

Vapour



Theme- From Research to Clinical Practice: Anaesthesiology keeps on progressing

HIGHLIGHTS

Dr. Madhuri Kurdi: From Research to Clinical Practice and vice versa...the show must go on...

Dr. Ankur Khandelwal: Breaking Bad News in Anaesthesiology: Translating Theory into Practice

Dr. Neeru Sahni: Endovascular resuscitation in blood loss-more than just fluids and blood products

Lt Col (Dr) Shibu Sasidharan: A Clinician's Perspective on Translating BTF and SIBICC Guidelines into Day-0 Severe TBI Practice

Dr. Bhavna Gupta: Carbon-Neutral Anaesthesia: Turning Research Evidence into Greener Anaesthesia Practices

Dr. Raksha Kundal: From Blocks to Better Recovery: Translating regional anaesthesia research into paediatric practice

Dr. Mayank Massand: Reading guidelines and applying them in clinical practice

Dr. Ranganatha Praveen CS: Advanced monitoring in neuroanaesthesia practices: An integration of clinical concepts with research

ISA ACTIVITIES

HISTORY, ART & LITERARY PAGES

Dr. Subbulaksmi Sundaram: Poem: The Silent Science - Pre Anaesthesia Protocol

Dr. Shital Varunjikar-Joshi: Bird Photography

KALEIDOSCOPE

A tryst with Dr Sunil Manohar Katkade

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PRACTITIONER PAGES

Dr. E Praveen Kumar: Academic challenges of the clinical anaesthesiologist

Dr. Muthukumar Rajagopalan: Letter to Editor

YUVA PAGES

Anaesthesia Quiz, Research Quiz

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EDITOR'S NOTE



Dear esteemed members,

Warm greetings from Indian Society of Anaesthesiologists (ISA) National Headquarters!

I am happy to present to you the February-March-April 2025 issue of VAPOUR. The theme is 'From Research to Clinical Practice, Anaesthesiology keeps on progressing'. This issue has articles based on this theme by a diverse array of our ISA members including the 'yuva' consultants, the seniors, the enthusiastic researchers from institutes of eminence, the teachers, the private practitioners and the postgraduate students.

Research has little meaning if its results cannot be applied in clinical practice. Research is the fundamental basis for clinical practice and provides the new knowledge and data that can be applied in the real world. Both research and practice are necessary and are complementary to each other. They are wings of the same bird of progress in anaesthesiology. They work together and the shortcomings in either wing can hinder the journey of this bird of progress. We thus need both, researchers and practitioners.

The ISA as a body is committed to giving impetus to the researchers in our nation. The research studies published in the official journal of our body, the Indian Journal of Anaesthesia and in Practical Evidence in Anaesthesia Knowledge, the official journal of the College of ISA (CISA) are a true testament to this. The ISA provides several prestigious podiums and awards for research paper presentations, innovations and poster presentations at its national and state conferences. Furthermore, research provides guidelines for clinical practice and the ISA has been regularly publishing clinical practice guidelines.

There are ample opportunities for research in today's world. No research is trivial. I believe that even research with 'insignificant' findings can serve as starting points for larger studies and can help researchers in refining the methodology for future research. Every piece of research, be it a small study or a large multicentric trial can contribute to the progress of our subject. As a nation, we have a diverse array of resources for research and researchers. We have the knowledge and the manpower. What we lack is the mindset for research. A practitioner with the research mindset can conduct good research even in a resource-poor setup such as a hospital in a small city or village. Nonetheless, clinical practitioners need to ignite the flame of research and keep the flame burning by providing fuel in the form of hypotheses obtained from their clinical observations. These observations can be sent to researchers in central institutes and the research can be designed in a multicentric pattern with involvement of both, the clinical practitioners and the core institute researchers.

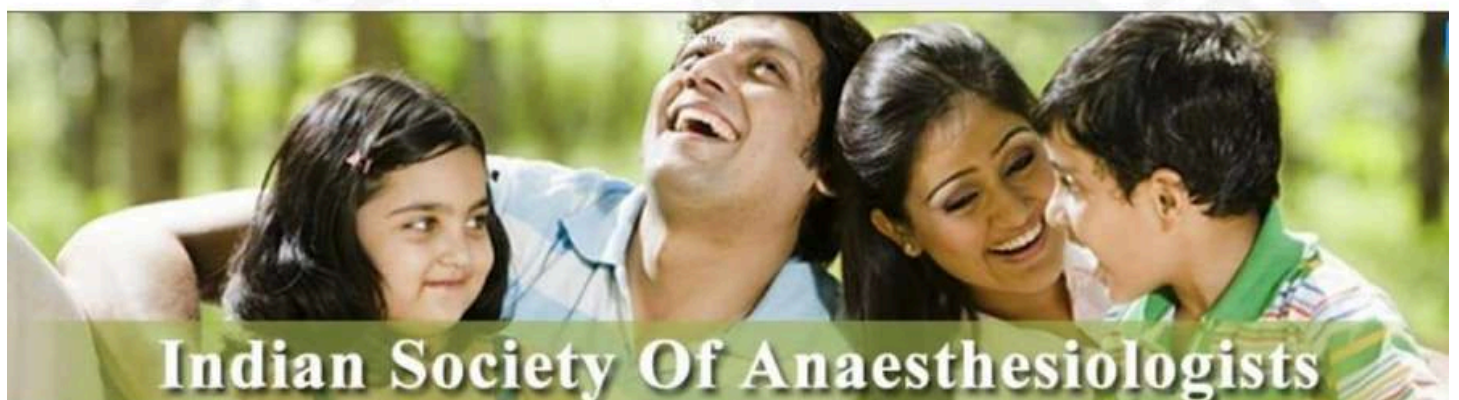
Regular participation in ISA city branch monthly academic activities, presentation of cases followed by discussion amongst the young and senior practitioners can bring pertinent points to the fore. Clinical guidelines can be discussed at ISA monthly meetings to keep the practitioners in touch with the latest evidence. All this can improve patient safety and outcomes. The ISA activities of several ISA branches that are described in this newsletter are very encouraging and are a clear revelation of the zeal of our members.

Happy reading of the ISA activities and theme-based articles!

Until we meet again, take care!

Long live ISA!

Dr. Sukhminder Jit Singh Bajwa
Honorary Secretary, ISA National
Editor-in-Chief
‘VAPOUR’
(The official newsletter of the ISA National)



Indian Society Of Anaesthesiologists **Family Benevolent Fund**



ISA NOTICE BOARD

CONFERENCE & CME CALENDER OF ISA (2025-26)

Conference/CME (Coming up)	Location	Organised by	Dates
ISA National Sponsored CME & Workshop	Patiala	ISA Punjab state branch	27 th & 28 th September 2025
ISACON North zone	Rohtak	ISA Rohtak	3 rd -5 th October 2025
ISACON West Bengal	Kolkata	ISA West Bengal state branch	4 th -5 th October 2025
ISACON Maharashtra	Mumbai	ISA Mumbai Metro branch	10 th -12 th October 2025
ISACON East Zone & BJSACON	Deoghar	Department of Anaesthesiology & Critical care, AIIMS, Deoghar	10 th -12 th October 2025
49 th ISACON Kerala	Kozhikode	ISA Kerala state chapter	11 th & 12 th October 2025
UPISACON 25 (47 th annual conference of ISA UP state)	Lucknow	Department of Anaesthesia, SGPGIMS, Lucknow & ISA Lucknow City branch	24 th -26 th October 2025
72 nd ISACON2025	Raipur	ISA Raipur	26 th - 30 th November 2025

Note: The dates mentioned in the above table are tentative & as per information received.

The list of upcoming conferences will be updated in subsequent issues.

ISA National PG online classes

These are being conducted regularly every Monday between 6.30 to 8pm. Experienced PG teachers are taking PG oriented classes including exam-oriented topics.

ISA academic webinar series
College of Indian Society of
Anaesthesiologists (CISA) under
the aegis of ISA National
presents webinars every month
on useful topics.

ACADEMICS: SPOTLIGHT:

Theme- From Research to Clinical Practice: Anaesthesiology keeps on progressing



From Research to Clinical Practice and vice versa...the show must go on...

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Introduction

Anaesthesia research has always had a huge impact on clinical practice. It has led to the development of new drugs, new formulations, drug delivery systems, novel anaesthetic techniques, devices and therapies. Currently, evidence-based medicine is the norm. This means that scientific knowledge must be linked to clinical practice. Research and clinical practice including patient care are closely associated and can be considered as two sides of the same coin and are dependent on each other. Research can translate to real-world clinical practice and vice versa; however just like not all roads lead to Rome; not all research translates to clinical practice because of challenges and obstacles in implementation.

Research translating to Clinical Practice and Clinical Practice translating to Research:

The ultimate goal of research is to generate knowledge capable of improving the patient's health outcomes in medical practice. Research in the laboratory has led to the development of several drugs which have made a huge difference to clinical practice. Neuromuscular blockers are examples of such drugs.

The observations in clinical practice offer ideas for future research. The best examples of these are the adverse effects of neuromuscular blockers such as tubocurarine, succinylcholine and pancuronium which drove researchers into finding better muscle relaxants.^[1] There have been several researchers whose work was driven by clinical practice. John Francis Nunn was one among them. He was fascinated by

how the lungs behave during artificial ventilation during the days when tubocurarine was adopted into clinical practice. This led him to work on understanding the respiratory physiology during general anaesthesia including the respiratory muscle activity, the effects of airway management on dead space and the effects of high inspired oxygen concentration on lung volumes. All this culminated in the publication of his famous book 'Applied Respiratory Physiology.'^[2]

The Gap between Research and Clinical Practice:

Not all research results are applied to clinical practice. Of the innumerable research articles published in relation to anaesthesia, only a few have been 'clinical game changers' that have resulted in revolutionary transformation in clinical practice.^[3]

Clinical research and medical care have grown apart and nowadays are considered independent activities, separated by clear boundaries.^[4] It has been observed that the resources being put into research do not result in proportionate improvements in treatment, diagnostic and preventive practices.^[5] Also, there is a 'knowledge to action gap', that means a delay in the production of research evidence and its application to policy and practise (around 17 years).^[6] An example of this is the Clinical Practice Guidelines. These are formed based on the scientific evidence built up over several years. However, clinical practitioners do not easily apply them in their practice.^[7] One of the main challenges in clinical research is how to integrate

experiments into routine clinical practice. Anaesthesiologists playing a dual role as practitioners and as researchers face an ethical conflict. As doctors, they must keep the patient's interest foremost, but as researchers, they must subordinate the individual patient's interests to the general interests of the community.^[4,8] Further, the cost and complexity of inculcating changes as per results of scientific research can hinder the application of research into clinical practice.

Narrowing the Research, Innovations-Clinical Practice gap:

The integration of clinical research and medical care will require researchers, clinicians, health care managers, and patients to reevaluate the way they understand both activities. Already, the obligation of informed consent,^[9] the requirement of "clinical equipoise"^[10] and the therapeutic orientation of randomised controlled trials^[11] have helped to reduce the gap between clinical research and medical care.

Identification of crucial research gaps can enable innovative research in the related areas and reduce research on mundane topics. Systematic reviews and metaanalyses can summarise existing evidence on a topic and identify research areas related to the topic. International research prioritisation exercises such as Delphi studies can also help to identify research priorities. This can help set the agenda for future researchers and guide research funding bodies. Eg- An international Delphi study identified and shortlisted eleven 'highest priority' research questions related to regional anaesthesia. These included questions related to pain management; training and assessment; clinical practice and efficacy; technology and equipment.^[12] However, one must keep in mind the pitfalls of systematic reviews and meta-analyses before applying their results in clinical practice.^[13] One must remember that the results of a randomised clinical trial can be applied in clinical practice provided the trial is of high-

quality and is conducted with a robust methodology.

Clinical practitioners can convert their simple observations in routine clinical practice into research questions. They can design research studies based on these research questions.

However, in healthcare systems where the main priority is the provision of care, it may be difficult for doctors, especially private practitioners to dedicate time to research.^[14]

We need clinical scientists like JF Nunn who can identify clinical needs and research upon them systematically. We need better collaboration between researchers and clinical practitioners. Translational research, simulation, platform trials and clinical practice guidelines can help to convert research into actual clinical practice.

Conclusion: Research and clinical practice in anaesthesiology are wheels of the same chariot. We, both researchers and clinical practitioners have to pull the chariot forward and take it in the right direction that can advance our subject in all areas.

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Breaking Bad News in Anaesthesiology: Translating Theory into Practice

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Introduction

Delivering bad news has always been one of the most difficult responsibilities in clinical medicine. For anaesthesiologists, whose traditional roles were often confined to the operating theatre and intensive care unit, this skill was historically less emphasised compared to physicians in oncology or palliative care. However, with the evolving role of anaesthesiologists as perioperative physicians, intensivists, and pain specialists, breaking bad news has become an unavoidable and integral part of practice.^[1] Translating theoretical frameworks into real-life practice requires skill, empathy, and structured training.

The Unique Challenge in Anaesthesiology

Unlike specialties such as oncology or palliative care, where patients and families may anticipate bad news, anaesthesiologists often face acute, high-stakes scenarios. Families expect surgery and anaesthesia to be restorative; when adverse outcomes occur, shock and denial are common. Furthermore, anaesthesiologists may have limited preoperative rapport with patients or relatives, making communication more challenging.

These factors create an urgent need for anaesthesiologists to be equipped with not just technical expertise but also refined communication skills.

Frameworks for Delivering Bad News

Several structured approaches exist to guide clinicians in difficult conversations.

The SPIKES protocol remains the most widely adopted.^[2] It includes six steps:

- Setting – Ensure privacy and appropriate environment.
- Perception – Assess what the patient or family already understands.
- Invitation – Seek permission before sharing sensitive details.
- Knowledge – Share information clearly, avoiding jargon.
- Emotions – Recognize and address emotional reactions.
- Strategy/Summary – Offer a plan and ongoing support.

Other frameworks, such as the GRIEVING model^[3] (Gather, Resources, Identify, Educate, Verify, _Give Space, Inquire, Nuts & Bolts, and Give), ABCDE model^[4] (Advance preparation, Build a therapeutic environment, Communicate well, Deal with reactions, and Encourage emotions) and BREAKS model^[5] (Background, Rapport, Explore, Announce, Kindling, and Summarize), SUNBURN model^[6] [Setup, Understand perception, Notify ('Warning Shot'), Brief narrative and break bad news, Understand emotions, Respond, Next steps] are particularly useful for death notification in acute settings. These protocols provide structure but must be adapted sensitively to individual circumstances.

From Theory to Practice

While theoretical models are valuable, the challenge lies in applying them under the intense time pressures and emotional

atmosphere of the perioperative or intensive care environment. Research shows that without training, clinicians often feel ill-prepared to break bad news, leading to variability in communication quality.

Simulation-based workshops, role-play with standardised patients, and debriefing sessions have demonstrated effectiveness in improving confidence and performance among anaesthesiology residents.^[7] However, incorporation of such training into routine anaesthesia curricula remains inconsistent.

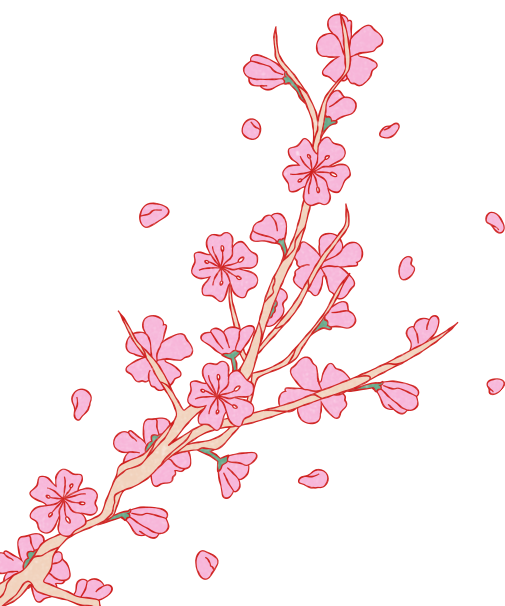
Practical Considerations for Anaesthesiologists

Anaesthesiologists can adopt a few practical strategies to bridge the gap between theory and practice:

- Prepare in advance: Anticipate possible complications and plan communication.
- Build rapport early: A brief preoperative interaction with families can help establish trust.
- Use simple, honest language: Avoid medical jargon and vague reassurances.
- Acknowledge emotions: Silence, empathy, and supportive non-verbal cues often speak louder than words.
- Offer continuity: Provide follow-up conversations and avoid leaving families isolated after disclosure.

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Endovascular resuscitation: More than just fluid, blood and vasopressors

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A collapsing patient in shock for a significant duration leading to multi-organ dysfunction, massive transfusion of blood and blood products, supramaximal vasopressors and the complications thereafter, leading to eventual mortality even in a young patient is a dreaded scenario in clinical practice. Despite maximal resuscitation and coordinated team effort, such patients have high mortality if the cause is not reversed. With the introduction of catheter-based resuscitative therapies termed as 'Endovascular resuscitation', there is a scope of survival in pathologies like haemorrhagic shock, cardiac tamponade and pulmonary embolism.^[1]

The goal of endovascular resuscitation is to restore haemodynamic stability by supporting central blood pressure and controlling haemorrhage, thereby optimising tissue perfusion. The techniques of endovascular resuscitation described are Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA),^[2] Selective Aortic Arch Perfusion (SAAP),^[3] Veno-Arterial Extracorporeal Membrane Oxygenation (VA ECMO)^[4] and Emergency Preservation Resuscitation (EPR).^[5] While REBOA is useful in torso haemorrhage which is non-compressible, SAAP has capability of infusing oxygenated resuscitation fluid and drugs directly into the aorta. VA ECMO is not a new term any more as many centres are practising it for patients failing mechanical ventilation. However, it can be used for circulatory support in patients of refractory shock (haemorrhagic or cardiogenic) when the pathology is reversible. Use of VA ECMO

in refractory cardiac arrest is termed Extracorporeal Cardio-Pulmonary Resuscitation (ECPR). The technique of EPR is aimed at supporting the bleeding cardiac arrest patients by inducing profound hypothermia, thereby producing a state of suspended animation. This temporary state provides time for damage control and resuscitation.

While the two techniques, REBOA and VA ECMO are more popular as the endovascular resuscitation translates into clinical practice, especially for patients in haemorrhagic shock and non-traumatic cardiac arrest, the use of endovascular resuscitation is not without limitations. One of the obvious hurdles is 'availability of resources'. The implementation requires trained practitioners, round-the-clock access, ability to initiate as soon as possible and a setup mimicking a hybrid theatre plus intensive care unit. Thus, it has definite implications in terms of funding and capital allocation that can only be justified if the volume of patients availing these facilities is high. Moreover, the use of two or more techniques may be applicable for the same patient at different stages. Initial resuscitation with REBOA may need to be escalated to SAAP, which can further progress to VA ECMO if return of spontaneous activity (ROSC) is not achieved. If the situation progresses to loss of cardiac activity, EPR may be required. Thus, whether the patient can be salvaged by only one of the available techniques of endovascular resuscitation is unclear.

To conclude, the evidence from advancements

in technology and some preclinical studies is assuring and the concept of endovascular resuscitation is gradually gaining traction. This approach offers the ability to manipulate physiology and optimise haemodynamics in patients in refractory shock, serving as a critical bridge to definitive care.

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A Clinician's Perspective on Translating BTF and SIBICC Guidelines into Day-0 Severe TBI Practice

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Abstract

The management of severe traumatic brain injury (sTBI) in the first 24 hours remains one of the most challenging aspects of neurocritical care. While the Brain Trauma Foundation Guidelines and Seattle International Severe Traumatic Brain Injury Consensus Conference protocols provide valuable evidence-based frameworks, translating these recommendations into immediate, actionable Day-0 interventions requires nuanced clinical judgment and systematic implementation strategies. This perspective examines the practical realities of applying current evidence to bedside care, highlighting implementation challenges, resource considerations, and the critical decision points that define successful Day-0 management. Drawing from clinical experience and recent evidence, we propose that successful translation of guidelines into practice requires not just knowledge of recommendations, but understanding of their limitations, recognition of institutional capabilities, and appreciation of the human factors that influence acute care delivery. The gap between evidence and practice is not merely academic—it represents the difference between optimal and suboptimal outcomes for our most critically injured patients.

Keywords: clinical implementation, evidence-based medicine, neurocritical care, quality improvement, traumatic brain injury

Introduction: The Translation Challenge

After three decades in neurocritical care, I have witnessed the evolution of severe traumatic brain injury (sTBI) management from

intuition-based approaches to evidence-driven protocols. Yet despite remarkable advances in our understanding of TBI pathophysiology and the development of comprehensive guidelines, significant gaps persist between what we know works and what we actually implement in the critical first hours of care.

The Brain Trauma Foundation (BTF) Guidelines, now in their 4th Edition, represent the gold standard for evidence-based TBI management. These guidelines have been associated with a 50% reduction in mortality when implemented systematically—an extraordinary achievement in a field where incremental improvements are the norm. Similarly, the Seattle International Severe Traumatic Brain Injury Consensus Conference (SIBICC) protocols have provided much-needed algorithmic approaches to bridge the gap between individual evidence-based recommendations and integrated patient care.

However, guidelines alone do not save lives—their implementation does. The reality of Day-0 sTBI management involves split-second decisions made under pressure, with incomplete information, in resource-constrained environments. This perspective examines the practical challenges of translating BTF and SIBICC guidance into immediate, effective interventions during the most critical period of TBI care.

The Imperfect Science of Perfect Guidelines

Evidence Limitations in the Real World

The BTF Guidelines deliberately provide recommendations only where sufficient evidence exists, resulting in relatively few Level I recommendations. This evidence-based rigor, while scientifically appropriate, leaves clinicians with limited guidance for many common clinical scenarios. For instance, the guidelines provide strong recommendations for intracranial pressure (ICP) monitoring in salvageable patients with abnormal CT scans, but offer limited guidance on timing, technique selection, or threshold decisions in borderline cases.

In my experience, the patients who require the most complex decision-making are often those who fall between guideline categories. The 75-year-old with moderate comorbidities, the patient with polytrauma and haemodynamic instability, or the individual with pre-existing anticoagulation presents scenarios where guidelines provide framework rather than prescriptive answers.

The SIBICC Contribution and Its Constraints

The SIBICC consensus process represents a crucial advancement, providing algorithmic approaches based on expert opinion where evidence is lacking. The consensus of 42 international experts offers practical guidance that many clinicians desperately needed. However, consensus-based recommendations inherently carry limitations that must be acknowledged in clinical application.

The SIBICC algorithms assume certain capabilities—ICP monitoring, brain tissue oxygen monitoring, advanced neuroimaging—that may not be universally available. More importantly, they assume a level of institutional experience and nursing expertise that varies significantly across practice settings. A tiered ICP management algorithm is only as effective as the team implementing it.

Day-0 Realities: From Theory to Bedside

The Critical First Hour

Day-0 sTBI management begins not with guideline consultation but with immediate life

-saving interventions. The initial assessment must simultaneously address potential life-threatening emergencies while gathering information necessary for subsequent decision-making. In practice, this means managing potential cervical spine injury, securing the airway, addressing haemodynamic instability, and performing rapid neurological assessment—often simultaneously.

The challenge lies not in knowing what to do, but in prioritising interventions when multiple critical issues demand attention. Should we delay intubation to complete a detailed neurological exam? How aggressively should we pursue normotension in a patient with suspected elevated ICP? These decisions, made in the first minutes of care, often determine the trajectory of the entire hospitalisation.

Resource Allocation and Institutional Capacity

One aspect rarely addressed in guidelines is the reality of resource constraints. Not every institution can provide continuous ICP monitoring, immediate neurosurgical consultation, or advanced neuromonitoring capabilities. The challenge lies in adapting evidence-based principles to available resources while maintaining quality of care.

In my experience at both academic medical centres and community hospitals, successful TBI programmes are built not just on protocols, but on realistic assessment of institutional capabilities and systematic approaches to optimise available resources. This might mean developing relationships with higher-level care centres for rapid transfer, training nursing staff in basic neuromonitoring principles, or establishing clear criteria for escalation of care.

Team-Based Decision-Making

Guidelines typically present recommendations as if made by individual clinicians, but Day-0 TBI management is fundamentally a team-based endeavour. Successful implementation requires coordination between emergency physicians, trauma surgeons, neurosurgeons, intensivists, anaesthesiologists, and specialised nursing staff. Each discipline brings unique

expertise and perspective, but also potential for conflicting approaches.

The translation of guidelines into practice requires not just clinical knowledge, but leadership skills to coordinate multidisciplinary care under pressure. Clear communication protocols, defined roles and responsibilities, and established escalation pathways are as important as knowledge of ICP thresholds or cerebral perfusion pressure (CPP) targets.

Implementation Strategies: Making Guidelines Work Systematic Approach to Day-0 Protocols

Based on experience implementing TBI protocols across multiple institutions, several key principles emerge for successful translation of guidelines into practice:

1. Standardised Assessment and Documentation

Reliable implementation begins with standardised approaches to initial assessment. We have found success with structured assessment tools that incorporate BTF recommendations while providing decision support for common clinical scenarios. These tools should be brief enough for use under pressure but comprehensive enough to capture essential information for subsequent care decisions.

2. Tiered Intervention Algorithms The SIBICC tiered approach to ICP management provides an excellent framework, but requires institutional adaptation. We recommend developing institution-specific algorithms that incorporate SIBICC principles while reflecting local capabilities and resources. This might mean simplifying complex protocols for community hospitals or developing advanced monitoring pathways for academic centers.

3. Quality Metrics and Feedback Systems

Guidelines implementation without measurement is hope, not strategy. Successful programs incorporate real-time quality metrics that provide feedback on adherence to evidence-based practices. Simple metrics—time to ICP monitor placement, achievement of CPP targets, avoidance of secondary insults—can drive systematic improvement in care delivery.

Addressing Common Implementation Barriers

Knowledge Translation The complexity of current guidelines presents challenges for frontline staff who may not have specialized neurocritical care training. We have found success with focused educational interventions that emphasise practical application rather than theoretical knowledge. Simulation-based training, particularly for high-stakes, low-frequency scenarios, has proven valuable for maintaining competency.

Technology Integration Modern TBI care increasingly relies on technology—from basic ICP monitors to advanced multimodal monitoring systems. However, technology is only as effective as the humans using it. Implementation strategies must address not just acquisition of technology, but training staff in its use, interpretation of data, and integration into clinical decision-making.

Institutional Culture Perhaps the most significant barrier to guideline implementation is institutional culture. Successful TBI programmes require organisational commitment to evidence-based practice, willingness to standardise care processes, and tolerance for the inevitable challenges that accompany change. Leadership support, physician buy-in, and nursing engagement are prerequisites for sustainable implementation.

The Economics of Evidence-Based TBI Care Cost-Effectiveness Considerations

While rarely discussed in clinical guidelines, economic considerations significantly influence implementation decisions. ICP monitoring, advanced neuroimaging, and intensive neuromonitoring represent significant costs that must be balanced against potential benefits. However, the economic argument for evidence-based TBI care is compelling—the BTF Guidelines have been associated not only with improved outcomes but also with reduced overall costs of care. In practice, this means making the case for investment in TBI capabilities based on both clinical and economic outcomes. Administrators respond to data demonstrating reduced length of stay, decreased complication rates, and improved

functional outcomes. Successful implementation requires presenting evidence in terms that resonate with institutional priorities.

Resource Optimisation

Given finite resources, optimisation strategies become crucial. This might involve developing protocols for selective use of advanced monitoring based on patient characteristics and injury patterns, establishing criteria for transfer to higher-level care centres, or creating regional networks for sharing specialised capabilities.

Controversies and Unresolved Questions

ICP Monitoring: Universal or Selective?

Despite BTF recommendations, significant controversy persists regarding ICP monitoring. The BEST-TRIP trial suggested that treatment based on imaging and clinical examination might be equivalent to ICP-guided management, challenging fundamental assumptions about monitoring strategies. In practice, this has led to institutional variation in monitoring approaches and ongoing debate about resource allocation.

From a practical perspective, ICP monitoring provides information that can guide therapy, but only if that information is acted upon appropriately. The value lies not in the monitoring itself, but in the systematic approach to management that monitoring enables. This distinction has important implications for implementation strategies and resource allocation decisions.

Decompressive Craniectomy: Timing and Selection

Recent updates to BTF guidelines regarding decompressive craniectomy reflect evolving evidence about this high-impact intervention. The RESCUE-ICP trial demonstrated mortality benefits but raised questions about functional outcomes and quality of life. In practice, this creates challenging discussions with families about acceptable outcomes and quality of life considerations. Implementation of craniectomy guidelines requires not just surgical expertise,

but sophisticated approaches to patient selection, family counseling, and long-term care planning. The decision to perform craniectomy often determines not just survival, but the nature of survival—a responsibility that extends far beyond the acute care period.

Precision Medicine Approaches

Emerging evidence suggests that personalised approaches to TBI management, incorporating genetic factors, biomarkers, and advanced imaging findings, may improve outcomes compared to population-based protocols. However, translation of precision medicine concepts into routine practice presents significant challenges in terms of technology requirements, expertise, and cost.

The future of TBI management likely lies in increasingly sophisticated approaches to patient stratification and therapy selection. However, current implementation challenges with existing guidelines suggest the need for careful attention to practical considerations as we move toward more complex treatment paradigms.

A Framework for the Future

Building Learning Health Systems

The ultimate goal of guideline implementation should be creation of learning health systems that continuously improve TBI care based on real-world outcomes. This requires systematic data collection, analysis of practice patterns, and feedback mechanisms that drive continuous improvement.

In my experience, the most successful TBI programmes are those that view guidelines not as static recommendations, but as starting points for systematic quality improvement. This approach requires institutional commitment to measurement, analysis, and change—characteristics that distinguish high-performing organisations from those that merely follow protocols.

Training the Next Generation

Medical education has traditionally focused on knowledge acquisition rather than implementation science. Training future clinicians to manage severe

TBI effectively requires not just knowledge of pathophysiology and treatment options, but understanding of systems-based practice, quality improvement methodologies, and leadership skills necessary for coordinating complex care.

This educational challenge extends beyond physician training to encompass nursing education, interdisciplinary team training, and continuing education for established practitioners. The complexity of modern TBI care requires sophisticated approaches to competency development and maintenance.

Conclusions: The Path Forward

After decades of caring for patients with sTBI, several conclusions emerge regarding the translation of evidence into practice:

First, guidelines provide essential frameworks for care, but their value lies in implementation rather than publication. The gap between evidence and practice is not primarily a knowledge gap, but an implementation gap that requires systematic attention to the practical realities of care delivery.

Second, successful TBI programmes are built on systematic approaches that adapt evidence-based principles to local capabilities and resources. One-size-fits-all implementations are unlikely to succeed given the diversity of practice settings and patient populations.

Third, the human factors of care delivery—team coordination, communication, decision-making under pressure—are as important as technical knowledge of treatment protocols. Guidelines must be implemented by humans working in teams, and attention to these factors is crucial for success.

Finally, the ultimate measure of guideline effectiveness is not adherence to recommendations, but improvement in patient outcomes. This requires sophisticated approaches to quality measurement, continuous improvement, and adaptation of practices based on real-world results.

The challenge facing the neurocritical care community is not developing better evidence—though continued research remains important—but translating existing evidence into systematic improvements in care delivery. This translation challenge represents both an opportunity and an obligation to our patients and their families who depend on our ability to bridge the gap between what we know and what we do.

The future of sTBI management lies not in revolutionary treatments, but in evolutionary improvements in our ability to implement existing evidence systematically, reliably, and effectively. The tools exist; the challenge is using them consistently to achieve the outcomes our patients deserve.

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Carbon-Neutral Anaesthesia: Turning Research Evidence into Greener Anaesthesia Practices

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Modern anaesthesia has not only evolved with technological advancements but also presents a paradox: while it may serve as a cornerstone in global health improvement, our speciality substantially contributes to environmental pollution through greenhouse gas (GHG) emissions and medical waste. In the 21st century, as climate change appears as the biggest threat to human life, the transformation to carbon-neutral anaesthesia practices is imperative, responding to the “dual crisis” of providing optimal perioperative care and, at the same time, reducing harm to the planet.

Health care settings account for 5-10% of greenhouse emissions while anaesthetic gases like desflurane and nitrous oxide account for majority of emissions as compared to rest of the agents. [1] Within the hospitals, operating rooms generate up to 30% of total waste, and volatile anaesthetic gases form 2% of the carbon footprint, according to statistics by the UK's National Health Service (NHS). Their global warming potential (GWP) is strikingly high: 1kg of desflurane equals 6,810 kg of CO₂-equivalent, with atmospheric lifetimes lasting more than 14 years.[1]

A fundamental strategy for carbon-neutral anaesthesia is selecting agents and techniques with lower GWP. Research consistently supports the use of Total intravenous anaesthesia (TIVA) using propofol, with negligible GWP, with life cycle analyses showing emissions almost 500-fold lower than desflurane-based approaches, at the same time, there is no adverse difference in outcomes for common or major surgeries. Regional Techniques (neuraxial, peripheral blocks) not only spare volatile agent usage but also frequently result in improved patient recovery and lower perioperative morbidity. Low-Flow Anaesthesia (<1L/min) minimises inhalational agent consumption, with ultra-low fresh gas flow (<0.5 l/min), reducing volatile gases requirements by up to 60%. [2] Countries and hospitals that eliminated desflurane have reported environmental and significant cost savings. Medical overuse is another hidden driver of carbon emissions. By avoiding unnecessary diagnostics, interventions, and “routine” high-flux volatile use, anaesthesiologists contribute to sustainability while preserving patient safety. During labour, intravenous or neuraxial analgesia options—such as epidural bupivacaine or remifentanyl patient controlled analgesia (PCA)—are more eco-friendly than nitrous oxide inhalation, delivering superior pain relief at a fraction (<1%) of the carbon footprint. [2]

Heating, ventilation, and air conditioning (HVAC) systems account for up to 99% of an operating room’s energy consumption. Adopting efficient designs, such as recirculation and heat recovery technologies, can reduce energy usage by 65–70% without jeopardising infection control. Further, unoccupied setback protocols—which turn down air treatments when operating rooms are empty—demonstrate up to 70% energy savings, require minimal investment, and maintain patient safety. [2]

There are many barriers and challenges, which we as anaesthesiologists will have to face to bring about that change. Many clinicians are less confident using TIVA, viewing it as riskier and more complex, especially when volatile-based anaesthesia is deeply ingrained from

training and habit. Uncertainties about practical safety, unfamiliarity with low-flow techniques, and evidence gaps—such as propofol waste’s environmental impact: impede broader adoption. Some anaesthesiologists perceive the speciality’s environmental impact as minor compared to other sources, questioning the efficacy of individual practice change.

Strategies for Overcoming Barriers and Turning Evidence Into Practice include education and training by incorporating sustainability into curricula, and continuing professional development ensures future practitioners are equipped to use low-flow, TIVA, and “greener” techniques safely and confidently. Regular departmental meetings and audits—translating carbon emissions data into relatable analogies and visual feedback—have a significant impact. Change is most effective when adopted at the departmental or hospital level, standardising low-flow anaesthesia, eliminating desflurane, and embedding sustainability into performance indicators and daily practice. Removal of high-GWP agents from anaesthesia machines (requiring explicit request and rationale for use) and prominent “green reminders” (labels, posters, metrics) can motivate practitioners toward evidence-based practices. Improved access to TIVA equipment, user-friendly protocols (especially in paediatric anaesthesia), and multidisciplinary cooperation yield substantial gains. Ensuring skilled support staff and streamlined medication ordering enhances sustainability, particularly for intravenous induction and maintenance protocols. [3]

Key priorities for advancing carbon-neutral anaesthesia practice include: Robust longitudinal research on the environmental fate of anaesthetic agents and drugs. Development of standardised sustainability metrics, including cradle-to-grave life cycle analysis databases for all medical devices and pharmaceuticals. Innovative gas adsorption, recycling, and renewable energy technology in operating room infrastructure. Policy and regulatory reforms align financial incentives, guideline mandates, and operational metrics with environmental sustainability. Cross-speciality collaborations

form integrated models of “Green Surgery” and “Green Perioperative Care.”[1-3] Achieving carbon neutral anaesthesia is an ethical, imperative and an attainable goal. There has been enough research and pragmatic recommendations support transitioning from high-GWP inhalational agents to TIVA, regional techniques, low-flow approaches, and reusable equipment. Overcoming barriers requires coordinated action—education, policy change, infrastructure investment, and sustained research. As a profession at the intersection of clinical innovation and patient advocacy, anaesthesiologists are uniquely positioned to lead the transformation toward greener, climate-conscious healthcare, ensuring safe, practical—and sustainable—care for future generations.

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From Blocks to Better Recovery: Translating Regional Anaesthesia Research into Paediatric Practice

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Imagine this:

In one corner of the recovery room, a mother sits peacefully with her little one cradled in her lap. The child, fresh out of surgery, is sleeping soundly—pain-free, calm, and comfortable. The mother's face glows with relief as she gently strokes her child's hair, her heart at ease. Now, picture the other side of the room. Another mother paces anxiously, rocking her baby in her arms, trying desperately to soothe his relentless cries. The child is writhing in discomfort, tears streaming down his face, and the mother's own stress mirrors his pain.

What made the difference?

A simple yet powerful intervention—a regional block administered during surgery. It transformed one child's postoperative journey into a pain-free, restful experience and gifted the mother peace of mind, while its absence left another family struggling with distress and exhaustion.

Regional anaesthesia (RA) innovations are changing perioperative care for children by improving pain management, reducing narcotic exposure, and hastening recovery. With

encouraging results, new research backs the integration of procedures including neuraxial approaches, nerve blocks, and fascial plane blocks into routine paediatric anaesthesia practice. [1,2]

The increasing number of randomised controlled trials (RCTs) showing that ultrasound-guided RA consistently lowers opioid use and enhances postoperative pain management without serious side effects is one of the main factors causing this change.

The safety and effectiveness of RA in children have been improved by the development of ultrasonography guidance. In addition to increasing block precision and onset time, ultrasound also decreases the volume of local anaesthetic used and lowers complication rates. For instance, ultrasound-guided caudal blocks have success rates of over 95%, especially when paired with adjuvants.[3]

Speaking of adjuvants, putting study discoveries into practice has greatly benefited from their cautious application. Although side-effects like drowsiness require careful dosing in children, agents like clonidine, dexmedetomidine and dexamethasone improve analgesia and prolong its duration.[4]

RA has demonstrated significant advantages when included in improved recovery after surgery (ERAS) programmes. In paediatric cardiac surgery, for instance, peripheral nerve blocks facilitate early extubation, shortened intensive care unit and hospital stays, and lower opioid-related morbidity.

Similarly, regional modalities are pillars of modern recovery strategies, reducing chronic pain progression, improving patient/family satisfaction, and decreasing healthcare costs.

Nonetheless, the transition from research to routine use is not without challenges.

Concerns over complications in vulnerable children and the steep learning curve for new techniques can impede adoption. Fascial plane blocks (FPBs) have sought to lower this barrier by offering easier-to-learn approaches that expand access and confidence among practitioners.

Lastly, interdisciplinary cooperation is necessary for the successful integration of RA research into paediatric treatment. Anaesthesiologists, nursing staff, allied personnel, and inter-professional teams must work together to ensure safe implementation. Monitoring, proper training, and postoperative vigilance—especially following neuraxial blocks—are critical for maintaining safety and optimising outcomes.

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Reading guidelines and Applying them in Clinical Practice

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Clinical guidelines are systematically developed statements designed to help doctors and health care professionals make decisions about appropriate care for specific clinical situations. When one is reading the guidelines, one has to identify the source and confirm whether it is from a reputed body such as the World Health Organization (WHO), National Institute for Health and Care Excellence (NICE), American Heart Association (AHA), etc. Secondly, the guidelines should be latest. Guidelines are usually long, but the summary is always well-tabulated at the end. There is a grading system in the guidelines to show the strength of recommendation and quality of evidence.

It is important that once we have read these guidelines, we need to apply them into our clinical practice. The steps for doing this are as follows:

1) Match the patient profile – Check whether the patient fits in the population profile in terms of age, severity and disease comorbidities.

2) Individualise – ONE SIZE FITS ALL is not correct. It is not necessary to apply all the points in the guidelines to be applied immediately in one's setting. Firstly, one has to check on which points can be applied in the first round and then move on to the next step.

3) Integrate into the workforce – Use checklists, protocols or order sets from guidelines to make them practical. Train your staff and make one of them head the programme.

Take timely feedbacks from that staff and after understanding the ebbs and flows of the system bring the other points of the guidelines into the system slowly. Always use flow charts, checklists and make them visually available at important points in the hospital.

4) Audit and feedback – A very important step. Monitor outcomes based on real time results and adapt accordingly. Clinical meetings should be conducted on a regular basis.

5) Educate and train staff – Conduct Continued Medical Education (CME) programmes, workshops, mockdrills. Put posters near the bedside, operation theatre, intensive care unit (ICU). Distribute small pocket cards. Involvement at all levels: doctors, nurses, technicians is important.

To summarise, one has to read and understand the guidelines and finally check on what is possible to be applied in one's setup. The final 'mantra' (rule) is monitor, audit and improve.

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Advanced monitoring in neuroanaesthesia practices: An integration of clinical concepts with research

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The beginning : For the first time after forty years of establishment of neurosurgery as a speciality, the neurosurgeons and the anaesthesiologists in the United States realised the need for the development of a dedicated anaesthesia discipline that would exclusively cater to neuro-patients. It all began with the modifications of the existing practices to match the neurosurgical principles marked by incorporating ideas of awake surgery vs general anaesthesia, spontaneous vs controlled ventilation, debating the use of vasodilator anaesthetics and fluid management.

This was the time when intraoperative electrocardiography was a luxury in the backdrop of a neurosurgical environment which was devoid of even operating microscopes.^[1]

The progress: With advancement in the field of neurosurgery- intellectual and organisational bodies of anaesthesia in America, Europe and Asia collaborated with their neurology and neurosurgical colleagues, which heralded the beginning of the era of modern neuroanesthesia and neurocritical care (NCC). Their global participation witnessed the beginning of the research towards understanding the mechanisms of brain and spinal cord injury, cerebral protection physiology and pharmacology of neuroanaesthesia-related intervention. Novel concepts on cerebral protection by hypothermia / metabolic depressant anaesthetics, cerebral protection from closed head injury emerged and the end point of this research was the development of various neuromonitors. [1]

The present: The primary goal of neuroanaesthesia is to maintain the adequate brain and spinal cord perfusion, achieve a reduction in intracranial pressure (ICP) along with maintaining overall haemodynamics and oxygenation. The clinical concepts on brain function, blood flow, ICP and metabolism has eventually led to the invention of various advanced monitors for assessment of the same and guide their management.^[2]

Monitoring the function of brain and spine

Electroencephalogram (EEG) based monitor – monitors the depth of anaesthesia, detects perioperative seizures, identifies acute ischaemia (when constantly monitored), supports brain death diagnosis and guides in providing neuroprotection (like barbiturate coma). Evoked potential monitors – Intraoperatively, motor evoked potential (MEP), somatosensory evoked potential (SSEP), electromyography (EMG) and brain auditory evoked potential (BAEP) determine the integrity of motor, sensory tract, cranial nerve/spinal root and brain stem respectively. SSEP is also used to determine cerebral ischaemia in NCC.^[2]

Monitoring the blood flow to brain and ICP

Transcranial doppler (TCD) is a surrogate of blood flow measurement to the brain by determining the flow velocities in the brain vessels.

Invasive monitors are classically used for ICP measurement. However non-invasive monitors such as optic nerve sheath diameter, brain ultrasound, TCD, pupillometer are gaining popularity.

Monitoring cerebral metabolism

Cerebral oxygenation monitors determine the oxygenation status of the brain. Jugular venous oximetry(SJVO₂) and brain tissue oxygen partial pressure (PbTO₂) are invasive monitors while near infrared spectroscopy (NIRS) is a non-invasive monitor. Cerebral microdialysis assesses the metabolism status (example-lactate pyruvate ratio) at the area of injury and is of major importance in acute severe neurological injury.^[3]

Other advanced monitors

Transoesophageal echocardiography (TEE), cardiac output monitors, co-oximetry, ultrasound (lung / deep vein thrombosis scanning) has revolutionised the field of neuroanaesthesia and NCC.

The future:A) Developing multimodal monitoring software that integrate the data from physiological variables, ICP monitors, PbTO₂ and cerebral microdialysis for better assessment of brain function, real-time detection of potential harm and for effective management to improve outcome.^[3] B) Integrating the best results of non-invasive monitors C) Artificial intelligence in record keeping, medical translation/education and research, perioperative management and neurocritical care.^[4]

Conclusion - The field of neuroanaesthesia has progressed significantly by leaps and bounds from the time of its inception by integrating various clinical concepts with research.

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ISA ACTIVITIES



ISA ACTIVITIES

ISA- NPL(National Premier League) Cricket Tournament Organised by ISA NOIDA GB NAGAR Branch

(Hosted by ISA-UP Branch)

(15th February 2025)

The inaugural ISA- NPL(National Premier league) Cricket Tournament brought together 15 teams from across the nation. Dr. Kapil Singhal was the Organising Secretary of this tournament. Four grounds were arranged to conduct various matches in close proximity at DS sports arena and SOP cricket ground, Noida.

The tournament consisted of four pools where 15 matches were played in league stage. The top teams from each pool then proceeded to the knockout stage i.e. Semifinals, culminating in the final match. Semifinals were played between Team Delhi Dominators versus Team Rajasthan Riders and Team Punjab Spartans versus Team Meerut Warriors.

All participants received medals for their participation in the tournament. Five trophies were awarded in each match, recognising individual and team achievements i.e. - Man of the Match, Fighter of Match, Best Batsman, Best Bowler and Best fielder. Awards were distributed by National, State and City branch office bearers. Delhi Dominators and the Winner's Trophy was lifted up by Captain Dr Kush. First Runners-up were Punjab Spartans and the trophy was given to Captain Dr Rohit.



The artistic excellence of Dream Artist was seen in every stroke placed on the faces of the players. The Physiotherapist team ensured the prompt treatment of sports injuries.

National Office bearers and GCs present on the ground were felicitated for their immense support during the whole planning and execution of this tournament. Felicitations were done to umpires, ground owners, game boys and sponsorers for their tireless efforts in making this tournament a great success.

Participating Teams



ISA National Secretary's XI



Haryana Hurricanes



Synergy Agra Warriors



Lucknow sher-e-awadh



Delhi Dominator



Ghaziabad Tranquil Titans



Gurugram Gladiators



Kanpur Titans

Participating Teams



Mathura Superkings



Meerut Warriors



Rajasthan Riders



Mahananda Noida Giants



Punjab Spartans



Uttarakhand Mountain Mavericks



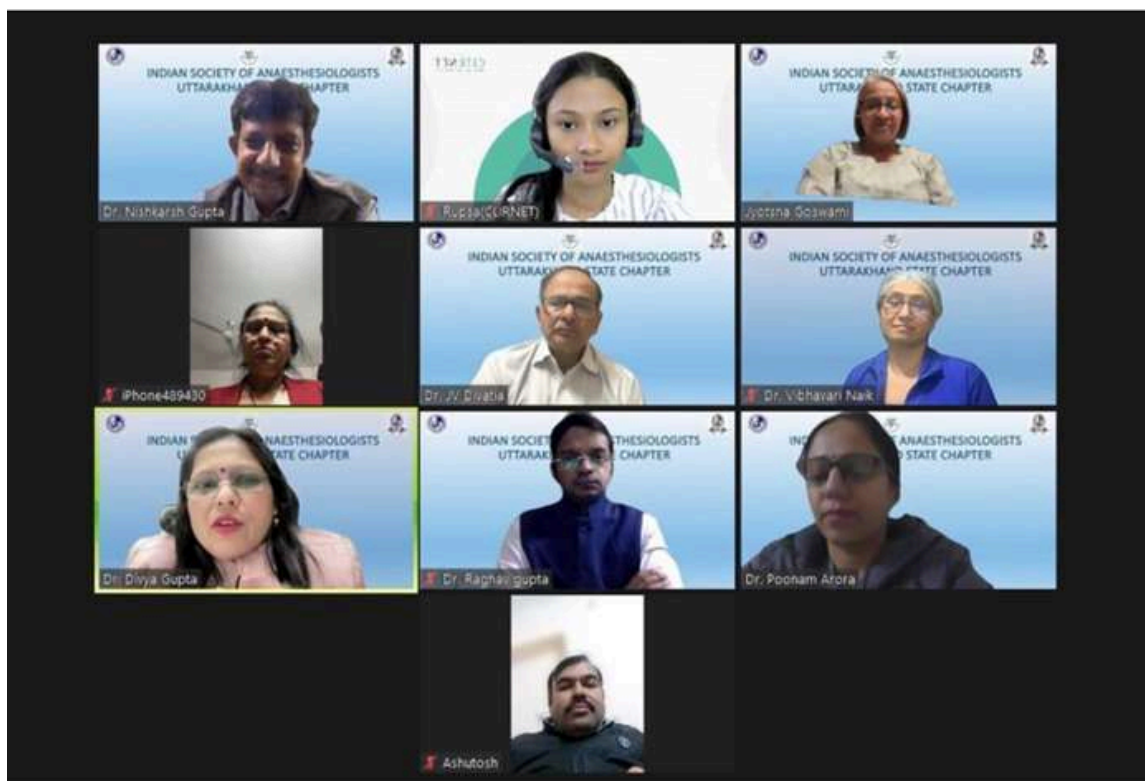
Bareilly Daredevils

ISA Uttarakhand State Chapter Activities

Webinar

Feb 4, 2025

A webinar was conducted by the ISA-Uttarakhand State Branch on February 4, 2025, on the occasion of World Cancer Day. The topic was “Comprehensive Care of Cancer Patients – The Role of the Anaesthesiologist.” The event featured a talk on patient-centric cancer care by Dr. Raghav Gupta, Assistant Professor at AIIMS Delhi (Jhajjar), based on this year’s theme – United by Unique. This was followed by a panel discussion with stalwarts of Oncoanaesthesia: Dr. J.V. Divatia, Head of Critical Care at Lilavati Hospital and Research Centre, Mumbai, and Immediate Past President of ISA National; Prof. Sushma Bhatnagar, Chief of Dr. BRAIRCH and Head of the Department of Oncoanaesthesia and Palliative Medicine, AIIMS Delhi; Dr. Jyotsna Goswami, Senior Consultant and Head of the Department of Oncoanaesthesia, Tata Medical Center, Kolkata; and Dr. Vibhavari Naik, Senior Consultant, Department of Oncoanaesthesia, Pain and Palliative Medicine, Basavatarakam Indo-American Cancer Hospital, Hyderabad. The discussion was moderated by Prof. Nishkarsh Gupta, Department of Oncoanaesthesia and Palliative Medicine, AIIMS Delhi. The panelists engaged in thoughtful discussions on various approaches to improving perioperative anaesthesia management, with a focus on patient safety and comfort during cancer treatments. The webinar was attended by around 70 delegates from across the nation.



Sports Activity

Feb 15 - 16, 2025

The ISA Uttarakhand State Chapter actively participated in the first-ever ISA National Premier League, followed by a one-day Pediatric CME organised by the ISA UP State Chapter, Noida Branch, on February 15-16, 2025. Further, Dr Divya Arora, senior resident from GEIMS, Dehradun bagged the first position in Poster Presentation



Participation in the first-ever ISA National Premier League



Dr. Divya Arora bagged the first position in Poster Presentation

Organised by ISA Erode

Short Film Festival Contest

(February 2025)

Conducted a State Level Short Film Festival Contest. Winners included Dr. Geetha J from ISA Tiruchirapalli City Branch, Runner-up was Dr. G. Shanmugavel (Coimbatore Medical College Hospital) and special winner was Dr. Aafreen (Kanchi Kamakoti Childs Trust Hospital, Chennai).

The contest was judged by professionals from Lowe's and Zoho, along with the O₂ Creative-Arts Team.



Cricket Practice

(21st March 2025)

The ESA Sports Cell held a Cricket Practice at Playzo33 Turf, Erode, from 7pm to 9pm. Members took part with great energy, improving their skills and team spirit.



Monthly meet (6th April 2025)

April monthly meet was held at D'Wayfarer Inn Resorts, Erode on occasion of Women's Day. Dr. Chitra Soundararaj, senior member of the branch shared her inspiring life experiences and advice for the younger generation. It was followed by a talk by Dr. Arunpandiyan V on the role of dexamethasone in anaesthesiology.



Organised by ISA Trivandrum (6th March 2025) BASIC LIFE SUPPORT TRAINING

Dr Hally T and Dr Mohanakumar of Trivandrum city branch conducted Basic Life Support (BLS) training programme for 90 college students and staff at the Department of History, Chempazhanthi SN College.



BASIC LIFE SUPPORT TRAINING

(03-04-2025 and 11-04-2025)

Basic Life Support Training was conducted in association with CRTC. Dr Mohanakumar and Dr Chacko Ramacha participated in the BLS training programmes.



Organised by ISA Malappuram

(12th, 19th, 20th and 26th March 2025)

Compression Only Life Support and First Aid awareness class for people coming for Driving License was organised on four days at Pain and Palliative Care Auditorium by IRCF, IMA and ISA with the help of Moulana Hospital. Approximately 575 people attended the event.





IFTAR Meet (20th March 2025)

Iftar meet was celebrated along with general body meeting. Members actively participated in discussions. It was followed by dinner.



ISA Visakhapatnam city branch

(22/03/2025)

ISA Visakhapatnam had an academic talk by Dr Subrata Singha, Professor and HOD, AIIMS Raipur. It was conducted in the department of Anaesthesiology, Andhra medical college followed by quiz for the post graduates.


INDIAN SOCIETY OF ANESTHESIOLOGISTS
Visakhapatnam City Branch
Monthly Academic Meet

DATE : 22nd March 2025, Saturday | **TIME :** 7.00 PM onwards
VENUE : Department of Anaesthesiology, Lecture hall, AMC

Topic
Overview of Hemodynamic monitoring

SPEAKER


Dr Subrata Singha
Professor and Head of the department
AIIMS Raipur

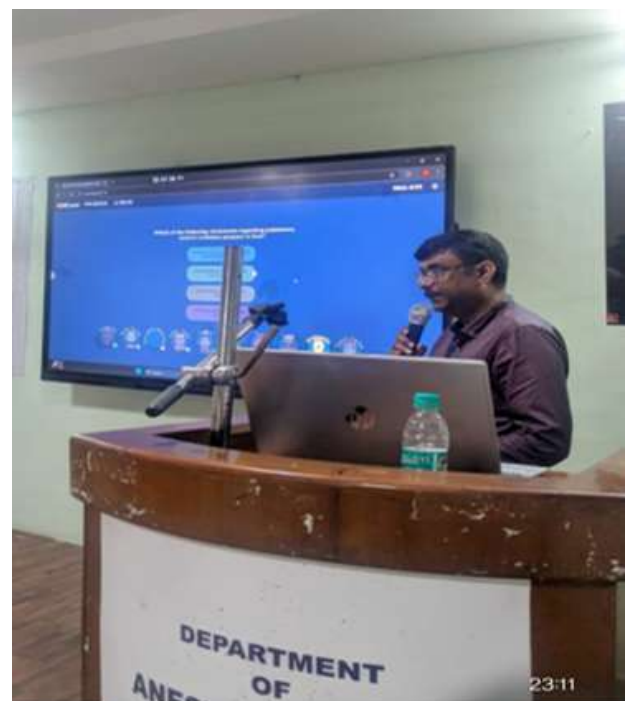
MODERATORS

Dr B. Annapoorna Sharma
Prof HOD MIMS

Dr Vara Prasad Dora
Senior consultant and
Cardiac Anesthesiologist
Apollo Hospital

Followed by Dinner

Executive Body
ISA Visakhapatnam City Branch



ISA Visakhapatnam

Monthly Academic Meet on Paediatric Anaesthesia (28/2/25)

ISA Visakhapatnam branch conducted monthly academic meet on 28/2/25 at Waltair Club to cover topics of Pediatric Anaesthesia. This meeting was presided by President city branch Dr. K Aparangi and convened by the Secretary city branch Dr. Praveen Kumar Moturi. The topic of discussion during this meeting were Intraoperative fluid management and blood transfusion strategies in paediatric surgeries and anaesthesia considerations in preemies which was followed by a Question and Answer session and concluded with the vote of thanks.



ISA Women's Day activities (7th March 2025)

ISA Nagpur City Branch

The city branch celebrated the occasion by organising an annual debate competition which was sponsored by Dr Hema Mankeshwar. The topics included: Modern anaesthesia gadgets are killers of clinical acumen, Fellowships in Anaesthesia sub-speciality, and Anaesthesiologist as master of Emergency Medicine Department. Dr Dilip Bhambani, a senior private practitioner spoke on 'Changing Era of free-lance Anaesthesia Practice' in the Dr Bhau Rajurkar Sponsored Private Practitioner Forum annual activity.



ISA Uttarakhand State Chapter

The branch celebrated the eternal feeling of womanhood over the weekend. Opening Event on 7th March was a panel discussion on 'Rendezvous with Leader Lady Anaesthesiologists of Uttarakhand.' On 8th March, Public Awareness Campaign and COLS Programme Campaign with training of more than 350 participants in 11 different centres across Uttarakhand were held in a single day. Closing Ceremony was with Health Awareness Campaign amongst women with MYBYK Cycle Ride at Himalayan Institute of Medical Sciences, Swami Rama Himalayan University, Dehradun which was attended by anaesthesiologists from Dehradun, Haridwar and Roorkee.

The Department of Anaesthesiology and UKSA organised a bike ride and 'Chai pe Charcha' event to pay tribute to women who have contributed to making the world a better place on 9th March 2025.



ISA Kolhapur (SAK) city branch

08-03-2025, Venue – Highland club, Kolhapur

Women's Day and National AOA success were celebrated with cake cutting and SAK's member cultural club. The AOA organisers: Dr Sheetal Desai, Dr Anjali Kaddu, Dr Shivaji Jadhav, Dr Sandeep Kadam and Dr Ashish Nalavade were felicitated by SAK President Dr Sangita Patil.



ISA Nagpur activities

(March 2025)

ISA Nagpur city branch (NCB) conducted COLS training activity for employees of Saint Gobain Factory, Butibori on 4th March 2025. Dr Ravi Gurbani, Senior ISA NCB member delivered the lecture, gave a demonstration on mannequin and delivered first responder lecture. 60 workers and security officers participated in the training.

ISA-NCB conducted BCLS activity on 13th March 2025 at Aarogyam Hospital, Nagpur. Around 45 people including consultants, RMO, nursing staff, administrative staff and ward boys attended the activity. Senior ISA-NCB member and past secretary ISA-NCB, Dr. Devayani Thakur and Dr. Rupali Shendre gave the demonstration and supervised the hands on. BCLS chart was donated to the hospital officials.

ISA-NCB conducted webinar series IKCARE- Innovations, Knowledge, Continued Academics, Research, Education on 19th March 2025 on zoom platform. The webinar started with introduction of the speakers, Dr. Sukhminder Jit Bajwa and Dr Pratibha Deshmukh and proceeded with series of lectures. The topics of discussion were as follows:

1. How to do a standard scientific publication?
2. Basics of Biomedical research

Both the speakers covered all important aspects of the topics and gave detailed and systematic planning for carrying out research. They answered the questions put up by the participants in the chat box.



ISA-NCB conducted a CPR awareness campaign at Government Engineering College Nagpur in collaboration with Rotaract club of VSPM physiotherapy department and Rotaract club of GCOEN on 21th March 2025. Faculty for the programme were Dr. Ravi Mundala ISA-NCB member and Dr Pallavi Meshram ISA-NCB executive member. More than 100 participants learned COLS life saving skills. The initiative was aimed at empowering individuals with knowledge and skills to act in emergencies. COLS chart was donated to the officials.

ISA-NCB in association with Department of Anaesthesiology and Department of Obstetrics and Gynaecology-AIIMS Nagpur and Association of Obstetric Anaesthesiologists of India jointly organised and conducted CME and Workshop on Obstetric Emergencies and Resuscitation EMBARK-“Emergency Maternal Birth Assistance and Resuscitation Knowledge” on 23th March 2025 at AIIMS Nagpur. The theme was “FROM CRISIS TO CARE.” The topics covered for the CME included obstetric mortality, approach to a critically ill mother, postpartum haemorrhage identification, management strategies and haemodynamic management of bleeding parturient. The speakers were Dr Suchita Mundle, Dr Manisha Shembekar, Dr Tarakeshwari Surapaneni, Dr Medha Davile and Dr Vaishali Shelgaonkar

It was followed by case scenario and role play on postpartum haemorrhage by Dr Prachi Dixit, Dr Amruta Choudhary and Ashutosh kumar and moderated by Dr Anu Kewlani and Dr Neha Gangane.

ISA-NCB conducted BCLS activity at ABO Ophthalmology hospital, Baidyanath Chowk, Nagpur on 25th March 2025. The initiative aimed at empowering RMO, nursing staff and paramedical staff with knowledge and skills to act in acute cardiopulmonary emergencies. Faculty for the programme were Dr Anant Atkar ISA-NCB executive member and Dr Pallavi Meshram. Mrs. Tripti Sawlani from ABO hospital was the coordinator for the training programme. 30 participants learned BCLS life saving skills. BCLS chart was donated to the hospital.



ISA Nashik city branch (April 2025)

INSTALLATION CEREMONY for TEAM 2025-26 was conducted on 5th April 2025 at hotel SSK SOLITAIRE.



ISA Karad COLS BLS, ACLS activities (April 2025)

Dr. Jayawant Patil, Hon. Secretary, ISA Karad conducted COLS, BLS and ACLS activity on the occasion of World Health Day on 7/4/25 at Subdistrict hospital, Karad for staff, CMOs and other 42 members.

Dr. Shekhar Kognulkar conducted COLS activity on the occasion of World Health Day at RH Undale for Staff, Nursing students and other 100 attendees.

Dr. Shekhar Kognulkar conducted a mega COLS Activity at Pharmacy college, Ghogaon on 9/4/25 on occasion of World Health Day for 200 attendees.

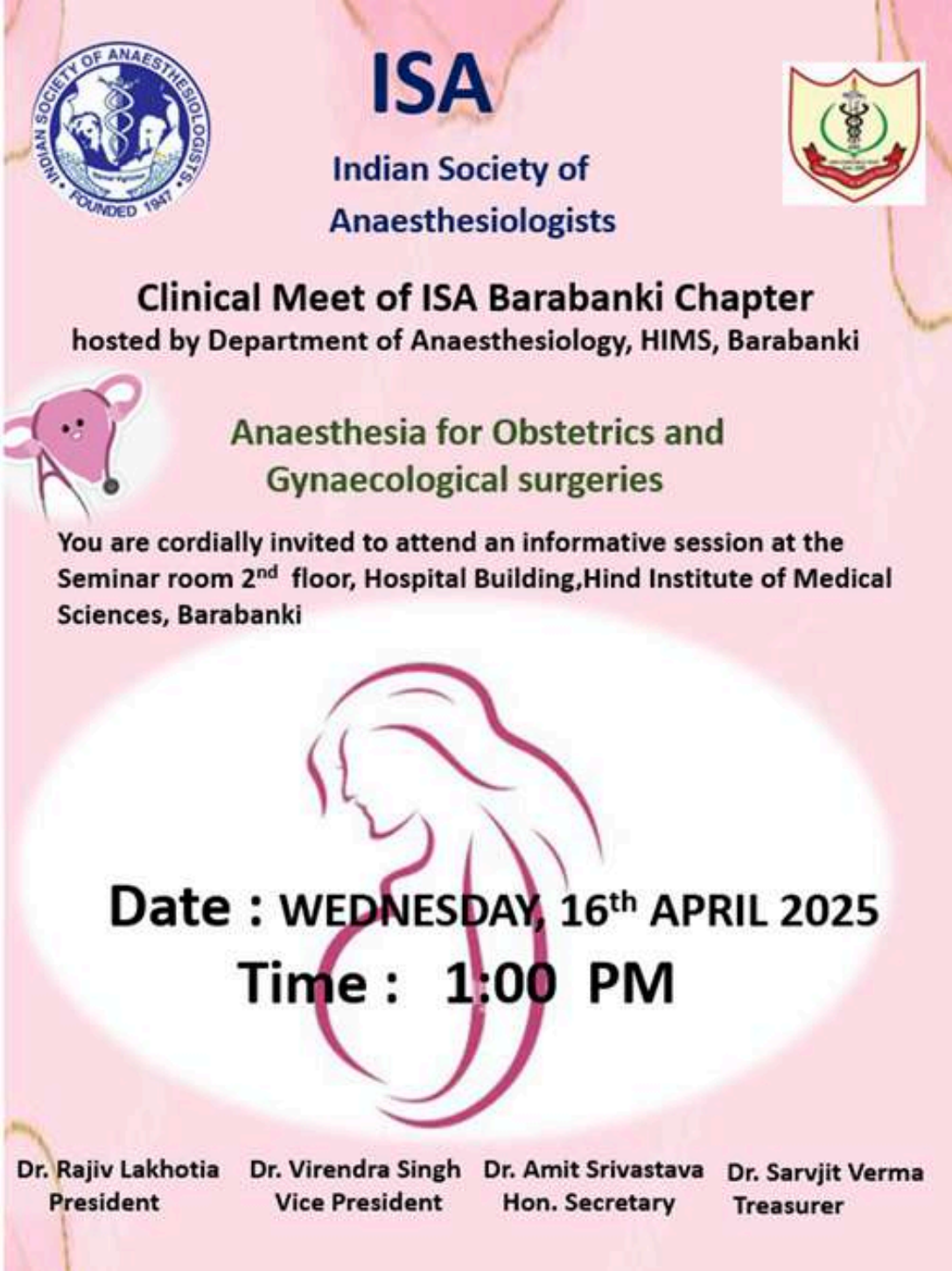


ISA Barabanki city branch

16-04-2025

Venue – Hind Institute of Medical Sciences (HIMS), Barabanki

First clinical meet of ISA Barabanki city branch was held on the topic “Anaesthesia for Obstetric and Gynaecological Surgeries”, hosted by Department of Anaesthesiology, HIMS, Barabanki. The welcome address was given by Dr Rajiv Lakhotia, President ISA Barabanki branch and vote of thanks was delivered by Dr Amit Srivastava, Honorary Secretary, ISA Barabanki branch



The poster is for a clinical meet organized by the Indian Society of Anaesthesiologists (ISA) Barabanki Chapter. It features the ISA logo on the top left, which includes the text 'INDIAN SOCIETY OF ANAESTHESIOLOGISTS' and 'FOUNDED 1947'. To the right of the logo is the text 'ISA Indian Society of Anaesthesiologists'. Further right is a crest with a caduceus. Below this, the text reads 'Clinical Meet of ISA Barabanki Chapter hosted by Department of Anaesthesiology, HIMS, Barabanki'. A small illustration of a pink heart with a stethoscope is on the left. The main topic is 'Anaesthesia for Obstetrics and Gynaecological surgeries'. An invitation text states: 'You are cordially invited to attend an informative session at the Seminar room 2nd floor, Hospital Building, Hind Institute of Medical Sciences, Barabanki'. The date and time are prominently displayed in a white oval: 'Date : WEDNESDAY, 16th APRIL 2025' and 'Time : 1:00 PM'. At the bottom, four names and titles are listed: Dr. Rajiv Lakhotia (President), Dr. Virendra Singh (Vice President), Dr. Amit Srivastava (Hon. Secretary), and Dr. Sarvjit Verma (Treasurer). A large, stylized illustration of a pregnant woman in profile is in the background of the lower half.

ISA
Indian Society of
Anaesthesiologists

Clinical Meet of ISA Barabanki Chapter
hosted by Department of Anaesthesiology, HIMS, Barabanki

**Anaesthesia for Obstetrics and
Gynaecological surgeries**

You are cordially invited to attend an informative session at the
Seminar room 2nd floor, Hospital Building, Hind Institute of Medical
Sciences, Barabanki

Date : WEDNESDAY, 16th APRIL 2025
Time : 1:00 PM

Dr. Rajiv Lakhotia Dr. Virendra Singh Dr. Amit Srivastava Dr. Sarvjit Verma
President Vice President Hon. Secretary Treasurer

ISA SDA Activities

April 2025

SDA Monthly Meet – April 2025:

"Certifying Death to Enabling Life: Navigating the Clinical, Ethical, and Administrative Continuum of Organ Donation"

The April 2025 edition of the SDA Monthly Meet was conducted on 16 April 2025 in a hybrid format with Command Hospital, Western Command serving as the organising centre.

The session, titled "Certifying Death to Enabling Life: Navigating the Clinical, Ethical, and Administrative Continuum of Organ Donation," witnessed the participation of 103 delegates, comprising healthcare professionals, administrators, and support personnel from across the Armed Forces Medical Services.

Key Highlights:

Lt Col Ravikant Nair, Col Anurag Garg, and Col R. K. Singhal delivered comprehensive presentations outlining the clinical criteria for brain death certification and the ethical considerations critical to organ donation practices.

The speakers emphasised the indispensable role of timely and accurate certification in enhancing the success rates of organ transplantation and addressed the sensitive communication required with families during the process.

Adding an administrative perspective, Maj Gen Matthew Jacob provided valuable insights into the logistical challenges associated with patient transfer between retriever and transplant centres, highlighting the necessity for meticulous coordination to optimize outcomes.

The session concluded with an interactive discussion, fostering deeper understanding and practical knowledge-sharing among attendees.

The SDA Monthly Meet continues to serve as an essential platform for advancing academic excellence, fostering ethical clinical practice, and promoting administrative preparedness within the Armed Forces Medical Services.



ISA Srinagar Activities – April 2025

Plantation Drive Organised by ISA City Branch, Srinagar

On 16 April 2025, the Indian Society of Anaesthesiologists (ISA) City Branch, Srinagar, in collaboration with the Department of Anaesthesia, Government Medical College, Srinagar, successfully organised a Plantation Drive under the "Go Green" initiative.

A total of 60 trees were planted at the Paediatric Hospital, an associated facility of GMC Srinagar, as part of this significant environmental stewardship effort.

This initiative underscores the ISA's commitment to promoting sustainable practices and fostering a greener, healthier environment, thereby enhancing the broader vision of public welfare beyond clinical practice.



ISA Bangalore Metro branch activities (April 25)

The monthly academic meet of ISA Bangalore metro branch was conducted on 25th April 2025 at Bangalore City Institute, Bangalore and it was hosted by the Department of Anaesthesia, Indira Gandhi Institute of Child Health. The theme was "Paediatric and Neonatal Emergencies" and programme was attended by 80 members.



ISA Madurai city branch (30-04-2025)

Venue- Grand by GRT Hotels, Madurai

A CME on “Tailored Anaesthesia: Solutions beyond GA” was conducted by Velammal Medical College and Hospital in association with ISA Madurai city branch in presence of ISA State President, Dr Kirupakaran and State Secretary, Dr Srinivasan. The CME included lectures by renowned national speakers and hands-on workshop for difficult airway, POCUS, USG guided nerve blocks and transoesophageal echocardiography. About 175 delegates attended the CME.



Tailored Anaesthesia - "Solutions beyond GA"

Registration - 08:15 am to 08:45 am

Inauguration - 08:45 am to 09:00 am

SESSION	TOPIC	SPEAKER
09:00 am to 09:30 am	"Balancing the break" - Mastered anesthesia for Mastectomy in respiratory Vulnerability.	Dr. Sivaprasad Associate Professor Madurai Medical College Madurai.
09:30 am to 10:00 am	"Beating the odds" - Shedding light on peripartum cardiomyopathy	Dr. Sunil Pandya Chief - Dept of Anaesthesia, Perioperative Medicine and Critical Care, AIG Hospitals, Hyderabad
10:00 am to 10:30 am	"Minimizing the hepatic stress" - A game changer for DCLD patients undergoing obstructed umbilical Hernia	Dr. Pankaj Kundra Professor, Dept of Anaesthesiology & Critical Care, JIPMER, Pondicherry Dean, School of Medicine, Pondicherry University
10:30 am to 11:00 am - Tea Break		
11:00 am to 11:30 pm	"The Perfect Storm" - Septic lower limb for above knee amputation	Dr. Sivashanmugam Professor & HOD Mahatma Gandhi Medical College, Pondicherry.
11:30 am to 12:00 am	"Case Capsules" - RA made the difference in children.	Dr. S. Ramesh Senior Consultant Kanchi Kamakodi child trust Hospital, Chennai.
12:00 am to 12:30 pm	"Heart falters prostate grows" - Safe guarding the poor heart in TURP surgery.	Dr. Ramanarayanan Senior Consultant, Bharathi Infinity Hospital, Madurai.

12:30 pm to 01:30 pm - Lunch

01:30 pm to 04:30 pm - Workshop



ISA National sponsored CMEs, Conferences, Webinars, Workshops & Meetings



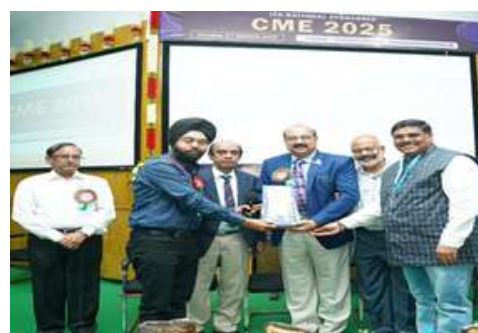
ISA National Sponsored CME at Noida (16th February 2025)



ISA National Sponsored CME at Itanagar (23rd February 2025)



ISA National Sponsored CME at Vizianagaram (2nd March 2025)



ISA National Sponsored CME at Chidambaram (9th March 2025)



ISA North Zone PG Assembly at Jammu (21st-23rd March 2025)



GMC CONDUCTS SUCCESSFUL NORTH ZONE PG ASSEMBLY

YB NEWS SERVICE
JAMMU, MAR 23

The Department of Anaesthesiology and Critical Care, Pain Medicine, Government Medical College (GMC) Jammu, in collaboration with the Indian Society of Anaesthesiologists (ISA), Jammu City Branch, successfully conducted a Teaching Programme and Academic Update as part of the North Zone PG Assembly from March 21 to March 23, 2025, at GMC Jammu.

The North Zone PG Assembly provided a valuable learning opportunity for postgraduate students from across the country. Eminent faculty members

Principal GMC Dr. Ashutosh Gupta being facilitated during a programme

Gupta, Principal and Dean, GMC Jammu, who graced the occasion as the Chief Guest. The event was further honoured by the presence of Dr. Sukhinder Singh Bajwa, Honourable Secretary, ISA National, and Dr. Manoj Kumar, Treasurer, ISA National.

Key dignitaries included Dr. Anita Vigi Kohli, Professor and Head, Department of Anaesthesia and Critical Care, GMC Jammu; Dr. Rajesh Mahajan, Scientific Chairperson; Dr. Madan Lal Katoch, Scientific Co-Chairperson; Dr. Ashwani Kumar, Organising Chairperson; Dr. Renu Wadhwa, Organising Secretary; Dr. Updesh Kumar, Co-Organising Secretary; Dr. Mush-taq Ahmed Wani, Vice President, ISA, Jammu; and Dr. Kunal Sharma, Treasurer, ISA Jammu. The event witnessed the participation of eminent faculty members from across the country, along with the ISA Jammu team, making it a grand academic success.

First MidTerm National Governing Council (GC) Meeting (5th & 6th April 2025) Hosted by ISA Trivandrum city branch



First Webinar of College of Indian Society of Anaesthesiologists (CISA) (11th April 2025)



ISA CISA WEBINAR

Programme : 11.04.2025 (6:00 PM to 7:45 PM)

6:00 PM - 6:05 PM	Introduction	Dr Sumalatha R Shetty, Mangaluru
6:05 PM - 6:15 PM	Successful Video laryngoscopy - Troubleshooting & Tips	Dr Amit Shah, Vadodara
6:15 PM - 6:30 PM	Intricacies of Paediatric Airway	Dr Raveendra US, Mangaluru
6:30 PM to 6:45 PM	Human Factors in Airway Management-	Dr Ramkumar V, Manipal
6:45 PM to 7:00 PM	Airway Ultrasound	Dr Anil Kumar, Mysuru
7:00 PM - 7:15 PM	Airway in ICU	Dr Syed Moied Ahmed, Aligarh
7:15 PM - 7:45 PM	Difficult Airway Case Discussion- Panelist	Dr Anand Bangera, Mangaluru
		Dr Sripada G M, Mangaluru
		Dr Parimala, Bellary
		Dr Manjula Devi, Bengaluru

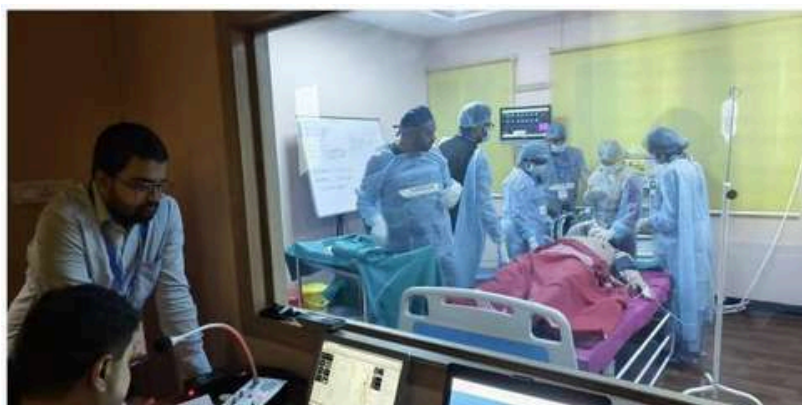
JOIN HERE **Zoom Link :** <https://us02web.zoom.us/j/2603479911?pwd=cmRUUVVVGbUR1ODhsMUUxUVVJ1MGRmUTQ9>
Id: 260 347 9911 **Password: ISANHQ**

**HONORARY SECRETARY ISA NATIONAL
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 Website: www.isaweb.in

It was held between 6 pm to 7.45 pm. It included talks on Airway Management and a panel discussion on Difficult airway. The speakers and panelists included Dr Amit Shah, Dr Raveendra US, Dr. Ramkumar V, Dr Anil Kumar, Dr Syed Moeid Ahmed, Dr Anand Bangera, Dr Sripada GM, Dr Parimala and Dr Manjula Devi.

ISA Simulation Workshop for Anaesthesiologists (12th April 2025)

It was conceived and curated by ISA National. It was held at Bangalore Medical College & Research Institute, Bangalore.



UPYUVAISACON (April 2025)

The first-ever UPYUVAISACON was successfully held from April 11th to 13th, 2025, hosted by the UP-State Branch of ISA under the leadership of State President Dr. Kapil Singhal and State Secretary Dr. Sandeep Sahu, and organised by the Mathura City Branch of ISA. The event commenced with a Hands-On Workshop at City Institute of Medical Sciences, Mathura, where faculties trained delegates in ultrasound-guided blocks and segmental spinal techniques. The ISA National President, Dr. J B Subramanian, inspired attendees with his visit, culminating in a lively faculty dinner. On Day 2, the ISA flag hoisting and oath ceremony took place at The SKS Grand Hotel, Mathura, in the presence of National GC member Dr. R K Bhasker, National IJA Editor Dr. Rakesh Garg, ISA-UP State President Dr. Kapil Singhal, ISA UP State Vice President Dr. Kushant Gupta, ISA UP State Secretary Dr. Sandeep Sahu, ISA UP State Treasurer Dr. Tanmay Tiwari followed by dynamic YUVA faculty sessions. The evening saw a grand inauguration with dignitaries Shri Shailesh Kumar Pandey, IAS (DIG Mathura), and Shri Chandra Prakash Singh, IAS (DM Mathura) gracing the occasion, alongside awards and honours presented under the patronage of Dr. Gaurav Bharadwaj.



IV th Annual National Conference of ISA YUVA CON 2025 & X th ISACON Telangana 2025

It was held on 26 th -27 th April 2025 at Jalvihar, Hyderabad with preconference Workshops on 25th April 2025. It was hosted by ISA National.



PRACTITIONER PAGES



Academic challenges faced by the clinical anaesthesiologist

Dr. E. Praveen Kumar

Consultant Anaesthesiologist,
KIMS Bollineni Hospitals, Rajahmundry
Andhra Pradesh
ISA No. P 1540



"What the mind does not know, the eyes cannot see"

is a fundamental axiom in medical education that holds profound relevance for every aspiring clinician. Anaesthesiology uniquely combines science and art—the scientific component is acquired through textbooks and journals, while the artistic mastery is developed through diligent practice in operating theatres, intensive care units, and outpatient anaesthesia sites. From the beginning of their careers, postgraduate students must develop keen observational skills and attention to minute details, as the slightest error can have catastrophic consequences.

Only a fraction of graduating anaesthesiologists join central and state-level institutes that prioritise academic development. The majority find employment in hospitals of varying sizes across different locations. While tier-2 cities are establishing more corporate-style hospitals, most lack comprehensive academic programmes. Even top-tier metropolitan hospitals with DNB programmes conduct them infrequently and with limited engagement. Few clinical anaesthesiologists willingly mentor DNB students, often due to their own lack of confidence in undertaking such responsibilities.

Many anaesthesiologists with academic inclinations inadvertently join hospitals with minimal academic programmes. The traditional belief that academic institutes offer lower compensation while corporate hospitals provide better financial incentives drives specialists toward corporate settings. However, this choice often leads to a more challenging

path, abandoning the time-tested academic environment that offers greater peace, stability, collaborative teamwork, and continuous learning opportunities among anaesthesiologists of all levels.

Corporate hospitals create several barriers to academic pursuit. Intensive patient loads and revenue targets leave little time or energy for academic activities. Hospitals employ minimal staff to offset higher salaries, creating excessive work pressure that exhausts clinicians and diminishes their academic interests. Many clinicians receive only 10-20 annual leave days, preventing attendance at Continuing Medical Education programmes. Skyrocketing CME fees, combined with travel and accommodation expenses, create financial burdens for anaesthesiologists who already earn less than practitioners in other specialities. Unlike academic institutions, most hospitals lack dedicated departmental or central libraries with essential books that stimulate academic growth.

Historically, anaesthesiology was viewed as subservient to other specialities. While senior professionals have gradually improved recognition, corporate hospitals continue prioritising revenue-generating clinicians. This environment often intimidates and pressures anaesthesiologists, particularly junior practitioners, unless they demonstrate exceptional dedication and maintain pleasant professional relationships. The "survival of the fittest" mentality has fostered inter- and intra-departmental conflicts of varying

intensity. This competitive atmosphere, focused on individual success at others' expense, has become commonplace in corporate hospitals and significantly impacts academic pursuits.

Anaesthesiology demands comprehensive knowledge across multiple domains including basic sciences like anatomy and physiology, bridging sciences like Pathology, Microbiology, Pharmacology and clinical specialties such as Medicine, Surgery, Obstetrics and Gynaecology. This broad knowledge base necessitates continuous learning and regular updates to maintain competency.

Despite these challenges, dedicated anaesthesiologists can pursue academic growth through various means. Traditional methods include self-study, attending available CME programmes, organising departmental journal clubs and presentations, and participating in local and state academic programmes. Digital resources have become increasingly valuable, including the OC Doctor app, Clarinet platform, Zoom webinars by pharmaceutical companies, YouTube academic classes by Mentor Exams, and other online educational platforms. The current era of information explosion provides unprecedented access to valuable educational materials, making technology-based learning essential when physical conference attendance is impossible. For anaesthesiologists with genuine academic interests, no obstacle should prevent knowledge acquisition.

As Lord Krishna stated, ***"Nothing is as purifying as knowledge on this earth."*** Just as a thief cannot rest peacefully knowing treasure lies behind a thin wall, an academically passionate anaesthesiologist cannot remain satisfied without mastering both the art and science of anaesthesiology through dedication, determination and discipline. The key lies in recognising that academic pursuits require deliberate effort and creative solutions within existing constraints. By leveraging available resources and maintaining unwavering commitment to continuous learning, clinical anaesthesiologists can overcome institutional limitations and achieve academic excellence while serving their patients effectively.

ISA National PG Online classes: Doing yeoman service to the student world...



Letter to the Editor

ISA National PG Online Classes: Keeping Private Practitioners Academically Updated

Dr. Muthukumar Rajagopalan



Dear Editor,

Being a practising anaesthesiologist in Coimbatore and a DNB guide in a corporate hospital, I am a regular attendee of the regularly conducted Postgraduate (PG) teaching online programme organised by the Indian Society of Anaesthesiologists (ISA) National.

It is a well-known fact that PG medical education traditionally involves long hours in the hospital, often limiting opportunities for academic discussion and evidence-based learning. PG students often do not get time to attend subject seminars (which are meant to complement hands-on clinical training) held in their departments mainly because of the long extended periods of work in the operation theatre and intensive care unit. The online classes help to bridge this gap by offering a platform where subject experts, teachers and PG students from different parts of our country can share their knowledge through interactive lectures and case-based discussions. It becomes more convenient for PG trainees to attend these classes after a hard day of clinical work. They can attend the classes in the comfort of their hostel rooms/ homes. They can also watch these recorded classes on YouTube whenever they are free.

Furthermore, the knowledge of Medicine is evergrowing and no specialty has evolved more rapidly than anaesthesiology. Anaesthesiology is a speciality where patient safety directly depends on the practitioner's skill, knowledge, and judgement. However, practitioners are likely to work purely on experience and not always in alignment with international best

practice. Nevertheless, clinical practice and approaches need to be regularly updated in the light of newly discovered evidence and research and practitioners need to stay tuned to the current best practice in anaesthesia. The PG online classes serve to refresh the knowledge of practitioners like me, provide exposure to evolving methodologies and updated approaches to patient care and enhance clinical decision-making. They have enabled me to manage anaesthesia for high-risk patients and also handle complex surgeries. They have helped to refine my practice with the use of novel drugs like remifentanyl and sugammadex and the incorporation of modern monitoring measures such as systolic pressure variation/pulse pressure variation, entropy and many others. I was unaware of the modern technique of TIVA/TCI which did not exist during the time of my postgraduation. The online classes have helped me to master this wonderful technique.

These PG online classes have several unique features. Distinguished faculty and experts provide information about the the most modern evidence-based practice and this enables up-to-date learning. A wide range of topics including those on anaesthesia techniques, pain relief, intensive care and emergency procedures are discussed. Professionals from various locations are able to experience world-class education with no boundaries. The case-based discussions, MCQs (Q&A sessions) and discussions that take place allow active participation of those attending the classes and promote their practical application. I confess that the classes keep me motivated as a teacher

and guide me in teaching my students.

The ISA PG online classes certainly mark a significant advancement in anaesthesia education in our country. In a speciality where precision and current knowledge directly impact patient safety, continuing education is not optional—it is essential. The classes contribute significantly to this and ensure that practitioners deliver the highest standards of anaesthesia care while progressing in their careers. I extend my sincere thanks to the Indian Society of Anaesthesiologists (ISA) for designing and conducting such impactful educational programmes.

Regards.

Sincerely yours,

Dr. Muthukumar Rajagopalan

Coimbatore

ISA No. M1288

RESEARCH QUIZ (Multiple Choice Questions)



**Dr. Rama Krishna Reddy
Mudiganti**
Professor of Anaesthesia,
PMRIMS, Hyderabad
GC Member, ISA



Dr. Abhyuday Kumar
Associate Professor,
Department of Anaesthesiology
AIIMS Patna

1. Which of the following combination of reporting guidelines and studies is an incorrect match?

- A. STROBE – Observational studies
- B. STRAD – Diagnostic studies
- C. CARE – Case Reports
- D. ARRIVE – Prognostic studies

Answer: D. ARRIVE – Prognostic studies

Reference: <https://www.equator-network.org/reporting-guidelines/>

2. As per the Indian Council of Medical Research (ICMR) guidelines, assent is required for research involving children of what minimum age?

- A. Below 5 years
- B. 7 years and above
- C. 12 years and above
- D. 18 years and above

Answer: B. 7 years and above

Reference: Indian Council of Medical Research (2017). National Ethical Guidelines for Biomedical and Health Research Involving Human Participants.

3. The implementation of a new anaesthetic technique in clinical practice is most often dependent on:

- A. The cost of the technique
- B. The experience and training of anaesthesiologists
- C. The publication of randomised controlled trials (RCTs) demonstrating its efficacy and safety
- D. The availability of anaesthetic equipment

Answer: C. The publication of randomised controlled trials (RCTs) demonstrating its efficacy and safety

Reference: Carr, D. B., & Ghoneim, M. M. (2008). Clinical trials in anaesthesia: Principles and practice. *Anesthesiology Clinics*, 26(3), 517-533.

4. The term "translational research" in anaesthesiology refers to:

- A. The process of translating medical terminology for patients
- B. The application of basic scientific research findings to clinical practice
- C. The translation of research findings into policy-making decisions
- D. The integration of technology into anaesthesia equipment

Answer: B. The application of basic scientific research findings to clinical practice

Reference: Ducharme, M. P., & McCartney, C. J. L. (2013). Translational research in anaesthesia. *Canadian Journal of Anaesthesia*, 60(8), 756-765.

5. Which of the following provides the lowest level of evidence in the hierarchy for treatment decisions?

- A. Randomised controlled trial (RCT)
- B. Systematic review of RCTs
- C. Expert opinion without explicit critical appraisal
- D. Cohort study

Answer: C. Expert opinion without explicit critical appraisal

Reference: Oxford Centre for Evidence-Based Medicine (2011). OCEBM Levels of Evidence.



HISTORY, ART & LITERARY PAGES



Dr. Subbulakshmi

Sundaram

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Associate Professor,

Department of Anaesthesia & Pain Medicine

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Cuddalore DT

Chidambaram, Tamilnadu

ISA No. S 2922



The Silent Science - Pre Anaesthesia Protocol

Before the sleep, before the still,
They guide with grace, unmatched in skill
A silent guard through night or trial,
The anaesthetist walks the extra mile.

No haste, no fear, no room for doubt,
As science walks compassion's route.
A racing pulse, a rhythmic beat,
The boiling blood, its rising heat...

Two lungs that breathe, the liver's role,
Each breath recorded, calm and whole.
With widened eyes, we search the vein,
Through crimson tests, the truths remain.

The weight is checked, the height is known,
The hours since the last meal shown.
Each tablet taken, dose and time,
Reviewed again like careful rhyme.

The turning head, the steady gaze,
The opened mouth, the tongue that sways.
We count the teeth, inspect the jaw,
Through open truth, we sketch the law.

The tongue is raised, the spine held straight,
We look for signs of age or fate.
And if the airways's path seems tight,
We gently ask, with calm and light.

Should questions arise or findings shift,
We pause the plan, a careful lift.
Another voice may join the care,
To weigh the needs, the risks laid bare.

The body type, the words they know,
We ask in ways their hearts can grow.
With clarity, we ease their doubt,
And guide them gently in and out.

Consent is sought, the plan made bright—
To gift them sleep and guard the night.
Before the cut, before the pain,
The quiet craft begins its reign.

முன் மயக்க சோதனை

அறுவை சிகிச்சை
குறித்தும் நிகழும்
விரைந்தும் நிகழும்
தயக்கமில்லா மயக்குனர் துணையால்!

துடிக்கும் நாடி தாளம் தெரிந்து
கொதிக்கும் ரத்தம் உச்சம் அறிந்து
ஈரல் இரண்டின் சுவாசம் உணர்ந்து...

இமைகள் பிரித்து இரத்தம் அறிந்து
குருதி சோதனையில்
பிற உறுப்பும் கணித்து....

எடையும் பார்த்து உயரம் குறித்து
உண்ணும் நேரம் உடனே கணித்து
மாத்திரை பலவும் முயன்றே பார்த்து...

தலையின் அசைவில் தயக்கம் தீர்த்து
திறந்த வாயில் மேலன்னம் பார்த்து
பற்கள் எண்ணிப் பலவும் குறித்து...

நீட்டிய நாவின் நலங்கள் அறிந்து
திரும்பிய முதுகைத் தெளிவாய்ப் பார்த்து
மாத்திரை பலவும் முயன்றே பார்த்து...
மாற்றம் இருப்பின்
சற்றே நிறுத்தித்
தேவை யிருப்பின் பிறர்தேர்வும் செய்து....

உடல்வகை பிரித்து
புரியும் மொழியில் கேள்விகள் கேட்டு
விளக்கம் கொடுத்து தயக்கம் தீர்த்து
மயக்கம் அளிக்க ஒப்பம் பெற்று...

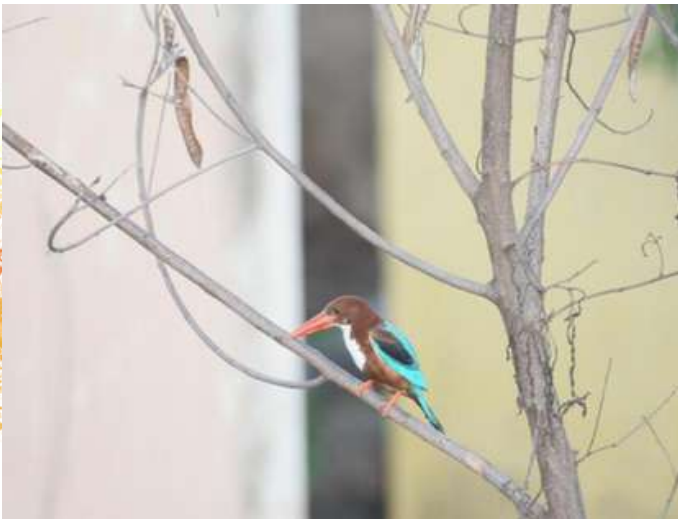
ஓம்பும் பண்டுவன்
உலகின் சிறப்பவன்....!

வலிகள் தீர்த்துப்
பிணியும் கழித்துப்
பின்னும் பார்க்கும்
பெருமை தேடா பெரும் வியப்பவன்....!

Dr. Shital Varunjikar-Joshi
Freelance anaesthetist
Daund, Maharashtra
ISA No.V1034



Bird Photography



**Presenting grace in every step, the art of
balance and the beauty of nature...**

Device: Nikon d5600 + Nikkor telelens

YUVA PAGES



Reflection on Understanding and Practising Research in Clinical Anaesthesia

Contributed by

Dr Jamie Varghese

Junior resident in Anaesthesia,
Kasturba Medical College, Manipal,
576104, Karnataka
ISA No. AP024086



Research has always underpinned the practice of medicine, yet my understanding of it has evolved considerably over the course of my clinical journey. Initially, I perceived research as something abstract, confined to laboratories or the pages of journals. Over time, however, I came to recognise that research and daily clinical decision-making are entwined. In anaesthesia, every choice— from preoperative optimisation of patients, selecting an anaesthetic technique, planning multimodal analgesia, or managing high-risk patients—relies on evidence that has been systematically generated, appraised, and applied.

In the early stages, I found the language of research daunting. Concepts such as randomised controlled trials, systematic reviews, and translational research felt inaccessible. Understanding and implementing statistical hypothesis tests felt impossible and difficult to fathom. Gradually, however, I began to appreciate the continuum that links them: basic science elucidates fundamental mechanisms, translational research bridges these discoveries to clinical applications, and clinical research evaluates their relevance in real-world settings.[1] Understanding this framework helped me see research not as an external activity but as an ongoing process that shapes and refines clinical practice.

Critical appraisal marked a turning point in my engagement with research. I realised that reading articles passively was insufficient; I needed to question methodology, biases, and clinical

applicability. The Users' Guides to the Medical Literature[2] provides a structured approach to appraising evidence. It encouraged me to ask: Was the study well-designed? Were the outcomes clinically meaningful? Could the findings be applied to my patient population? These guiding questions gradually transformed research into a practical tool rather than just an academic exercise that would be an impressive addition to the resume.

I also came to understand that research is not only about consuming knowledge but also about contributing to it. Even small-scale inquiries—whether observing patterns in perioperative responses, reflecting on patient outcomes, or questioning routine protocols—are integral to a research-oriented mindset. As van Raan[3] notes, knowledge production is cumulative and collaborative, embedded in context rather than isolated in individual studies. In anaesthesia practice, I see this reflected in how evidence, clinical expertise, and patient preferences intersect to guide safe and effective care. This is what we practise as evidence-based medicine.

Looking to the future, I believe research will play a transformative role in anaesthesia. Advances in genomics and pharmacogenetics promise personalised anaesthetic plans, reducing adverse effects and improving recovery. Research into enhanced recovery

protocols, regional anaesthesia, and opioid-sparing strategies is already reshaping standards of care towards safer, more patient-centred practice. Furthermore, research in global health is identifying innovative approaches to delivering safe anaesthesia in resource-limited settings, extending its impact beyond high-technology environments.

Although my evolving relationship with research began with a requirement to clear my examination, it has shifted from initial uncertainty to an active, reflective engagement. It has become clear to me that research is not simply the accumulation of facts but a mindset—one that requires openness, critical thinking, and humility. For clinicians, engaging with research is not optional but essential. It ensures that practice remains dynamic, responsive, and aligned with the evolving body of medical knowledge.

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Dr. Ankita

DNB ANAESTHESIA

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Anaesthesia Quiz

Q.1 A simple historical device consisting of a crystal ball for ether, a sponge & a wooden spout connected to the patient's mouth is known as?

- a) Clover's Inhaler
- b) Morton's Ether Inhaler
- c) Snow's Inhaler
- d) Schimmelbusch Mask

Q.2 A soft rubber bulb & a metal cone; an early precursor to modern LMAs was?

- a) Guedel Airway
- b) Leech Airway
- c) Jackson Rees
- d) Magill's Forceps

Q.3 Modified version of Etomidate with improved haemodynamic profile is?

- a) MOC-Etomidate
- b) Fospropofol
- c) Alphaxalone
- d) None of the above

Q.4 Ultra-short acting benzodiazepine recently introduced in anaesthesia is?

- a) Midazolam
- b) Diazepam
- c) Remimazolam
- d) Lorazepam

Q.5 Novel drug delivery system designed to improve precision & safety of drug administration is?

- a) Patient controlled analgesia (PCA)
- b) Target controlled infusion (TCI)
- c) Bispectral index (BIS)
- d) None

Q.6 NM blocker introduced in 1990s to replace Suxamethonium but later withdrawn due to side effects was?

- a) Rocuronium
- b) Mivacurium
- c) Rapacuronium
- d) Cisatracurium

Q.7 Water-soluble prodrug of propofol whose clinical use was limited by burning perineal pain is?

- a) Etomidate
- b) Fospropofol
- c) Ketamine
- d) Propanidid

Q.8 The context-sensitive half-time for propofol infusions of up to 8 hours is?

- a) <40 min
- b) 60 min
- c) >120 min
- d) <120 min but >60 min

Q.9 The preferred pathway for passage of nasal airway devices is?

- a) Inferior meatus
- b) Middle meatus
- c) Any of the above
- d) None

Q.10 Sellick's manoeuvre involves application of cricoid pressure during rapid sequence induction (RSI). The recommended force in adults is?

- a) 20N when awake; 40N after loss of consciousness
- b) 10N when awake; 30N after LOC
- c) 30N always
- d) None

Answer Key

Q1. b) Morton's Ether Inhaler

Q2. b) Leech Airway

Q3. a) MOC-Etomidate

Q4. c) Remimazolam

Q5. b) Target Controlled Infusion (TCI)

Q6. c) Rapacuronium

Q7. b) Fospropofol

Q8. b) 60 min

Q9. a) Inferior meatus

Q10. a) 20N when awake; 40N after loss of consciousness

Kaleidoscope

A tryst with..... Dr. Sunil Manohar Katkade

**Consultant Anaesthesiologist,
Ex-Chief Medical Director and
Advisor, Shree Mahavir Jain
Hospital, Thane, Mumbai
Ex- C.E.O., Solaris Hospital, Thane
ISA No. K0458**



Dr Sunil M. Katkade is a senior anaesthesia professional, guide and inspiration to many.

Hello Sir! Warm greetings from the ISA Newsletter "Vapour"!

You have been a versatile anaesthesia professional who has experienced various facets of our branch, including teaching in a medical college, being a busy practitioner anaesthetising patients in nursing homes, practising in corporate hospitals, and serving as a Medical Director, C.E.O., Advisor. Today, we have the opportunity to hear about your professional journey and obtain insights from these varied roles.

1. Please tell us about yourself. You started your career as a teacher. What challenges did you face in the early days of your profession?

Ans. I passed M.B.B.S. from Grant Medical College, Mumbai, in 1975. During my surgery posting as a medical student in 1973, I was deeply impressed by a team of anaesthesiologists who successfully resuscitated a patient who had suffered cardiac arrest on the operating table. That moment inspired me to pursue anaesthesiology.

My father passed away before I joined medical college, and my mother, a school teacher, supported our family. Alongside my studies, I worked in small jobs—as a chemist in a factory, a supervisor for school examinations, and a storekeeper—to support myself.

During my internship (1975), I administered sedation for an emergency caesarean section for a ruptured uterus under local anaesthesia. I also administered spinal anaesthesia and sedation for many tubectomies, which gave me early exposure to clinical anaesthesia practice.

I practised as a general practitioner for almost 40 years while simultaneously doing anaesthesia work. This dual practice allowed me to serve society and build lifelong bonds with patients and their families. My anaesthesia training enriched my general practice, and vice versa.

After completing my first year of residency, I was appointed as a Lecturer. In those days, many residents were promoted as lecturers for administrative reasons, although salaries for teachers were very low.

I began private anaesthesia practice in 1979. Over the years, I have served as an Honorary Assistant Professor at Grant Medical College, an Honorary Anaesthetist in Municipal Hospitals, and as a Consultant Anaesthetist in corporate hospitals.

The early days of practice posed many challenges. There was a lack of oxygen, nitrous oxide, and modern drugs, proper communication facilities (telephones, pagers, mobile phones, internet, or trained technicians). A landline telephone connection took 5–7 years, and obtaining a new oxygen cylinder took 3–4 years. I carried oxygen cylinders and a foot

suction machine in my car to manage emergencies. Power cuts, water shortages, and linen unavailability frequently led to the postponement of surgeries.

Facilities for academic growth were limited, with only a few books and journals in libraries, and fewer opportunities to present or attend conferences. Anaesthesia was practised without pulse oximeters, capnography, cardiac monitors, or advanced airway devices.

I often travelled by public transport, local trains, taxis, and even small boats to reach my patients. My anaesthesia kit always included bellows, instruments, and agents like Ethyl Chloride spray, Ether, Trilene, and Halothane.

Anaesthesia medications were purchased directly from manufacturers, and many drugs were often in short supply. We reused sterilised syringes, needles, and spinal/epidural sets after autoclaving or boiling. I also carried blood from blood banks when needed and helped organise surgeries such as orthopaedic, ENT, and ophthalmic procedures.

Many nursing homes lacked proper intensive care units(ICUs), so accepting high-risk elective patients was a major challenge.

To enhance safety, I invested my own finances and took loans to purchase ventilators, monitors, nerve locators, a video laryngoscope, a flexible fiberoptic laryngoscope and even a portable Cadet Boyle's anaesthesia machine.

2. You later shifted more towards private practice. Your professional career is dominated by private practice and teaching occasionally. Were you more inclined towards private practice or teaching?

Ans. I thoroughly enjoyed both roles—teaching and private practice. As an Assistant Honorary Professor in a medical college, I had the privilege of guiding young residents. Many of those who were interested in private practice would accompany me for cases, and I made it a point to teach them not just the science of anaesthesia, but also the art of practising it outside the academic setting. Sharing the nuances of private practice was deeply rewarding.

Alongside my academic commitments, I worked in corporate hospitals and built a thriving private practice. Private practice is in many ways an entrepreneurial journey. One becomes one's own boss, yet simultaneously remains dependent on colleagues for collaboration and success. As an entrepreneur, I was able to create opportunities for others to work and grow, which brought me immense satisfaction. Each aspect of my career offered unique joys. Teaching allowed me to stay connected with young minds, full of curiosity and energy, while private practice gave me independence, responsibility, and the fulfilment of directly serving patients. Both roles complemented each other, enriching my experience as a doctor.

Throughout my career, I worked sincerely and gave my maximum efforts to both professions, always striving to balance service, learning, and growth.

3. During your teaching career, were you involved in research work? Kindly share your experience as a researcher.

Ans. I had certain limitations in pursuing extensive research work. At that time, cardiovascular anaesthesia was an emerging super-speciality. We were actively involved in pioneering work on beating-heart surgeries. Most of the patients were critically ill, and valve replacement was the most common cardiac procedure.

We explored the use of epidural analgesia for postoperative pain relief in cardiac surgical patients.

We also attempted epidural analgesia for painless labour in women with cardiac disease. Labour analgesia itself was an emerging technique for painless childbirth. Unfortunately, we did not have access to disposable epidural sets or Tuohy needles. Instead, we used simple blunt lumbar puncture needles, autoclaved polythene tubes, and Inj. Lidocaine for epidural analgesia.

I presented several papers at state and national conferences, covering topics such as the use of ventilators, safe transport of patients, and

critical care.

Many of these papers were based on my private practice experiences.

I also uploaded instructional videos on the use of videolaryngoscopes to YouTube.

Unfortunately, data collection and maintenance during those years were not as systematic as today.

Over the years, I also guided many resident doctors in preparing their dissertations.

4. If given a chance, would you opt for more research work? What are the reasons that deter private practitioners from taking up research work? How can practitioners keep themselves updated academically?

Ans. Yes, I will surely do more research work. Many reasons deter private practitioners from researching, such as erratic working hours and lack of access to great libraries.

They do not attend the conferences or make presentations in the conferences.

The new gadgets or instruments are expensive. They have more faith in the drugs or inhalation anaesthetic agents that they have used. There is a lack of funds, motivation, time, infrastructure, accessibility to scientific journals, and functional ethical committees in the hospitals that they visit.

To practise research widely, they have to broaden their sources by exploring interdisciplinary perspectives and reading beyond their immediate field.

They must use academic databases and library resources to find scholarly articles and review papers,

The practitioner must engage with experts by discussing ideas and attending conferences, conducting personal experiments or tackling real-world problems to build their own practice and curiosity.

They must follow guidelines, participate actively in local C.M.E.s, webinars etc.

5. Do you agree that research is necessary for clinical practice and vice versa? What is your take on this statement?

Ans. Research and clinical practice are interdependent and mutually necessary;

research provides the evidence-base and innovative treatments that inform clinical practice. Clinical practice generates real-world data, identifies gaps in knowledge, and offers insights into patient needs that drive new research. This symbiotic relationship, often referred to as evidence-based medicine, ensures continuous improvement in patient care by using the best available evidence, clinical expertise, and patient needs to guide decision-making and develop more effective interventions.

6. Do you think research remains limited only to medical colleges or central institutes, i.e., institutes of national importance? Can it be practised more widely?

Ans. Yes. I agree that the research remains limited only to medical colleges or central institutes, i.e., institutes of national importance. Surely, it can be practised more widely. I also feel that private practitioners should be allowed to work in teaching institutes as visiting faculty, assistant honorary, etc., and private practising anaesthesiologists must take advantage of academic opportunities.

7. Do you believe private practitioners in anaesthesia can design research studies based on their clinical observations? How can they contribute to research?

Ans. Yes, private anaesthesia practitioners can definitely design and conduct research based on their clinical observations. They can contribute significantly to research by identifying unmet clinical needs, collecting real-world data, fostering innovation, and bridging the gap between clinical practice and larger academic research. Their direct experience offers unique insights into patient care, helping to generate hypotheses and gather valuable data that might be missed in other settings.

How Can Private Practitioners Design and contribute to Research?

- **Identify Clinical Questions:**

They can observe gaps in current anaesthesia practices, patient responses to treatments, or unique patient populations that they encounter.

- **Formulate Hypotheses:**

These observations can lead to well-defined research questions and testable hypotheses about improving patient outcomes or understanding new clinical phenomena.

- **Design Methodologies:**

They can design studies, including retrospective analyses of patient data, prospective observational studies, or even small-scale clinical trials, ensuring they adhere to ethical guidelines and patient consent requirements.

- **Utilise Data:**

They can leverage anonymised patient data from their practice to explore patterns, identify trends, and investigate new treatment approaches.

- **Collaborate and Disseminate:**

They can partner with academic institutions or research bodies to gain access to resources and expertise for larger projects. They can also present their findings at conferences or in peer-reviewed journals to share their knowledge with the wider anaesthesia community.

- **Real-World Data Collection:**

Private practitioners are uniquely positioned to gather diverse, real-world data from various patient groups and clinical scenarios, providing valuable insights not always available in academic settings.

- **Innovation in Practice:**

By identifying unique clinical challenges and proposing evidence-based solutions, they can drive innovation and contribute to developing new anaesthetic techniques and protocols.

- **Bridging the Gap:**

They are a vital link between the frontline clinical practice and academic research, translating theoretical knowledge into practical application and vice versa.

- **Improving Patient Outcomes:**

Their research can lead to improved patient safety, better pain management strategies, and more effective anaesthesia delivery, directly enhancing the quality of care.

- **Mentorship and Education:**

Their direct experience can be invaluable for training and educating junior anaesthesiologists and other healthcare professionals, fostering

a culture of continuous learning and evidence-based practice.

8. You have also served as a medical director, managed projects, and made Standard Operating Protocols (SOPs). Has your experience in anaesthesia helped you in this administrative role?

Ans. Yes. My experience in anaesthesia greatly contributed to my role as an administrator. I became fluent in managing hospital operations, ICUs, and emergencies. I consistently encouraged nursing and paramedical staff to acquire new skills, raising the overall standard of care.

I served as Chief Medical Director & Advisor to a new multispeciality hospital and as CEO of a super speciality hospital. As a disciplined administrator, my focus was always on helping patients and improving healthcare delivery. I played a key role in establishing several super-speciality departments, including neonatal ICU, Cardiac Surgery, and Kidney Transplant units.

During both the coronavirus disease (COVID)-19 pandemics, I worked tirelessly on all fronts. My efforts were widely appreciated and recognised by authorities. I organised donations from Indian and international donors, acquiring critical equipment such as ventilators, oxygenators, and high flow nasal oxygen (HFNO) machines. At the same time, I ensured that doctors and staff were well supported and cared for.

My leadership extended beyond the hospital as well. As President of the Rotary Club, I initiated programmes that benefited needy patients and families.

I also had the privilege of being:

- **Founder & President of I.S.A., Thane**
- **Founder & Chairman of I.S.C.C.M., Thane**
- **President & Office Bearer of Rotary Club**
- **Executive Member of I.M.A., Thane**

These positions significantly shaped and strengthened my leadership qualities, allowing me to balance clinical expertise, administrative efficiency, and compassionate service.

9. If given a chance, would you prefer being a practitioner, teacher, researcher, or administrator?

Ans. Each path has its own flavour and impact:

- **Practitioner** → Hands-on, directly helping people, solving problems in real time. Very fulfilling if you enjoy seeing the results of your work immediately.
- **Researcher** → Discovering new knowledge, innovating, pushing boundaries. Best if you like curiosity, patience, and creating long-term impact.
- **Teacher** → Sharing knowledge, shaping minds, inspiring others. Great if you enjoy mentoring, communication, and seeing others grow.
- **Administrator** → Leadership, management, building systems and organisations. Suits people who like strategy, coordination, and decision-making.

I want to work as a practitioner and join a teaching institute or corporate hospital as a visiting faculty. I would like to spend two to three days per week in the institute. I will also take an active part as administrator.

10. You have contributed a lot to ISA. How can ISA encourage private practitioners to participate more in academic and research activities?

Ans. The Indian Society of Anaesthesiologists (ISA) can encourage private practitioners in many ways.

1. Professional Development-

CME programmes, workshops, and conferences to stay updated with the latest techniques, drugs, and guidelines.

ISA webinars and online modules for continuous learning.

Access to the Indian Journal of Anaesthesia (IJA) for research updates and case studies.

2. Networking & Collaboration

Connects anaesthetists across India for sharing experiences, referrals, and mentorship.

Opportunities to collaborate in research, multicentre studies and clinical trials.

3. Advocacy & Representation

Represents anaesthetists' interests at national and state medical bodies.

Works on improving recognition of anaesthesiology as a specialty and ensuring fair working conditions.

Provides legal and professional support in case of disputes or medico-legal issues.

4. Practice Support

ISA publishes guidelines for safe anesthesia practice in India (e.g., COVID protocols, perioperative care, monitoring standards).

Helps standardise protocols and improve patient safety.

Promotes use of checklists and quality assurance practices.

5. Recognition & Career Growth

Awards, fellowships, and orations for outstanding contributions.

Support for young anaesthesiologists through ISA trainee sessions.

6. Community & Public Awareness

Organises public education campaigns (e.g., importance of anaesthesia, pain medicine, ICU care).

Helps in projecting anaesthesiologists as perioperative physicians rather than just operation theatre (OT) doctors.

In short, ISA acts as a knowledge hub, support system, and advocacy body for practising anaesthetists, ensuring that they grow academically, professionally, and socially.

11. What advice would you give to today's anaesthesia practitioners and teachers in India?

Ans. To today's anaesthesia practitioners, I would advise constant updating of skills, strict adherence to safety protocols, and compassionate patient care beyond the operating room. They must take care of their health, family. They can try to become entrepreneurs by starting their pain clinics, hospital etc. They must generate their passive source of income.

To teachers, I would emphasise the importance of inspiring curiosity, mentoring with patience, and preparing trainees not just as skilled anaesthetists but also as critical thinkers,

communicators, and leaders of tomorrow. I also request them to guide their past students in practice

12. Many are of the opinion that private practitioners should spend time documenting and publishing case reports. What is your opinion on this?

Ans. Yes. I agree that private practitioners should spend some time documenting and publishing their own case reports. They should also devote more time to research, as it helps them stay updated with advances in medical science, improves patient outcomes, and contributes valuable real-world clinical data to the medical community.

I sincerely thank the Editor-in-Chief, Dr. Sukhminder Jit Singh Bajwa, and the entire editorial team of VAPOUR for giving me this opportunity and featuring me on this prestigious podium of Kaleidoscope.

Thank you sir. We are grateful to you for your amazing inputs. You are a guiding light and beacon of inspiration for us.

**Editorial team
VAPOUR**



With Mother Teresa



Emergency Flood relief camp planning



With honourable Shri Eknathji Shinde



With Shri Chidambaram



With Dr. Ronald Miller



With Padma Vibhushan Anil Kakodkar



72nd Annual Conference of the Indian Society of Anaesthesiologists

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CONFERENCE HIGHLIGHTS

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Discover breakthroughs redefining perioperative care.



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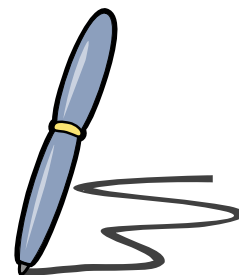
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INVITATION TO CONTRIBUTE



‘Vapour’, the official newsletter of the Indian Society of Anaesthesiologists invites contribution of articles originally written by ISA members (Life and associate). The articles can be in the form of interesting case reports for discussion, articles on topics of current clinical relevance, photo-essays, articles on medicolegal /health/ financial/extracurricular issues of interest to the anaesthesiologists. Original literary works such as poems, funny cartoons or paintings on topics of anaesthesia are also welcome. Information about extraordinary achievements /experiences of ISA members, book publication can be sent.

The articles should be brief and written in font Times New Roman 12-14 size and presented in Microsoft office word document (rtf/doc files). Plagiarism and violation of copyrights should be strictly avoided. The articles should be e-mailed to isanhqvapour@yahoo.com with a covering letter addressed to the Honorary Secretary ISA National.

Dr Sukhminder Jit Singh Bajwa

Honorary Secretary, ISA National

&

Editor-in-Chief

VAPOUR

(The official newsletter of the ISA National)

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