A Monthly Bulletin of IMA Chennai Kodambakkam branch

IMACK

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ISSUE 7

Empowering Medical Professionals Through Excellence in Education

The 522nd CME of IMA Chennai Kodambakkam Branch was held on 26th July 2026 at 2:00 PM at Aaditya Hotel, Vadapalani, Chennai.

The program commenced with Tamil Thai Vazhthu, IMA Prayer, and the Flag Salute in accordance with IMA protocol. Secretary, Dr. Shahul Hameed, conducted the meeting.

CME lectures were delivered and the LTA Awardee was honoured. Around 90 members attended the CME and one TNMC credit hour was awarded to the participating members.

நலம் நலமறிய ஆவல்

Under this initiative of the IMA Chennai Kodambakkam Branch, the office-bearers visited Dr. P. Manorama, a senior paediatrician, on Thursday, 23rd July 2026 at 3:00 PM. Dr. Nirmala Ponnambalam, Dr. Shahul Hameed, Dr. Subramanian and Dr. Priya Kannan enquired about her health and honoured her with a shawl and a garland. She appreciated the gesture and thanked us.

Dr. P. Manorama is a renowned paediatric gastroenterologist based in Chennai. She served as an Assistant Professor at the Institute of Child Health, Chennai, before dedicating her career full-time to community health and social welfare. In 1993, Dr. Manorama started Community Health Education Society (CHES). Dr. Manorama's work is centered on three pillars: child welfare and paediatric care, HIV/AIDS care, and empowerment of women and grassroots communities. She is widely recognized as a leader in compassionate, community-driven healthcare. She was recently honoured with the IMA Doctor's Day Award for Best Community Service.

Dr. P. Mahendran MBBS, DA

Dr. P. Mahendran is an Anaesthetist and Family Physician with 30 years of dedicated service at Government Stanley Hospital, Chennai, retiring in 2023. An alumnus of Madras Medical College - MBBS and Stanley Medical College - PG, he joined Stanley in 1995. From 2010 to 2019, he served in the Department of Hand & Plastic Surgery and was part of the anaesthesia team for Tamil Nadu's first bilateral cadaver hand transplant in 2017.

With a Fellowship in Chronic Pain Management from Kolkata and Delhi, he initiated and led the Pain Clinic at Stanley, providing care for chronic and cancer pain patients through various interventional procedures. He has presented at multiple State, City, and World Anaesthesia Day CMEs, and served in the COVID ICU during both waves.

He currently practices as Consultant Anaesthetist at 5 leading hospitals and has been running General Practice at T. Nagar for 38 years.

CME PROGRAMME

1. **IMA PRAYER AND FLAG SALUTATION - Dr. M.I.Shahul Hameed**

2. **The headache that isn't a headache**
   Dr. Swathi T, Senior Consultant Neurologist, SRM Prime.

3. **The Gut Never Lies: Recognizing GI Red Flags Before It's Too Late ! Dr. Dinesh Ramaswamy, Consultant Gastroenterologist, SIMS Vadapalani.**

4. **Recent advancement in management of DVT**
   Dr.N.Sekar, Senior Consultant Vascular Surgeon, Kauvery Hospital. Alwarpet.

5. **My Professional Journey - Dr.Mahendran**
   (Life Time Achievement Awardee)

6. **Major. Dr.V.Parthasarathy Endowment Oration**
   Topic: Drug - Induced Movement Disorders
   Dr U Meenakshisundaram, Senior Consultant Neurologist, Apollo Speciality Hospital

7. **Probiotic precision:Quality matters!**
   Dr Dhanasekhar Kesavelu, Consultant Paediatrician, Apollo Hospital, Chennai.

8. **Mindful medicine: Integrating yoga into clinical life.**
   Mrs. Sunith and Mrs .Sasi Devi.

9. **Medical quiz: Dr.Shahul Hameed**

AN OVERVIEW OF THE PRESENTATION IS GIVEN BELOW.

Probiotic Precision:Quality matters!

Dr Dhanasekhar Kesavelu

The human gut microbiome is one of the most important determinants of health, influencing digestion, nutrition, immunity, metabolism, and overall well-being. Over the last two decades, our understanding of the gut microbiota has grown tremendously, and probiotics have emerged as an important therapeutic option in several pediatric and adult gastrointestinal disorders. However, it is important to recognize that not all probiotics are the same. Their benefits are strain-specific, indication-specific, and most importantly, quality-dependent.

Today, probiotics are recommended by several national and international scientific bodies for carefully selected clinical conditions such as acute gastroenteritis, antibiotic-associated diarrhoea, and selected functional gastrointestinal disorders. While the evidence supporting probiotics continues to expand, clinicians must understand that the success of probiotic therapy depends not only on selecting the right strain but also on ensuring that the product being prescribed is of consistently high quality.

One of the important aspects discussed in this presentation is the comparison of different single-strain probiotics used in children with acute gastroenteritis. The available evidence demonstrates that probiotics can reduce the duration of diarrhoea and improve recovery when used appropriately as an adjunct to standard treatment. At the same time, differences in clinical outcomes between strains reinforce the fact that probiotics should never be considered interchangeable simply because they belong to the same category of microorganisms.

Equally important is the quality of probiotic products available in the market. Clinical efficacy cannot be achieved unless the product contains the correct strain, the appropriate number of viable organisms, and maintains its microbiological integrity throughout its shelf life. Laboratory evaluation of commercially available probiotic formulations has shown that there may be considerable variation in viable counts, strain composition, purity, contamination, and other quality parameters despite similar label claims. Such variability has important clinical implications because product quality directly influences therapeutic outcomes.

As clinicians, our responsibility extends beyond simply prescribing a probiotic. We must critically evaluate the available evidence, understand the quality standards followed during manufacturing, and choose products that have been supported by robust scientific and clinical data. Prescribing should always be based on the right indication, the right strain, and the right quality, rather than on familiarity or marketing alone.

In conclusion, probiotics continue to play an important role in modern clinical practice, but their effectiveness depends on an evidence-based and quality-focused approach. Selecting the appropriate strain for the appropriate clinical condition, together with ensuring high manufacturing standards and consistent product quality, remains the key to achieving the best possible outcomes for our patients. A thoughtful, science-driven approach to probiotic selection is essential if we are to translate the growing body of microbiome research into meaningful improvements in patient care.

The Gut Never Lies: Recognizing GI Red Flags Before It's Too Late !

Dr. Dinesh Ramaswamy

Recognizing uncommon gastrointestinal emergencies requires identifying key red-flag conditions: progressive dysphagia, colon cancer presentations, weight loss with new diabetes, painless jaundice, persistent vomiting, ischemic bowel pain, and Charcot's triad.

Gastrointestinal Red Flags

- Progressive dysphagia: Signals possible esophageal malignancy or stricture requiring urgent endoscopy.
- Three faces of colon cancer: Includes bleeding, obstruction, or iron-deficiency anemia; never ignore a change in bowel habits.
- Weight loss with new-onset diabetes: Can be an early warning sign of underlying pancreatic cancer.
- Painless jaundice: Strongly points toward obstructive biliary malignancy or pancreatic head tumors.
- Persistent vomiting: May indicate gastric outlet obstruction or severe motility disorders.
- Pain out of proportion to exam: A classic hallmark of acute mesenteric ischemia requiring immediate vascular imaging.
- Charcot's triad: Fever, jaundice, and right upper quadrant pain indicate acute cholangitis, a true surgical emergency.

The ABCD Framework

- A – Alarm symptoms: Unexplained weight loss, progressive difficulty swallowing, or persistent vomiting.
- B – Blood and Labs: Iron-deficiency anemia, new diabetes with weight loss, or elevated bilirubin/liver enzymes.
- C – Colicky or Constant Pain: Pain that is out of proportion to physical exam findings or linked to jaundice.
- D – Diagnostics: Prompt referral for endoscopy, imaging, or specialized scans when red flags appear.

The gut whispers before it screams. Our job is to listen.

RECENT ADVANCES IN THE MANAGEMENT OF DVT

Prof.Dr.N.Sekar

1.Standard Therapy for Acute DVT:

Prevent thrombus propagation, reduce PE risk

- **Bed rest + leg elevation**
- **Anticoagulation: Heparin LMWH or unfractionated → then Oral VKA/NOAC for 3-6 months**
- **Compression: bandage or stockings**

2. Why It Matters: Complications

- Acute:
  - Fatal PE: ~10% of hospital deaths
  - Venous gangrene
- Chronic:
- **Chronic pulmonary artery hypertension**
- **Chronic limb venous hypertension**
- **Post-Phlebitic syndrome PPS**

3. Post-Thrombotic Syndrome PPS

- Cause: Residual thrombus, venous outflow obstruction, valvular incompetence

- Incidence: 35% to 69% at 3 years, 49% to 100% at 5-10 years after DVT

- After conventional treatment:

- Complete clot lysis only in ~5%

- 95% of iliofemoral DVT patients have venous hypertension at 5 years

- ~90% develop PPS from incomplete dissolution + valve destruction

4. Treatment Aims

- **Dissolve thrombus, avoid PE, prevent venous gangrene, preserve valve function, prevent PPS**

5. Thrombus Removal Strategies in Acute DVT

- Systemic thrombolysis
- Open surgical thrombectomy
- Catheter-directed thrombolysis CDT
- Percutaneous mechanical thrombectomy
- Pharmaco-mechanical thrombolysis

Surgical Thrombectomy

- **Technique: IVC filter/balloon occlusion, transfemoral iliac thrombectomy, Esmarch compression, balloon flushing, small AV fistula**
- **Advantage: Immediate decompression, avoids gangrene. ~60% patency, better than heparin alone**
- **Disadvantage: PE risk, rethrombosis, valve damage, blood loss**

Catheter-Directed Thrombolysis CDT

- **First-line interventional strategy: Intrathrombus infusion of plasminogen activators**
- **Benefits: Rapid lysis with lower doses, lower bleeding**
- **Indications: Extensive iliofemoral or IVC thrombosis <14 days, acute limb compromise, age 20-70, no contraindication to lytics. Best in young, fit patients**

Key data:

- **CaVenT trial: At 2 years, PTS 41% CDT vs 55% control. Absolute risk reduction 14.4%. Iliofemoral patency at 6 months: 66% vs 47%. Major bleeding 1.4%**
- **ATTRACT trial: PCDT did not prevent PTS overall at 2 years, higher major bleeding, no QOL or recurrent VTE benefit. But: less leg pain/swelling at 30 days and reduced PTS severity**

Percutaneous Mechanical Thrombectomy

- **Aspiration of clot for quick edema relief**
- **Lowers lytic dose, time, hospital stay, bleeding risk**
- **Devices: Trellis, AngioJet, Oasis**

Pharmaco-mechanical: Balloon occlusion + lytic infusion + spinning catheter fragmentation + aspiration

- **Results: ~90% thrombus removal, shorter treatment, less tPA, any underlying venous stenosis can be treated**
- **Disadvantages: Endothelial damage risk, fragmentation/PE, hemolysis, cost**

6. Adjuncts

- **IVC Filter:**
- **Absolute: Progression despite anticoagulation, contraindication/complication of anticoagulation**
- **Relative: Free-floating IVC thrombus, recurrent PE with PAH, prophylaxis in high-risk**
- **Iliac Vein Stenting: For post-phlebitic patients with occluded iliac vein. Relieves venous hypertension and symptoms**

7. Take-Home

Femoro-popliteal DVT: Conventional therapy

Iliofemoral DVT: Consider thrombolysis, especially in young,
fit patients without lytic contraindications

Address associated iliac vein pathology

CDT does not eliminate PPS, but it reduces its severity.

The Headache That Isn't a Headache

Dr. Swathi T

The Big Picture

90% of headaches in GP are primary: migraine or tension-type. Fundamentally benign.
1-3% are secondary and serious: vascular, infective, neoplastic, ophthalmic.
1 miss can be permanent: GCA, SAH, angle-closure glaucoma.

Ask These 2 Questions Every Time

1. Known primary pattern? Stereotyped, recurrent, matches their "usual" migraine/tension. Same triggers, character, response.
2. Anything new or different? Change in pattern, new symptom, or red flag. If yes, override "tension" or "sinus" label.

SNOOP - 30 Second Red Flag Screen

Any 1 positive = change the pathway

S - Systemic: Fever, weight loss, malignancy history, immunosuppression
N - Neurologic: Confusion, weakness, diplopia, ataxia, abnormal exam
O - Onset: Thunderclap. Max intensity in <60 seconds
O - Older: New headache after age 50
P - Pattern change: Different frequency, severity, or character
P - Papilledema/Positional/Precipitated: Worse lying flat, Valsalva, cough, straining

The Impostors to Remember

1. "Sinus headache" that isn't
- Usually migraine. Nasal congestion/facial pressure = trigeminal-autonomic activation
- Imaging and cultures normal. If chronic and antibiotic-resistant, think migraine first

2. Giant Cell Arteritis - VISION EMERGENCY
- Age >50, new headache, temporal
- Scalp tenderness, jaw claudication, visual disturbance/amaurosis fugax
- High ESR/CRP. May overlap with PMR
- Action: Same-day high-dose steroids. Do NOT wait for biopsy

3. Thunderclap Headache - LIFE EMERGENCY
- Max in <60 sec. Not just about severity
- Causes: SAH, RCVS, cervical artery dissection, pituitary apoplexy, CVST, primary thunderclap
- Pathway: Urgent non-contrast CT <6h → if negative but high suspicion, LP for xanthochromia → CTA/MRA/CTV

4. Musculoskeletal Mimics
- Cervicogenic: Unilateral, worse with neck movement/posture, reduced ROM, tender C1-C3
- TMJ: Temporal/pre-auricular pain, clicking/locking, worse with chewing/talking
- Pearl: Check neck and jaw in "refractory migraine"

5. Acute Angle-Closure Glaucoma - VISION EMERGENCY
- Sudden severe unilateral eye pain + headache
- Blurred vision with halos, red eye, fixed mid-dilated pupil, N/V
- Globe feels firm
- Action: Same-day ophthalmology. Not a migraine

6. Idiopathic Intracranial Hypertension
-Typical: Young woman, often with obesity
-Daily headache worse lying flat/on waking, worse with Valsalva
-Transient visual obscurations, pulsatile tinnitus, papilledema
- Action: Neuroimaging first, then LP for opening pressure

7. Medication Overuse Headache
-Headache ≥15 days/month for >3 months
-Thresholds: Simple analgesics ≥15 days/mo. Triptans/opioids/combos ≥10 days/mo
Management: Identify → structured withdrawal → start prevention → follow-up

8. Cardiac Cephalalgia
-Headache as angina equivalent. Worse with exertion, better with rest/nitrates
- Risk: Giving triptan can worsen cardiac ischemia
- Ask about exertion and cardiac risk before prescribing

9. Cervical Artery Dissection
-New headache/neck pain, sometimes post trauma/manipulation
- May have Horner's or focal neuro deficit
- Leading cause of stroke in young adults. Low threshold for vascular imaging

Clinic Pathway
1. History: Usual pattern or new? Run SNOOP
2. Focused exam: Fundoscopy, temporal arteries, neck/jaw, cranial nerves, BP
3. Red flag present? Yes → same-day action: imaging, ophtho, rheum, or ED
4. No red flags: Treat as primary. Imaging not routine if criteria met + normal exam

Case to Remember: Mrs R, 68y old

3weeks headache, called "tension".
Paracetamol/ibuprofen not working.
Clues missed: scalp tender brushing hair, jaw tired chewing, no fundoscopy/temples felt.
Diagnosis: Giant Cell Arteritis. ESR 98.
Outcome: Same-day steroids saved her sight.

5 Take-Homes

1. Most are benign, but screen every time for the dangerous minority

2. New. Different. Sudden. Older. Positional. Systemic. Any one = pause and reassess

3. Don't anchor on "sinus" or "tension" before excluding mimics

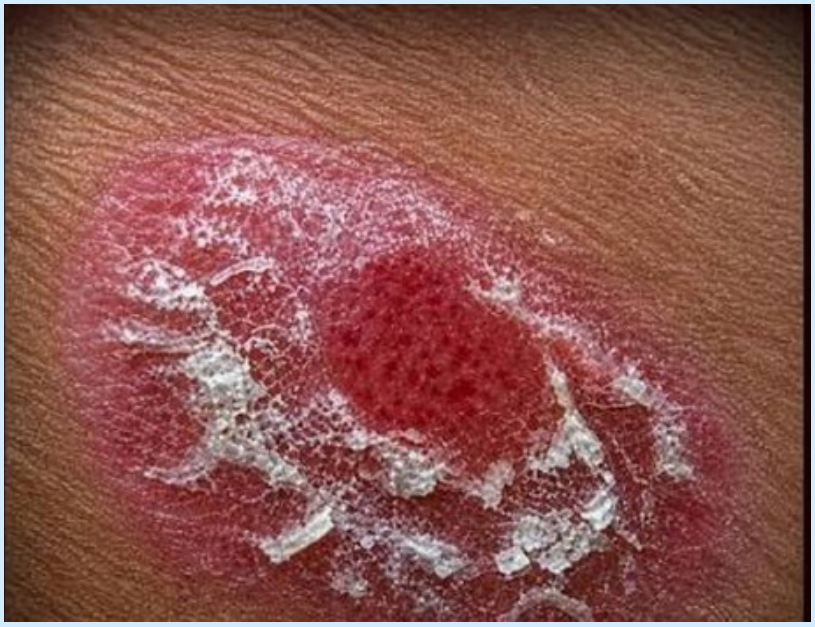
4. GCA, angle-closure, SAH, dissection need same-day action

5. Exam diagnoses before scans: Look at eyes. Feel temples. Move neck

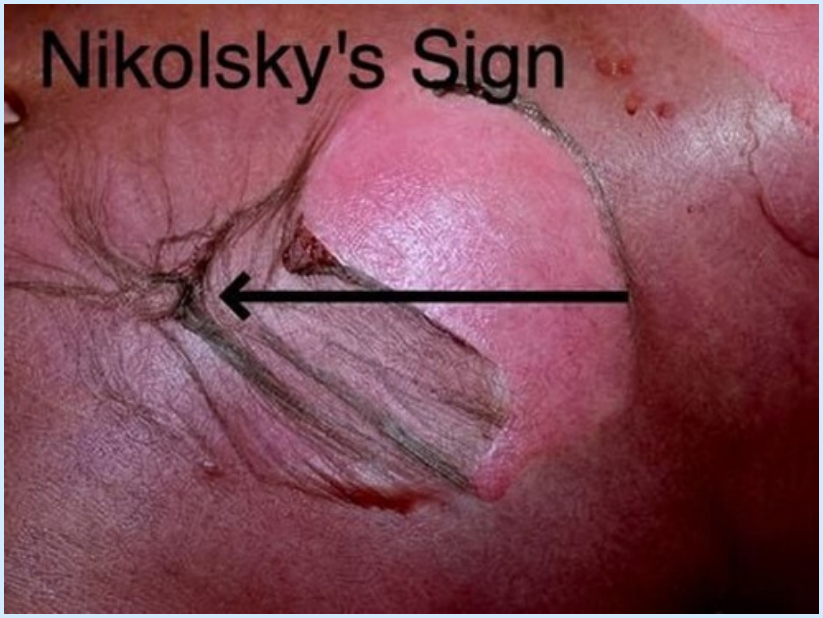
MEDICAL QUIZ

By Dr.M.I. Shahul Hameed

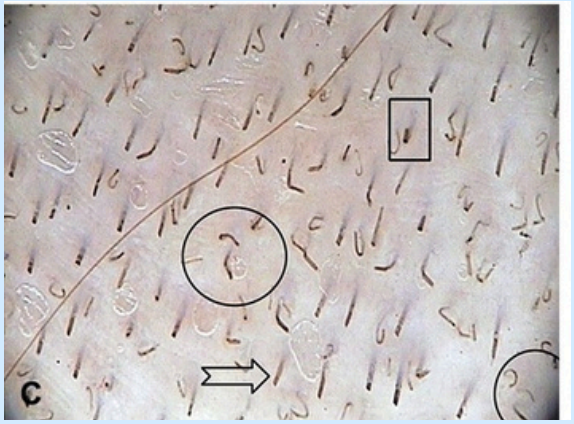
QUESTION NO.1
Auspitz sign is classically seen in?



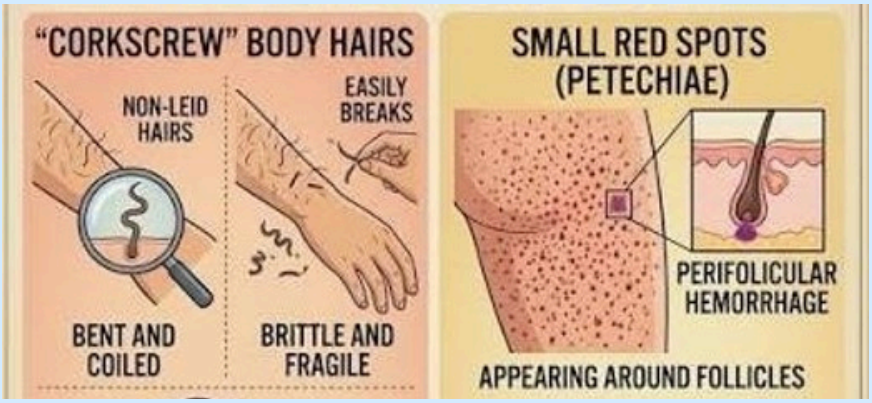
QUESTION NO.2
Nikolsky sign positive is characteristic of?



QUESTION NO.3
“Comma hairs" are seen in?



QUESTION NO 4
Which deficiency causes "perifollicular hemorrhage & corkscrew hairs"?



QUESTION NO.5
A sudden painless loss of vision with a "curtain" effect is most suggestive of?

QUESTION NO.6
The hallmark finding in diabetic retinopathy that warrants urgent laser is?

QUESTION NO.7
Which cranial nerve is tested by the corneal reflex?

QUESTION NO.8
What does "20/40 vision" actually mean?

QUESTION NO.9
The gold standard for the diagnosis of Pulmonary Arterial Hypertension (PAH) ?

QUESTION NO.10
What is the difference between MDR-TB and XDR-TB ?

ANSWERS

QUESTION NO.1

Hallmark of Psoriasis

It refers to the appearance of pinpoint bleeding spots when the overlying silvery or white scales are scraped off or removed from a skin plaque.

It occurs due to the thinning of the epidermal layer (suprapapillary plate) directly over elongated dermal papillae. The micro-vessels within these papillae are dilated and highly fragile, rupturing easily when the protective scale is forced away.

It can also occasionally be produced in other scaling dermatological conditions, such as Darier's disease and actinic keratosis

QUESTION NO 2

A positive Nikolsky sign occurs when gentle lateral pressure on the skin causes the superficial epidermis to shear away from the underlying layer. This happens due to acantholysis—the loss of cellular adhesion between keratinocytess.

It is classically associated with blistering disorders such as Pemphigus Vulgaris and can help differentiate intraepidermal from subepidermal blistering conditions. Understanding this clinical sign is important when evaluating patients with fragile skin and blistering eruptions.

QUESTION NO 3

"Comma hairs" are a distinctive scalp dermoscopy marker seen in tinea capitis (scalp ringworm).

They are short, C-shaped hair shafts of uniform thickness and color with a marked distal angulation, caused by the cracking and bending of hair shafts heavily filled with fungal hyphae. A highly predictive bedside tool to quickly diagnose tinea capitis from other non-scarring hair loss conditions like alopecia areata.

QUESTION NO.4
Vitamin C (ascorbic acid) deficiency, Scurvy,

Collagen Defects: Vitamin C is a mandatory cofactor for the enzymes prolyl and lysyl hydroxylase, which stabilize the collagen triple helix structure.

Fragile Capillaries: Without stable collagen, blood vessel walls weaken, leading to red blood cell leakage and pinpoint bleeding specifically around the hair follicles (perifollicular hemorrhage).

Impaired Hair Keratinization: Disrupted collagen matrix synthesis compromises the structural support of the hair follicle, causing the hair shaft to warp, twist, and break into a tight coil (corkscrew hairs)

QUESTION NO.5
Retinal detachment
When the neural retina peels away from its underlying supportive tissue, it loses its oxygen and nutrient supply. This creates a progressive, dark "curtain" shadow over the field of vision. Often preceded by a sudden shower of floaters (dark spots) and flashes of light (photopsia).
This is an ophthalmic emergency requiring immediate surgical repair to preserve vision.

Amaurosis fugax
A brief block in blood flow to the retina, usually caused by a small clot traveling from a damaged carotid artery. Patients classically describe a dark shade or curtain descending vertically over one eyes and it typically lasts for a few seconds to minutes before resolving entirely on its own. Even if vision returns to normal, it is a critical warning sign of a potential stroke or Transient Ischemic Attack (TIA).

QUESTION NO.6

Neovascularization, which defines the onset of Proliferative Diabetic Retinopathy.
Neovascularization of the disc (NVD) covering more than 1/4 to 1/3 of the optic disc area.
Any amount of NVD when associated with a vitreous hemorrhage or preretinal hemorrhage.
Neovascularization of the iris (NVI) / Rubeosis iridis, which can quickly cause neovascular glaucoma.

QUESTION NO.7
The corneal reflex simultaneously tests two cranial nerves: the trigeminal nerve (CN V) and the facial nerve (CN VII)

Afferent Limb (Sensory): The Trigeminal Nerve (CN V), specifically its ophthalmic division (V_1), detects the tactile stimulus when the cornea is touched and carries the sensory signal to the brainstem.

Efferent Limb (Motor): The Facial Nerve (CN VII) receives the signal in the brainstem and carries the motor command to the orbicularis oculi muscle, causing both eyelids to blink involuntarily.

QUESTION NO.8
Visual Acuity—typically using a standard Snellen eye chart.

The Top Number (20): This is the testing distance. You stand exactly 20 feet away from the eye chart.
The Bottom Number (40): This represents the distance from which a standard, healthy eye can read that same line of text.
20/40 vision is considered a mild visual impairment and is very common. In fact, 20/40 is the minimum unrestricted standard required to pass a driving test

QUESTION NO.9

Right heart catheterization (RHC)

While non-invasive tests can suggest the condition, an RHC is required to directly measure internal cardiovascular pressures and confirm the diagnosis before starting any PAH-specific therapy.

Mean Pulmonary Artery Pressure (mPAP): Greater than 20 mmHg.

Pulmonary Artery Wedge Pressure (PAWP): Less than or equal to 15 mmHg (rules out left-sided heart disease).

Pulmonary Vascular Resistance (PVR): Greater than or equal to 3 Wood units (WU)

QUESTION NO.10

MDR TB (Multidrug-Resistant Tuberculosis):

The bacteria are resistant to at least isoniazid and rifampicin, which are the two most powerful, standard first-line drugs used to cure tuberculosis.

XDR TB (Extensively Drug-Resistant Tuberculosis):

This is a more severe subset of MDR TB. The bacteria are resistant to isoniazid and rifampicin, plus any fluoroquinolone (a vital second-line drug), plus at least one Group A drug (such as bedaquiline or linezolid)

Myth 1: A Doctor's Permanent Registration Expires Every Five Years

Incorrect.

A doctor who has obtained Permanent Registration after fulfilling all statutory requirements remains a Registered Medical Practitioner throughout his or her professional life unless the registration is suspended or cancelled through due process of law for proven professional misconduct or other legally recognised grounds.

Permanent Registration is exactly what its name signifies—it is permanent.

The five-year exercise is not a renewal of registration, nor is it a fresh licence to practise medicine.

Myth 2: Registration Updation Means Renewal of Registration

Again, incorrect.

Registration updation is essentially an administrative exercise meant to keep the Medical Register accurate and up to date.

Its purpose is to record information such as:

- **Additional qualifications obtained by the doctor.**
- **Change of residential or professional address.**
- **Transfer from one State Medical Council to another.**
- **Change in practice status.**
- **Other relevant professional particulars.**
- **Confirmation that the registered practitioner is alive and continues to practise.**

It is not a mechanism to revalidate a doctor's permanent registration.

Dr.T.Swathi

Dr.Dineshi

Dr.N.Sekar

Dr.Dhanasekhar

Mrs.Sunith & Mrs.Sasi

Dr.U.Meenakshisundaram

Yoga Classes

The four sessions with Mrs. Sundarambal and Mrs.Sasi Devi were exactly what we needed to reset both body and mind. We started with the basics — introduction to asanas and pranayama, basic breathing, and foundational standing poses like Tadasana, Ardha Uttanasana, Virabhadrasana, and Trikonasana. By Session four we were flowing into Bridge, Bhujangasana, and Bhramari with so much more ease.

From cat/cow, neck exercises, and twists to savasana, apanasana, and janusirasana, every class had space for both release and rest.

The awareness exercises, journaling prompts, progressive muscle relaxation, emotion check-ins, and mind-body meditation made it feel like more than just yoga. Session 3 on chakras with sound and colour was especially powerful. Conscious breathing, alternate nostril breathing, the "Hmm" sound, and the white board RESET technique are things I'm already using on busy days.

We, wholeheartedly thank Mrs. Sundarambal and Mrs.Sasi Devi for creating such a calm, supportive space. You made yoga feel accessible, intentional, and deeply healing.

CEA Registration & Renewals

The IMA State Council meeting in Chennai on 14.06.2026 addressed key issues around TN Clinical Establishments Act (TNCEA) registration and renewal.

Deadlines & Process

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

Documents Required

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

Important Notes

- Registration validity is tied to accreditation date.
- Non-registered establishments by August 2026 risk being classified as quackery institutions and face possible sealing. Register immediately if you haven't yet.

FSS 1 & FSS 2

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

FSS 1 & FSS 2
Should be a life member of IMA TNSB
Age limit upto 55 years.
Joining Non-Refundable amount is as follows,

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

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

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

All the FSS 2 members will contribute Rs. 300 each for the death of any FSS 2 member. Every year 40 deaths were estimated (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 2 applications should be forwarded by the local branch secretary.

IMA TNSB SCHEMES

IMA FSS FAMILY HEALTH SCHEME

All the members and their spouses of FSS 1 and FSS 2 of IMA TNSB are eligible.
Up to Rs.30000/- per claim every 6 months up to 2 claims in a year for the members in either FSS 1 or FSS 2.
Up to Rs.60000/- per claim every 6 months up to 2 claims in a year for the members in both FSS 1 and FSS 2.

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

IMA MEMBERSHIP

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

IMA NSSS
(IMA National Social Security Scheme)

The schemes purely designed on brotherhood fraternity basis, and try to help the family member (Nominee) of the member on the event of death of IMA NSSS member.
Any life member of I.M.A., up to age of 60 years residing in India is eligible to become a member of this scheme but members above the age of 40 years and below the age of 60 years, must be life member of IMA at least for 3 years on the day of joining the scheme.
At present we have 19,564 members enrolled and paid ₹ 11,31,130.00 to the last deceased member's nominee
On event of death (by any cause), rest of the members contribute a token share of Rs. 100-00, from which Rs. 70-00 is passed on to the nominee.
After 25 years of continuous membership, the member need not contribute the same and the Fraternity Contribution (F.C.) will be paid to the nominee by the scheme.

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

Contact for Membership
Kindly contact on below email / call to get the membership information
Call us +91-79-26585430
Mail: imansss1@gmail.com
Mail: contact@imansss.org
https://www.imansss.org/

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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
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Crisis Management Committee	Dr M Arunachalam
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	Dr P Puspha
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	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