



519th CME of IMA Chennai Kodambakkam branch was held on 26th April 2026 at 2 Pm, Aaditya Hotel, Vadapalani, Chennai.

The program was smoothly conducted by our branch office bearers Dr. Priya Kannan (Vice President), Dr.S.Indra (Joint Secretary) and Dr. Vamsi Krishna (Treasure).

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

LIFETIME ACHIEVEMENT AWARD



Dr. M. VELRANI, MBBS, MD, DGO.

An alumna of Madras Medical College, Dr. M. Velrani graduated with MBBS in 1972, completed DGO from Madras Medical College in 1975, and MD (O&G) from Stanley Medical College in 1982. With a professional career spanning over five decades, she has established herself as a distinguished Gynaecologist in Chennai.

She has rendered yeoman service at premier institutions including ESI Hospital and the Institute of Obstetrics & Gynaecology, Egmore. Renowned for her clinical acumen, she has successfully managed numerous high-risk and complex cases, contributing immensely to women and child healthcare through dedicated practice and academic publications.

An active member of leading professional bodies, she has consistently engaged in academic pursuits and social service, including the conduct of free medical camps for the underprivileged. In recognition of her exemplary service, she has been conferred with prestigious honours, including the “USV Pharma Lifetime Achievement Award” and the “COVID Warrior Award”.

CME PROGRAMME

1. IMA PRAYER AND PHYSICIAN'S PRAYER - Dr. A.Bhavani
2. Interesting GI Cases -
Dr Umalakshmi Premnath, MD, DM(MGE)
Consultant, MGM hospital
3. Sudden Cardiac arrest in young adults, Is it any
Different ?
Dr K Jai Shankar MD DM
Sr. Director Cardiology, SIMS
4. Chronic Kidney Disease
Dr R Balasubramaniam
Chief of nephrology, Kauvery hospital. Alwarpet
5. My Professional Journey - Dr M Velrani
(Life Time Achievement Awardee)
6. Robotic Assisted Knee Replacement
Dr J Panthala Rajakumaran,
Sr. Consultant Orthopaedic Surgeon VS Hospitals, Chennai
7. Spectrum of ENT, Neurotology and Skull Base Surgery
Dr M Arulalan, Consultant ENT Surgeon, SRM Prime
8. Dr S Sivakumar Endowment Oration
Topic : Memorable Cases in my Career
Dr C Jagadeesh, Senior Consultant, Apollo Hospital
9. Clinical Insights - Dr C Rajendiran
10. Quiz - Dr B Srinivas

AN OVERVIEW OF THE LECTURES PRESENTED IS GIVEN BELOW.

Interesting GI Pathologies

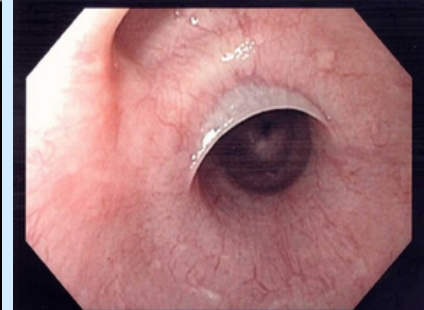
Dr. Umalakshmi Premnath presented on GI pathologies and used excellent pictures to explain it.



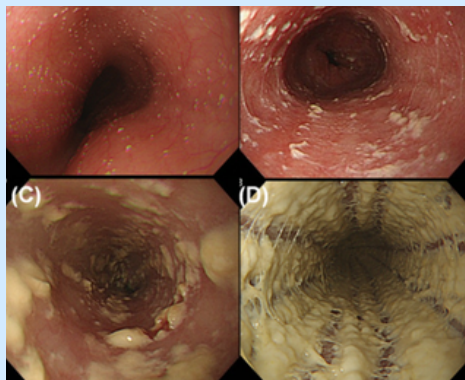
Normal Structures



Post cricoid Malignancy



Post cricoid Web



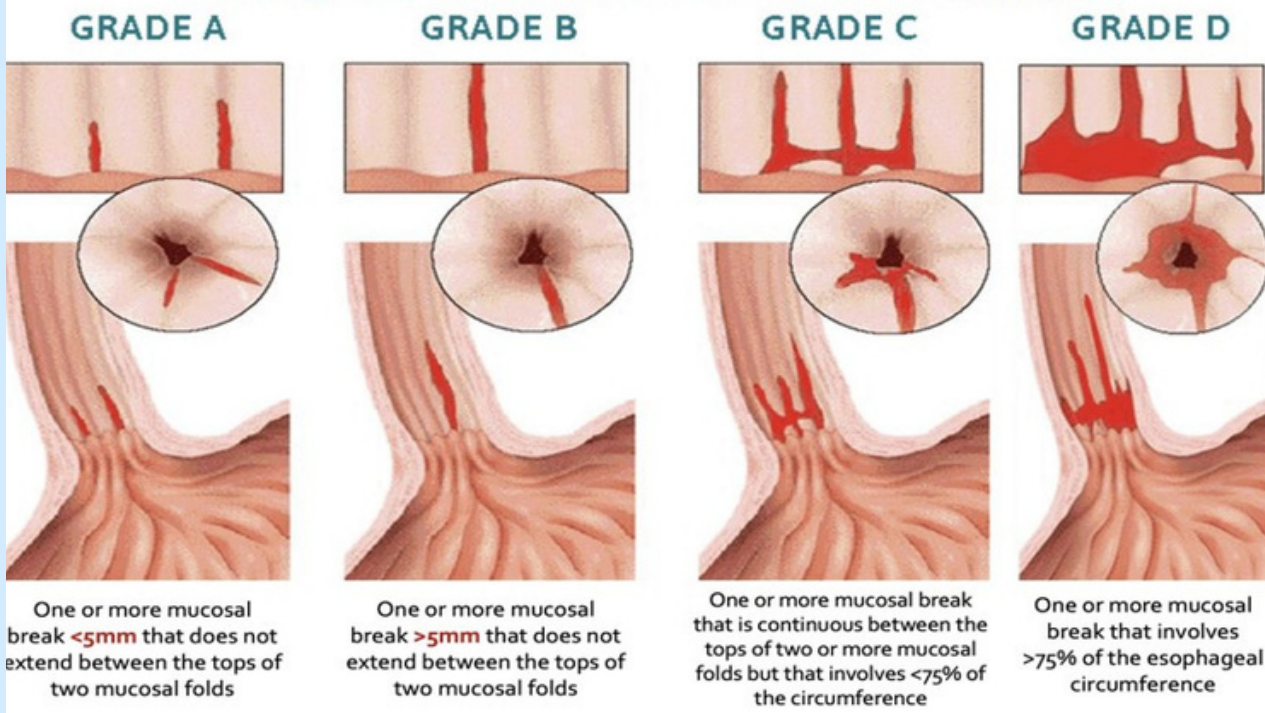
Grading oesophageal candidiasis: Endoscopic

LIFE FUNGAI EDUCATION

Kodsi endoscopic severity grading

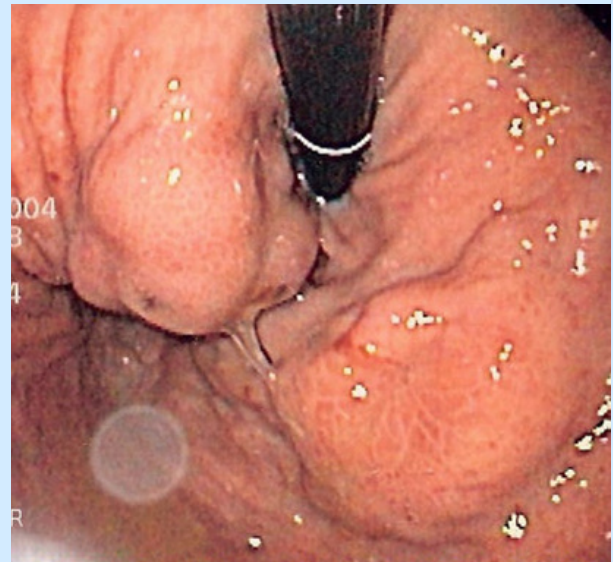
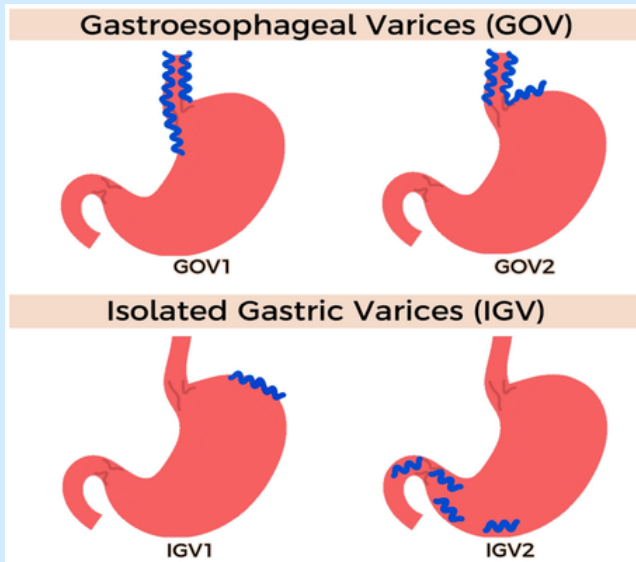
- Grade 0:** Normal oesophageal mucosa
- Grade 1:** Raised white plaques are 2 mm or less in size
- Grade 2:** Raised white plaques greater than 2 mm in size
- Grade 3:** Mucosal ulceration is present or a confluent, thick plaque like membrane coats the oesophageal mucosa
- Grade 4:** Finding of grade III with increased friability of the mucous membranes and occasional narrowing of the lumen

Los Angeles Classification of Reflux Esophagitis



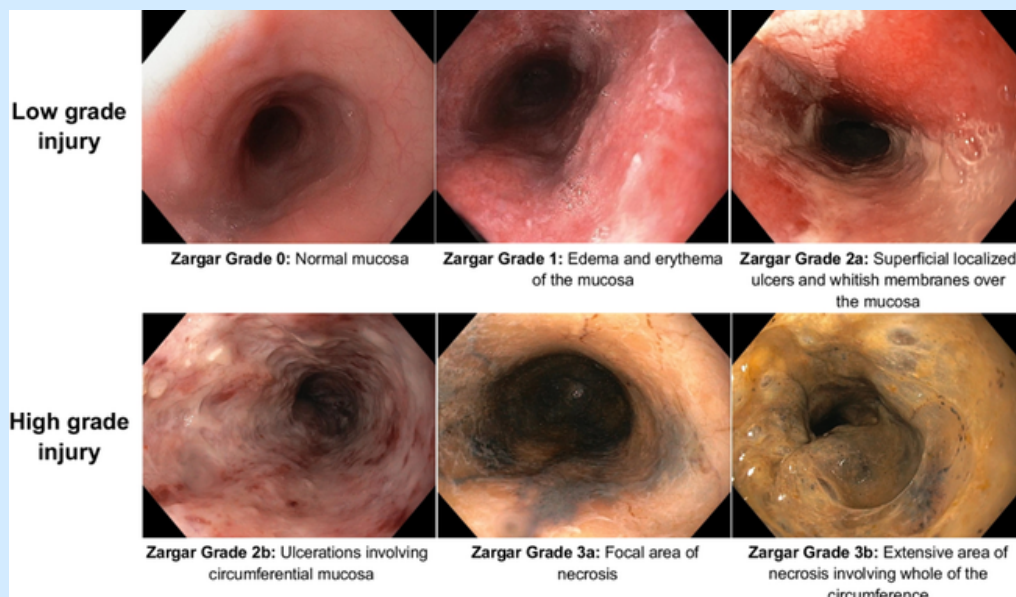


Esophageal Varices



Gastric Varices

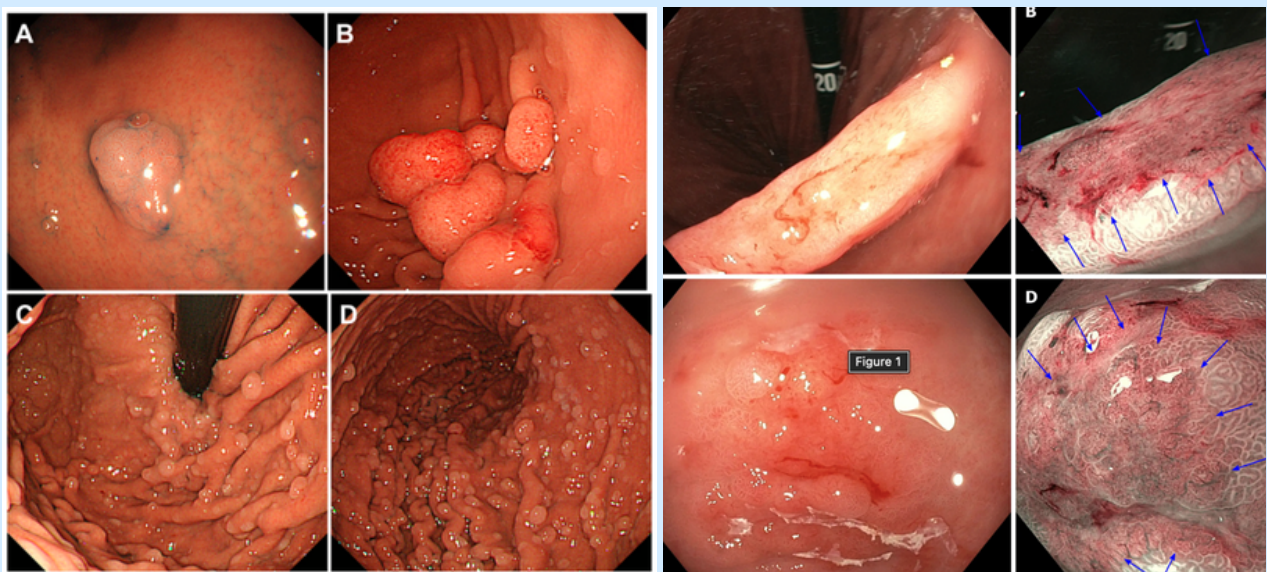
Corrosive Injury





OGJ TUMOUR

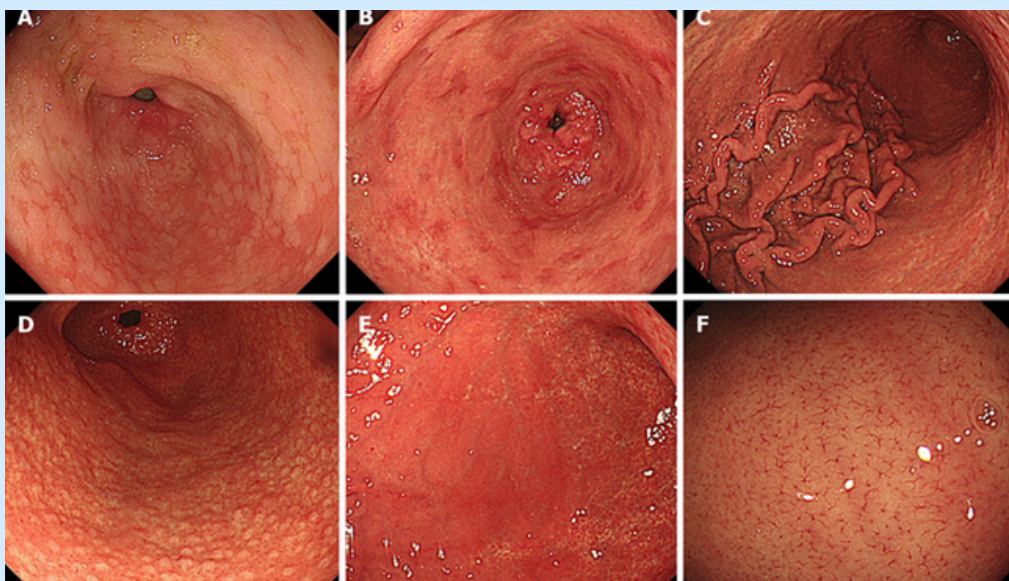
ATOROPHIC GASTRITIS

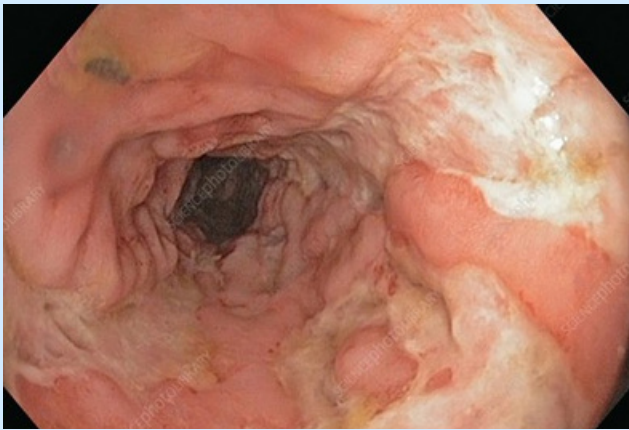


Gastric Polyp

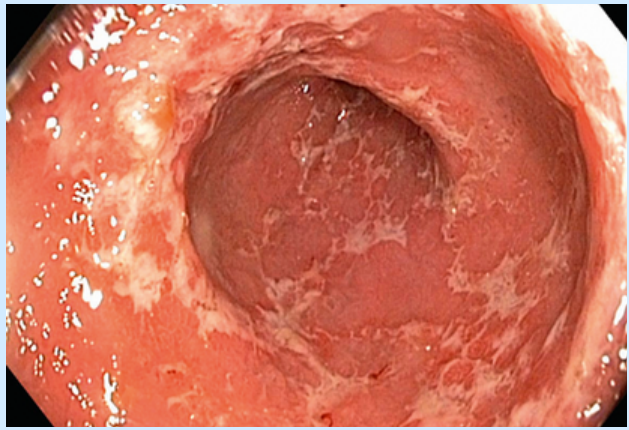
EGC

H.Pyroli Infection



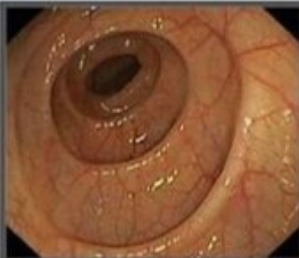
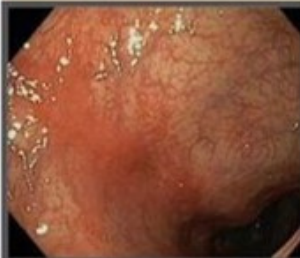
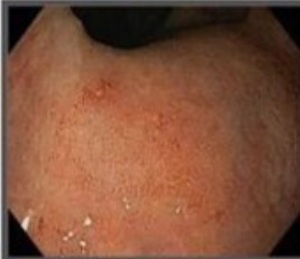
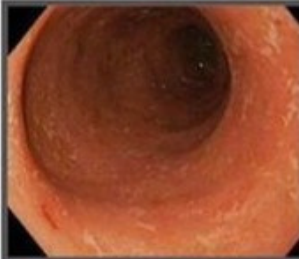


CROHN'S DISEASE



ULCERATIVE COLITIS

Mayo Score for Ulcerative Colitis

Mayo UC Endoscopic Score = 0 (normal or inactive disease)	Mayo UC Endoscopic Score = 1 (mild disease)	Mayo UC Endoscopic Score = 2 (moderate disease)	Mayo UC Endoscopic Score = 3 (severe disease)
			
			
Normal vascular pattern	Erythema, decreased vascular pattern, mild friability	Marked erythema, absent vascular pattern, friability, erosions	Spontaneous bleeding, ulcerations

Sudden Cardiac Death in Young Individuals

Dr K Jai Shankar MD DM

SCD/SCA is an unexpected death due to cardiac causes that occurs in a short time period (generally within 1 hour of symptom onset) in a person with known/unknown cardiac disease. Patients at risk for SCD may have prodromes of chest pain, fatigue, palpitations, and other non-specific complaints. 75% of Indians below the age of 50 years are at high risk for SCD.

Etiology of SCD

Ischemic heart disease: 60-70%

Structural heart disease: 10%

Valvular heart disease, HCM, coronary artery anomaly, myocarditis, cardiomyopathies

In younger population (<40 years of age) this group amounts to about one-third of all SCDs

Primary electric disorders: 10%

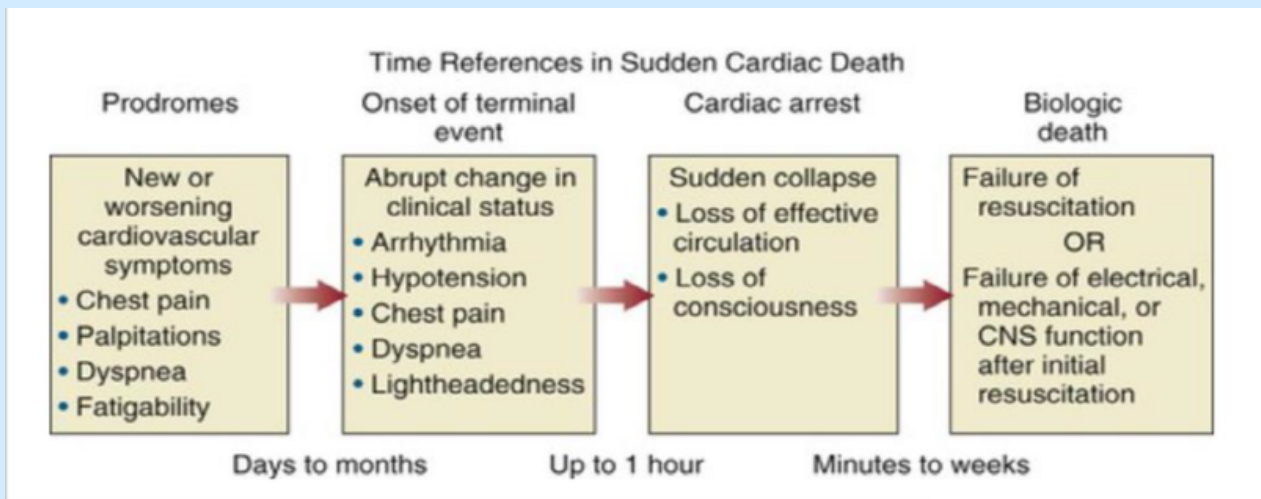
BrS, congenital LQTS, catecholaminergic polymorphic VT, IVF, SQTS, Wolf-Parkinson-White syndrome

Noncardiac: 15-25%

Trauma, bleeding, drug and toxins, pulmonary embolism, hemorrhagic stroke, asphyxia

Risk factors for SCD

Family history of SCD/premature coronary artery disease
Hypertension, Sedentary lifestyle, Dyslipidemia, Diabetes, Smoking, Obesity and Pollution ?



Clinical features suggestive of SCD

Exertional symptoms such as dyspnea/fatigue or palpitations.

Syncope or seizures, Chest pain/discomfort/tightness/pressure related to exertion related or not related to exertion

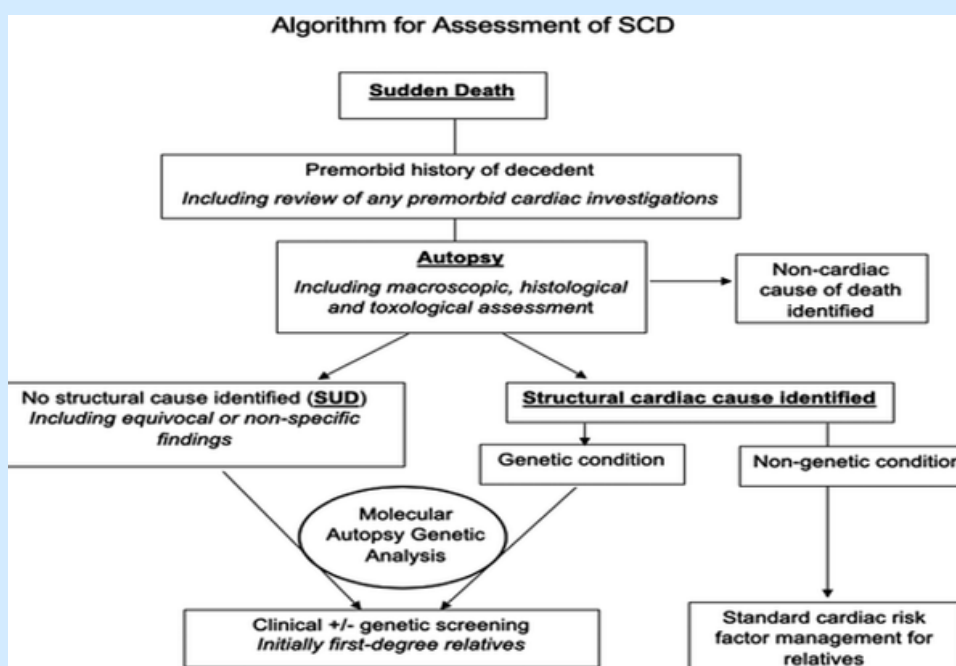
Intercurrent illnesses and any known cardiac investigations, such as electrocardiogram or cardiac imaging, which must be reviewed where available.

Elevated blood pressure

History of drug use (prescribed or illicit)

Premature death or disability before age 50 attributed to heart disease in a relative

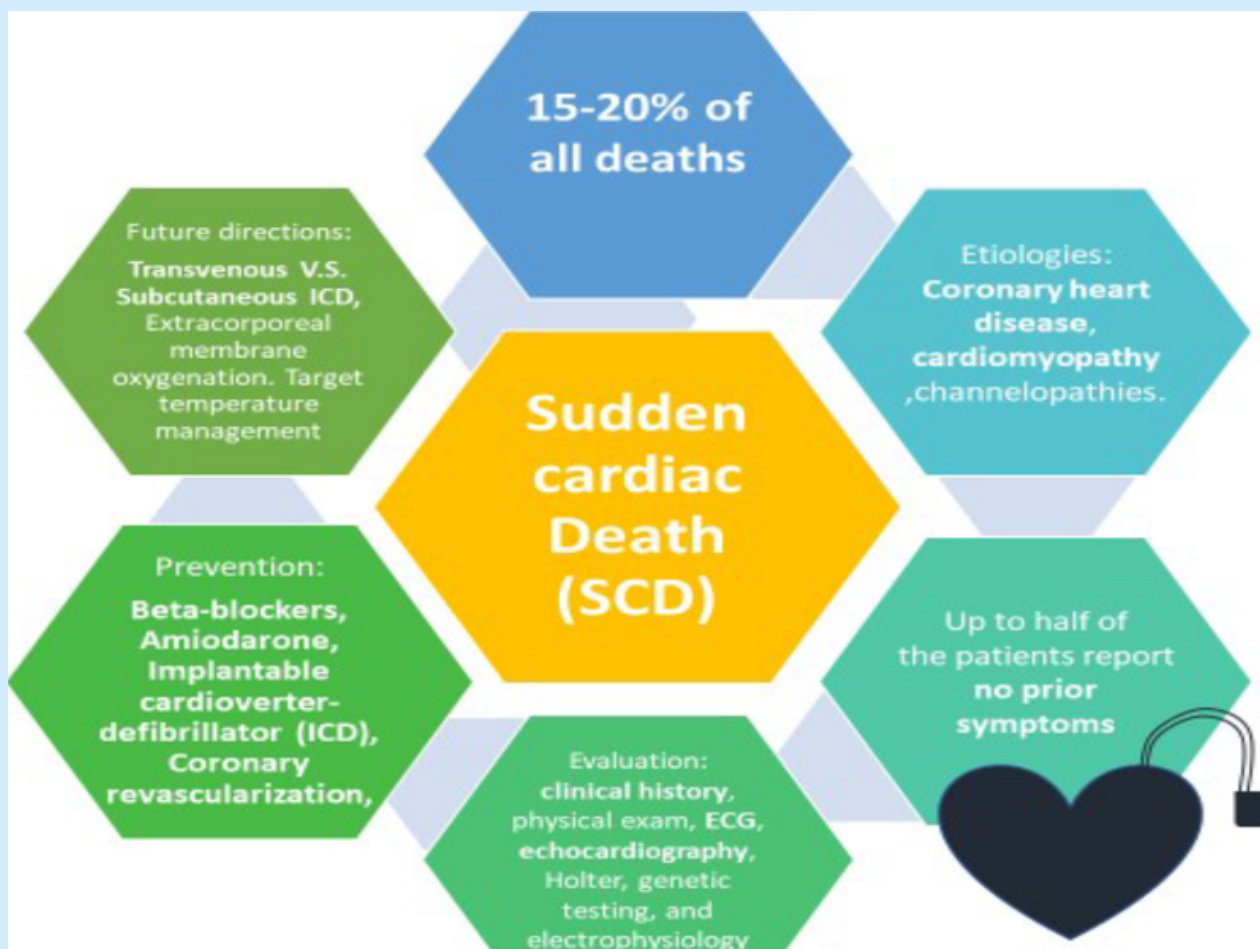
Cardiac diseases, such as hypertrophic or dilated cardiomyopathy, channelopathies, Marfan syndrome, or clinically significant arrhythmia.



Electrocardiogram markers for sudden cardiac death risk stratification

Microvolt T-wave alternans (MTWA)	T-wave duration difference between alternate beats at the microvolt level
T-peak–T-end interval	The interval from the peak to the end of the T-wave
QRS fragmentation	Presence of an R' wave or spikes in the QRS complex.
QRS duration	Duration of the QRS complex

Cardiovascular risk	·Adults should be routinely assessed for psychosocial stressors and provided with appropriate counseling. ·Health literacy should be assessed every 4 to 6 y to maximize recommendation effectiveness.
Diet	·In addition to the prescription of diet modifications, body size perception, as well as social and cultural influences, should be assessed. ·Potential barriers to adhering to a heart-healthy diet should be assessed, including food access and economic factors; these factors may be particularly relevant to persons from vulnerable populations, such as individuals residing in either inner-city or rural environments,
Exercise and physical activity	·In addition to the prescription of exercise, neighborhood environment and access to facilities for physical activity should be assessed.
Obesity and weight loss	·Lifestyle counseling for weight loss should include assessment of and interventional recommendations for psychosocial stressors, sleep hygiene, and other individualized barriers. ·Weight maintenance should be promoted in patients with overweight/obesity who are unable to achieve recommended weight loss.



- Promote a healthy lifestyle
- All adults should consume a healthy diet
- Adults with overweight and obesity- counseling and caloric restriction are recommended for achieving and maintaining weight loss
- Adults should engage in at least 150 minutes per week of accumulated moderate-intensity physical activity or 75 minutes per week of vigorous-intensity physical activity
- Tobacco users should be assisted and strongly advised to quit
- Cardiac evaluation in first degree relatives with SCD – genetic testing and counselling
- Educate patients with cardiovascular disease and their families about the warning signs of impending sudden cardiac arrest and promote early intervention

Chronic Kidney Disease (CKD)

Dr R Balasubramaniyam

Definition:

Structural or functional abnormalities of the kidneys for > 3 months as manifested by,

1. Kidney damage , with or without decrease in GFR as manifested by
 * markers of kidney damage in the blood (azotemia) or in the urine (proteinuria) or abnormalities in renal imaging (contracted kidneys on ultrasonogram)

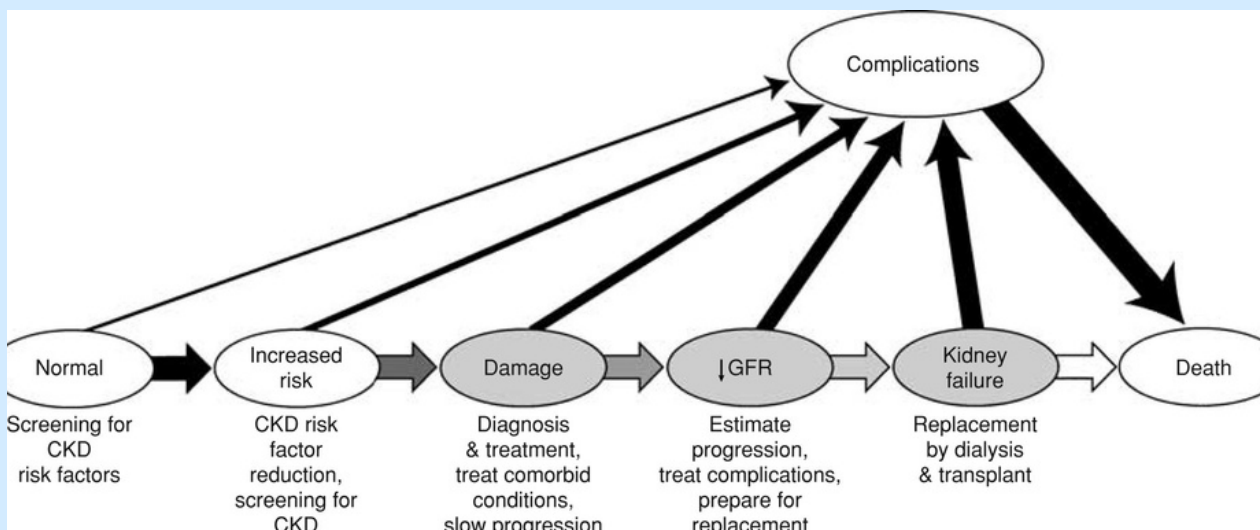
* pathological abnormalities

2. reduction in GFR < 60 ml / minute , with or without signs of kidney damage

CKD affects 1 in 10 people worldwide.

			Persistent albuminuria categories			
			A1 Normal to mildly increased <30 mg/g <3 mg/mmol	A2 Moderately increased 30–300 mg/g 3–30 mg/mmol	A3 Severely increased >300 mg/g >30 mg/mmol	
GFR categories (ml/min/1.73 m ²)	G1 Normal or high	>90	Low risk	Moderately increased risk	High risk	Low risk Moderately increased risk High risk Very high risk
	G2 Mildly decreased	60–89	Low risk	Moderately increased risk	High risk	
	G3a Mildly to moderately decreased	45–59	Moderately increased risk	High risk	Very high risk	
	G3b Moderately to severely decreased	30–44	High risk	Very high risk	Very high risk	
	G4 Severely decreased	15–29	Very high risk	Very high risk	Very high risk	
	G5 Kidney failure	<15	Very high risk	Very high risk	Very high risk	

Nature Reviews | Disease Primers





ISN
INTERNATIONAL SOCIETY
OF NEPHROLOGY

Chronic Kidney Disease (CKD) Early Identification and Intervention

CKD causes a
global burden



CKD disproportionately
affects socially
disadvantaged populations

Determine At-Risk
Individuals and Populations



Screen for CKD in individuals with
hypertension, diabetes, and/or
cardiovascular disease

Consider other factors including
Demographics, older age, race/ ethnicity
Other systemic diseases that impact
kidneys
Genetic risk factors
Environmental exposures

Screening and Diagnosis
of CKD



Measure kidney function

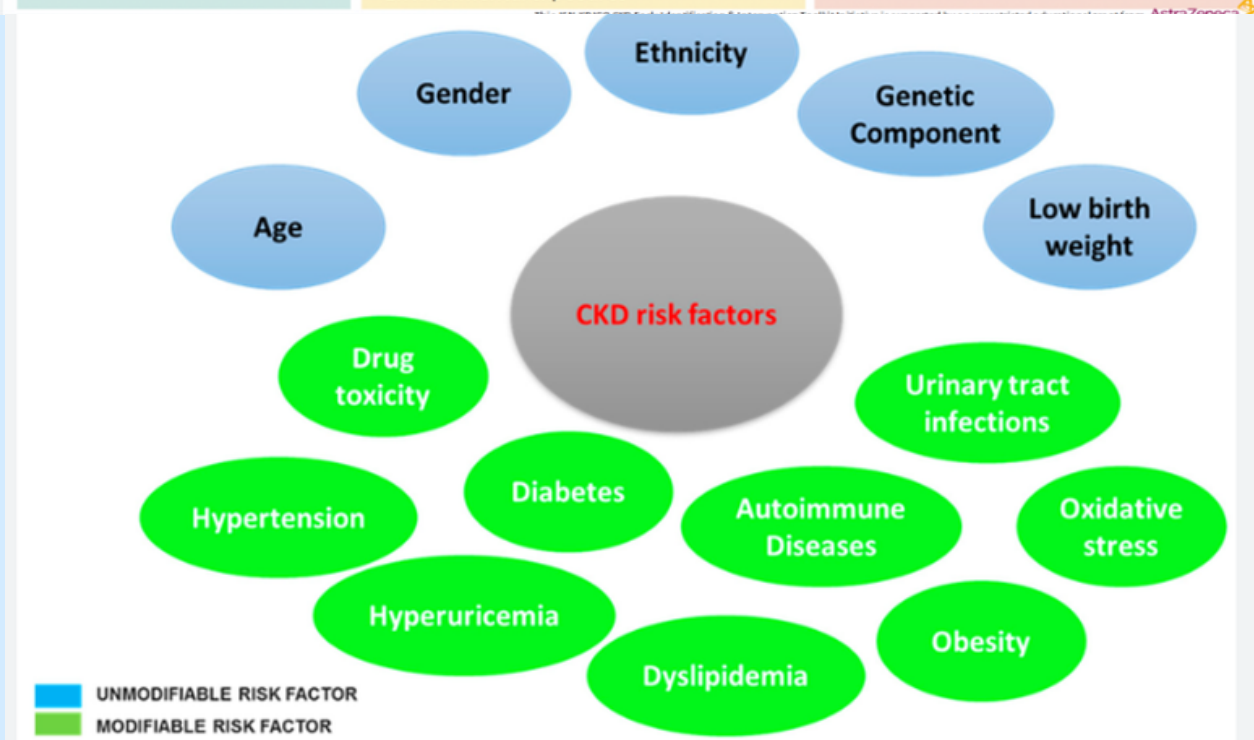
Serum creatinine

Serum Cystatin C if available for more
accurate staging

Measure kidney injury

Urine albumin-to-creatinine ratio (UACR)

Urine dipstick if UACR not available



Impact of Improved Diagnosis and Treatment on Holistic Chronic Kidney Disease Burden



8 country populations were simulated for 25-years using the IMPACT CKD model

Patients can be treated with one or multiple therapies
Treatment effects were assumed to be multiplicative

GDMT Guideline Directed Medical Therapy

- Kidney protection
- Glucose lowering
- Lipid lowering
- Anti-HTN
- Lifestyle interventions

Scenarios with improved GDMT adherence projected cumulative improvements (vs. current practice over 10 years)

Scenario	Improvement
Dialysis	-3.2% to -23.2%
CV Events	-12.2% to -41.4%
Death	-2.3% to -9.3%

Projections as a result of delayed CKD progression (vs. current practice)

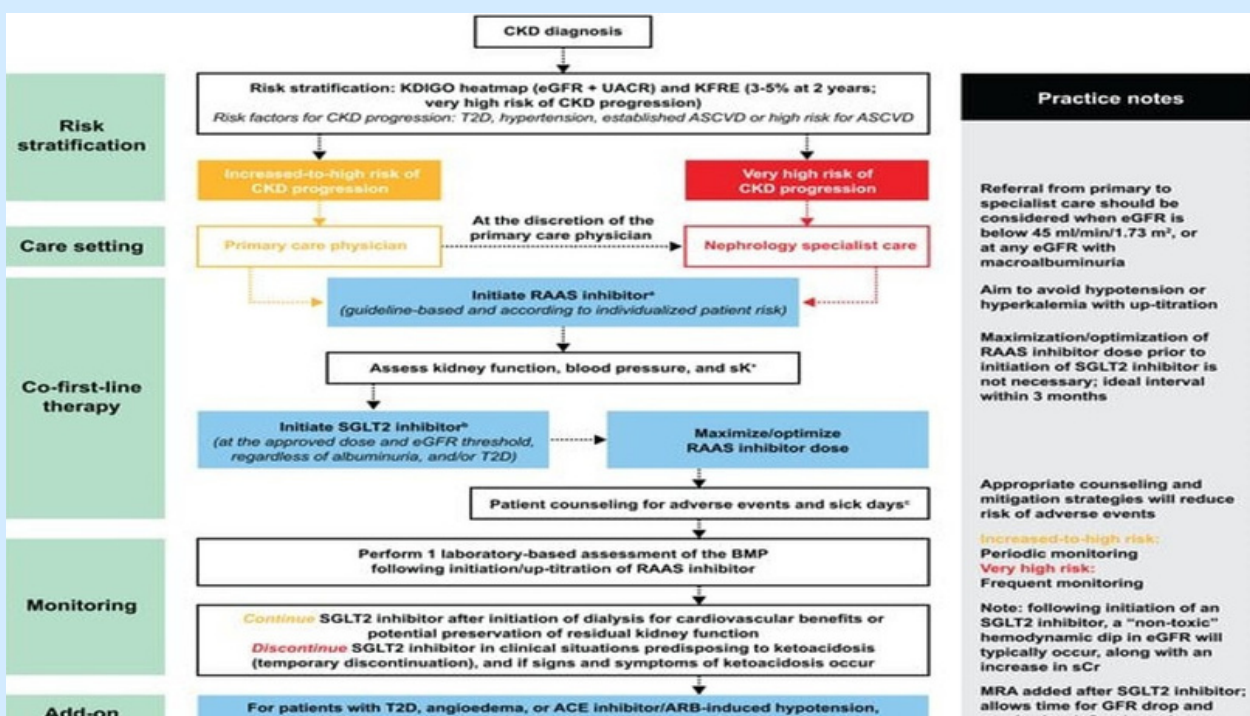
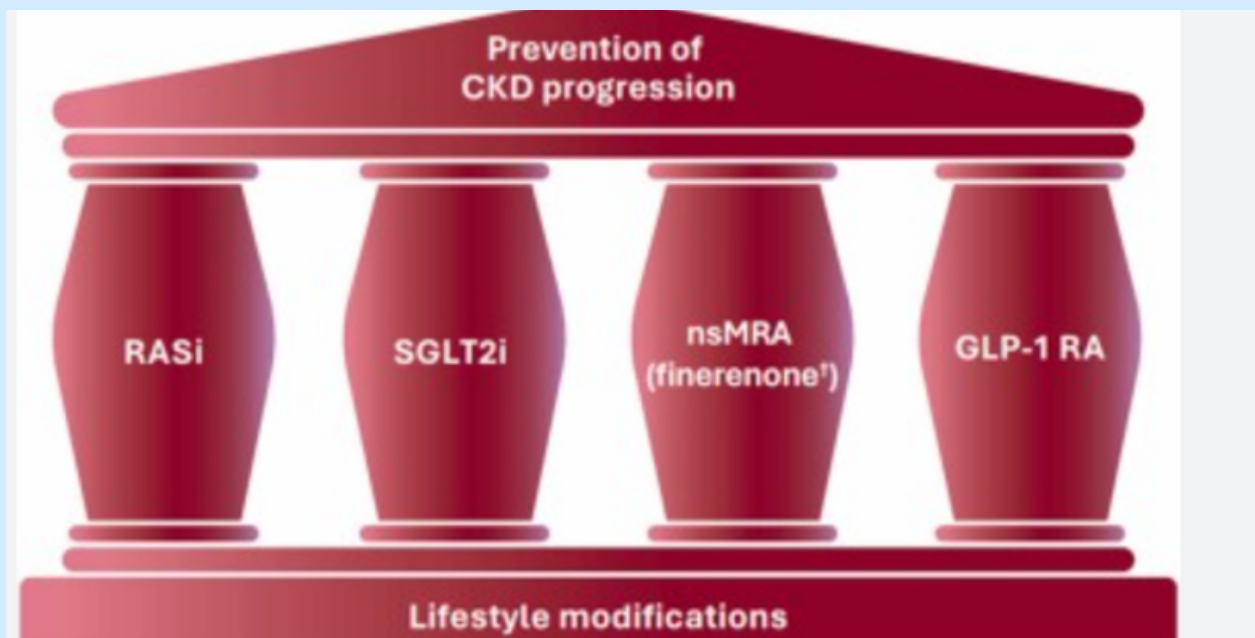
Scenario	Improvement
Kidney Replacement Therapy costs	-2.5% to -19.4%
Environmental burden	-2.7% to -21.2%

All treatment scenarios predicted greater improvements over 25-years, underscoring the long-term impact of CKD, and highlighting the importance of early intervention

Conclusion Differences in projected impacts between countries are multifactorial, though are sensitive to demographics and healthcare systems. Implementation of policies that lead to improved detection and treatment of CKD are urgently required across the globe to mitigate the growing burdens of CKD on patients and caregivers, healthcare systems, society, and our environment

KI REPORTS
Kidney International Reports

Tangri N et al, 2025
Visual abstract by:
Edgar Lerma, MD, FASN
X @edaarvlermamd



Treatment of CKD complications:

Diet – salt , fluid , potassium , proteins

Blood pressure control , sugar control , lipid lowering , life style modifications

When the patients renal disease progresses and reaches ESRD , we advice dialysis and transplantation , if no contra indications

Create an AVF when GFR < 10 ml / mt

DIALYSIS options and transplant discussed

HEMODIALYSIS

Hospital based treatment

Blood is removed and send it through an ARTIFICIAL kidney where it is purified

3 SESSIONS PER week – intermittent therapy

Good uremic , volume and metabolic control can be achieved

Risk of infections (hepatitis AND BACTERIAL) bleeding , blood loss, cardiac complications

Elderly , children and those with cardiac risks and vascular access issues – major concerns

CAPD

Uses patients peritoneal cavity for dialysis

Dialysis fluid is instilled inside the peritoneal cavity , stays for few hours (DWELL TIME) , replaced 3 to 4 times a day depending on their peritoneal transport.

Continuous dialysis , stable biochemistry , no diet restrictions, less blood loss and infections. Ideal for children and with patients having cardiac disease

Renal transplantation

Provides permanent cure for kidney failure

Risk of rejection as we keep a foreign organ inside – that is genetically different

Immuno suppression is key to graft survival

One year success rate is > 95 % and 5 year graft survival is > 80 %, Better HLA typing and Tissue crossmatch techniques, availability of newer immune suppressive agents, surgical advancements (Lap donor nephrectomies, Robotic surgery).

Robotic Assisted Knee Replacement

Dr J Panthala Rajakumaran

Total Knee Replacement represents the gold standard surgical intervention for end-stage knee osteoarthritis when conservative treatments have been exhausted. Three Compartments Medial, lateral, and patellofemoral regions damaged bone and cartilage are replaced with metal and polyethylene implants to restore function and provide long-lasting pain relief.

The Challenge of Traditional TKR

Conventional total knee replacement relies heavily on surgeon experience, manual instruments, and visual estimation. While effective, this approach has inherent variability that can impact outcomes.

The Robotic Advantage

Robotic systems provide comprehensive 3D preoperative planning combined with real-time intraoperative precision guidance. This technology enhances accuracy and safety while keeping the surgeon in complete control. The robot is a sophisticated tool that augments the surgeon's capabilities, it does not replace clinical judgment or surgical expertise.

The robotic assisted TKR process begins with advanced imaging to create a patient-specific surgical blueprint. During surgery, the robotic arm provides sub-millimeter accuracy while the surgeon maintains full control. Haptic feedback and real-time monitoring ensure preservation of healthy tissue and optimal implant placement for each individual patient.

SUPERIOR ALIGNMENT:

Improved implant alignment and positioning reduces outliers by over 50% compared to conventional TKR, as demonstrated in recent studies

ENHANCED BALANCE

Enhanced soft tissue balancing leads to better knee kinematics, more natural movement, and significantly improved patient satisfaction scores

FASTER RECOVERY

Reduced intraoperative trauma and blood loss contribute to faster recovery times, less postoperative pain, and earlier return to daily activities

LOWER RISK

Lower risk of complications such as implant loosening and early failure, potentially extending the functional life of the replacement

While robotic assisted TKR offers significant advantages, the technology faces challenges including high initial investment costs and the learning curve required for optimal utilization. Long-term data on implant survival beyond 10-15 years continues to accumulate.



AI IN PATIENT CARE: A BOON OR A BANE

Introduction:

Artificial Intelligence (AI) is an advanced, augmenting tool that leverages computer based machine learning that plays a role in medicine due to its ability to process complex medical/ healthcare data. AI can aid in improving healthcare system in India by assisting physicians with rapid, accurate diagnostics, personalized treatment planning, and improving administrative efficiency. AI is auxiliary and acts as an adjunct tool that aids the medical practitioner like an additional pair of eyes in improving efficiency, accuracy, and supports empathetic patient care. It can provide support for clinical decisions, prognosis, risk prediction and help improve patient outcomes.

Artificial Intelligence (AI) has the capacity to transform healthcare delivery across India. In a country like ours with large population with uneven healthcare access, and a dual burden of both communicable and non-communicable diseases, AI is gradually moving from research to real-world clinical integration and plays an important role in personalised care in large tertiary super-specialty hospitals.

The main applications of AI for physicians includes:

1. Automated analysis for image-based diagnosis:

AI or deep learning algorithms analyse images (ophthalmology- retinal images- fundus photographs, optical coherence tomography (OCT scans) to diagnose diabetic retinopathy and in radiology (X-rays, ultrasound, CT and MRI scans), where various lesions in the images can be detected by training the algorithms with thousands of images to provide accurate diagnosis of various ocular disorders or systemic diseases. Lesions in imaging missed by human eye, are often picked up by AI tool.

AI helps in improving accuracy in diagnosis and risk prediction. Precision medicine, personalised treatment and tailoring management for various disorders is possible based on AI analysis of comprehensive patient data. Robotic surgery assistance is provided with the use of AI enabled operating systems.

4. AI assisted workflow optimisation at hospitals: AI assists in automating routine tasks such as scheduling patient appointments, manage electronic medical records (EMR), and providing reminders for appointment follow-ups. AI tools can help streamline workflow for very busy doctors, scheduling appointments and follow-ups, patient monitoring, and administrative tasks. It can reduce administrative burdens such as documentation and improve administrative efficiency. AI chatbots are available on websites / apps of many large tertiary care hospitals to interact virtually with patients AI and revolutionize clinical workflow in hospitals. AI enabled reminders for vaccinations or appointments for next consultation through WhatsApp are now possible.

5. AI-Powered Practice Solutions: There are many AI-enabled platforms useful for physicians like Doctors App, Health Plix, Practo Ray, Eka Care, etc available now in India. They provide AI-powered appointment optimisation, basic analytics to manage OPD, AI-assisted clinical documentation of findings, medical reports and stylus-enabled digital medicine prescriptions. AI systems cross-reference new medicine prescriptions with patient history to flag any drug allergies or drug interactions.

6. AI enabled telemedicine: AI can help bridge the accessibility gap and support rural telemedicine screening programmes, especially in underserved rural and remote areas, by enabling remote monitoring and virtual, AI-powered videoconsultation by expert medical specialists. AI tools facilitate remote consultations and telemedicine-based follow-ups. Teleophthalmology based detection of sight-threatening diabetic retinopathy, glaucoma and other eye disorders is possible with advice regarding urgent referral is possible with use of AI.

7. Access to Literature: Large language models (LLMs) can instantly search latest medical literature, providing evidence and insights during consultations between doctors and with patients.

Limitations and Challenges in the use of AI by physicians:

A robust IT infrastructure is required for use of AI based systems, and this requires a significant investment that may be a challenge in smaller hospitals or single physicians' clinics. For AI based diagnosis to be accurate, training with robust high-quality, diverse datasets is mandatory. An AI tool not trained to detect a particular disease, may miss the diagnosis. High resolution good image quality is key for AI based diagnosis of disorders from medical imaging. Liabilities in case of error in the diagnosis or a missed diagnosis by an AI tool has to be borne in mind by the physicians. The 'black box' phenomena with the use of deep learning algorithms with lack of transparency regarding the diagnosis decision by the AI tool, creates a fear regarding its use among clinicians. With use of AI and cloud-based diagnosis, caution is required with respect to data security and data privacy. Use of anonymised data and ensuring data privacy of patients is essential, as the patients are becoming aware and concerned regarding their personal medical reports and records being used in AI applications and research. There is a fear regarding AI among general practitioners that AI is transforming healthcare in India, may lead to doctors, especially those in imaging diagnostics, losing their jobs. AI in medicine serves as an auxiliary tool to support care, and cannot replace the physician. AI enabled systems should focus on managing routine tasks, allowing physicians to focus on empathetic patient care. The Indian government has prioritized the responsible adoption of AI ensuring data privacy and data security.

Training in use of AI for physicians:

It is important for practitioners to become aware about various AI applications being used with advancing healthcare in India. Training must be provided to improve the AI literacy and competency of physicians.

The National Board of Examinations in Medical Sciences (NBEMS) has started a new online course for doctors to understand various AI applications and implications.

Conclusion:

AI integration in healthcare is definitely transforming medical care in India, enhancing the quality and efficiency of diagnostic systems. AI system which is properly validated will be a boon for physicians, especially when it is transparent with explainability, and it is integrated into the clinical workflow that would provide support to the doctors' role as the primary and essential part of patient care. Conversely, AI can be a bane when it is opaque, deployed without proper validation, integrated poorly, causes bias in interpretation. AI tools should be suitably tailored to the needs and requirements of medical practitioners. Integration of artificial intelligence into medical practice in India requires a holistic approach that involves technological upgradation, addressing the practical challenges involved in implementation and ensuring that AI complements human-centered ethical practice in patient care.

By
DR.R.Rajalakshmi
Winner



MEDICAL QUIZ

BY Dr B Srinivas

QUESTION NO.1

The organism causing this sexually transmitted disease was identified in India, Name the disease, Who identified it, where and when?

Granuloma Inguinale- Caused by Klebsiella Granulomatis Identified in 1905 by Charles Donovan in Madras at the Government General Hospital. Hence the name Donovanosis

QUESTION NO.2



Tinea Incognito

What causes it?

Application of a steroid or a combination of an antifungal and a steroid ointment. Steroid ointment reduces inflammation but the fungus spreads under steroid cover.

How is it treated?

Treated by withdrawing the offending agent and by applying topical antifungals. Oral antifungals are also used

QUESTION 3



Erythrasma

Name the causative organism, How is it treated?

Caused by *Corynebacterium Minutissimum*

Treated topically with Fusidic Acid cream

Clindamycin Solution, Benzoyl Peroxide, Erythromycin and Tetracycline

QUESTION NO 4



A middle aged man presented with asymptomatic papules in the perineum and root of penis. What is this condition?

What is the cause?

Molluscum Contagiosum - Caused by a DNA virus belonging to the Pox family. The location suggests a sexual transmission. Giant Molluscum Contagiosum is seen in HIV positive patients.

QUESTION NO.5

What is this condition? An intensely pruritic condition in the leg treated with topical steroid, responded dramatically to two tablets.



Larva Migrans

What is the cause?How is it treated?

Caused by larval nematode wandering in the subcutaneous tissue.

A.braziliense, A.caninum are frequently known to cause this condition

Treated with oral Albendazole or Ivermectin

QUESTION NO.6



PSORIASIS

Name some commonly used groups of anti hypertensive drugs Worsening Psoriasis?

Ace Inhibitors, Beta Blockers, Calcium Channel Blockers.

QUESTION NO 7



Koebner Phenomenon

Also called Isomorphic Phenomenon

**It is the occurrence of new lesions along the lines of trauma
Seen in Lichen Planus, Psoriasis, Warts Vitiligo ,Molluscum
Contagiosum.**

**Also seen in Lichen Striatus, Necrobiosis Lipoidica
Diabeticorum, PRP.**

QUESTION NO.8

A forty year old lady presented with pruritic papules,plaques in legs, What is this condition? Name some conditions associated with this



Kyrle's Disease

Hyperkeratosis follicularis et parafollicularis in cutem penetrans, Seen in Diabetes Mellitus, Liver Disease, Chronic Kidney Disease, Congestive Heart Failure



**Alopecia Areata Alopecia Areata runs in families.
True or false? Name some conditions associated with it?**

**True. Alopecia areata runs in families
Type I Diabetes Mellitus, Vitiligo, Rheumatoid Arthritis
Coeliac Disease, Thyroid disorders are associated with it.**

QUESTION NO.10



Acne Rosacea

How does one differentiate Acne Rosacea from Acne Vulgaris?

Absence of Whiteheads and Blackheads

Facial Flushing and Erythema

Involvement of face and rarely the chest

Sparing of the back and shoulders



“Did You Know?”

Primary Care Stats – India Context

~65% of Indians first contact a private practitioner for illness – family physicians are the backbone of care.

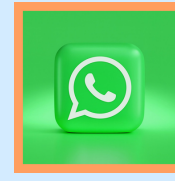
NCDs cause 63% of deaths in India – hypertension & diabetes screening at every OPD visit saves lives.

Average consultation time in India is ~2 minutes. Even +1 minute improves diagnosis & satisfaction.

Vaccination wins: India's UIP is one of the world's largest – prevents 4-5 million deaths yearly.

IMA Chennai Kodambakkam branch Photo Gallery





Dr.Lakshminarayanan

Abulia is a psychiatric and neurological syndrome characterized by a severe lack of will, initiative, drive, and spontaneity, resulting in reduced behavior, speech, and emotional responsiveness.

It is not laziness, but a genuine inability to initiate action or make decisions, often stemming from brain injury or dysfunction in frontal-subcortical. Includes long delays before acting or speaking, passivity, reduced social interaction, indifference, and sometimes remaining motionless or speechless for long periods.

Causes: Common causes include stroke, traumatic brain injury (TBI), neurodegenerative diseases (like Alzheimer's or Parkinson's), and tumor, often affecting the frontal lobes or basal ganglia.

Usage Examples: A patient with abulia might sit in a chair all day, not due to sadness (like depression) but due to a lack of mental drive to move. A person might understand they need to eat but lack the motivation to pick up a spoon.

“Did You Know?”

Seven Professional ethics are honesty, trustworthiness, transparency, accountability, confidentiality, objectivity, respect, obedience to the law, and loyalty.

“Did You Know?”

Blood Vessels: If laid end-to-end, an adult's blood vessels could circle the Earth's equator four times.

Bacteria: The average person has 67 different species of bacteria in their belly button.

Heart Beats: The human heart beats more than three billion times in an average lifespan.

Bone Count: Infants are born with roughly 300 bones, but by adulthood, this reduces to 206 due to fusion.

Brain Power: Despite being only 2% of body mass, the brain uses 20% of the body's oxygen and blood supply.

The "Fastest" Hairs: Beards are actually the fastest-growing hairs on the human body

Skin Shedding: Humans lose about 4kg of skin cells every year.

Unique Tongue: Like fingerprints, every individual has a unique tongue

Smallest & Hardest Bones: The middle ear contains the three smallest bones in the human body—the malleus, incus, and stapes—all of which could fit on a penny. Conversely, the temporal bone, which encases the inner ear, is the hardest bone in the body.

IMA TNSB SCHEMES

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 ($200 \times 90 = 18,000$) 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 II members will contribute Rs. 300 each for the death of any FSS II 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 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

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
President
Mobile No : 94442 39494

Dr M I Shahul Hameed
Secretary
Mobile No : 98401 41167

Dr S Vamsi Krishna
Treasurer
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 has not to 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 liable after completion of one year of membership of I.M.A. N.S.S.S. However nominee of member be entitled for such benefits if death of member occurs in accident event 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/>

LAST DATE FOR IMA NSSS ANNUAL PAYMENT IS 15/5/2026.



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.



Drawing/ Painting Competition Exclusive for Doctors

We warmly invite all our talented doctors to showcase their Drawing/ painting skills .

- 🎨 Please send a picture of your drawing / Painting .
It can be - A pencil drawing/ coloured painting.
- Please send another picture- of yours - holding both - Fine arts logo & Drawing / Painting you did.
- 🎨 Kindly send these 2 pictures along with your name and IMA branch.
- please send it to North Zone Coordinator Dr. Nishapriya 99528 14433.
- 📅 Last date for submission: 25.05.2026

Fine Arts Committee 🌸
IMA TNSB

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

Academic Coordinators

**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**

CONTACT:

**EXECUTIVE OFFICE: 2/20, Ist Main Road, Saddiq Basha Nagar,
Virugambakkam, Chennai 600092.**

**REGISTERED OFFICE: No.4, 6th Cross Street, United India
Colony, Kodambakkam< Chennai-600024.**

EMAIL: imakodambakkam1@gmail.com

