A Monthly Bulletin of IMA Chennai Kodambakkam branch

# IMACK

FEBRUARY 2026

ISSUE 2

*Empowering Medical Professionals Through Excellence in Education*

**517th CME of IMA Chennai Kodambakkam branch was held on 22nd February 2026 at 2 Pm, Aaditya Hotel, Vadapalani, chennai.**

**The program was smoothly conducted by office bearers Dr. Nirmala Ponnambalam (President) and Dr. Shahul Hameed (Secretary).**

**Around 75 members attended the CME and one TNMC Credit Hour was awarded to the participated members.**

## Dr. S. CHITRA, MBBS

**On this date, the 22nd of February 2026, this Citation is awarded to Dr. S. Chitra, in recognition of her outstanding contribution to society in the field of General Medicine.**

**Dr. S. Chitra is an alumnus of Thanjavur Medical College, graduating with an MBBS in 1983. With a career spanning over 40 years, she has established a robust practice at V.K. Nursing Home, Alwarthirunagar, specializing in Family Medicine and Diabetes. Her illustrious career includes stints at prestigious organizations like the Institute of Child Health (ICH), Egmore, and the Primary Health Centre (PHC), West Mambalam.**

**In 1992, Dr. Chitra founded V.K. Nursing Home with her family and friends, a noble endeavor that has served the poor and needy for the last 33 years. Her commitment to community service is evident in the numerous free medical camps she has organized and her participation in national and international conferences.**

# CME PROGRAMME

1. **IMA Prayer and Physician's Prayer - Dr. S. Shanthi**

1. **Why adult immunization matters now, Dr Sowmya Sridharan, Consultant Infectious Diseases, Kauvery Hospital, Alwarpet.**

2. **Adult Vaccines 2026 - Updates you can't Ignore, Dr R Surendran, Consultant Infectious Diseases, SIMS hospital, Chennai.**

3. **My Professional Journey - Dr Chitra Srinivasan**
   **( Life Time Achievement Awardee )**

5. **Pneumococcal Vaccines: Simplified for daily Practice - Dr Madhumitha Ramabhadran, Consultant Infectious Diseases, MGM Hospital, Chennai.**

6. **Prevention of Shingles in Co-morbid conditions, Dr P Senthur Nambi, Consultant Infectious Diseases, Apollo Hospital, Chennai.**

8. **Dr Hema Venkatesan Endowment Oration**
   **Chair Person : Dr Madhumitha, Dr. Nirmala Ponnambalam**
   **Topic : HPV Vaccines: Stop cancer before it starts**
   **Speaker : Dr Vijayalakshmi Balakrishnan, Consultant Infectious Diseases, Kauvery Hospital, Chennai.**

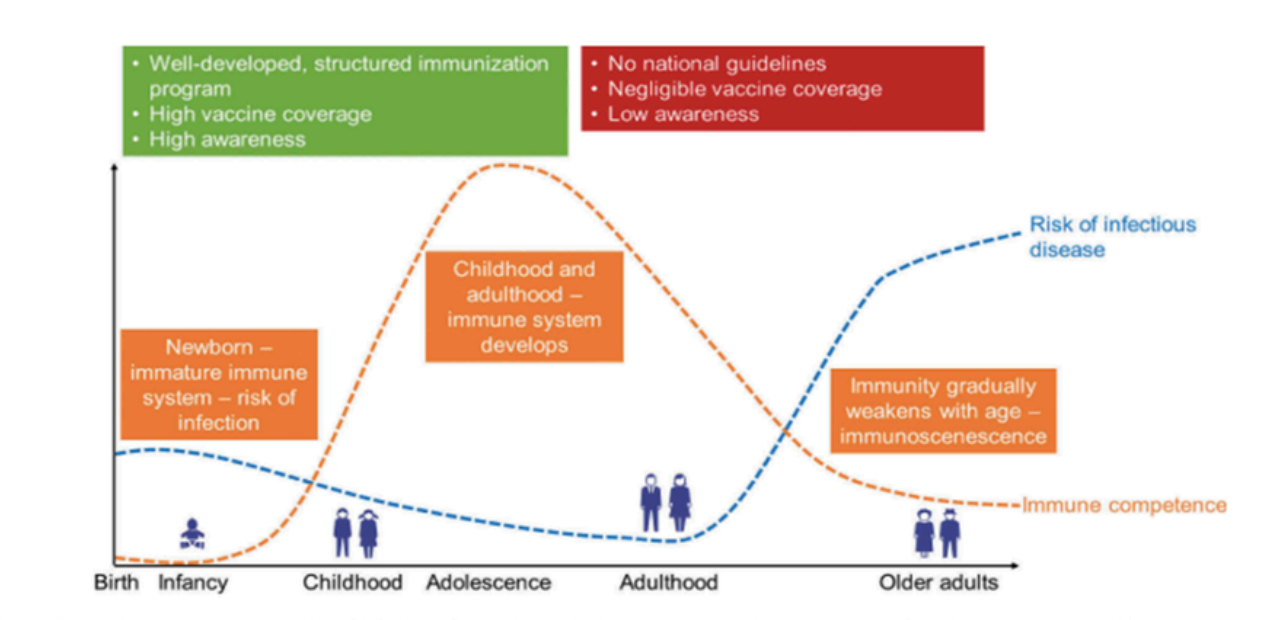
8. **Tropical threats, preventable future, Dr C R Pugazhvanan, Consultant Infectious Diseases, Apollo Hospital, Vanagaram.**

9. **Adult Immunization - Panel Discussion, Dr Vidya Krishna, Consultant Infectious Diseases, Apollo Hospital**

10. **Quiz - Dr M I Shahul Hameed, ENT Consultant, Virugambakkam.**

**An overview of the lectures presented is given below.**

# Why Adult Immunization Matters Now




**Why adult Immunization matters now ?**
**(1) High burden of mortality and morbidity due to vaccine-preventable diseases (VPDs) like influenza, pneumonia, typhoid, and cervical cancer (2) Epidemiological shift in VPDs like diphtheria and pertussis among adults, (3) Immunosenescence and waning immunity increase vulnerability to VPDs.**

**Types of Vaccines:**

- **Inactivated vaccines - killed version, booster shots**
- **Live-attenuated vaccines -strong and long-lasting**
- **mRNA vaccines - work by introducing a piece of mRNA**
- **Subunit vaccines : piece of a pathogen, not the whole**
- **Viral vector vaccines - use a harmless virus to deliver to the hosts cells the genetic code of the antigen.**

**Vaccine-Preventable Diseases in India:**

- **Influenza: 51.1 deaths/100,000 population among adults 65+ years.**
- **Pneumonia: 39% of hospitalizations, 19% mortality rate (increases to 30% in 50-60 years).**
- **Japanese encephalitis: 66% of acute encephalitis cases in adults**
- **Cervical cancer: 2nd leading cause of cancer-related deaths in women (60% mortality).**

**Cont...**

**Challenges in Adult Immunization:**

- Lack of awareness and missed opportunities
- Inadequate access and fragmented healthcare system
- Vaccine hesitancy and misinformation
- Expense and lack of insurance coverage

**Opportunities for Improvement:**

- National adult immunization program
- Strengthened awareness campaigns
- Integration with routine healthcare and child health programs
- Strengthen healthcare workforce training
- Public-private partnerships
- Robust data management and surveillance system

**Myths in Adult Immunization:**

- Vaccines are not safe
- Natural immunity is healthier
- Herd immunity eliminates need for vaccination
- Vaccines have harmful long-term side effects

**Take Home Message**

**Adults need vaccines too!**
**Adult immunization is a critical but neglected component of preventive health in India**
**A coordinated approach — backed by policy, education and delivery system reforms — could transform adult immunization in India.**

**(The above is a summary of the presentation made by Dr Sowmya Sridharan, Consultant Infectious Diseases, Kauvery Hospital, Alwarpet.)**

# Pneumococcal Vaccines: Simplified for Daily Practice

Patients with COPD, chronic renal failure, and diabetes have a higher risk of pneumococcal pneumonia (PP) and invasive pneumococcal disease (IPD) compared to healthy individuals aged 50-64 years.

S. pneumoniae accounts for 30-55% of community-acquired pneumonia (CAP) among adults in India.

Pneumococcal disease can be invasive (e.g., bacteremia, meningitis) or non-invasive (e.g., pneumonia, otitis media).

S. pneumoniae invades the myocardium, causing myocardial damage and cardiac complications.

Pneumococcal vaccines can reduce morbidity and mortality, especially in high-risk groups.

Vaccine Options:

- PPV23 (polysaccharide vaccine): Covers 23 serotypes, but less effective in young children and immunocompromised individuals.

- PCV13 (conjugate vaccine): Covers 13 serotypes, more effective than PPV23.

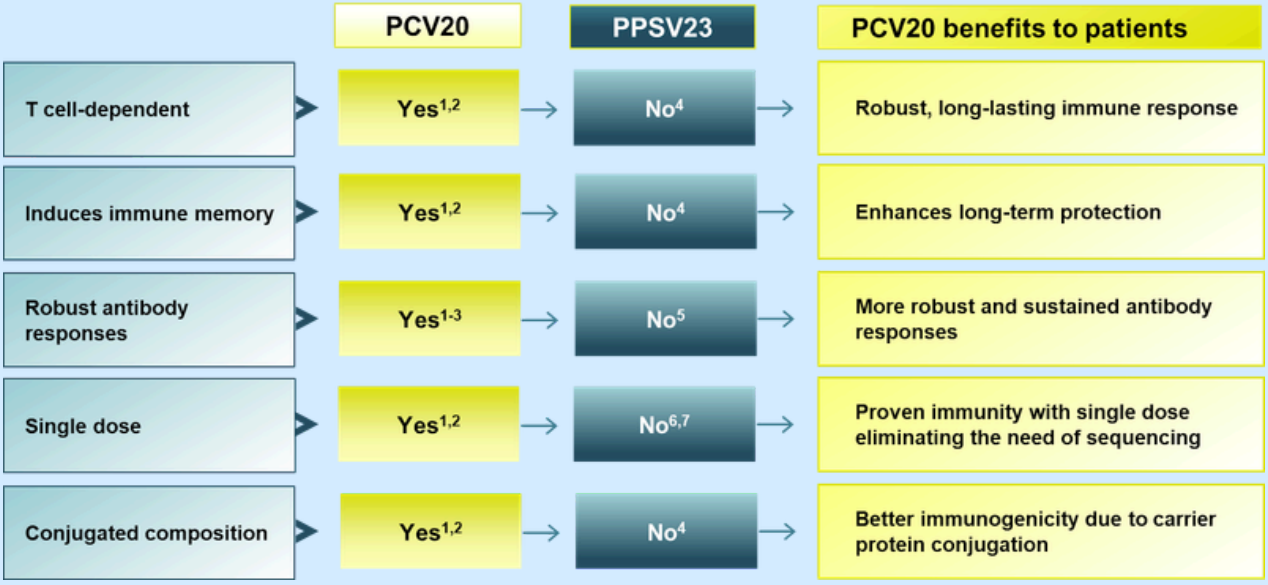
- PCV20 (conjugate vaccine): Covers 20 serotypes, approved for adults 18+ years, offers wider coverage and long-term protection.

Mechanism of Action:

- Pneumococcal vaccines induce IgG antibodies and OPA proteins, providing protection against pneumococcal disease.

Cont...

## *PCV20 Offers Robust & Long-term Protection over PPSV23?*




**PCV20 Benefits:**

- **Protects against 20 serotypes of S. pneumoniae**
- **Single dose of 0.5 ml intramuscular injection**
- **Long-term protection due to strong immune memory**
- **Reduces antimicrobial resistance by reducing antibiotic use**

**High-Risk Groups:**

- **Adults 50+ years**
- **Individuals with COPD, chronic renal failure, diabetes, heart disease, or chronic lung disease**
- **Immunocompromised individuals**

**(The above is a summary of the presentation made by Dr Madhumitha Ramabhadran, Consultant Infectious Diseases, MGM Hospital, Chennai.)**

# Prevention of Shingles in Comorbid conditions

**Varicella Zoster Virus (VZV) and Shingles:**

- 99.5% of adults ≥50 years old are infected with VZV
- 1 in 3 people will develop shingles in their lifetime due to VZV reactivation

**Shingles Symptoms and Complications:**

- Acute presentation: unilateral, vesicular rash, severe pain, headache, photophobia, malaise, fever
- Complications:
  - Post-Herpetic Neuralgia (PHN): neuropathic pain >3 months (up to 30% of patients)
  - Herpes Zoster Ophthalmicus (HZO): vision loss (up to 25% of patients)
  - Other: disseminated disease, hearing loss, scarring, neurological complications, cardiovascular events

**Risk Factors:**

- Age >50 years
- Diabetes mellitus (increased risk of PHN and glycaemic control issues)
- COPD (increased risk of shingles, especially with steroid use)
- Comorbidities (increased risk of recurrence and complications)
- Herpes zoster associated with 30% higher long-term risk of major cardiovascular event
- Increased risk of atrial fibrillation, stroke, myocardial infarction

Cont..

**Incidence:**

- **Worldwide: 3.0-5.0/1000 person-years**
- **India: 15-81% of people >50 years old, PHN in 10-54%**
- **Recurrence: 5-10% of patients**

**Global Bodies Recommending RZV**

| Health condition | Society | Recommendation |
|---|---|---|
| Adults aged 50 years and above | CDC[1] | RZV may be used in adults aged ≥50 years, irrespective of prior receipt of varicella vaccine or ZVL, and does not require screening for a history of chickenpox (varicella) |
| >50 years with special conditions | ACIP (CDC)[1] | Adults (ages ≥50 years) with chronic medical conditions (eg , chronic renal failure, diabetes mellitus, rheumatoid arthritis, and chronic pulmonary disease) should receive RZV |
| Diabetes | ADA[2] | Highly recommends adults ages ≥50 years are vaccinated with 2 dose Shingrix, even if previously vaccinated |
| COPD | ACIP (CDC)[1] | Adults (ages ≥50 years) chronic pulmonary disease should receive RZV |
| | GOLD[3] | Zoster vaccine to protect against shingles for adults with COPD age ≥50 years |
| Asthma | ACIP (CDC)[1] | Adults (ages ≥50 years) chronic pulmonary disease should receive RZV |
| | AAFA[4] | Recommends the shingles vaccine for people aged 60 years and older |

Disclaimer: Shingrix is indicated for prevention of herpes zoster (HZ) and postherpetic neuralgia (PHN), in adults 50 years of age or older.

**Vaccine:**

- **Recombinant zoster vaccine (RZV)**
- **2 doses, 2-6 months apart**

**Indications:**

- **Adults >50 years**
- **Immunocompromised individuals >19 years**

**Efficacy:**

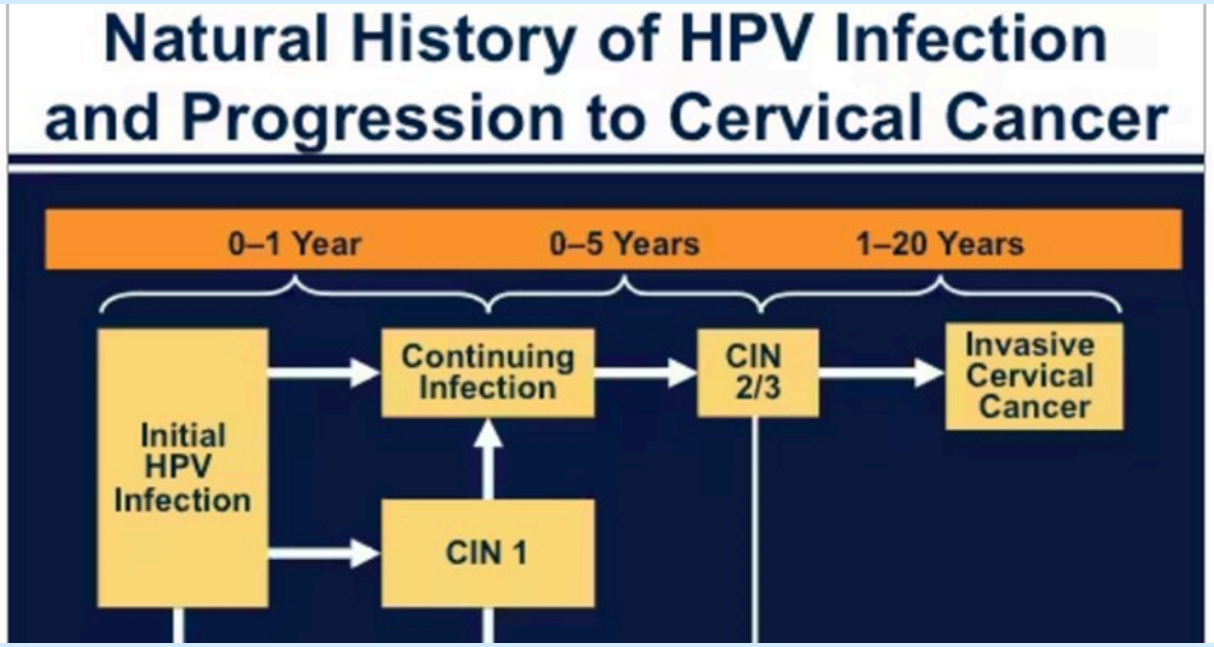
- **90% effective in preventing shingles**
- **85% effective in preventing post-herpetic neuralgia**

**Safety:**

- **Generally well-tolerated**
- **Common side effects: injection site reactions, fatigue, headache.**

**(The above is a summary of the presentation made by Dr P Senthur Nambi, Consultant Infectious Diseases, Apollo Hospital, Chennai.)**

# HPV vaccines
# Stop cancer before it starts




**The global HPV prevalence (all types) among adult women with normal cytological findings is estimated to be 12%, as detected in cervical specimens.**
**Age peak < 25 yrs: HPV16 and HPV18 together are responsible globally for 71% of cases of cervical cancer: Women infected with one HPV type may be reinfected with the same type or co-infected or subsequently infected with other types**

**HPV-Related Cancers**
- **Cervical cancer (most common in India)**
- **Anal cancer**
- **Oropharyngeal cancer (throat cancer)**
- **Penile cancer**
- **Vulvar cancer**
- **Vaginal cancer**

**HPV Vaccine**
- **Recombinant protein capsid liquid vaccine (e.g., Gardasil 9)**
- **Protects against 9 HPV types (6, 11, 16, 18, 31, 33, 45, 52, 58)**
- **Given as 2 or 3 doses, depending on age of initiation.**

**Cont....**

**Who Should Get Vaccinated?**

- Routine vaccination recommended for:
  - Children and young adults (9-26 years)
  - Ideally before becoming sexually active
- Shared clinical decision for:
  - Adults 27-45 years (if not previously vaccinated and at risk)

**Benefits**

- Prevents 90% of HPV-related cancers
- Safe and effective in preventing:
  - Cervical dysplasia (precancerous cells)
  - Genital warts
  - Anal, oropharyngeal, and other HPV-related cancers

**Safety and Efficacy**

- Generally well-tolerated
- Common side effects: injection site reactions, fatigue, headache
- > 90% efficacy in preventing HPV-related diseases

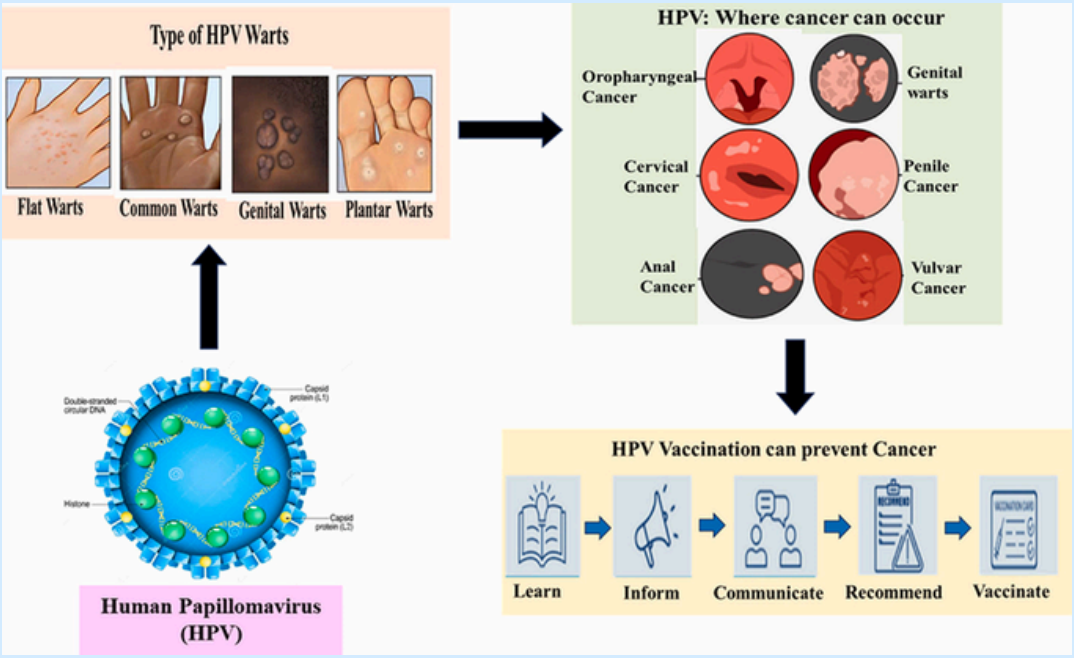
**India-Specific Guidelines**

- National Immunization Schedule (NIS) includes HPV vaccine for girls aged 9-14 years (2 doses, 6 months apart)
- Catch-up vaccination recommended for unvaccinated individuals up to 26 years

| Primary target | Secondary targets | Catch up | Others |
|---|---|---|---|
| • Girls 9-14 yrs<br>• 1 or 2 doses | • Girls 15-21 yrs<br>• Boys 9- 20 yrs<br>• 1 or 2 doses | • Girls 21- 26<br>• 2 doses | • Immunocomp 3 doses<br>• Women 26-45 yrs 3 doses |

Conti....

## Do we need to vaccinate boys? Yes




**Can Cervical cancer be eradicated? Success Stories**

**Australia**

- **2007: Quadrivalent vaccine introduced for girls (12–13 yrs, catch-up till 26 yrs).**
- **2013: Boys included (12–13 yrs).**
- **2018: Nonavalent vaccine adopted.**
- **2023: Single-dose schedule (ages 9–21); immunocompromised → 3 doses.**

**Impact:**

- **HPV type prevalence ↓ up to 94% in vaccinated young women.**
- **Genital warts ↓ >90% in vaccinated cohorts.**
- **High-grade cervical lesions ↓ in young women.**
- **Persistent anogenital infection ↓ >85% in men.**
- **Juvenile respiratory papillomatosis cases ↓ (maternal transmission).**

**Nordic Cohort**

- **15 years of data.**
- **Significant decrease in HPV-related disease**

**(The above is a summary of the presentation made by Dr Vijayalakshmi Balakrishnan, Consultant Infectious, Diseases, Kauvery Hospital, Chennai).**

# TROPICAL THREATS PREVENTABLE FUTURE

**Vaccines are the primary medical tool used to prevent Infectious diseases by training the immune system to recognize and fight specific pathogens without causing the disease itself.**

## *Preventable Diseases and* Common Vaccines

| Diseases | Approved vaccine | Vaccines in reseach |
|---|---|---|
| Dengue | ✔ Dengvaxia (CYD-TCV) approved in many countries; Takeda's TAK-003 licensed in several regions | Additional candidates in phase III (TV003/TV005) |
| Chikungunya | ✔ CHIKV vaccine (e.g., VLA1553) approved by some regulators | Multiple live/viral vector vaccines in trials |
| Zika | — | Multiple vaccines (DNA, mRNA, viral vectors) in clinical trials |
| Japanese encephalitis | ✔ Inactivated and live JE vaccines (e.g., SA14-14-2) | — |
| West Nile virus | — | Several candidates evaluated in early trials |
| Rift Valley fever | ✔ Veterinary vaccines (in some countries) | Human vaccines in early clinical research |
| Ebola virus disease | ✔ rVSV-ZEBOV approved (several African approvals/WHO prequalified) | Other candidates in development |
| Marburg virus disease | — | Vaccines in early clinical/preclinical research |

| Diseases | Approved vaccine | Vaccines in reseach |
|---|---|---|
| Rabies | ✔ Inactivated vaccines (human use, widespread) | — |
| HIV/AIDS | — | Multiple approaches in advanced research (vector, mRNA, mosaic) |
| Measles | ✔ Routine childhood MMR | — |
| Cholera | ✔ Oral killed OCVs (Dukoral, Shanchol, Euvichol) | Improved formulations |
| Typhoid | ✔ Typhoid conjugate vaccines (TCV) | — |
| Shigellosis | — | Conjugate and live attenuated candidates in trials |
| Mycobacterium tuberculosis | ✔ BCG (variable efficacy) | New candidates in late development (MVA85A, VPM1002) |
| Leptospirosis | ✔ Some regional inactivated vaccines | Recombinant vaccines in development |
| Anthrax | ✔ Anthrax vaccine (cell-free) | Next-gen vaccines in research |
| Melioidosis | — | Several candidates in preclinical |
| Malaria | ✔ RTS,S/AS01 (Mosquirix) approved for children in | Next-gen (R21/Matrix-M) in late trials |

**(The above is a summary of the presentation made by Dr C R Pugazhvanan, Consultant Infectious Diseases, Apollo Hospital, Vanagaram.**

# Adult Vaccines 2026 – Key Updates

**According to data from 64,714 adults aged 45 years and older, vaccination coverage in India is alarmingly low:**

**Influenza: 1.5%, Pneumococcal: 0.6%, Typhoid: 1.9%,**
**Hepatitis B: 1.9%.**
**In contrast, vaccination coverage is significantly higher in other countries: Influenza: >75% in UK, 65% in USA, 70% in Canada, 7.4% in China.**

**INFLUIENZA VACCINE:**

**- Inactivated influenza vaccine (trivalent and quadrivalent) is recommended**
**- Vaccination timing varies by region:**
  **- September-October (temperate seasonality)**
  **- April-May (monsoon season)**
**- WHO influenza virus vaccine recommendation should be followed**

**PNEUMOCOCCAL VACCINE:**

**- Initial PCV13 amplifies response to subsequent PPSV23**
**- Initial PPSV23 diminishes response to subsequent PCV13**

**2025 ACIP Guidelines:**

**- > 50 years, not exposed previously:**
  **PCV15 → PPSV23.(1 year later), or PCV20, or PCV21**
**- Exposed to PCV13: PCV20 or PCV21 after 1 year**
**- Exposed to PPSV23: PCV15, PCV20, or PCV21 after 1 year**
**- Previously received both PCV13 and PPSV23, but no PPSV23 after 65: PCV20 or PCV21 (5 years after last dose)**

**Cont...**

**SHINGLES (Herpes Zoster) VACCINE:**

- Recombinant vaccine
- Dosage: 2 doses, 2-6 months apart
- Eligibility:
  - > 50 years
  - > 19 years with immune compromising conditions (including HIV)
- Previous Chickenpox History: Irrelevant; vaccination recommended regardless
- Varicella Serology: No need to check

**HPV VACCINE:**

- Recombinant protein capsid liquid vaccine
- Recommended Age: <26 years
- Dosage: 2 or 3 doses based on age of initiation
- Pregnancy: No recommendation
- 26-45 years: Shared clinical decision for high-risk individuals

**TYPHOID VACCINE:**

- Vaccine Types:
  - Inactivated vaccine
  - Vi polysaccharide vaccine
  - Typhoid conjugate vaccine (im) - single dose, booster after 3 years
  - Live vaccine (oral)
- Indications:
  - Professional food handlers
  - Unvaccinated adults (18-45 years) in endemic areas
  - Travelers at risk of exposure
  - During outbreaks

Cont....

**MENINGIOCOCCAL VACCINE:**

- Vaccine Types:
  - Purified bacterial capsular polysaccharide vaccine (s.c)
  - Conjugate vaccine (im)
- Indications:
  - Adolescents or travelers to high-risk countries: 1 dose
  - High-risk individuals: 2 doses (8 weeks apart)
  - Anatomical and functional asplenia

**HEPATITIS B VACCINE:**

- Recombinant DNA or plasma-derived inactivated subunit vaccine
- Dosage: 3 doses at 0, 1, 6 months (IM)
- Indications:
  - Chronic liver disease (e.g., hepatitis C, cirrhosis, fatty liver disease, etc.)
  - HIV infection
  - Men who have sex with men
  - Injection or non-injection drug use

**DIPHTHERIA, PERTUSSIS, AND TETANUS VACCINE:**

- Vaccine Types:
  - Tdap: Diphtheria and tetanus toxoids and acellular pertussis antigens
  - Td: Diphtheria (reduced dose) and tetanus toxoids
- Dosage: IM
- Schedule:
  - Age 21, followed by every 10 years
  - 1 dose of Tdap during each pregnancy (27-36 weeks gestation)
- Wound Management:
  - Tdap/Td if >10 years since last dose for clean/minor wounds
  - > 5 years for other wounds
  - Prefer Tdap for those without previous Tdap history

Cont....

**NEWER VACCINES:**

- **Malaria:**
  - **RTS,S/AS01 (2021): administered to children through routine immunization programs**
- **Dengue:**
  - **CYD-TDV (Dengvaxia, Sanofi): 3 doses, 6 months apart (past dengue infection)**
  - **TAK-003 (Qdenga, Takeda): 2 doses, 3-month interval**
- **Hepatitis E:**
  - **Recombinant HEV 239: 3-dose schedule (0, 1, 6 months), IM**
  - **High efficacy (>90%) against HEV infection**
  - **Available in India for:**
    - **18-65 years, High-risk groups: animal husbandry, catering, students, military, travelers to endemic areas, etc.**

**VACCINATION GUIDLINES FOR SPECIAL POPULATION:**

- **Pregnancy:**
  - **Influenza: desirable**
  - **Tdap: vital**
  - **Hep B: essential**
  - **COVID: essential (during pandemics or local epidemics)**
- **Splenectomy:**
  - **Influenza: stat, followed by annual**
  - **Pneumococcal: PCV13 → PPSV23 (8 weeks apart) or PCV20**
  - **Hib**
  - **Meningococcal vaccine**

**GENERAL PRINCIPLES OF VACCINATION:**

- **Non-live vaccines: can be given simultaneously or at any interval**
- **Live and non-live vaccines: can be given simultaneously or at any interval.**

**(The above is a summary of the presentation made by Dr. Surendran, Consultant Infectious Diseases, SIMS.**

## QUESTION NO.1

**NAME THE CONDITION AND THE DRUG OF CHOICE ?**
**RAPID IN ONSET WITH MULTI-SYSTEM INVOLVEMENT**


## QUESTION NO.2

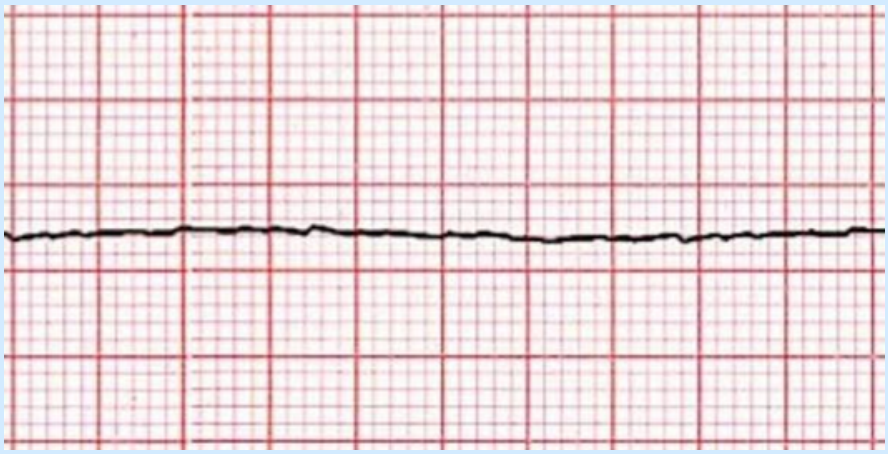
**What is the difference between Anaphylaxis and Anaphylactoid reaction ? Give an example of an Anaphylactoid reaction ?**

## QUESTION 3

**In Anaphylaxis, Adrenaline is best given in what DILUTION ? WHAT ROUTE ? and in WHICH SITE ?**

## QUESTION NO 4

**NAME THE CONDITION AND THE MANAGEMENT ?**

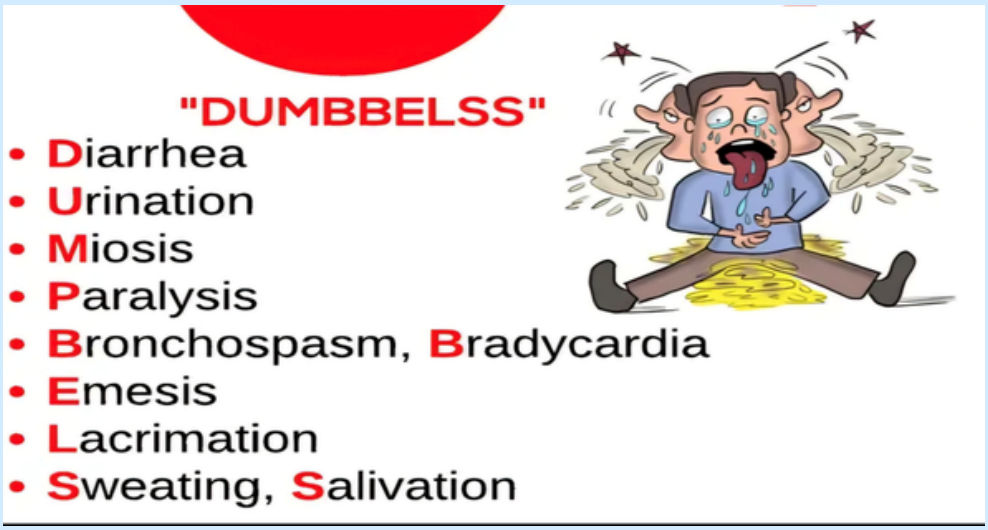


**QUESTION NO.5**

**To prepare 1:10000 dilution of Adrenaline, how many ml of NS is used ?**

**QUESTION NO.6**

**NAME THE CONDITION AND THE MANAGEMENT ?**

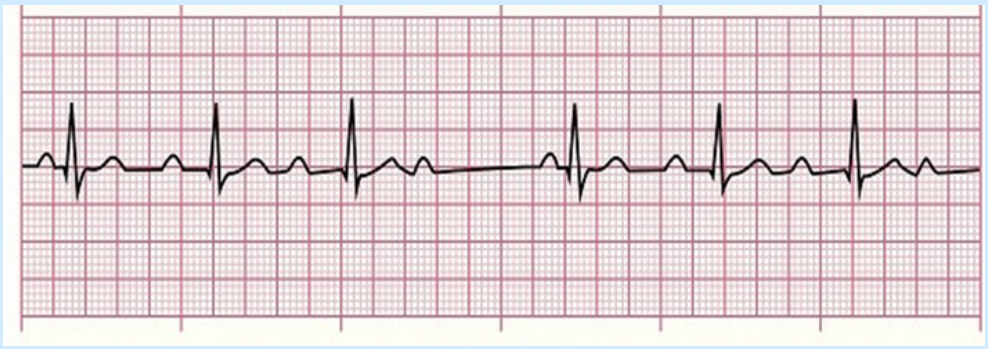



**QUESTION NO 7**

**What is the most reliable Endpoint to assess Adequate Atropinization in OP poisoning?**

**QUESTION NO.8**

**Name the condition and the Management ?**

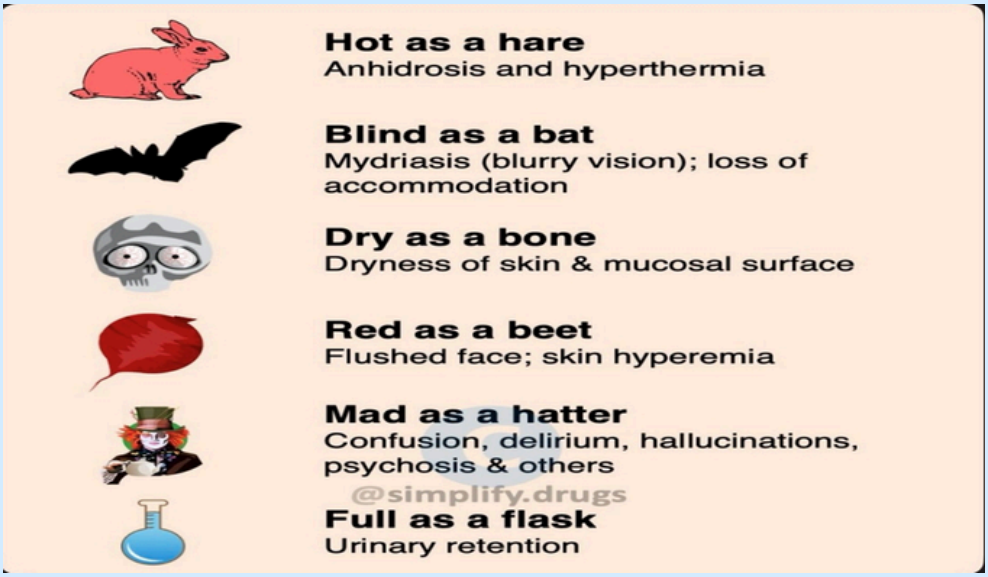


**QUESTION NO.9**

**Atropine is least effective in which types of Bradyarrhythmia ?**

**QUESTION NO.10**

**Name the Condition which is best remembered by the mnemonic**




## MEDICAL QUIZ ANSWERS

### 1.ANAPHYLAXIS

**An Ig E-mediated (type 1) hypersensitivity reaction that involves the release of numerous chemical mediators from the degranulation of basophils and mast cells after re-exposure to a specific antigen.**

**Multi-Organ involvement**

**Cutaneous, Respiratory, Cardiovascular, Gastrointestinal**

**THE DRUG OF CHOICE - INJ. ADRENALINE (EPINEPHRINE)**

### 2.Anaphylactoid reactions

**(now often called non-Ig E-mediated anaphylaxis)**

**Similar to anaphylaxis but caused by direct mast cell activation rather than through Ig E mediation.**

**Often triggered by drugs or substances like Opiates, NSAIDs, IV contrast dye, or Neuromuscular blockers.**

### 3.1:1000 Dilution

**(0.5 mg IM in Adult; 0.01 mg/kg in children below 30kg IM)**

**Mid Anterolateral Thigh (Vastus lateralis muscle), repeated every 5 to 15 minutes if needed.**

## 4.ASYSTOLE

**A terminal cardiac rhythm indicating complete cessation of electrical and mechanical activity, appearing as a straight or nearly flat line on an ECG.**
**It represents a non-shockable, pulseless cardiac arrest with a very poor prognosis,**
**MANAGEMENT:**
**Immediate CPR, Epinephrine, and identification of reversible causes**
**Inj. Epinephrine in 1:10000 dilution**
**1mg (10ml)IV bolus, 0.5mg (5ml) repeated 3-5 minutes if needed.**

## 5.(9ml of NS plus 1ml of Adrenaline) = 1:10000

**For Local Anesthesia**
**79ml of NS plus 1ml of Adrenaline = 1: 80000**
**99ml of NS plus 1ml of Adrenaline = 1:100000**
**199ml of NS plus 1ml of Adrenaline = 1:200000**
**399ml of NS plus 1ml of Adrenaline = 1:400000**

## 6.Organophosphorus Poisoning

**The effects of organophosphate poisoning on muscarinic receptors are recalled using the mnemonic DUMBBELLS**
**MANAGEMENT:**
**Inj. Atropine 1- 3mg IV,**
**Double the dose till full atropinization ;**
**IV Pralidoxime**

**7.Clear Chest with absence of bronchorrhea**
**heart rate above 80/min, Dry axilla and adequate BP**

**Dilatation of pupils not a reliable sign because atropine toxicity can occur.**

## 8.Mobitz Type 1 (Wenckebach) Heart Block

**A type of second-degree AV block characterized by a progressive lengthening of the PR interval until a QRS complex is dropped.**

**Mobitz Type 1 (Wenckebach) Heart Block**
**Requires no treatment if the patient is Asymptomatic**
**Focus on removing reversible causes like nodal-blocking drugs (beta-blockers, calcium channel blockers, digoxin).**
**If symptomatic (hypotension, dizziness), Atropine is the first-line treatment.**

## 9.Complete heart block (3rd degree)

**Mobitz type 2 blocks**
**Infranodal blocks**

**It may paradoxically worsen the block and progress to Ventricular Asystole**

## 10.Mnemonic for Anticholinergic Toxicity(antimuscarinic toxidrome)

**Occurs when excessive amounts of drugs like Diphenhydramine (Benadryl),**
**Amitriptyline, Datura, Atropa belladonna poisoning which block acetylcholine receptors, causing the symptoms.**

**Treatment includes stopping the causative agent, administering activated charcoal for recent ingestions, and using benzodiazepines for agitation. Physostigmine is the specific antidote for severe cases.**

**(Presented by Dr.M.I.Shahul Hameed, ENT Consultant, Virugambakkam.)**

# IMA Chennai Kodambakkam branch Chess Tournament

**Our Branch Chess tournament was conducted on 1st of March 2026 at Chess Gurukul, T.Nagar, Chennai. Around five members participated along with Chess Master. The following members participated in the tournament,**

**DR.S.S.K.SANDEEP; DR.M.I.SHAHUL HAMEED; DR.ANANTHAN DR.ARJUN GANESH; DR.VAMSI KRISHNA.**

**All players were given a chance to play against every other player and the maximum winner was selected.**

**DR.ARJUN GANESH - WINNER; DR.ANANTHAN - RUNNER**

# IMA Chennai Kodambakkam branch Photo Gallery





# FSS1 & FSS 11

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

**FSS 1 & FSS 11**
**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*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 II members will contribute Rs. 300 each for the death of any FSS II member. Every year 40 deaths were estimated (300x40=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 II 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 11 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 11.
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 11.

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


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

# 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**

Dr. R. Ramnarayan,

What is Spinal Cord Stimulation (SCS)?
A neuromodulation therapy for chronic, intractable pain when the cause cannot be reversed.

Involves implantation of:
Epidural electrode over dorsal columns, Connected to a pulse generator, Modulates pain signals before they reach the brain.

Mechanisms of Action – Beyond Pain Relief - Gate control theory:
Activation of Aβ fibers inhibits nociceptive transmission from small fibers, Supraspinal inhibition of pain pathways, Spinothalamic tract modulation, Sympathetic inhibition → vasodilatation & collateral formation, Key benefit in peripheral vascular disease (PVD), Activation of neurotransmitters → sustained analgesia even after stimulation stops

Indications for SCS in Diabetic Peripheral Neuropathy (DPN)

Severe bilateral neuropathic pain (VAS >5/10)
Persistent symptoms despite:
≥12 months of conservative therapy
≥6 months of pregabalin + duloxetine
Drug intolerance or major QoL impairment
No major psychological contraindications

**When to Refer a Patient (Key Clinical Triggers)**

**Refractory painful DPN despite maximal medical therapy ≥6 months**
**ADA diabetic foot risk category 3 or SVS WIfI grade ≥2**
**Preserved vibration perception threshold**
**Non-healing ulcers >12 weeks or recurrent ulcers despite aggressive care**
**≥50% pain relief during trial stimulation → predicts success**

**Contraindications for SCS**
**Absolute - Local infection, Coagulopathy / anticoagulation, Prior surgery or trauma obliterating epidural space**

**Relative - Pacemaker in situ, Major psychiatric illness, Spina bifida**

**Complications – What to Counsel Patients About**

**Infection: 3–6%**
**Epidural hematoma: ~0.6–0.75%**
**CSF leak: 0.05–0.3%**
**Spinal cord injury: <0.1%**
**Serious neurological complications: ~1.7–2.3%**

**Evidence Update (2025)**
**Long-term data (SENZA-PDN extension):**
**~76% achieved clinically meaningful pain relief, ~85% improved quality of life, Sustained benefits at 24 months**

**Additional benefits observed:**
**Modest HbA1c reduction (greater in poorly controlled T2D), Weight reduction, Confirms 10-kHz SCS as a durable, cost-effective therapy for PDN.**

DR.Suresh

Most of us give routine injections like Diclofenac, Emeset, or Paracetamol without a second thought. But what if something unexpected happens?
Imagine this: A patient develops anaphylaxis—a severe allergic reaction—and collapses, or even dies, after an injection or vaccination. The family files a medical negligence case.
In such cases, the legal focus isn't on why the reaction happened... But on how well the emergency was handled.

What the Court Will Look At:
• Was the clinic equipped to handle emergencies?
• Did the doctor follow the proper anaphylaxis management protocol?
• Were life-saving drugs like Adrenaline, Avil, and Hydrocortisone given in time?
• Were essential emergency tools like an Ambu bag or intubation kit available?

When Is It Considered Negligence?
If your clinic is prepared and you act quickly using the right protocol, you may not be held responsible.
But if you're missing basic emergency medicines or equipment, it can be considered negligence, and compensation may run into lakhs of rupees.

Medico-Legal Advice
No matter how small your clinic is, it's mandatory to keep:
• Emergency drugs to treat anaphylaxis
• Basic tools to help with resuscitation

## 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.**

**So far, only 310 members have submitted the Google form. Those who haven't filled it out please do so as early as possible.**

## THANK YOU MEMBERS

**The IMA Chennai Kodambakkam branch extends its gratitude to all members who participated in the Essay Competition and Chess Competition.**

**We also appreciate the members who availed the master health check-up services provided by VRR Diagnostics.**

## EXECUTIVE COMMETTE MEMBERS

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| 1. | Dr Nirmala Ponnambalam | 9444239494 | nimmipons@yahoo.com |
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# STATE COUNCIL MEMBERS

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| 2.Dr M I Shahul Hameed | TN/19764/94/768/158102/2011-12/L |
| 3. Dr S Sri Vamsi Krishna | TN/26905/94/1085/245570/2018-19/L |
| 4. Dr S S K Sandeep | TN/19975/94/773/160077/2011-12/L |
| 5. Dr Priya Kannan | TN/22555/94/858/185039/2013-14/L |
| 6. Dr A Aravind | TN/12809/94/485/114112/2004-05/L |
| 7. Dr D Boopathy John | TN/2852/94/714/47620/1995-96/L |
| 8. Dr K Subramanian | TN/2110/94/72/40220/1994-95/L |
| 9. Dr R Ezhil Arasan | TN/3227/94/113/52440/1996-97/L |
| 10. Dr P Chowdappa | TN/1534/94/16/32999/1993-94/L |
| 11. Dr M Arunachalam | TN/5196/94/229/66223/1998-99/L |
| 12. Dr P M Venkatasai | TN/3795/94/166/57769/1996-97/L |
| 13. Dr A Sreedharan | TN/1539/94/21/33004/1993-94/CL |
| 14. Dr T Muthum Perumal | TN/2113/94/75/40223/1994-95/L |
| 15. Dr K Selvam | TN/3235/94/117/52444/1996-97/L |
| 16. Dr K A Venkatachalam | TN/17377/94/681/142402/2009-10/L |
| 17. Dr U MeenakshiSundaram | TN/21884/94/822/179507/2013-14/L |
| 18. Dr M Balakrishnan | TN/5753/94/249/69384/1999-00/L |
| 19. Dr S Indra | TN/1533/94/15/32998/1993-94/L |
| 20. Dr M Veldurai | TN/9978/94/423/96057/2002-03/L |
| 21. Dr G Vargunapandian | TN/11504/94/456/107240/2004-05/L |
| 22. Dr P Mahendran | TN/10658/94/436/98700/2003-04/L |
| 23. Dr Duddi Pratap Prakash | TN/24367/94/939/202860/2015-16/L |
| 24. Dr S Vijay Alagappan | TN/21885/94/823/179508/2013-14/L |
| 25. Dr Sukumar | TN/4360/94/189/63402/1998-99/L |
| 26. Dr R Muthiah | TN/15231/94/943/131471/2006-07/L |
| 27. Dr P Umapathy | TN/6772/94/256/75501/2000-01/L |
| 28. Dr S Soundappan | TN/9631/94/399/94077/2002-03/L |
| 29. Dr Babu Ezhumalai | TN/35623/94/1300/172634/2012-13/L |
| 30. Dr D Rajesh Babu | TN/26867/94/1047/245532/2018-19/L |
| 31. Dr K Mohan Raj | TN/3849/94/162/58293/1996-97/L |

# CENTRAL COUNCIL MEMBERS

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| 3. | Dr S Sri Vamsi Krishna | TN/26905/94/1085/245570/2018-19/L |
| 4. | Dr S S K Sandeep | TN/19975/94/773/160077/2011-12/L |
| 5. | Dr Priya Kannan | TN/22555/94/858/185039/2013-14/L |
| 6. | Dr A Aravind | TN/12809/94/485/114112/2004-05/L |
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| 9. | Dr R Ezhil Arasan | TN/3227/94/113/52440/1996-97/L |
| 10. | Dr P Chowdappa | TN/1534/94/16/32999/1993-94/L |
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| 15. | Dr K Selvam | TN/3235/94/117/52444/1996-97/L |
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| 17. | Dr U MeenakshiSundaram | TN/21884/94/822/179507/2013-14/L |
| 18. | Dr M Veldurai | TN/9978/94/423/96057/2002-03/L |

## 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<br>Dr P Puspha |
| PPLSSS &FSS | Dr M Balakrishnan<br>Dr M Veldurai |
| Young Doctors Wing | Dr.S.Vijay Alagappan<br>Dr Jackin Moses; Dr.Vivek VVV |
| Private Hospitals & NHB | Dr P Chowdappa |

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Dr R Ezhilarasan; Dr PM Venkatasai; Dr U Meenakshisundaram; Dr K Subramanian

**Advisors**

Dr.K.Selvam; Dr R Ezhilarasan; Dr.A.Sreedharan; Dr.D.Boopathy John

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