



Empowering Medical Professionals Through Excellence in Education



The Executive Committee of IMA Chennai Kodambakkam branch extend our warmest congratulations to the winners of the Essay Competition: Artificial Intelligence in Patient Care: A Boon or a Bane for Medical Practitioners?

We appreciate the outstanding achievements of the winners Dr. A. Bhavani, Dr. R. Rajalakshmi, Dr. A. Sudha, and Dr. S.S.K. Sandeep. Each winner has been awarded a cash prize of Rs.5000. We commend their hard work and dedication.

LIFETIME ACHIEVEMENT AWARD



Dr. C. MANOHAR, MBBS, MD

This Citation was awarded to Dr. C. Manohar on the 29th day of March 2026, in recognition of his outstanding contributions to the field of Forensic Medicine.

A distinguished alumnus of Chengalpattu Medical College, Dr. Manohar graduated with MBBS in 1984 and completed his MD in Forensic Medicine in 1994 from Madras Medical College. With a career spanning over 40 years, he has established a reputable practice in Virugambakkam. He has served in various institutions, including Madras Medical College, Stanley Medical College, and Kilpauk Medical College. Notably, he has handled a significant number of medico-legal cases in Chennai.

Dr. Manohar was conferred the Best Worker Award by Kilpauk Medical College in 2007 and he is currently affiliated with Sri Balaji Medical College, Chromepet.

CME PROGRAMME

1. IMA PRAYER AND PHYSICIAN'S PRAYER - Dr. S. INDRA
2. RECENT ADVANCES IN CATH LAB PROCEDURES:
DR. BABU EZHUMALAI, SENIOR CONSULTANT - INTERVENTIONAL
CARDIOLOGY, STRUCTURAL AND ENDOVASCULAR INTERVENTIONS
AT MGM HEALTH CARE
3. CARDIAC SARCOIDOSIS THE GREAT MASQUERADOR:
DR. P. V. SANJAI, CLINICAL LEAD CARDIAC ELECTROPHYSIOLOGY
AND ADVANCED CARDIAC PACING AT SIMS
4. LIFE TIME ACHIEVEMENT AWARD - DR. C. MANOHAR
5. CRT & ICD IMPLANT IN SARCOID RELATED HEART FAILURE:
DR. DEEP CHANDH RAJA - SENIOR CONSULTANT CARDIOLOGIST
AND DIRECTOR OF CARDIAC ELECTROPHYSIOLOGY AT KAUVERY
ALWARPET AND VADAPALANI.
6. ACUTE CORONARY SYNDROME FROM RECOGNITION TO
REPERFUSION: DR. S. BALAMURUGAN, CONSULTANT
INTERVENTIONAL CARDIOLOGIST AT SRM PRIME HOSP
7. DR V RAJU ENDOWMENT ORATION
CHAIRPERSONS - DR. V. S. ANANTHAN, DR. S. KUMAR
TOPIC: RECENT UPDATES IN TUBERCULOSIS MANAGEMENT

SPEAKER - DR. T. DHANASEKAR, PROFESSOR,
RESPIRATORY MEDICINE, SRMC.
8. CLINICAL INSIGHTS - DR. R. MANI,
MENTAL HEALTH PROFESSIONAL.
9. MEDICAL QUIZ- Dr M I SHAHUL HAMEED, ENT CONSULTANT.

AN OVERVIEW OF THE LECTURES PRESENTED IS GIVEN BELOW.

RECENT ADVANCES IN CATH LAB PROCEDURES

DR. BABU EZHUMALAI

Dr Babu Ezhumalai presented on the recent advances in cardiac catheterization laboratory (cath lab) procedures, emphasizing minimally invasive, catheter-based therapies for structural and coronary heart diseases.

A major focus is on transcatheter valve interventions such as Transcatheter Aortic Valve Replacement (TAVR), which enables valve implantation via a groin vessel without open-heart surgery, particularly benefiting high-risk or elderly patients. Similar innovations include MitraClip for mitral regurgitation, Transcatheter Pulmonary Valve Implantation (TPVI), and emerging therapies for tricuspid valve disease.

The presentation also discusses left atrial appendage occlusion devices for stroke prevention in atrial fibrillation, and endovascular repairs like EVAR and TEVAR for aortic aneurysms. Advances in device technology are evident in leadless pacemakers, which eliminate the need for traditional leads and reduce complications.

In coronary interventions, the concept of Complex High-risk Indicated Percutaneous Coronary Intervention (CHIP) is introduced, supported by tools like Fractional Flow Reserve (FFR) for lesion assessment and imaging modalities such as IVUS and OCT. Techniques like intravascular lithotripsy, rotational, orbital, and laser atherectomy address heavily calcified lesions.

Finally, mechanical circulatory support systems (IABP, ECMO, Impella) enhance safety during high-risk procedures. Overall, the presentation underscores a shift toward less invasive, technologically advanced, and patient-specific cardiovascular care.

CARDIAC SARCOIDOSIS THE GREAT MASQUERADOR

DR. P. V. SANJAI

Cardiac sarcoidosis (CS) is known as the "great masquerader" because its clinical presentation—such as heart block, ventricular arrhythmias, and heart failure—overlaps significantly with many other cardiac conditions.

Sarcoidosis is a multisystem disorder characterized by the formation of non-caseating granulomas in various organs, including the lungs, skin, eyes, and heart. It can infiltrate any part of the heart, including: Myocardium, Conduction system, Pericardium.

Symptoms vary widely and can include: Palpitations, Shortness of breath, Chest pain, Fatigue, Syncope.

Diagnosis is tough because it mimics other heart conditions. Tests may include:

ECG: The most promising discriminatory parameters are higher-degree AVB, increase and fragmentation of QRS, as well as certain T wave abnormalities.

Echocardiography: It is a primary screening and monitoring tool for cardiac sarcoidosis (CS). Basal Septal Thinning, Regional Wall Motion Abnormalities, Myocardial Wall Changes (Thickening, Aneurysms), Systolic and Diastolic Dysfunction (Reduced LVEF) and Pericardial Effusion.

Speckle-Tracking Echocardiography (Strain Imaging): Reduced Global Longitudinal Strain (GLS) is often the earliest sign of heart involvement, even when the overall pumping function (LVEF) appears normal.

Three-Dimensional (3D) ECHO: Provides more accurate volume and ejection fraction measurements and can better assess the complex geometry of the right ventricle, which is also commonly affected in CS.

Treatment for cardiac sarcoidosis (CS) focuses on reducing heart inflammation using immunosuppressants and managing complications like arrhythmias or heart failure. Early diagnosis and treatment can significantly improve outcomes, with 5-year survival rates ranging from 90–96% in some studies.

CRT & ICD IMPLANT IN SARCOID RELATED HEART FAILURE

DR.DEEP CHANDH RAJA

For patients with heart failure due to cardiac sarcoidosis (CS), Cardiac Resynchronization Therapy (CRT) and Implantable Cardioverter-Defibrillators (ICD) are critical interventions used to manage poor heart function and prevent sudden cardiac death (SCD)

ICDs are primarily used to prevent SCD, which is a major risk in CS due to myocardial scarring that triggers dangerous heart rhythms like ventricular tachycardia (VT).

Indications: In CS, patients with LVEF less than 35% or those who have survived a cardiac arrest or sustained VT.

In CS, even patients with an LVEF > 35% may be considered for an ICD if they have significant scarring (Late Gadolinium Enhancement on MRI) or require a permanent pacemaker due to heart block.

CRT is used to help the heart's chambers pump in a coordinated way, improving efficiency and reducing symptoms like shortness of breath.

Combined Therapy (CRT-D) - Most CS patients who meet the criteria for CRT also receive an ICD in the same device (CRT-D) because of their high arrhythmic risk. Many patients initially receive a standard pacemaker for heart block and are later "upgraded" to a CRT-D if their heart function declines.

TAKE HOME MESSAGES:

VT in Non-Ischemic HF, Think of Inflammatory Cardiomyopathy.

Repeat Cardiac PET-CT needed post immunosuppression.

Beware of limited yield from biopsies, Clinical suspicion and imaging inferences more important.

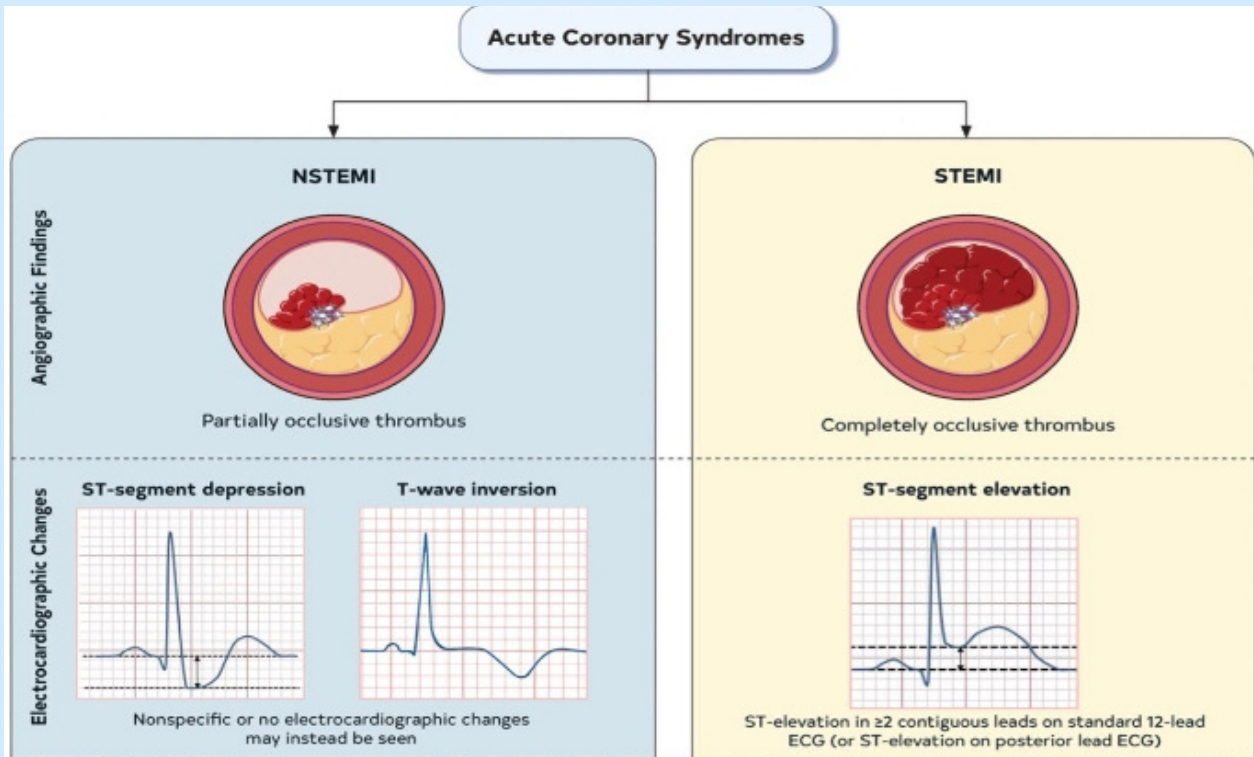
Any young HF, Think of Inflammatory Cardiomyopathy.

Beware of Waxing and Waning course

Current strategies of myocardial biopsy have better yield than conventional methods.

ACUTE CORONARY SYNDROME FROM RECOGNITION TO REPERFUSION

DR.S.BALAMURUGAN



ACS is a term for conditions caused by reduced blood flow to the heart, often due to a blockage. It includes: Unstable Angina, Non-ST Elevation Myocardial Infarction (NSTEMI), ST Elevation Myocardial Infarction (STEMI). Major Causes include Disruption of an unstable atherosclerotic plaque, Partial or complete coronary artery thrombosis.

Several factors contribute to delayed treatment:

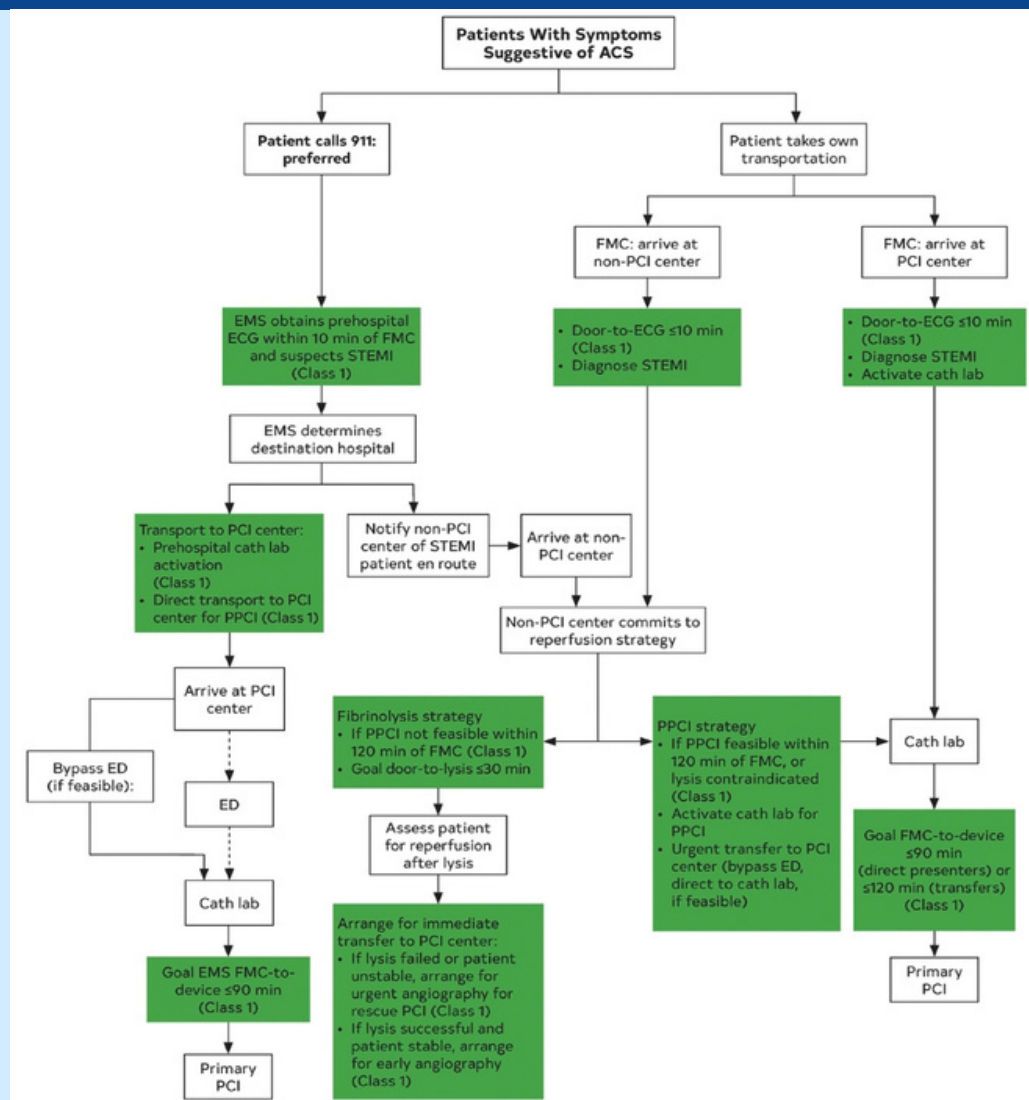
- Atypical symptoms (e.g., dyspnea, fatigue, epigastric discomfort)
- Self-medication with antacids or analgesics
- Over-reliance on "classical chest pain" presentation
- Single ECG interpretation
- Ignoring subtle signs and Financial hesitation

Recognition

- Think beyond typical angina; consider atypical presentations
- Use ECG within 10 minutes; repeat if symptoms persist
- Cardiac troponins (Troponin I, T, or high-sensitivity Troponin) are key biomarkers

Cont....

7



Reperfusion Strategies

1. Thrombolysis: If Primary PCI isn't feasible within 120 minutes

- Within 12 hours of symptom onset
- Benefit in 12-24 hours is debated

2. Primary PCI: Best if available within 120 minutes

Post-Thrombolysis

- "Thrombolysis is not the end – it's the beginning of reperfusion strategy"

- Pharmacoinvasive PCI (2-24 hours) if reperfusion is successful
- Rescue PCI if thrombolysis fails

Standard Medical Therapy

- Dual antiplatelets
- Statins
- Beta blockers
- ACEI/ARB
- MRA
- SGLT2 inhibitors.

CHILDHOOD DEPRESSION

DR.R.MANI

Childhood depression is not uncommon. Of late we are seeing more and more children suffering from depression. The causes are multifactorial namely biological, psychological and sociological.

Biological causes are due to family history of depression in one of the parents or any other family members.

Psychological causes are the way the child was brought by their parents. Substance abuse among the parents, parental pressures for academic excellence.

Sociological causes are social media, gadgets addiction and gaming addiction.

Childhood depression is eminently treatable. We have very good drugs like SSRI which are safe and less toxic. The treatment given to the children by a team which consists of psychiatrists, Psychologist and social workers. Participation by the parents is very very important and more so regular follow up.

Two patients of mine, one of which is an 11 years old girl child, self immolated due to academic pressure.

The next child of 6 years old clearly expressed suicidal ideas and death wis

In both cases the father was an alcoholic. Modern day children are very intelligent, observant and sensitive. They are pushed to suicidal ideas by peer pressure, bullying and teacher's unrealistic expectations Mass media and sensational journalism corrupt the young minds.

Cont....

I would like to share my personal experience of getting a very violent slap by a patient and in the bargain my left tympanic membrane was completely ruptured. This incident happened because one of the cardiologists from a popular centre abruptly stopped half a tablet of trincalm forte in a well stabilised schizophrenic patient.

This incidence is to highlight the practitioners of different branches not to stop psychiatric drugs abruptly. I request all the doctors to recognize childhood depression and refer them to psychiatrists. Recently one of the pediatricians discouraged my prescriptions stating that children need not be given anti depressants.



HOW CME BEGAN IN NEUROSCIENCES

After attending a Commonwealth CME in Montreal in 1977, Prof. Dr.S.Kalyanaraman proposed the idea to the Neurological Society of India (NSI). Though initially skeptical, NSI asked him to conduct the first neuroscience CME at its December 1978 annual conference.

From June onwards, Prof.Dr.S.Kalyanaraman personally collected articles, had them vetted and edited by experts, typeset them into books, and printed 300-500 copies. He carried them by train to the venue to distribute to delegates.

At the 1978 CME, he was given only a small hall. By lunchtime it was full, and by evening the hall was overflowing while other parallel sessions were empty. The NSI President had to request him to pause so the inauguration could proceed.

This runaway success led NSI to institute a yearly CME and later dedicate a full day to it. Prof.Dr.Kalyanaraman pioneered organized CME in Indian neurosciences, setting a model others adopted nationwide.

AI IN PATIENT CARE: A BOON OR A BANE

Opening: A Doctor's Quiet Question

One evening after a long clinic, I sat at my desk looking at a computer screen filled with blood sugar graphs, alerts, and automated suggestions generated by a software system. Everything looked neat, fast, and impressive. Yet one question stayed with me:

Where do I fit into this picture?

For more than four decades, my medical life has been shaped by listening — listening to patients, their fears, their habits, their families, and sometimes their silence. Today, Artificial Intelligence (AI) is beginning to “listen” too — but in a very different way.

This essay is not written from a laboratory, a conference stage, or a technology company. It comes from the consulting room, from years of patient care, and from the quiet moments when a doctor reflects on change.

Is AI in patient care a boon or a bane for medical practitioners? From my experience, the answer is both — depending on how we use it and how much of our humanity we protect.

Medicine Has Always Changed — But the Heart Must Remain

When I began practice, medicine relied heavily on:

- Clinical judgment • Patient history • Physical examination

Investigations were fewer, slower, and expensive.

We spent more time talking, observing, and thinking.

Over the years, we welcomed:

- Glucometers
- HbA1c testing
- Imaging
- Electronic records
- Telemedicine
- Now, Artificial Intelligence

Each new tool promised better care — and most delivered it.

A senior teacher once told me:

“Technology should sharpen the doctor’s mind, not replace it.”

AI is the most powerful tool medicine has encountered so far.

AI as a Boon: Where It Truly Helps

1. Seeing What the Human Eye May Miss

AI excels at detecting patterns.

It can analyse thousands of reports and images in seconds.

In diabetes care, AI can analyse Continuous Glucose Monitoring (CGM) data and identify:

- **Night-time hypoglycaemia**
- **Post-meal spikes**
- **Erratic glucose variability**

Statistics

- **AI-based diabetic retinopathy detection shows 90–95% accuracy.**
- **AI tools can detect early complications months before symptoms appear.**

Mini Case 1 – Early Warning Saves Complications

A middle-aged patient using a CGM device received repeated alerts of rising night time sugars. He visited the clinic earlier than scheduled. Adjustment of medication prevented long-term complications. Early warning is often the difference between control and complication.

2. Saving Time in an Overloaded System

Indian doctors face enormous pressure:

- **High patient load**
- **Limited consultation time**
- **Heavy documentation**

Studies show:

- **AI can reduce documentation time by 30–40%.**
- **Doctors spend nearly 50% of their time on paperwork.**

AI tools can:

- **Summarise patient history**
- **Flag abnormal results**
- **Suggest follow-up tests**

**This does not make us better doctors —
It gives us time to be better humans.**

Time to:

- **Explain**
- **Reassure**
- **Listen**

Listening remains one of the most powerful treatments in medicine.

3. Supporting Long-Term Care

Chronic diseases require years of follow-up and motivation.

AI-powered reminders help patients:

- **Take medicines**
- **Monitor diet**
- **Track exercise**
- **Attend follow-ups**

Mini Case 2 – Technology Motivates Compliance

A young professional patient frequently missed follow-ups due to work pressure. After starting an AI health app, he received reminders and progress charts. His HbA1c improved from 8.5% to 6.9% in 8 months.

AI became a silent assistant, not a replacement.

AI as a Bane: Where Caution Is Essential

1. The Risk of Losing the Human Touch

A patient once told me:

“Doctor, the machine says I am fine — but I don’t feel fine.”

AI cannot understand:

- **Fear**
- **Grief**
- **Financial stress**
- **Loneliness**

Only a doctor can hear what is not spoken.

If we depend too much on screens, medicine risks becoming a technical service instead of a healing relationship.

2. Data Is Not the Same as Truth

AI depends on data. But data can be:

- Incomplete
- Biased
- Not suited to Indian populations

Many systems are trained on Western data.

They may not reflect:

- Indian diets
- Cultural habits
- Economic realities
- Genetic differences

A machine may give a perfect answer that is practically wrong.

Doctors must always ask: “Does this make sense for my patient?”

3. When AI Suggestions Need Correction

Mini Case 3 – Clinical Judgment Still Matters

An AI recommendation suggested increasing medication dosage based on glucose trends. But the patient had recently changed diet due to financial difficulties and was eating irregularly.

Adjusting lifestyle advice — not medication — solved the issue.

This reinforced an important truth:

AI sees numbers. Doctors see lives.

4. Legal Responsibility

If AI makes an error:

- The doctor is still responsible.

Machines do not attend court.

Doctors do. AI must remain a supporting tool, not a decision-maker.

5. The Danger for Young Doctors

There is a quiet risk that young doctors may trust AI more than their own judgment.

Clinical wisdom develops through:

- Experience
- Reflection
- Mistakes

No algorithm can replace this journey.

AI should support learning, not shortcut it.

Doctor–Patient Relationship: The Core That Must Not Break
In India, the doctor–patient relationship is deeply personal.
Patients come with faith, not just symptoms.

One elderly patient told me:

“Doctor, I don’t understand my disease, but I trust you.”

Trust cannot be automated.

AI may calculate risk.

But trust is built through:

- Presence
- Honesty
- Compassion

The Future of Private Clinics in the AI Era

AI will reshape private practice in profound ways.

Expected Changes

By 2030:

- Global AI healthcare market expected to exceed \$180 billion.
- Telemedicine visits projected to grow 3–5×.
- Remote monitoring will become routine.

Private clinics may evolve into:

- Hybrid physical–digital care centres
- Preventive health hubs
- Remote monitoring coordinators

Future clinic workflow may include:

- AI pre-consultation summaries
- Remote patient monitoring dashboards
- Automated follow-up systems

Doctors will spend:

- Less time on paperwork
- More time on personalised care

The private clinic of the future may become smaller physically but larger digitally.

AI Ethics and Regulation

With great power comes great responsibility.

Key ethical concerns include:

- **Data privacy**
- **Algorithm bias**
- **Transparency**
- **Accountability**

Patients must know:

- **When AI is being used**
- **How their data is protected**

Healthcare data is deeply personal. Misuse can erode trust.

Governments and medical councils must ensure:

- **Safe AI standards**
- **Clear accountability rules**
- **Ethical deployment**

Technology must grow with ethics, not ahead of it.

The Right Balance: Human Wisdom with Artificial Support

AI is neither enemy nor saviour.

Used wisely, it can:

- **Improve accuracy**
- **Reduce workload**
- **Enable early intervention**

AI should work behind the doctor, not in front of the patient.

A Message to Fellow Doctors

We must remain:

- **Curious, not fearful**
- **Open, but critical**
- **Technologically aware, but human-centred**

Our value lies not only in what we know, but in how we care.

Patients may forget what we prescribed. They never forget how we made them feel. AI cannot replace that.

Closing: The Future We Must Choose

After forty years in medicine, one truth is clear:

Medicine will continue to change —

But healing will always remain human.

AI will become:

- **More powerful**
- **More accurate**
- **More widespread**

But the final:

- **Responsibility**
- **Judgment**
- **Compassion**

Must always belong to the doctor.

If AI makes us efficient but less empathetic, it becomes a bane.

If AI strengthens judgment and deepens care, it becomes a boon.

The future of medicine does not belong to machines alone.

It belongs to doctors who know how to use machines without losing their soul.

DR.A.BHAVANI

WINNER



MEDICAL QUIZ

QUESTION NO.1

WHAT IS NORMAL PLASMA OSMOLARITY LEVEL ?

Normal plasma (or serum) osmolality in adults generally ranges from 275 to 295 mOsm/L

It measures the concentration of solutes (primarily sodium, glucose, and urea) in blood plasma.

High Osmolality (Hyperosmolality): Indicates water deficit (dehydration) or high solutes, seen in diabetes insipidus or hyperglycemia.

Low Osmolality (Hypoosmolality): Indicates excess water relative to solute, causing cell swelling (e.g., SIADH).

QUESTION NO.2

NORMAL SALINE IS A MISNOMER – TRUE OR FALSE ?

EXPLAIN ?

Yes, Normal Saline (NS) is considered a historical misnomer, because of

Higher Chloride Content:

NS contains 154 mmol/L of chloride, which is significantly higher than the roughly 100 mmol/L found in human serum.

Osmolarity: 308 mOsmol/L

It does not match the electrolyte composition of human blood, as it contains only sodium and chloride, lacking other important electrolytes found in the body like potassium, calcium, or magnesium.

It should be rightly called as 0.9% NaCl and not Normal Saline.

QUESTION 3

What electrolyte change occurs most commonly after excess NS infusion (>2L) ?

Hyperchloremic Metabolic Acidosis.

This occurs because NS (0.9% Sodium Chloride) contains a much higher concentration of chloride (154 mEq/L) than human plasma (around 100 mEq/L).

The excess chloride forces a decrease in bicarbonate to maintain electrical neutrality in the blood, leading to an acidic state.

QUESTION NO 4

Which IV fluid is Isotonic in bottle and Hypotonic when infused, Explain?

5% Dextrose in Water (D5W)

Once infused, the body rapidly metabolizes the glucose, leaving behind free water, which acts as a hypotonic solution.

QUESTION NO.5

I.V Fluids contraindicated in Acute Head Injury patients?

Hypotonic fluids, such as

0.45% NaCl (half-normal saline) and

D5W (5% Dextrose in water), are strictly contraindicated in acute head injuries.

These solutions decrease serum osmolality, which causes water to shift into brain cells, increasing intracranial pressure (ICP) and worsening cerebral edema

QUESTION NO.6

What is the caloric value of 1 liter of 5% dextrose in water (D5W)

One liter of 5% dextrose in water (D5W) provides 170 kilocalories (kcal)

D5W is primarily used for hydration and as a vehicle for IV medications.

It provides minimal nutritional support; for example, an infusion at 125mL/hr provides only about 510 Kcal/day, which is insufficient for total maintenance.

QUESTION NO 7

Which IV fluid should not be used along with blood transfusion?
Explain

Lactated Ringer's (RL) and 5% Dextrose in Water (D5W)

Lactated Ringer's (RL) / Hartmann's Solution:

These contain calcium, which can react with the citrate anticoagulant used in stored blood products and leads to Clot formation within the administration tubing.

5% Dextrose in Water (D5W):

This is a hypotonic solution that can cause Haemolysis (rupturing) of red blood cells due to osmotic shifts.

QUESTION NO.8

Name the primary intravenous fluids used to reduce elevated intracranial pressure (ICP)?

Hyperosmolar Fluids,

Mannitol (20% or 25% solution) and

Hypertonic Saline (3% to 23.4% NaCl).

These solutions work by pulling water out of the brain tissue and into the vascular space, decreasing cerebral edema.

QUESTION NO.9

What is Holliday-Segar formula?

The Holliday-Segar formula calculates daily pediatric maintenance fluid requirements based on body weight

100 mL/kg for the first 10 kg, 50 mL/kg for the next 10 kg, and 20 mL/kg for every kg over 20.

A common, simplified hourly "4-2-1 rule" is
4 mL/kg/hr (<10kg),
40 mL + 2 mL/kg/hr (11-20kg), and
60 mL + 1 mL/kg/hr (>20kg).

QUESTION NO.10

Where RL Solution is contraindicated?

Neonatal Ceftriaxone Use:

Contraindicated in newborns (<28 days) receiving concomitant ceftriaxone, even if via separate infusion lines, due to risk of fatal ceftriaxone-calcium precipitation.

Liver Disease/Failure:

Lactate is metabolized in the liver; therefore, severe liver failure prevents proper metabolism, which can lead to metabolic acidosis.



“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.

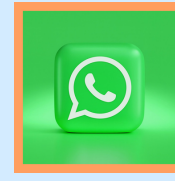
NCDs cause 63% of deaths in India – hypertension & diabetes screening at every OPD visit saves lives.

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. Ezhil Arasan,

FDA Okays Orforglipron for Weight Management

The FDA approved Eli Lilly's once-daily orforglipron GLP-1 pill (brand name Foundayo) for weight management in adults.

The indication is "for use in combination with a reduced-calorie diet and increased physical activity to reduce excess body weight and maintain weight reduction long term in adults with obesity or adults with overweight in the presence of at least one weight-related comorbid condition," according to an FDA statement.

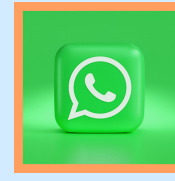
Orforglipron is the first small molecule (nonpeptide) for obesity, meaning that it — unlike the current semaglutide (Wegovy) pill — can be taken any time of day without food or water restrictions. It will be available in oral tablets of 0.8 mg, 2.5 mg, 5.5 mg, 9 mg, 14.5 mg, and 17.2 mg.

The approval was based on results from Lilly's ATTAIN clinical trial program in people with obesity/overweight, with and without type 2 diabetes. In ATTAIN-1, those taking the highest dose who stayed on the drug for the entire 72-week trial lost an average of 27.3 pounds (12.4%) compared to 2.2 pounds (0.9%) with placebo. Regardless of trial completion, participants lost an average of 25 pounds (11.1%) vs just 5.3 pounds (2.1%) with placebo.

Across the ATTAIN trials and for all doses, orforglipron also was associated with reductions in cardiovascular risk markers, including waist circumference, non-HDL cholesterol, triglycerides, and systolic blood pressure.

As with other GLP-1 drugs, orforglipron is associated with gastrointestinal adverse events including nausea, constipation, vomiting, dyspepsia, and abdominal pain, as well as headache, fatigue, and hair loss. The label will contain warnings and precautions about pancreatitis, severe gastrointestinal reactions, acute kidney injury due to volume depletion, hypoglycemia, and diabetic retinopathy in those with diabetes, among others. It will also carry a boxed warning for thyroid C-cell tumors.

Orforglipron is the first “new molecular entity” and the fifth drug overall to be approved under the FDA’s Commissioner’s National Priority Voucher pilot program, which aims to “expedite approval of applications that address critical national health priorities,” according to the FDA. The approval came 50 days after Lilly’s filing, 294 days before the anticipated date of January 20, 2027.



DR.Suresh

Medicolegal Tip: Take a Request Letter Before Issuing Any Medical Document

The Issue

Doctors often issue certificates, discharge summaries, or medical records based on oral requests from patients, relatives, police, or other authorities. The common mistake is not taking a written request letter.

Legal Risk

If a document is issued without a written request, the patient may later claim that their medical information was released without consent. Medical councils and courts take such privacy breaches seriously and may hold the doctor responsible.

Legal Protection

- Take a written request letter for every medical document you issue.
- If the patient is requesting, their signature serves as consent.
- If a third party is requesting, ensure the patient also signs the request letter.
- Never issue any medical document based only on an oral request.

Medicolegal Advice

Courts have repeatedly held that releasing medical information without documented consent amounts to breach of confidentiality and professional misconduct.

A simple written request letter protects you legally and ensures patient privacy is respected.

IMA TNSB SCHEMES



IMA TAMILNADU STATE BRANCH IMA, PPLSSS & FSS 1

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CATEGORY	Rs. 10 lakhs Compensation	Rs. 20 Lakhs Compensation	Rs. 30 Lakhs Compensation
General Practitioner	₹7000+₹1260=₹8260	₹13000+₹2340=₹15340	₹20000+₹3600=₹23600
Specialists	₹9000+₹1620=₹10,620	₹17000+₹3060=₹20060	₹24000+₹4320=₹28320

PPLSSS DISCOUNTED TARIFF

PPLSSS NEW MEMBERS SUBSCRIPTION (Block of five years) + 18% GST

CATEGORY	Rs. 10 lakhs Compensation	Rs. 20 Lakhs Compensation	Rs. 30 Lakhs Compensation
General Practitioner	₹6500+₹1170=₹7670	₹12000+₹2160=₹14160	₹18500+₹3330=₹21830
Specialists	₹8500+₹1530=₹10,030	₹16000+₹2880=₹18880	₹22500+₹4050=₹26550

FSS 1 - Current & Discounted Tariff

AGE	NRD AMOUNT	DISCOUNTED TARIFF	+AFC
Upto 35 Years	₹3,000	₹2,500	+ ₹20,000
36-40 Years	₹10,000	₹7,500	+ ₹20,000
41-45 Years	₹30,000	₹25,000	+ ₹20,000
46-50 Years	₹50,000	₹45,000	+ ₹20,000
51-55 Years	₹55,000	₹50,000	+ ₹20,000

Period 01.04.2026 to 30.04.2026 7:52 PM

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**

Membership One Month Special Offer (01.04.2026 to 30.04.2026)

IMA Single Life Membership - Rs-23000/- to Rs 17000/-
IMA Couple Life Membership - Rs-36000/- to Rs 27000/-

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
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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 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.

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.



IMA Chennai Kodambakkam branch

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1. Dr Nirmala Ponnambalam	9444239494	nimmipons@yahoo.com
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38. Dr. S. Jeyarajan	9940143321	entdoctorsjey@gmail.com

STATE COUNCIL MEMBERS

1. Dr Nirmala Ponnambalam TN/24006/94/920/199896/2014-15/L
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 Meenakshi Sundaram 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

1. Dr Nirmala Ponnambalam	TN/24006/94/920/199896/2014-15/L
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 Meenakshi Sundaram	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
	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**

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