IMA Chennai Kodambakkam branch has decided to collect member details using the Google Form link provided below. Please Copy the link and paste it in google search.

https://docs.google.com/forms/d/e/1FAIpQLSfJ9lJ_5u_v6Yfc7AfnUBAGOzd9vKNi74-wtmF3md457qla-w/viewform?usp=publish-editor

You are requested to fill out the form and submit it at your earliest convenience. The compiled data will be used to create a directory of IMA Chennai Kodambakkam branch members.



The IMA Chennai Kodambakkam Branch is pleased to announce free online yoga classes for its members as part of our wellness initiative.

Details of the Program:

- Dates: Sunday, 14 June 2026; Sunday, 21 June 2026; Sunday, 5 July 2026; and Sunday, 12 July 2026
- Duration: 1 hour per session - Time: 7:00 AM to 8:00 AM

-Participation: Open to all IMA members and their immediate family

Prior registration is appreciated to make suitable arrangements. The meeting link will be shared with registered participants.

For registration please SMS your Name and cell number to,
Mrs.Sundarambal Uvarajan
9840952126

IMA TNSB SCHEMES

FSS 1 & FSS 2

IMATNSB is running two schemes Family Security Scheme I & Family Security Scheme 2 with an objective of "To provide immediate Financial aid to the family in case of death of a FSS member".

FSS 1 & FSS 2

Should be a life member of IMA TNSB

Age limit upto 55 years.

Joining Non-Refundable amount is as follows,

Below 30 years - 3000/-	31-40 years	- 10000/-
41-45 years - 30000/-	46-50 years	- 50000/-
51-55 years - 55000/-		

All the FSS I member will contribute Rs.200 each for the death of any FSS I member Every year 60 death was estimated ($200 \times 90 = 18,000$) and the amount should be paid in advance.

Advance amount can be paid without penalty from January to March, then 200 will be added to advance amount for every three months. Currently the death benefit for the FSS I members is 18 lakhs.

All the FSS 2 members will contribute Rs. 300 each for the death of any FSS 2 member. Every year 40 deaths were estimated ($300 \times 40 = 12,000$) and the amount should be paid in advance. Currently the membership joined was nearly 3,000 and we are looking forward to reaching a target of 5,000 members. Currently the claim amount with 3,000 members is Rs. 8 Lakhs when the membership increases, the claim amount also increases.

FSS I & FSS 2 applications should be forwarded by the local branch secretary.

IMA TNSB SCHEMES

IMA FSS FAMILY HEALTH SCHEME

All the members and their spouses of FSS 1 and FSS 2 of IMA TNSB are eligible.

Up to Rs.30000/- per claim every 6 months up to 2 claims in a year for the members in either FSS 1 or FSS 2.

Up to Rs.60000/- per claim every 6 months up to 2 claims in a year for the members in both FSS 1 and FSS 2.

IMA FSS Secretary Office
77, Chinna Kadai Street,
1st Floor (Opp. District Forest Office),
Tiruvannamalai, Tamil Nadu, Pin: 606601.
Phone: 9840537178; Mobile No: 9840537178
Email: imatnsbfss@gmail.com

IMA MEMBERSHIP



**Indian Medical Association
Chennai Kodambakkam Branch**

IMA Single Life Membership - Rs 23000/-
IMA Couple Life Membership - Rs 36000/-

Bank Details :

Account Name : Indian Medical Association Kodambakkam Branch
Bank Name : Indian Overseas Bank
Account No : 046301000016250
Branch : Ashok Nagar, Chennai (0463), Pin code - 600083
IFSC Code : IOBA0000463

Dr Nirmala Ponnambalam **Dr M I Shahul Hameed** **Dr S Vamsi Krishna**
President **Secretary** **Treasurer**
Mobile No : 94442 39494 **Mobile No : 98401 41167** **Mobile No : 72993 53535**

For details, please contact our office secretary Mr. Narayanan, contact No.9841661112.

For forms visit,

<http://ima-india.org/ima/pdfdata/membership-form-2024.pdf>

IMA TNSB SCHEMES

PPLSSS

(Professional Protection Linked Social Security Scheme)

Helps you to counter C.P.A; Makes you to shed your defensive practice

Best defense in the offensive society; Coverage from the day of enrolment; Guidance & Safeguarding from day one of receiving notice.

Compensation upto Rs. 30/- Lakhs for 5 years (based on the Subscription); Immediate Financial grant Rs. 1,00,000- in case of demise of a member, Rs. 50,000/- for membership below 5 years.

PPLSSS NEW MEMBERS SUBSCRIPTION (for a block of 5 years)

Compensation	Rs.10 lakhs	20 lakhs	30 lakhs
General Practitioner	8260	15340	23600
Specialist	10620	20060	28320

Payment options DD. DD should be taken in the name of "PPLSSS OF IMA TN" Payable at Dharmapuri

PPLSSS RENEWAL MEMBERS -(BLOCK OF 5 YEARS)

Compensation	Rs.10 lakhs	20 lakhs	30 lakhs
General Practitioner	7080	14160	22420
Specialist	9440	18880	27140

Payment options DD. DD should be taken in the name of "PPLSSS OF IMA TN" Payable at Dharmapuri

Contact:

Dr. M.Chandrasekar,
Hony. Secretary of PPLSSS IMA TNSB,
Prahadeesh Hospital,
66/27, South Railway Line Road, Kumaraswamy Pettai,
Dharmapuri - 636701.

Mob:9487272627, 9150515253

E-mail: secretarypplsss@gmail.com

IMA SCHEMES

IMA NSSS (IMA National Social Security Scheme)

The schemes purely designed on brotherhood fraternity basis, and try to help the family member (Nominee) of the member on the event of death of IMA NSSS member.

Any life member of I.M.A., up to age of 60 years residing in India is eligible to become a member of this scheme but members above the age of 40 years and below the age of 60 years, must be life member of IMA at least for 3 years on the day of joining the scheme.

At present we have 19,564 members enrolled and paid ₹ 11,31,130.00 to the last deceased member's nominee

On event of death (by any cause), rest of the members contribute a token share of Rs. 100-00, from which Rs. 70-00 is passed on to the nominee.

After 25 years of continuous membership, the member need not contribute the same and the Fraternity Contribution (F.C.) will be paid to the nominee by the scheme.

BENEFIT FOR MEMBERS ENROLLED AFTER 19/07/2002 : For members enrolled after 19/07/2002, benefit of Fraternity Contribution of the scheme is eligible after completion of one year of membership of I.M.A. N.S.S.S. However nominee of member is entitled for such benefits if death of member occurs by accident even within one year of joining the scheme.

Contact for Membership

Kindly contact on below email / call to get the membership information

Call us +91-79-26585430

Mail: imanssss1@gmail.com

Mail: contact@imanssss.org

<https://www.imanssss.org/>

IMA Chennai Kodambakkam branch

OFFICE-BEARERS

President	Dr Nirmala Ponnambalam
Secretary	Dr M.I.Shahul Hameed
President Elect	Dr DP Prakash,
Vice President	Dr Priya Kannan
Finance Secretary	Dr S Vamsi Krishna
Joint Secretary	Dr S.Indra
Communications Secretary	Dr R.Muthiah
Sports Committee Chairman	Dr S.S.K.Sandeep
Crisis Management Committee	Dr M Arunachalam
Service Doctor's Wing	Dr A.Aravind; Dr P.Umapathy
Women's forum	Dr S Sheela; Dr B Rekha
	Dr P Puspha
PPLSSS &FSS	Dr M Balakrishnan
	Dr M Veldurai
Young Doctors Wing	Dr S.Vijay Alagappan
	Dr Jackin Moses; Dr Vivek VVV
Private Hospitals & NHB	Dr P Chowdappa

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Dr K Subramanian

Advisors

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Dr.D.Boopathy John

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