Jaipur MID TERM Pida 2025

PEDIATRIC INFECTIOUS DISEASE ACADEMY CONFERENCE

HOSTED BY IAP JAIPUR

Date : 05th & 06th July 2025 | Venue : Rajasthan International Centre (RIC) Jaipur

THEME: PEDIATRIC INFECTIONS: EMERGING THREATS, EVOLVING STRATEGIES

Date : 05th & 06th July 2025

Venue : Rajasthan International Centre (RIC), Jaipur

Souvenir

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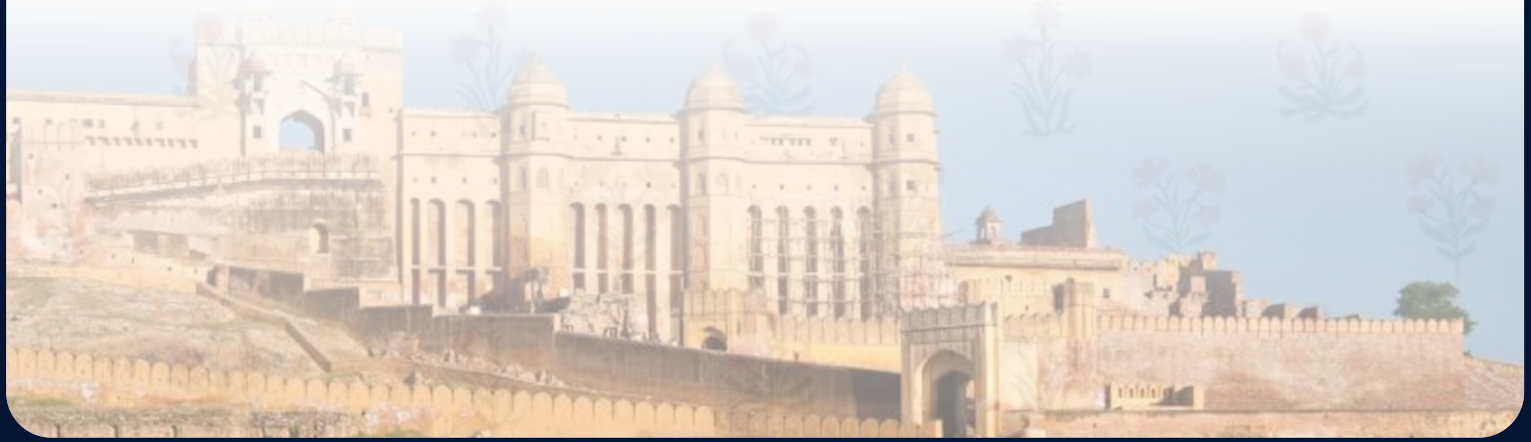
Scientific Program

DAY 01 | 05TH JULY 2025 | SATURDAY					
HALL A					
TIME	**TYPE OF SESSION / DURATION**	**TOPIC**	**SPEAKER / MODERATOR**	**PANELIST**	**CHAIRPERSON**
08:00 - 09:00 HRS	**BREAKFAST & REGISTRATION**				
09:00 - 09:15 HRS	**GUEST LECTURE** / 15MIN EACH	HEPATITIS SEROLOGY	DR.PRITI VIJAY		DR. RAMBABU SHARMA DR. A K KAMDAR DR. ATUL SHANKER
09:15 - 09:30 HRS		INFECTIVE ENDOCARDITIS IN CHD: DIAGNOSTIC AND THERAPEUTIC DILEMMAS	DR.SANJAY KHATRI		
09:30 - 09:45 HRS		MALARIA TODAY-PEDIATRIC MALARIAL UPDATE	DR.R K MAHESHWARI		
10:00 - 10:45 HRS	**PANEL DISCUSSION** / 45MIN	NEONATAL SEPSIS - EARLY RECOGNITION, TAILORED THERAPY AND PROPHYLAXIS	DR.KHEYA GHOSH UTTAM	DR. VARUN KUMAR SHARMA DR. SURENDER SINGH BISHT DR. VIVEK ATHWANI DR. GUNJANA KUMAR DR. JAI SINGH	DR. NEHA AGARWAL DR. YOGESH VIJAY DR. SAURABH SINGH
10:45 - 11:10 HRS	**GUEST LECTURE** / 25MIN EACH	LATEST UPDATES IN DENGUE PREVENTION	DR.CHETAN TRIVEDI		DR. B.K JAIN DR. PARMESHWARI MISHRA DR. ATUL HEDA
11:15 - 12:00 HRS	**PANEL DISCUSSION** / 45MIN	CULTURE & BEYOND - STRIVING CLARITY IN ID	DR. SHYAM KUKREJA	DR. MANISHA GOYAL DR. DINESH TOMAR DR. PANKAJ AGARWAL DR. RAMESH CHOUDHARY DR. DHIRAJ MOHAN GUPTA	DR. BHARAT BHUSHAN GUPTA DR. VIVEK SHARMA DR. SUNIL AGARWAL
12:00 - 12:15 HRS	**GUEST LECTURE** / 15MIN EACH	COMPLICATIONS OF BCG	DR.RITABRATA KUNDU		DR. B M RATURI DR. KUSUM DEVPURA DR. A A PATHAN
12:15 - 12:30 HRS		FEVER WITH LYMPHADENOPATHY	DR.CHETAN TRIVEDI		
12:30 - 13:10 HRS	**DR TAPAN GHOSH MEMORIAL ORATION**	RABIES RIDDLES TOWARDS ONE HEALTH	DR.JAYDEEP CHOUDHURY		DR. BHASKAR SHENOY DR. CHETAN TRIVEDI
13:15 - 13:55 HRS	**PANEL DISCUSSION** / 40MIN	"FEVER WITHOUT FOCUS" – PRACTICAL APPROACH BEFORE EMPIRICS	DR.SANJAY GHORPADE	DR. M SURENDRANATH DR. B L MEGHWAL DR SANJAY DESHMUKH DR.GAURAV GOMBER DR. NEHA AGARWAL	DR. SUBHASH BHARDWAJ DR. KIRTI VISHWAKARMA DR. KULDEEP SINGH DR.RAJIV JAIN

14:00 - 14:15 HRS	**GUEST LECTURE**	DENGUE CONUDRUM- SCIENTIFIC PERSPECTIVE ON MARKERS OF SEVERITY	DR. B NANDEESH		DR. DEEPAK SHIVPURI DR. SUSHIL SANGHI DR. YOGRAJ KHINCHI
14:15 - 14:30 HRS		PICTORIAL PEDIATRICS ID	DR. RANGANATH DARURU		
14:30 - 14:50 HRS		JE- FREE TOMORROW: THE POWER OF PREVENTION TODAY (BHARAT BIOTECH)	DR. ROHIT AGARWAL		
14:55 - 15:35 HRS	**PANEL DISCUSSION** / 40MIN	DON'T MISS - INFECTION MIMICS	DR. BHASKAR SHENOY	DR. JANANI SANKAR DR. CHIRAG SETHI DR. RAKESH JORA DR. ABHAY SHIVPURI DR. ASHWANI K SOOD	DR. ANIL BHANDARI DR. D K NIRMAL DR. PIYUSH KUMAR BANSAL
15:40 - 16:00 HRS	**GUEST LECTURE** / 20MIN	INFANTILE COLIC: CAN PROBIOTICS OFFER GENTLE RELIEF? (SPONSORED SESSION - ARISTO)	DR. NEELAM MOHAN		DR. ROHIT AGARWAL DR. R K AGARWAL DR. CB DASS GUPTA
16:00 - 16:40 HRS	**PANEL DISCUSSION** / 40MIN	STANDARDISING THE APPROACH TO BONE AND JOINT INFECTIONS	DR M RAVISHANKARA	DR. NEELI RHRSCHANDER DR. RAJAT MALOT DR. KAPIL GANGWAL PROF (DR) NC PRAJAPATI DR. ALOK BHANDARI	DR. ASHOK KHANDELWAL DR. SHISHER AGARWAL DR. SAHAJ PRAJAPATI
16:40 - 17:00 HRS	**DEBATE** / 20MIN	LOW DOSE VS HIGH DOSE AMOXYCILLIN IN AOM	"DR. PRIYANSHU MATHUR - FOR VS DR. SHEKHAR BISWAS - AGAINST"		DR. MADHU RATURI DR. USHA ACHARYA DR. GHANSHYAM SWAMI
17:00 - 17:40 HRS	**PANEL DISCUSSION** / 40MIN	PERINATAL INFECTIONS AND NERURODEVELOPMENTAL OUTCOME	DR. SAMIR DALWAI	DR. GEETA PATIL DR. RUCHIRA GUPTA DR. ANURAG SINGH DR. PREETI GALAGALI DR. JOGINDER DHANKHAR	DR. SWATI GHATE DR. VARNIT SHANKER DR. ALOK CHAUDHARY
18:30 - 19:30 HRS	**INAUGURAL FUNCTION**				
19:30 HRS	**BANQUET**				

DAY 01 | 05TH JULY 2025 | SATURDAY					
HALL B					
TIME	**TYPE OF SESSION / DURATION**	**TOPIC**	**SPEAKER / MODERATOR**	**PANELIST**	**CHAIRPERSON**
08:00 - 09:00 HRS	**BREAKFAST & REGISTRATION**				
09:00 - 09:15 HRS	**GUEST LECTURE** / 15MIN EACH	THE CHAMELEON VIRUS - ADENOVIRUS	DR.KHEYA GHOSH UTTAM		DR. SURENDRA SONKHIYA DR. ASHOK KASLIWAL DR. S.P. SUDRANIA
09:15 - 09:30 HRS		ANGRY AND ITCHY - SKIN AND SOFT TISSUE INFECTIONS	DR. RAM KUMAR GULATI		
09:30 - 09:45 HRS		"THE COMEBACK BUGS" – MYCOPLASMA AND THE RESURGENCE OF ATYPICAL INFECTIONS	DR. BHASKAR SHENOY		
10:00 - 10:40 HRS	**PANEL DISCUSSION** / 40MIN	ZOONOTIC DISEASE	DR.SANJAY GHORPADE	DR. ALOK GUPTA DR. SONIA BHATT DR. MANMEET SODHI DR.AMOL PAWAR DR. ATANU BHADRA	DR. USHA SHARMA DR. ANUPAM CHATURVEDI DR. KAILASH MEENA
10:45 - 11:10 HRS	SPONSORED SESSION	INFECTIONS THAT SILENCE THE CELLS - UNMASKING APLASTIC ANEMIA (BHARAT SERUMS AND VACCINES LTD)	DR. KAPIL GARG		DR.RAJESH PATHAK DR. VIKAS BARSARA DR. VIKAL CHACHAN DR. R L SUMAN
11:00 - 11:15 HRS	**GUEST LECTURE** / 15MIN	"BEYOND THE USUAL BUGS - THINK BRUCELLA!"	DR. P C KHATRI		DR. BABU LAL MEENA
11:15 - 11:55 HRS	**PANEL DISCUSSION** / 40MIN	NON RESPONDING DIARRHOEA	DR. UDAY PAI	DR. AASHAY SHAH DR NATWAR PARWAL DR GAURAV AGARWAL DR. N K BHAT DR. LAXMAN SINGH CHARAN	DR. PARAG GOYAL DR MAHESH MEENA DR SHYAM SUNDAR SHARMA DR ARIHANT JAIN
12:00 - 12:25 HRS	**GUEST LECTURE** / 25MIN	TINY LIVERS, BIG CHALLENGES- PAEDIATRIC LIVER ABSCESS: DIAGNOSTIC AND MANAGEMENT CHALLENGES	DR. NEELAM MOHAN		DR. DHANANJAY MANGAL DR JAYDEEP MATHUR DR. KULDEEP SAHAI
12:30 - 13:10 HRS	**ORATION**	HALL A			
13:15 - 13:55 HRS	**PANEL DISCUSSION** / 40MIN	TACKLING RESISTANT INFECTION IN THE PEDIATRIC ICU-STRATEGIES, STEWARDSHIP AND SOLUTION	DR. DAISY KHERA	DR M SINGARVELU DR. G. V. BASAVARAJA PROF. ANANDA KESAVAN.T.M. DR.ARAKALA BHASKAR DR. ABHIJIT ARI	DR. PRASHANT MITHARWAL DR. ARUN KUMAR SURA DR. RAVI SHARMA



14:00 - 14:15 HRS	**GUEST LECTURE** / 15MIN EACH	NON MYCOBACTERIUM TUBERCULOSIS	DR. SUNIL KUMAR AGARWALLA		DR. O P GAUR DR. AMRITA SETHI DR. ANIL KHICHAR
14:15 - 14:30 HRS		DILI DUE TO TB DRUG THERAPY	DR. VAIBHAV SHAH		
14:30 - 14:45 HRS		WORMS IN THE BRAIN: UNMASKING THE SILENT INVADER	DR. S SITARAMAN		
14:55 - 15:35 HRS	**PANEL DISCUSSION** / 40MIN	POCT(POINT OF CARE TEST) IN PAEDIATRIC INFECTIOUS DISEASE	DR. MAHESH MOHITE	DR. G S TANWAR (BIKANER) DR. CHANDRA MOHAN KUMAR DR. MANISH SHARMA DR. SUNIL DUTT SHARMA	DR.MANJEET SINGH DR. KULDEEP SINGH BITHU DR. ASHOK CHANDAK
16:00 - 16:40 HRS	**PANEL DISCUSSION** / 40MIN	PEDIATRIC MENINGITIS AND ENCEPHALITIS. HOW FAR SHOULD WE GO WITH DIAGNOSTICS?	DR. SHARAD SHARMA	DR.MEENAL GARG DR. KARUNAKARA BP DR. G. V. BASAVARAJA DR. DILEEP SETHI DR. JUHI GUPTA	DR. DHEERAJ SHARMA DR P R CHAUDHARY DR G P KAUSHAL DR. RAMESH SETHIA
16:40 - 17:20 HRS	**PANEL DISCUSSION** / 40MIN	ERRORS IN VACCINATION: MISSED DOSES MIXED MESSAGES, AND MEDICAL ERRORS	DR. SUMITHA NAYAK	DR. HIMABINDU SINGH DR. KULBHUSHAN GUPTA DR. RAJIV KUMAR BANSAL DR. LALIT MENDIRATTA DR. JANANI SANKAR	DR. SHYAM SUNDAR AGARWAL DR. O P BALODIA DR. HARI RAM MEENA
17:30 - 18:30 HRS	**EB MEETING**				
18:30 - 19:30 HRS	**INAUGRATION AT HALL A**				
19:30 HRS	**BANQUET**				

DAY 02 | 06TH JULY 2025 | SUNDAY					
HALL A					
TIME	**TYPE OF SESSION / DURATION**	**TOPIC**	**SPEAKER / MODERATOR**	**PANELIST**	**CHAIRPERSON**
08:00 - 09:00 HRS	CHAI PE CHARCHA/ 60MIN	PRIORITIES AND PRACTICALITIES – VACCINE	DR. MOHIT VOHRA		DR. JAGVEER SINGH DR. RAJINDER SINGH SIHAG DR. VIVEK GUPTA
09:00 - 09:25 HRS	**GUEST LECTURE** / 25MIN EACH	COMMONLY USED ANTIFUNGAL IN PAEDIATRICS	DR. A J CHITKARA		
09:25 -09:50 HRS		DECODING PICU INFECTION	DR. MANINDER SINGH DHALIWAL		
10:00 - 10:45 HRS	**PANEL DISCUSSION** / 45MIN	ANTIVIRALS IN OPD	DR. UPENDRA KINJAWADEKAR	DR. RUPESH MASAND DR. ASHOK GUPTA DR. PANKAJ KUMAR PROF. AJAY KUMAR (SAFDARJUNG) DR. DEVAJIT KUMAR SHARMA	DR. DEEPENDRA GARG DR. JITENDRA BHAMBOO DR. S P SETHI
10:45 - 11:10 HRS	**MOBILE PHONE QUIZ ON VACCINOLOGY**	VACCINE SAMVAD	DR. CHETAN TRIVEDI DR. NITIN SHAH		
11:15 - 12:00 HRS	**PANEL DISCUSSION** / 45MIN	SPOT THE RASH	DR. ABHAY SHAH	DR. B S KARNAWAT DR. VINOD DURGADAS GANDHI DR. KUSUM KALLA DR. YOGESH JOPAT	DR. HARPREET SINGH DR HEMANT TIWARI DR. KAPIL SHARMA
12:00 - 12:20 HRS	**GUEST LECTURE**	REAL-LIFE NICU INFECTION CASE SCENARIO WITH AUDIENCE PARTICIPATION	DR. SUMIT CHAKRAVARTY		DR. ALOK TYAGI DR ARUN SAXENA DR. LOKESH AGARWAL DR. GANESH CHOUDHARY
12:20 - 12:35 HRS	SPONSORED SESSION	ROLE OF PROCALCITONIN IN PICU (THERMOFISHER)	DR. PUNEET JAIN		
12:40 - 13:30 HRS	**PANEL DISCUSSION** / 50MIN	RATIONAL ANTIBIOTICS IN OFFICE PRACTICE	DR. VIJAY N YEWALE	DR. ROHIT AGARWAL DR. PRAMOD M KULKARNI DR. SHIKHA GARG DR. SAMIR R SHAH DR. JEETENDRA GAVHANE	DR. MADHU MATHUR DR. ANIL KUMAR TIWARI DR. SARVESHWAR AGARWAL
13:30 - 13:50 HRS	**GUEST LECTURE** / 20MIN EACH	CNS INFECTION IN NEONATES	DR. BIRAJ NANDINI THAKKAR		DR. ANURAG SHARMA DR. VINAY GILL DR. SHELIN SHARMA
13:50 - 14:10 HRS		CHIKUNGUNYA CHRONICLES	DR. AJIT SAXENA		
14:15 - 14:25 HRS	SPONSORED SESSION	GUT MICROBIOME IMBALANCE DUE TO ANTIBIOTIC EXPOSURE (SANOFI PROBIOTIC)	DR. J.K MITTAL		DR. AJAY KABRA DR. SANJAY GUPTA DR KIRAN PABARI DR VARUN SABOO
14:25 - 14:55 HRS		APPROACH TO A PANCYTOPENIA IN AFEBRILE CHILD-CASE BASED	DR. NITIN SHAH		DR. ARVIND KUMAR DR. HARIOM RAWAT
15:40 - 16:00 HRS	**ID QUIZ HALL B**				
16:00 HRS	**VALEDICTORY**				
16:30 HRS	**HI TEA**				

DAY 02 | 06TH JULY 2025 | SUNDAY					
HALL B					
TIME	**TYPE OF SESSION / DURATION**	**TOPIC**	**SPEAKER / MODERATOR**	**PANELIST**	**CHAIRPERSON**
08:00 - 09:00 HRS	CHAI PE CHARCHA	HALL A			
09:00 - 09:25 HRS	**GUEST LECTURE** / 25MIN EACH	WORMS AND GERMS" – HELMINTHS AND HIDDEN THREATS	DR. LALIT BHARADIA		DR.VIKAS SHARMA DR. LUVDEEP DOGRA DR. ANSHUL MITTAL
09:25 - 09:50 HRS		UTI: WHAT'S NEW IN TREATMENT GUIDELINES	DR. A S VASUDEV		
10:00 - 10:40 HRS	**PANEL DISCUSSION** / 40MIN	CLEARING THE COBWEB – IMMUNISATION DIALOGUE	DR. S G KASI	DR. FAUZIA ARIF DR. RAMESH BAJANIA DR. ASHISH AGARWAL DR. RAJKUMAR GOYAL DR. TARUN PATNI	DR. HARISH KUMAR PEMDE DR. RAJESH HALWAI DR. RAJESH SOMARA
10:45 - 11:00 HRS	**GUEST LECTURE** / 15MIN	HEPATIC HAVOK - LIVER INVOLVEMENT IN TROPICAL ID (MALARIA, DENGUE, LEPTOSPIROSIS AND TYPHOID)	DR. SHIVANI DESWAL		DR. YATISH SINGH DR. UMANG UPADHYA DR. G C MITTAL
11:00 - 11:25 HRS	**GUEST LECTURE** / 25MIN	CONGENITAL TORCH INFECTIONS:WHATS NEW AND WHAT'S STILL MISSED?	DR. SANJAY WAZIR		
11:25 - 12:10 HRS	**PANEL DISCUSSION** / 45MIN	BREATHING BATTLES - AIRWAY INFECTIONS AND PAEDIATRIC LUNG CHALLENGES	DR. SUBRAMANYA N K	DR NEETU TALWAR DR. MUKESH GUPTA (JAIPUR) DR. SATISH SHARMA DR. SAPNA TANEJA DR. SANDIP TRIVEDI	DR.VIRENDRA MITTAL DR. B.S SHARMA DR. JAGDEESH SINGH MEENA
12:10 - 12:30 HRS	SPONSORED 20 MIN	CHANGING LANDSCAPE OF RSV PREVENTION WITH NIRSEVIMAB FOR ALL INFANTS - SANOFI DRL	DR. VIJAY N YEWALE		DR. MANISH MITTAL DR. JAWAHAR BHAKRU DR. MONISHA SAHAI DR. S D SHARMA
12:30 - 13:10 HRS	**PANEL DISCUSSION** / 40MIN	NON RESPONDING PNEUMONIA	DR MANISH MEHTA	DR. RAVISHANKARA M DR. A.YASHOWANTH RAO DR K OBULA REDDY DR.ANURAG AGARWAL DR. PRITY SHARMA	DR. ANURAG TOMAR DR. R.S RINWA DR. SHEO BACHAN SINGH
13:15 - 13:30 HRS	**GUEST LECTURE** / 15MIN	FECAL CALPROTECTIN INPEDIATRIC GI INFECTION A MARKER OR MISLEADER	DR. NISHANT WADHWA		DR. RAJESH MATHURIA DR. ALOK GOYAL DR. S.D.SHARMA (MDD)
13:30 - 13:45 HRS		MIC BREAKPOINTS	DR. MEENAKSHI DEY		
13:45 - 14:00 HRS		XPERT CARBA R TEST	DR RAVIKANT PORWAL		

Message from President-Elect - IAP

President-Elect, Indian Academy of Pediatrics (IAP)

It is with immense admiration and joy that I pen this message as Guest of Honour for the **PIDA – MIDTERM 2025 Conference**, hosted by IAP Jaipur.

With the theme, **"Pediatric Infections: Emerging Threats, Evolving Strategies,"** this scientific gathering goes beyond the expectations of a midterm meeting—it truly reflects the spirit and depth of a national-level academic event. The scale, structure, and scholarly finesse of this conference are not only inspiring but also a testament to what focused leadership and collective intent can accomplish.

What strikes me most is the thoughtful curation of the scientific program. It is both comprehensive and contemporary, addressing pressing challenges in pediatric infectious diseases while embracing innovation and evidence-based updates. From malaria, dengue, tuberculosis, and zoonotic threats, to antimicrobial resistance, PICU infections, vaccine dilemmas, helminths, TORCH infections, and fecal calprotectin, the breadth of topics is remarkable. The panels delve deep—from common outpatient infections to critical care dilemmas, from rational antibiotic use to emerging diagnostics and even included neonates—leaving no stone unturned in enriching pediatricians at every level of practice.

The inclusion of oral and e-poster presentations encourages participation from young minds and researchers, making this conference a vibrant platform for mentorship and academic growth. It promotes not only knowledge exchange but also scientific inquiry, curiosity, and community building.

I extend heartfelt congratulations to the Organising Chairperson **Dr. Atul Shanker,** Chief Organising Secretary **Dr. Mohit Vohra,** Co-Organising Secretaries Dr. S. P. Sethi and Dr. Anurag Tomar, Treasurer Dr. Neha Agarwal & Dr. Shikha Garg (Souvenir)—for the stupendous efforts, meticulous planning, and unflinching dedication. I would sincerely congratulate the PIDA team Dr. Bhaskar Shenoy and Dr. Chetan Trivedi for their guidance on scientific content.
To all the delegates and speakers: may this conference ignite new collaborations, refresh perspectives, and renew our commitment to protect and heal the children we serve.
Indeed, **Jaipur shines not only in heritage but also in academic excellence and infectious enthusiasm!**

Dr. Neelam Mohan
President Elect – Indian Academy of Pediatrics
Senior Director – Department of Pediatric Gastroenterology
Hepatology & Liver Transplantation
Medanta The Medicity, Gurugram

Message from Organizing Chairperson

Dear Colleagues,

It gives me immense pleasure to welcome you all to the PIDA MIDTERM Infectious Diseases Conference 2025, hosted in the vibrant city of Jaipur on the 5th and 6th of July. This midterm meet is not just a confluence of academic exchange but a celebration of our collective journey in pediatric care.

Infectious diseases continue to pose a significant challenge in pediatric practice and through this conference we aim to address these evolving concerns with clarity, evidence and collaboration. We are privileged to host renowned faculty and enthusiastic delegates, all committed to the cause of child health.

This souvenir is a humble heartfelt tribute to our fraternity. It brings together a spectrum of contributions — from insightful academic articles to thought-provoking non-academic reflections, poems and lived experiences. A special highlight is "Kal Aaj Kal", capturing inspiring glimpses from the lives of our senior-most IAPians whose dedication continues to inspire the younger generation.

I extend my deepest appreciation to the souvenir team —
Dr. Shikha Garg, Dr. Kiran Pabri, Dr. Lalita Kanojiya, Dr. Manisha Goyal, and Dr. Mohit Vohra — for their creativity, diligence, and passion in bringing this edition to life. Your efforts have truly woven the spirit of the conference into these pages.

As we turn each page, may we find knowledge, nostalgia, inspiration, and joy — and may this souvenir serve as a keepsake of camaraderie and learning that defines our vibrant pediatric community.

With warm regards,

Dr. Atul Shanker
Organizing Chairperson
PIDA MIDTERM ID CONFERENCE – 2025
President, IAP Jaipur Branch

Message from President-Elect - IAP - Jaipur

Message from the President Elect, IAP Jaipur

It gives me immense pleasure to welcome you all to the Annual Conference of Pediatric Infectious Diseases being held in the vibrant and historic Pink City, Jaipur, on the 5th and 6th of July 2025.

This conference is a vital platform for pediatricians, infectious disease experts, and healthcare professionals to exchange knowledge, share best practices, and discuss the evolving landscape of pediatric infectious diseases. As we continue to navigate new challenges in pediatric care, including antimicrobial resistance, emerging infections, and post-pandemic implications, such academic gatherings are more important than ever.

I am confident that the scientific sessions, discussions, and collaborations during this conference will not only enrich our understanding but also strengthen our collective efforts to improve child health outcomes across the region and beyond.

On behalf of IAP Jaipur, I extend my heartfelt gratitude to the organizing committee for their tireless efforts and to all delegates for their participation. I hope you take back valuable insights and fond memories from your time in Jaipur.

Wishing the conference grand success.

Warm regards,

Dr.Dhananjay K Mangal
President Elect(25-26),IAP Jaipur
Annual Conference on Pediatric Infectious Diseases, PIDA 2025

Message From Chief Organizing Secretary

Chief Organizing Secretary's Message

It is with immense pride and heartfelt joy that I welcome you all to the Pediatric Infectious Disease Conference 2025.

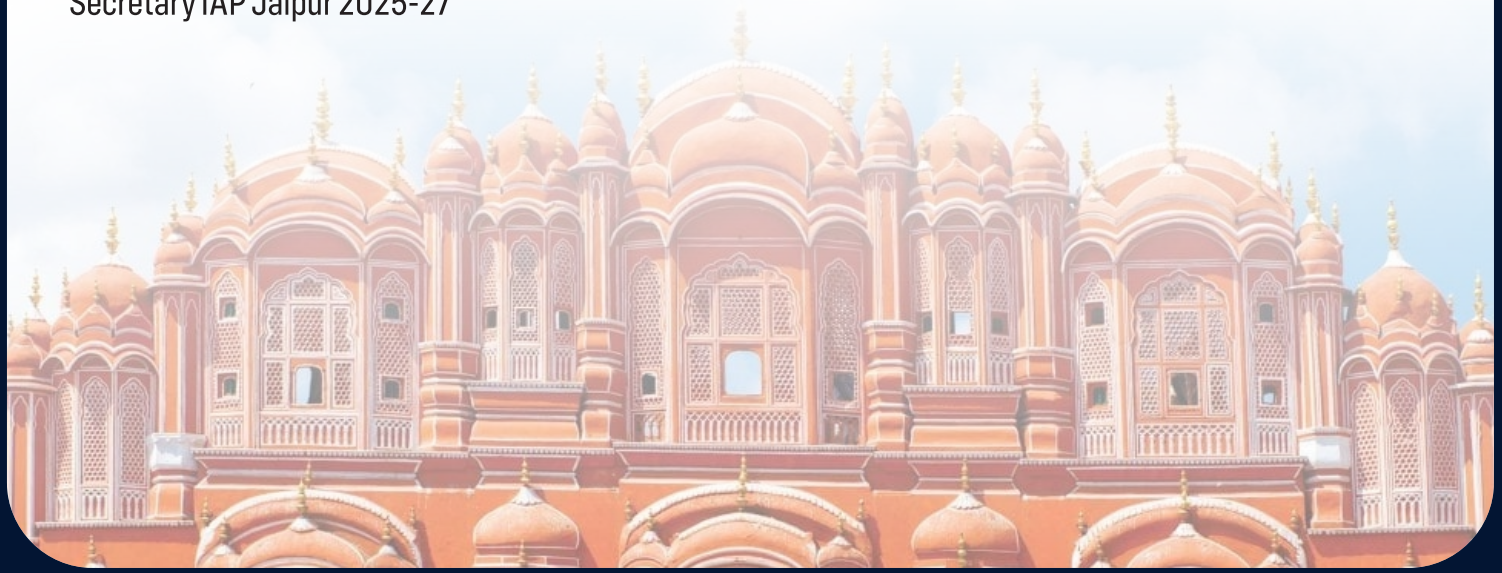
This conference stands as a testament to our shared commitment to the advancement of pediatric infectious disease care—bringing together clinicians, researchers, and thought leaders from across the country. With a rich blend of scientific sessions, panel discussions, and case-based deliberations, we aim to foster meaningful dialogue, encourage innovation, and strengthen our collective resolve in tackling the evolving challenges in pediatric infections.

Behind this endeavor lies the relentless dedication of an enthusiastic team, the unwavering support of our faculty and delegates, and the blessings of our seniors and mentors. I express my deep gratitude to each one of you for contributing to the success of this academic celebration.

May this conference ignite fresh ideas, strengthen collaborations, and inspire us all to serve our young patients with greater knowledge and compassion.

Warm Regards

Dr. Mohit Vohra
Chief Organizing Secretary
Pediatric Infectious Disease (Midterm) Conference 2025
Secretary IAP Jaipur 2025-27



Message from Chairperson - PIDA

Dear Esteemed Colleagues and friends,

It is my great pleasure to contribute a message to the souvenir of this esteemed conference on Pediatric Infectious Diseases, Midterm CME, being held at Jaipur on 5 th & 6th July 2025. As we gather to share knowledge, exchange ideas, and advance our understanding of infectious diseases in children, I am reminded of the critical importance of our work.

Pediatric infectious diseases pose significant challenges to healthcare systems worldwide, and it is our collective responsibility to stay at the forefront of research, diagnosis, and treatment. This conference provides a valuable platform for us to come together, learn from each other, and forge collaborations that will shape the future of pediatric infectious diseases.

Pediatric Infectious Disease Academy is one of the most vibrant subchapters of IAP which aims at promoting the advancement of knowledge and expertise in the diagnosis, prevention and treatment of Pediatric Infectious Diseases in India .ID Chapter has been in the forefront for providing evidence-based care to the children of our country. I hope this conference will upgrade knowledge and clinical skills of all the delegates. This conference will add to the concept of dissemination of knowledge adding another feather in the cap of ID chapter

I salute the organising team and the scientific committee for their dedication, commitment and hard work. The organizing committee has taken a lot of pain and effort to bring eminent speakers from all over India. I convey my best wishes to all members of the organizing committee for successfully organising the conference, under the able leadership of Dr Atul Shanker, Dr Mohit Vora, Dr Neha Agarwal and the whole organizing team of the “Midterm CME 2025”. The topics of the CME are of practical nature and will be useful for the practicing pediatricians, PG students, Faculty members and ID Specialists.

The team Jaipur is known for the excellent hospitality and superior organising skills, which Iam sure each one of us will enjoy and cherish. I extend my heartfelt gratitude to the organizers, speakers, and participants for their tireless efforts and dedication. I am confident that this conference will inspire new insights, foster innovative solutions, and ultimately improve the health and well-being of children globally.

Wishing you all a productive and enriching learning.

Sincerely,
Dr Bhaskar Shenoy
Chairperson,
Pediatric Infectious Diseases Academy

Message From Organizing Secretary PIDA

Message from the Secretary, Pediatric Infectious Disease Academy (PIDA)

Dear friends,
It is with great pride and enthusiasm that I extend my warmest greetings to all members, delegates, and esteemed guests on the occasion of the Mid-Term Conference of the Pediatric Infectious Disease Academy (PIDA) to be held during 5-6th July 2025 at Pink city Jaipur! This conference is flagship event of PIDA which represents a significant milestone in our collective journey towards advancing pediatric infectious disease knowledge, research, and clinical excellence.

I would like to take this opportunity to express my heartfelt appreciation and kudos to the entire organizing team whose dedication and hard work have made this event possible. Special thanks to Dr. Mohit Vora, our Chief Organizing Secretary, whose visionary leadership has been instrumental in steering the conference to fruition. I also commend Dr. Atul Shankar, our Organizing Chairperson, for his unwavering commitment and meticulous planning. Our gratitude extends to Dr. Surya Sethi, the Organizing Secretary, for his tireless efforts in coordinating the many facets of this event.

Furthermore, I would like to acknowledge the exemplary work of the editorial team, ably led by Dr. Shikha Garg, whose expertise and diligence have ensured the production of this high-quality souvenir. This publication stands as a testament to the academic rigor and collaborative spirit that define PIDA.

As we come together to share knowledge, exchange ideas, and foster collaborations, I am confident that this conference will inspire new initiatives and strengthen our resolve to improve the health and well-being of children affected by infectious diseases.

Wishing everyone a fruitful and enriching conference.

Dr Chetan Trivedi
Hon Sec PIDA 2024-25

Professor, Dr. Rambabu Sharma
Senior Professor & Unit Head
Pediatric Cardiology
J.K. Lone Hospital Jaipur

सर पद्मपत इंस्टिट्यूट (JkLon)

कल आज और कल .....।

प्राप्त जानकारी के अनुसार जे. के. लोन अस्पताल का निर्माण कोटा के औद्योगिक घराने जे. के. ग्रुप ने कराया था और उसी के अनुरूप नामकरण भी किया गया। बाल दिवस 14 नवंबर 1979 को यह इमारत राज्य सरकार को सौंपी गयी तथा 1980 में इस संस्था ने अपना विधिवत कार्य शुरु कर दिया था। यह राजस्थान की प्रथम संस्था थी जो केवल बच्चों के उपचार के लिये समर्पित की गई। अपने मूल स्वरूप में जे. एल. एन. मार्ग पर स्थापित बरबस ध्यान खींचने वाली आकर्षक संस्था, दो गोलाकार भवन एवं बीच में एक पोर्च और एक रास्ता, दो मेडिकल यूनिट्स, एक सर्जिकल यूनिट, एक छोटा सा रेडियोलोजी विभाग और बस।

जैसा कि सामान्यतया होता है छोटा परिवार सुखी परिवार। उतना ही स्नेह ! उतनी ही प्रगाढ़ता, उतना ही लगाव और एक दूजे की चिंता। वार्ड में ड्यूटी करते समय कोई डाक्टर होता था न नर्स। कोई कार्य विभाजन नहीं, एक टीम की तरह काम, साथ उठना-बैठना, हँसी ठिठोली। एक अहम् किरदार - बहुमुखी प्रतिभा की धनी, स्नेहिल एवम् सुरक्षा कवच की तरह डा. शकुंतला सक्सेना। उनकी चर्चा के बगैर ये कहानी पूरी नही हो सकती कहानी बेजान हो जायेगी। बेहद अनुशासन प्रिय समय की एकदम पाबंद। जब अस्पताल आती लोग उनको देखकर अपनी घडियों का समय मिलाते थे। पूछताछ कक्ष पर तैनात कर्मियों के हाव-भाव से आप पता लगा सकते थे कि मैडम अस्पताल के अंदर हैं या बाहर। उनके एवम् उनके बाद के दशक को जे.के लोन का स्वर्णिम काल कहा जाये तो कोई अतिश्योक्ति नहीं होगी।

इस दौरान इस संस्था में कार्यरत एवम् अध्ययनरत चिकित्सकों ने तो मानो इतिहास ही रच डाला। उस दौर की इन विभूतियों ने क्या USA, क्या Delhi AllMS, क्या Centar IAP तथा अनेक राष्ट्रीय स्तर के संस्थानों में विशिष्ट स्थान बनाकर इस संस्था का परचम चहुँ ओर फहराया। वहीं दूसरी ओर राजस्थान के बहु प्रतिष्ठित अस्पतालों से लेकर मेडिकल कालेज एवं मेडिकल यूनिवर्सिटीज की स्थापना कर राज्य के बाल स्वास्थ्य सेवाओं के सुदृढ़ीकरण में अपना महत्वपूर्ण योगदान दिया है।

उन दिनों की रेजीडेंसी भी कुछ अलग ही तरह की होती थी। राऊंड पूरा हो जाने पर सभी यूनिट्स के रेजिडेंट्स एक साथ अस्पताल की छोटी सी कैंटीन में एकत्रित हो जाते थे। ऐसी कैंटीन जिसमें तीन ही चीजें उपलब्ध होती थी चाय, बिस्कुट, समोसा- कोफ्ता। सारा सदाचार – शिष्टाचार, सुख-दुख का आदान-प्रदान, नुक्ता- चीनी और घटनाओ का पोस्ट-मार्टम यही पर हो जाता था। लोहे की टेबिल का टॉप एक वाद्य यंत्र बन जाता था। वहीं पर सभी टेंशन-डिप्रेशन, उदासी उड़न छू हो जाया करती थी।

एकेडेमिक्स का स्तर इतना उच्च होता था कि बस पूछो मत । सब एक से बढकर एक Journal Clubs, seminars और Case Presentation करने की फिराक में रहते थे । Case Presentation तो न केवल Residents अपितु फैकल्टी की भी नॉलेज के प्रदर्शन का अखाड़ा होता था । यदि किसी को ये पता लग जाये कि कोई रेजिडेंट डिप्रेशन में चल रहा है या छोड कर जाने की कोशिश में है, तो सभी त्वरित गति से कार्यवाही करते । सब उसको बिना शर्त

support करने लगते तथा हॉस्टल या घर जहाँ पर भी हो पहुंच जाते थे । तू बस बैठा रह । तेरा काम भी हम कर लेंगे । तेरी थीसिस भी हम ही लिख देंगे । फिर क्या जैसे ही उसकी Transient Depression की स्थिति खत्म होती वही बंदा दुगनी फुर्ती के साथ काम में लग जाया करता था । एक और चीज जो रेजिडेंट्स के दिल के करीब थी वो थी जनाना हॉस्पिटल की posting वहाँ free समय में मैं फैकल्टी और residents का साथ में मनोरंजन करना जैस ताश-पत्ती खेलना और हवन का आयोजन ।

उन दिनों Antibiotics के नाम पर CP, Cotrimoxazole, C.P, chloramphenicol, Ampicillen Gentamycin Amoxycillin आदि ही उपलब्ध होती थी, इनसे ही सारे मरीज ठीक हो जाया करते थे। cefotaxim and USG Machine आदि 1986-87 में आये थे । 6 Bed की Peadiatric ICU जिसमें Partition ही थे oxygen तो cylinder द्वारा ही दी जाती थी तथा केवल एक ही Incubater था । सुविधाएँ तो एक दम आधारभूत थी पर सभी डॉक्टर्स व Nurses में सेवा का जज्बा बहुत ही ज्यादा था।

पहले और आज के समय के जे.के. लोन में काफी कुछ बदल चुका है। पहले छात्रों के लिए केवल Text books, Journals, seminars a तथा seniors के notes ही पढने के लिए उपलब्ध होते थे । लेकिन आज का समय Gadgets, online studies & Social Media का है । आज के students किताबें खरीदें ये जरूरी नही बल्कि अधिकांश छात्र नही भी खरीदते हैं । पहले pediatrics में residents कतार से toppers आते थे पर अब mix population आती है । इसमें कोई संदेह नहीं यदि working को देखें तो हमारे रेजिडेंट्स अन्य विभागों की तुलना में आज भी ज्यादा गंभीर एवं प्रति बद्ध हैं । वे अपनी फैकल्टी को भी पूरा सम्मान देते हैं । ये अलग बात है कि पहले के PG. उसी कालेज के UG भी हुआ करते थे अत: अंतरंगता एवं लगाव स्वाभाविक तौर पर ज्यादा था । विभिन्न राज्यों एवं अलग- अलग कालेजों से आने के कारण उतनी bonding एवं समरसता आजकल नहीं मिलती । वर्तमान में विभिन्न super specialities एवं sub specialities के होने से जे. के लोन में teaching एवं traning उच्च स्तरीय हो गयी है । अभी main bulding के अलावा नया OT Campus नयी Emergency, नयी CT VS यूनिट,नयी सुपर स्पेशिलिटी बिल्डिंग के अलावा नियोनेटल तथा हीमेटोओनकोलोजी विंग्स भी बन चूकी हैं ।

वर्तमान में जे. के. लोन अपने विराट स्वरूप में विद्यमान है । देश की शायद ही ऐसी कोई pediatric institute है जो जे. के. लोन से आगे हो । लगभग 894 बेड्स है जिन में से NICU 268 Beds एवं PICU 155 Beds हैं । विभिन्न विभागों में Ped. Medicine, Pad. Surgery. Ped Radiology, Ped. Cardiology & Ped. Cardio –Thorasic Surgery. Pediatric hemato-Oncology, Ped. Nephrology, Ped. Medical genetics एवं. CDC तथा Pediatric Nerology हैं । इसके अलावा Ped. Gastroentrology, Ped. Endocrinology, Ped. Rheumatology तथा Ped. Pulmology-allergy clinics भी सुचारू रूप से चालू हैं ।

मै अन्य संस्थाओं की बात नही करता परंतु जे. के. लोन के वातावरण में आज भी अपनापन है, सहयोग है, समरसता है एवं मरीजों के प्रति संवेदनशीलता है। जे.के. लोन एक वरदान के रूप में उत्तर भारत के बच्चों के लिए सुस्थापित उन्नत एवं समर्पित स्वास्थ सेवाएँ प्रदान कर रहा है।

दोस्तो खुशी की बात ये है कि जे . के लोन एलुमिनाई ने प्रोफेशन में कितनी भी तरक्की करली हो, कितनी भी आर्थिक एवं सामाजिक उप उपलब्धियाँ हाँसिल कर ली हो, कितना भी बड़ा आदमी बन गया हो फिर भी किसी समारोह, या conference के अवसर पर मिलते है तो वही याराना, वही आत्मीयता वही जिंदा दिली, वही खुलुस एवं वही जोश देखने को मिलता है। जब भी मिलेंगे बराबर के होंगे होगे, भाई होंगे तथा एक दूसरे के साथ मिल कर बिताये बेहतरीन पलों को याद करते है तथा सीनीयर्स व Teachers का दिल से सम्मान करते हैं।

ऐसी ही है हमारी मातृ-संस्था और उसके द्वारा प्रदत्त संस्कार ।

Dr. Surya Sethi
Senior Pediatric Consultant, Director – Sethi Hospital, Jaipur
EB Member Rajasthan– CIAP 2025
Co - organising Secretary , PIDA Midterm ID Conference,
Founder Secretary – AHA Jaipur
Former Secretary – IAP Jaipur

In between patients....

As pediatricians, our daily schedule overflows — from newborns and vaccinations to emergencies and counseling anxious parents. But it's the moments in between patients that often leave a lasting mark on our hearts.

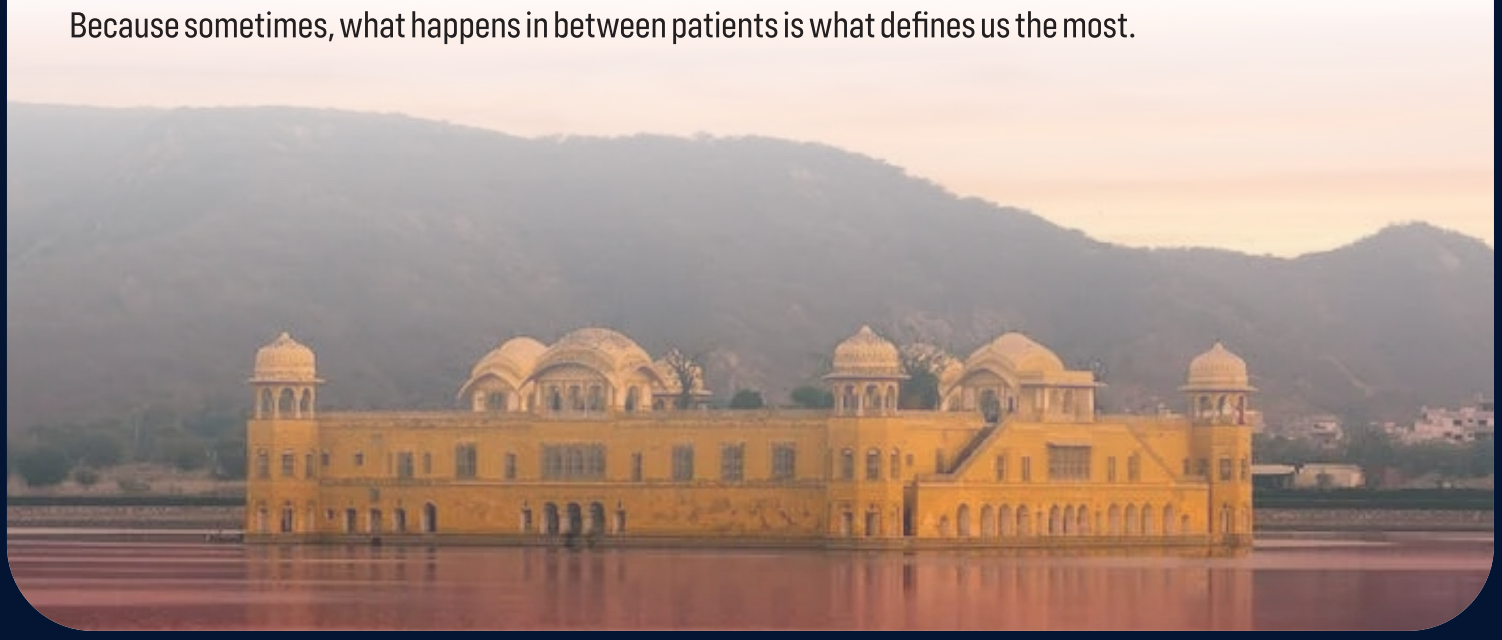
I still remember a mother visiting with her fourth child. Smiling,
she said, “Doctor sahab, sabhi bachchon ki dekhbhal aapne hi ki hai... aap toh parivaar ke jaise ho gaye ho.” That one sentence carried decades of trust — a silent but powerful acknowledgment that we become more than doctors; we become family.

Over 25+ years of practice, I've seen medicine transform — from thermometers to tech — but the essence of paediatrics is unchanged: Compassion. Connection. Care.

These are found in little things — a child's drawing, a hesitant thank-you from a nervous parent, or that moment when a sick child finally smiles. They're not recorded in files or statistics, but they shape our identity as paediatricians.

There are also the difficult moments: a life we couldn't save, a chronic illness we can only manage, not cure. These experiences humble us, remind us of our limits, and strengthen our resolve.

As we come together for the PIDA MIDTERM ID Conference 2025, let's take a step back to appreciate these silent stories — moments that never make it to the mic but build the very foundation of our practice.
Because sometimes, what happens in between patients is what defines us the most.



Dr. Madhu Raturi
Senior Consultant
Past President IAP- Jaipur, 2024

।। अंतर्मन।।

अपने अंतरमन में डूब कर
स्वयं को पा लेना
है बहुत बड़ा संबल
जिससे मिलेगा
कई अनुत्तरित प्रश्नों का हल

तू खुद की तलाश में निकल
खुद को खुद से मिला
जमाने की परवाह में
खुद को न तू भुला

जिंदगी के सफर में
मिलेंगे कई रहगुज़र
यूं मुलाहिजों में
अपना कीमती वक्त ना गवां

अपने साफ सुथरे मन पर
न लाद उलझनो का बोझ
ईश्वर पे रख भरोसा
डाल उलझनों को उसकी गोद
कुछ तो उनका हल होगा
कुछ तो उसका मंसब होगा

तू निरंतर चला चल
अपनी मंजिल की ओर
मन की खुशियों और शांति की ओर
क्यूंकि
इन सब के निमित्त
हम स्वयं ही हैं

Dr Jai Krishan Mittal
Prof and Head, Department of Neonatology,
National Institute of Medical Sciences
Jaipur, Rajasthan, Founder and Director,
Neoclinic Hospital, Jaipur

Dr. Gunjana Kumar
Associate Professor Neonatology,
NIMS, Jaipur

Shielding Our Newborns: Tackling MDR Organisms in Neonatal Practice

Neonatal Sepsis in the MDR Era: A Call for Vigilance

Neonatal sepsis remains a leading cause of mortality and morbidity, particularly in low- and middle-income countries. The emergence of multidrug-resistant (MDR) organisms has further complicated the management of these vulnerable infants. MDR bacteria resist multiple classes of commonly used antibiotics, leaving clinicians with limited treatment options and contributing to higher mortality rates, longer NICU stays, and escalating healthcare costs.

Common MDR pathogens in neonatal sepsis include:

- Gram-negative bacilli: Klebsiella pneumoniae, Acinetobacter baumannii, Pseudomonas aeruginosa
- Gram-positive cocci: Methicillin-resistant Staphylococcus aureus (MRSA), Vancomycin-resistant Enterococcus (VRE)

Why a surge of MDR Organisms in NICUs?

Several factors contribute to MDR emergence in neonatal practice

Contributing Factor	**Impact**
Overuse of broad-spectrum antibiotics	Selective pressure favouring resistant strains
Invasive devices (central lines, ventilators)	Entry points for MDR pathogens
Prolonged hospital stays	Increased risk of colonization and infection
Overcrowded NICUs, inadequate infection control	Enhanced transmission of MDR organisms

MDR pathogens in NICUs—such as Klebsiella pneumoniae, Acinetobacter baumannii, Pseudomonas aeruginosa, MRSA, and VRE—have been associated with:

➡ Increased rates of treatment failure
➡ Prolonged mechanical ventilation and hospital stay
➡ Higher healthcare costs
➡ Elevated risk of mortality

The emergence of these organisms is closely linked to factors such as widespread use of broad-spectrum antibiotics, prolonged hospitalization, invasive procedures, and lapses in infection control practices. Addressing MDR neonatal sepsis thus demands a comprehensive strategy that integrates judicious antibiotic use, robust infection prevention, and timely, targeted therapy guided by sensitivity patterns.

As neonatal caregivers, our collective responsibility is to preserve the efficacy of available antimicrobials and safeguard the most vulnerable patients—the newborns entrusted to our care.

Management of MDR Neonatal Sepsis: Evidence-Based Approach

The management of multidrug-resistant (MDR) neonatal sepsis demands a prompt, systematic, and multidisciplinary approach tailored to the unique vulnerabilities of neonates. Early identification, appropriate empirical antimicrobial therapy guided by local epidemiology, and meticulous supportive care are critical to improving survival. At the heart of this approach lies the integration of antimicrobial stewardship principles, infection prevention strategies, and continuous reassessment to ensure timely de-escalation or escalation of therapy based on culture and sensitivity results. This section outlines the initial steps in managing MDR neonatal sepsis, rooted in current evidence and best practices recommended by global and national guidelines.

General Principles

- Always send cultures before starting antibiotics
- Use local antibiogram data to guide empiric therapy
- Early de-escalation once culture and sensitivity are available
- Adjust dosing based on neonatal pharmacokinetics

CDC-aligned Treatment Approach

Pathogen / Resistance Pattern	**Recommended Treatment (as per CDC & international guidance)**
ESBL-producing Enterobacterales	Carbapenems (meropenem preferred in neonates)
Carbapenem-resistant Enterobacterales (CRE)	Colistin + tigecycline (caution in neonates) or ceftazidime - avibactam (if available)
Pathogen/Resistance Pattern	**Recommended Treatment (as per CDC & international - guidance)**
MDR *Acinetobacter baumannii*	Colistin ± sulbactam (where available)
MDR *Pseudomonas aeruginosa*	High-dose ceftazidime or meropenem (if sensitive); colistin in resistant cases
MRSA (Methicillin -resistant *Staphylococcus aureus*)	Vancomycin (first -line); linezolid (if vancomyci n failure or contraindicated)
VRE (Vancomycin -resistant *Enterococcus*)	Linezolid (preferred); daptomycin (off-label, with caution)

CDC emphasises individualising therapy based on sensitivity patterns, avoiding unnecessary combination therapies, and ensuring appropriate dosing for age and weight.

Key CDC Recommendations

- Avoid blanket empiric use of carbapenems or colistin unless MDR risk is high
- Implement antibiotic time-outs at 48–72 hours to reassess need
- Use therapeutic drug monitoring (TDM) for vancomycin, aminoglycosides, colistin

Emerging Options (with caution in neonates)

- Ceftolozane-tazobactam: For MDR Pseudomonas (not routinely used in neonates yet)
- Cefiderocol: Investigational for neonatal use

Preventing Treatment Failure

- Source control (e.g., remove infected central lines)
- Adjunctive supportive care: fluids, pressors, ventilatory support as needed
- Multidisciplinary care team (infectious disease, neonatology, microbiology)

Nutshell:

Hence, as a whole, the key points to remember in a nutshell include:

Step	Key Actions	Evidence-Based Guidance
1 Early Identification	Recognize risk factors (prolonged hospital stay, invasive devices, prior antibiotic exposure)	CDC & WHO emphasize risk stratification in suspected sepsis for timely intervention.
2. Prompt Blood Cultures	Obtain appropriate cultures *before* starting antibiotics (blood, CSF, urine, etc. as indicated)	Standard neonatal sepsis protocols (AAP, CDC) recommend cultures before therapy.
3 Empiric Therapy	Initiate broad-spectrum antibiotics guided by local antibiograms and resistance patterns	Empiric regimens should cover likely MDR pathogens; de-escalate once cultures return.
4 Supportive Care	Stabilize with fluid resuscitation, inotropes if needed, respiratory support	Evidence shows early supportive care reduces mortality in septic neonates.
5 Infection Control	Isolate MDR cases, enforce hand hygiene, minimize device use	CDC recommends strict adherence to infection prevention protocols.

Conclusion:

The emergence and proliferation of multidrug-resistant (MDR) pathogens in neonatal sepsis represent a critical threat to neonatal survival and public health. This escalating challenge underscores the urgent need for a comprehensive, evidence-based strategy integrating robust antimicrobial stewardship, stringent infection prevention measures, and continuous surveillance of resistance patterns. Prioritizing early diagnosis, judicious antibiotic use, and the development of novel therapeutics and diagnostics will be pivotal in mitigating the impact of MDR sepsis and improving neonatal outcomes globally.

Dr. Sumita Nayak
Senior Consultant
President IAP Bengaluru

Sri Krishna Ras Leela

Dr. Sanjeev Hooja
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The Corona Glossary

It has been 4 years since the epidemic has died down yet the corona virus rears it's ugly head every now and then. In memory of the corona epidemic let us revise some Corona Glossary in a lighter note.

Coronery: A small corona hotspot
Corontine: A state of isolation due to coronavirus
Coro'nium: rules to be followed during lockdown
Covidient: One who follows the rules of lockdown
Covidiot: One flouting the rules of lockdown
Coronation: When royalty gets infected/diseased
Coronicle: Record of the Corona times
Coronache: The pain of lifestyle adjustments
Cobesity: Inches/kilos added while 'corontined"
Coronet: Safety net thrown by the administration for containment
Coronial: The present time of living through Corona
Coronopaedia: Comprehensive knowledge of all aspects of Covid-19
Coroney: Friend(s) made during Corona times
Corondrum: Uncertainty on when Covid shall end

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Jackpot

"I call her the Jackpot!".
Pardon me for calling her that but she helped me at the time when I needed help the most.
The entire MBBS is a journey full of obstacles, the final MBBS appears to be the steepest and the most difficult hurdle to cross. Both the theory as well as the practical exams come across a difficult proposition but the theory exam offers some reprieve in the fact that what you write is known only to the examiner who is checking your copy.

The practical is a different proposition altogether, here one has to present cases before a team of people. The examiners both external and internal, the faculties assigned to help in the exam, the PG students accompanying their chiefs. In short, the practical exam is full of theatrics which aren't seen in the theory exam.

Having spent most of my clinical posting days away from the wards exploring the nook and corner of Poona, I knew I would meet my waterloo in the practical exams. Apart from trying to master the clinical examination skills by going through Hutchinson Hunter one also had to learn to befriend the PG trainees who knew which cases were being kept for the exam. Many a times one would come across a jovial PG trainee who over a cup of coffee who reveal the list of cases, instruments and X-rays.

As students we often forget that our teachers have gone through the same grind and many were smart enough to release a dummy list of cases so as to stump the students.
In this conundrum of what was going to be my fate, I approached the pediatric viva with a lot of fear and trepidation.

The PG trainee in charge of distribution of cases allotted me case number six.
There I was standing in my neatly starched ironed white apron in front of Bed 6 who was going to play an important role in deciding my fate. I introduced myself and gave the little girl a Cadbury thereby establishing an immediate rapport with the child.

The child introduced herself as Madhavi. Madhavi was a cheerful child. She put all my fears to rest by saying My name is Madhavi , I am 10 years of age, am a known case of Thalassemia Major. Before I could ask as to what brought her here, she responded by a wave of hand and told me to write down the presenting complaints.

I was quite stunned, she put all my doubts to rest by saying that she has been here quite often and has been an exam case in previous exams also.

Joy whipped my heart to a gallop and I started writing down furiously whatever she told. She gave me an exact description of the presenting complaints as mentioned in the text book. She told me to tell the examiner that she had a significant past history which involved multiple episodes of blood transfusion as she was a known case of thalassemia major.

When I started to examine her she rattled off the questions which the examiner had asked the previous day. As to how you look for jaundice, how to palpate the spleen, the various methods of palpating the spleen etc. She coached me like a seasoned pro as to what questions would be asked to me in the case viva.

The moment of reckoning had come, I was to present the case before the team of examiners along with others involved in conducting the exam. The final MBBS practical is quite resembling to the days of British Raj wherein an Indian peasant would be flayed by the officers of the British Raj at the slightest of his follies. Here the poor candidate was the peasant and the examiners the officers of the Raj.

Needless to say, my coach had coached me well and I passed quite comfortably.
Thanking her profusely I gave her all the chocolates I had and wished her all the best.
With a beaming face and a 56-inch chest I walked out like a gladiator who had won the battle, waiting outside the ward my was friend Lala who asked "How did it go". I just said "Aaj to Jackpot lag gaya yaar".

Dr. Swati Ghate
Adolescent Paediatrician
Babylon's Newton ICAD

रूक जा

उन्मत्त मानव, रूक जा जरा
मदमस्त मानव, ठहर जरा
जंगल से मंगल के आगे
बहुत हो चुका सफर तेरा

सृष्टी का अनुपम नजराना
विविधाओं से हराभरा
रंग जमा कर, अपनी जिद से
मोल लिया खुद को खतरा

जगज्जेता बन कर रीता
हाथ, जानता तू है तेरा
मानक क्या हो प्रगति का यह
सोच ले, कर ले गौर जरा

रोक ले अपने बढते कदम अब
मन में झांक ले..क्या है मेरा
खींच ना सबकुछ औरों से
यहाँ हरेक का हक पूरापूरा

अंधी दौड में सुख पाने की
दुखी पूरा कुनबा है तेरा
प्रशस्त करने आंगन अपना
यूँ रौंद ना सुंदर वसुंधरा।

Dr Sandhya Gupta
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Adolescent Vaccination & Challenges

“Adolescence is a border between childhood and adulthood. Like all borders it's teeming with energy and fraught with dangers.” Mary Pipher.

The adolescent age group 10- 19 years, around 243 million of them live in India. These are the building years in life. It is time for close peer relationships, study related travel and exposure to unrelated, crowded environment. The most effective way to prevent the incidence of infectious disease in this age group is immunisation as certain diseases have higher morbidity when occur in this age as chicken pox, hepatitis A. some show higher incidence like mumps and meningococcal disease.

As the immunisation coverage increased in infancy and toddlers, certain conditions show epidemiological shift to adolescent and adults. Also there is waning immunity imparted by childhood immunisation thus requiring age specific boosters.

HPV vaccine is the only one to prevent mortality from HPV causing cancer, with the high risk behaviour in adolescent age group it is imperative to immunise them against diseases which show up later in life.
Adolescent immunisation is crucial in the control and elimination program for certain conditions like measles, congenital rubella syndrome. Immunisation coverage in this wide age range helps to increase herd immunity and interrupt spread of infectious disease.

Achieving and maintaining health by preventive medicine is not only cost effective for the country but with active surveillance, paves way for appropriate utilisation of resources for further research and development.

PROF Dr Manmeet Kaur Sodhi
MD FIAP
PROF & HEAD
DEPARTMENT OF PEDIATRICS
GOVERNMENT MEDICAL COLLEGE
AMRITSAR

The Screen Between Us:
दीवारें बनी, रिश्ते नहीं"

In a world designed to connect us, screens have silently built walls—especially between parents and children. What was once a means to bridge distances has become a barrier in our very homes. Dinner tables have fallen silent, laughter has been replaced by notifications, and the glow on our faces no longer comes from joy, but from blue light.

"वो दौर और था जब बातें हुआ करती थीं,
अब तो खामोशी में भी स्क्रीनें बोलती हैं।"

It's heartbreaking to see a child choosing YouTube over a bedtime story, or a parent lost in WhatsApp chats while their little one yearns for eye contact. We scroll through reels of strangers but skip the real moments with our own children. The irony is bitter—we're most reachable when we're emotionally unavailable.

"कभी आंखों में आंखें डाल कर बात होती थी,
अब स्क्रीन की स्लाइड में हर मुलाक़ात होती है।
घर के अंदर भी रिश्तों में फासला है,
हर चेहरे के आगे एक मोबाइल का ताला है।"

Working parents try to compensate time with gadgets, thinking they are giving love through the latest technology. But what a child needs most is not a tablet, but time. Not virtual gifts, but real hugs. Not emojis, but emotions.

We say we're working for them, for their future. But in doing so, are we forgetting their present? What happens to the child's soul that never feels heard, or to the parent who regrets the years lost behind a screen?

"जिस घर में खिलखिलाहटें गूंजती थीं पहले,
अब हर कमरा सन्नाटों से भरा है।
मोबाइल की बत्ती में सब कुछ दिखता है,
बस अपनों का प्यार अब धुंधला पड़ा है।"

It's time we reclaim our relationships. Let's replace screen time with storytelling, emojis with embraces, and scrolling with strolling—hand in hand.
Let the screen be a tool, not a wall.
Let it build bridges, not boundaries.
Let us be present, not just online.

"मुलाक़ात हो असली, स्क्रीन से नहीं,
रिश्ते निभें बातों से, मशीन से नहीं।
आज वक़्त है, सीने से लगा लो बच्चों को,
कल ये लम्हें, याद बन कर रुलायेंगे तुम्हें।"

Let's put the phone down—and pick our children up.
Before the screen becomes the only thing that remembers us.

Shwet Shyam
Dr Shyam Agrawal
Consultant Pediatrician
Bikaner

वृक्ष की गवाही

मैं कभी एक वृक्ष था, जीवंत, बेफिक्र और आत्म-मुग्ध।
हवा की कोमल स्पर्श मुझे रोमांचित कर देती थी।
मेरे खुरदरे पत्ते हर स्पर्श पर सरसराते थे,
मेरी शाखाएं फूलते कोंपलों के भार से नाचती थीं।

मैं महान था, जीवन की एक पूरी दुनिया मुझ पर निर्भर थी।
लेकिन पास ही एक और दुनिया थी - हत्यारों की,
आदमियों की कुल्हाड़ियों और आरी से,
जो काटने, चीरने और चीर-फाड़ में माहिर थे।

उनकी समृद्धि विनाश पर आधारित थी, जीवन लेने पर।
मेरी दुनिया उनके धारदार औजारों की पकड़ में थी।
मैं एक वृक्ष था, शुद्ध और मासूम, मृत्यु से अनजान।
जीवन की खुशियाँ और गम, प्रकृति की लय,
मेरी वास्तविकता थी, सूरज और चाँद मुझे सहलाते थे बारी-बारी से।

फिर भी, पास ही क्रूर आदमी छिपे थे, मुनाफे की नज़र से,
व्यापार में मृत्यु की तलाश में।
एक दिन, जब मैं खुशी से झूम रहा था, नए कोंपल फूट रहे थे,
हत्यारे की नज़र मुझ पर पड़ी।

एक राक्षसी कृत्य ने मेरे शरीर को अंग-अंग से अलग कर दिया,
एक जीवित प्राणी को निर्जीव टुकड़ों में बदल दिया।
हत्यारे ने मेरी आंसुओं को लकड़ी के फिनिश के नीचे छुपा दिया,

वर्निश की गंध ने मेरे जीवन के सबूतों को दबा दिया।
घाव, जख्म, दर्द सब छुप गए।

हत्यारों की दुनिया में बच पाना मुश्किल है,
प्रकृति की रचनाएं, जीवन स्वयं, असुरक्षित है।
इस प्रकार, निर्दयी आदमियों ने लोभ में आकर मेरा जीवन छीन लिया।
मेरे शरीर से उन्होंने फर्नीचर, सजावट और बहुत कुछ बनाया।

मैं कभी अमूल्य था, प्राकृतिक दुनिया में अपूरणीय।
लेकिन आदमी ने अपनी विनाशकारी प्रकृति से मुझे अपना शिकार बना लिया।
मैं कभी एक वृक्ष था, जीवंत, नाचता-गाता।
अब मैं निर्जीव हूँ, एक वस्तु मात्र, मानव लोभ का शिकार।

वृक्ष को बचाएं, पृथ्वी को बचाएं, बचपन को बचाएं।

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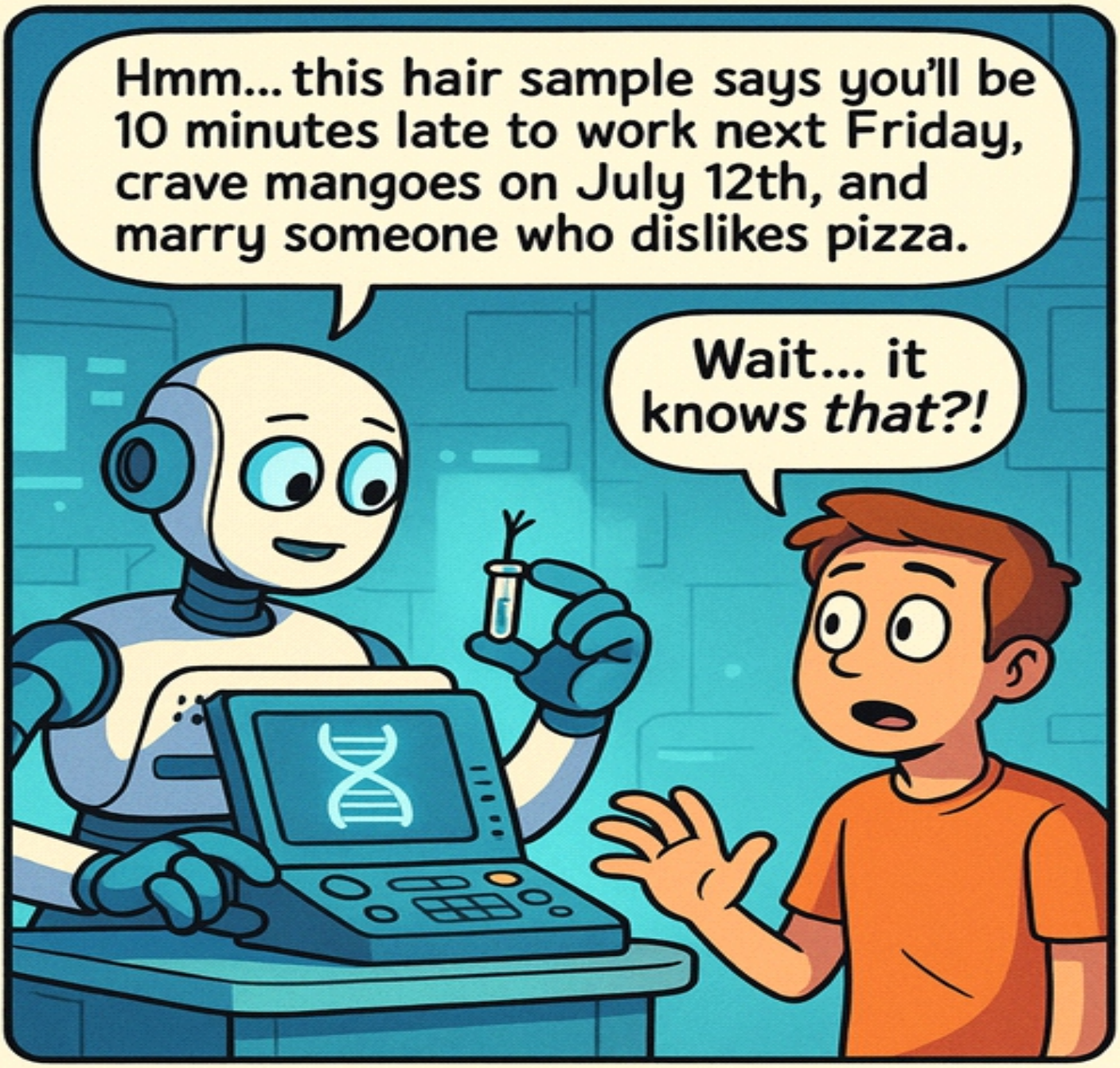
DNA TESTING IN 2050...



When DNA tests know more about your future than you do.

Dr. Atul Shanker
President
IAP Jaipur, 2025

The Pediatric Con-Fusion

I packed my coat and stethoscope,
With just a dash of dwindling hope.
"Another ped conf?" my spouse gave me a glare,
"That's the third one—just this May, I swear!"

We spoke of coughs, we spoke of poop,
And viral fevers in a never-ending loop.
One speaker said, "Kids never complain,"
While shots brought tears like monsoon rain.

A workshop showed the endoscope's might,
"High-frequency vents are the future bright!"
Another made us proudly chant:
"Probiotics — the new health grant!"

The trade stalls offered tea and charts,
With monographs and glossy arts.
We clicked some pics with practiced grace,
Prescribing evidence—just in case.

Awards were given with thunderous cheer,
To a talk so dry—it killed the atmosphere.
I clapped and smiled, but deep inside,
My neurons wanted to run and hide.

Each weekend now is booked and dear,
"Update on Pediatrics"—the 10th this year!
And if I skip one CME day,
They hunt me down yelling, "Mayday, Mayday!"

Banquets are where the gossip flows,
And networking hits professional highs and lows.
Elections approach, and suddenly you find,
You're everyone's favorite—how kind!

Conferences, CMEs, workshops galore—
Oh pediatric Gods, I can take no more!
Spare me a Sunday, grant me peace,
Let this academic chaos briefly cease!

Dr. Priyanshu Mathur
& Team
Dr. Gayatri Dhanger
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How Drug Repurposing is Transforming the Treatment of Genetic and Metabolic Disorders

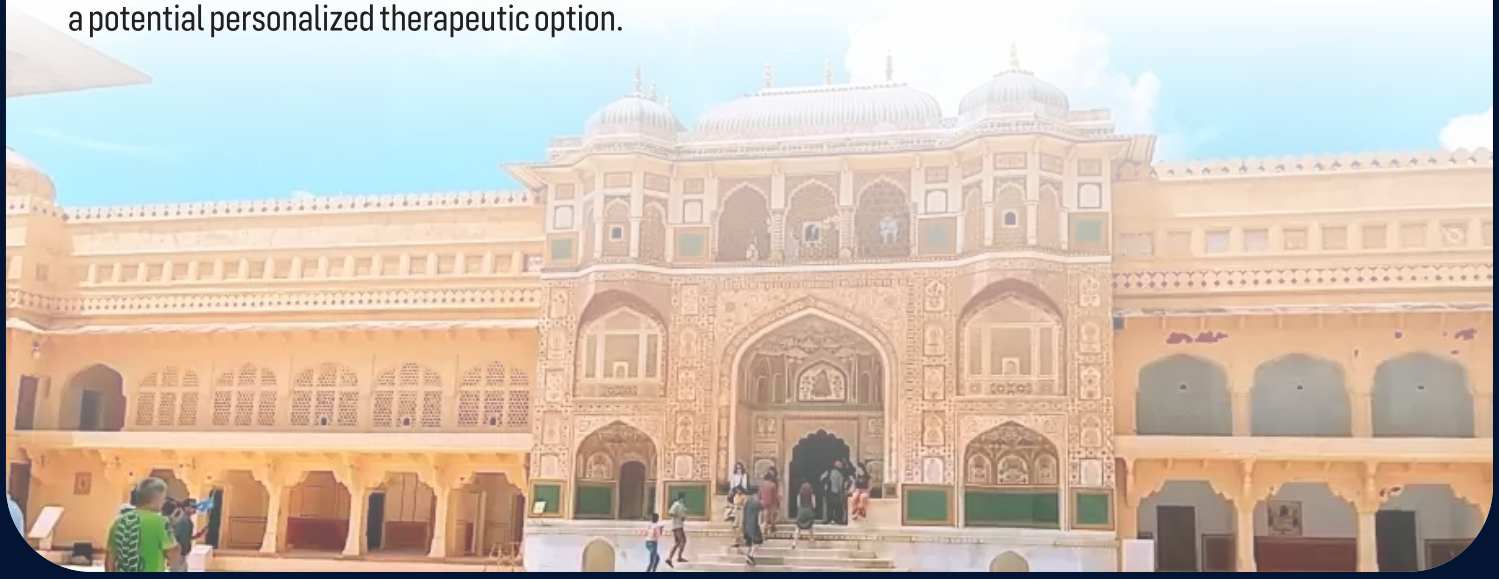
Drug repurposing, also known as drug repositioning, is the strategy of using existing drugs—originally developed and approved for other conditions—for the treatment of new diseases. In the field of rare genetic and metabolic disorders, this approach is proving to be revolutionary. Many of these disorders lack targeted therapies, primarily due to the high cost and complexity involved in developing new drugs for a small patient population. Repurposing existing drugs—whose safety profiles are already known—offers a faster, more economical, and sometimes life-saving option for patients with otherwise untreatable conditions.

Why Drug Repurposing?

1. Faster Translation to Clinic: Since safety data already exists, repurposed drugs can reach patients more quickly.
2. Cost-Effective: Avoids the enormous costs of early-phase drug discovery.
3. Immediate Availability: Drugs are often already accessible in the market or hospital formularies.
4. Hope for Rare Disorders: Many ultra-rare diseases are not commercially viable for de novo drug development. Repurposing fills this gap.

Examples of Drug Repurposing in Genetic and Metabolic Disorders:

1. Calcium Channel Blocker in CACNA1D-Related Disorders: Patients with CACNA1D gene mutations may exhibit severe neurodevelopmental disorders with seizures and autism spectrum features. The gene encodes the L-type calcium channel Cav1.3. Studies have demonstrated that isradipine, a calcium channel blocker approved for hypertension, can reduce channel overactivity in CACNA1D mutations in vitro, offering a potential personalized therapeutic option.



2. Tocilizumab and Mycophenolate Mofetil in SLC26A3 Deficiency: Congenital Chloride Diarrhea caused by SLC26A3 gene mutations typically presents with life-threatening diarrhea and electrolyte imbalances. In certain cases, associated enterocolitis or autoimmune inflammation has responded well to tocilizumab (an IL-6 inhibitor) and mycophenolate mofetil (an immunosuppressant). These agents help in modulating immune dysregulation and reducing intestinal inflammation in genetically predisposed individuals.

3. Alpha-Lipoic Acid in MECR Deficiency: Mitochondrial Enoyl CoA Reductase Protein Associated Neurodegeneration (MEPAN syndrome) due to MECR gene defects affects mitochondrial fatty acid synthesis and results in progressive neurological dysfunction. Alpha-lipoic acid, a mitochondrial cofactor, has shown promising effects by supporting residual enzyme activity and improving cellular energy metabolism.

4. Ambroxol as a Chaperone Therapy in Gaucher Disease: In Gaucher disease, mutations in the GBA1 gene impair glucocerebrosidase enzyme folding and function. Ambroxol, traditionally a mucolytic agent, has shown potential as a pharmacological chaperone that stabilizes mutant glucocerebrosidase, enhances its trafficking to lysosomes, and restores partial enzymatic activity. This approach is especially valuable for neuronopathic Gaucher types, for which enzyme replacement therapy is ineffective.

5. Sodium Phenylbutyrate in Urea Cycle Disorders (UCDs): Patients with UCDs suffer from toxic accumulation of ammonia. Sodium phenylbutyrate, initially used as a histone deacetylase inhibitor, has been repurposed to conjugate with nitrogen and facilitate its excretion, reducing hyperammonemia in disorders like OTC or CPS1 deficiency.

6. Sirolimus (Rapamycin) in mTORopathies: Mutations in MTOR pathway genes (e.g., TSC1/TSC2) result in disorders like tuberous sclerosis complex and other "mTORopathies." Sirolimus, an mTOR inhibitor originally developed as an immunosuppressant, is now effectively used to reduce tumor growth (e.g., SEGAs), seizures, and skin manifestations in these patients.

7. Bezafibrate in Mitochondrial β-Oxidation Defects: Long-chain fatty acid oxidation disorders such as CPT2 or VLCAD deficiency impair energy generation during fasting or exercise. Bezafibrate, a lipid-lowering drug, has been investigated to enhance residual enzyme activity by acting as a PPAR agonist and upregulating mitochondrial fatty acid oxidation pathways.

8. Quinidine in KCNT1-Related Epileptic Encephalopathy: Gain-of-function mutations in KCNT1 lead to severe epileptic encephalopathies. Quinidine, a cardiac antiarrhythmic drug, has been shown to inhibit the overactive KCNT1 channel in vitro and has been trialed in drug-resistant epilepsy patients with some success.

9. Acetazolamide in Channelopathies (e.g., Episodic Ataxia Type 2): Patients with CACNA1A mutations causing episodic ataxia benefit from acetazolamide, a carbonic anhydrase inhibitor. Though originally used for glaucoma and altitude sickness, it reduces channel excitability and decreases frequency of ataxic episodes.

Challenges and Future Directions:
Despite its promise, drug repurposing is not without challenges:
Variability in Response: Genetic heterogeneity leads to variable drug efficacy.
Lack of Clinical Trials: Most repurposed uses are based on case reports or small cohorts.
Dosing and Safety: Appropriate pediatric dosing and long-term safety data may be lacking.
Regulatory Hurdles: Off-label use often requires institutional or ethical approvals.

However, with advances in functional genomics, high-throughput drug screening, and patient-derived cellular models, the field of repurposing is poised for exponential growth. Collaborative networks, such as Undiagnosed Diseases Network (UDN) and Treatabolome, are actively building databases to match genetic mutations with actionable therapies.

Conclusion: Drug repurposing is becoming a cornerstone of personalized medicine in genetic and metabolic disorders. For many families and clinicians navigating rare, often devastating conditions, it provides a ray of hope where none existed before. The growing number of success stories—from ambroxol in Gaucher disease to alpha-lipoic acid in mitochondrial neurodegeneration—highlights the untapped potential lying within our existing pharmacopeia. With continued investment in research, cross-disciplinary collaboration, and supportive policy frameworks, drug repurposing becoming a standard pillar in rare disease management.

Dr Neha Agarwal
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To new beginnings...

The winds are gusty and the dark clouds do over shroud
The minds are clouded with millions of doubts
Each morning ,with some graying hair,can hear my heart ache
Wishful thinking , newspapers are but,beacons of plague
The doubts, the dread ,the stench of crimes, the untimely death

Alas, all I wish each morning is, I am not a prey to these shocking plots.
The sun rising on the horizon ,tells me I am made for lots

As old scriptures said ,there will be an grand end to the unholy life.. Somewhere in my black box ,I see a opposite strife.

So each morning ,I do read the wishful horoscope
And the beaming words give me some dope

In the passion of this beautiful life below the iceberg,
I rise and promise to bring some solace to the unrestful jibe.

That's what made us human ,to mold and hold on to the unsurprising heat
The beauty will then, beat the beast

To wishful dreams and plenty do I see .
But my karma is what I ll strive to be!!

So to all young lads with promise and sunshine
Some roadblocks and back biting people are just fine .

Success is there for you at every step and mile
Just hold on to your guts for a while

For only those who tasted the poison will value the prime
For failures,struggles and dirt around you ,don't give a dime

Rise and shine to take your shot at goals you decide
May have to walk miles together before you go to other side.

So no matter where we live and work, its our mind we need to win Opportunities await us ,on the clock ,to begin..

Dr. Yash Paul
Pediatrician, Jaipur

DOCTOR'S DILEMMA – LAB. INVESTIGATIONS.

Dilemma is a situation in which a difficult choice has to made between two alternatives.
Management of a disease is based on symptoms(complaints), history (present, past and family) and signs (findings on examination of the patient). Sometimes there is a need for investigations, to arrive at a proper diagnosis. Many times doctors are accused and maligned that they recommend un-necessary investigations because of financial gain offered by investigating houses.

Investigations are done to arrive at a proper diagnosis and to provide right treatment. The author cites some examples where proper and timely investigations are mandatory.

Children born to diabetic mothers should be screened at birth and later too for hypoglycemia to avoid neurologic damage to these children. In case of children born to parents having thalassemia, children should be investigated to confirm or exclude thalassemia before staring treatment for anemia. A child born in a family having history of hemophilia should be investigated for hemophilia to prevent excessive or life threatening bleeding resulting even with intramuscular injections. Patients suffering from seizures, fainting attacks should be provided symptomatic treatment and investigated in case not diagnosed earlier. Incidence of cardiac anomaly is high in case of Downs Syndrome, every child with Down Syndrome should be investigated to evaluate heart disease.

Back to the question: why dilemma? In case, no investigations are done, accurate diagnosis may be missed and if asked to get investigations done, doctors may be accused of collusion with laboratories.

The way out is while recommending investigations it should be clearly stated that these investigations are needed to confirm diagnosis, or rule out disease(s). This process has two benefits: (i) doctor will suggest only those investigations which are necessary, and (ii) this process will act as a shield for doctors against misperceived perceptions and legal hassles.

To conclude: Every doctor should know 'When and what to investigate'.

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A GREAT IRONY - NOBEL PEACE PRIZE.

Irony is odd or amusing because it involves a contrast.
Alfred Berhard Nobel (1833-1891) was a Swedish chemist. He was a great inventor, dynamite was among his many inventions, which made him very rich. Dynamite was invented in the year 1886, it is used to make bombs, canons and rockets etc. all used in warfare to kill the enemy (human beings) The person who provided a weapon to kill human beings started in year 1901 The Nobel Peace Prize.
Most appropriate idiom for Alfred Nobel is

नौ सौ चूहे खा के बिल्ली हज को चली।

Dr Shikha Garg
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“विकास का कमरा: चुप्पियों और चहक का संगम"

(एक बाल विकास चिकित्सक की मुस्कान के पीछे छुपा संघर्ष:)

यह मेरा कमरा नहीं,
यह हर उस माँ की आँखों का आइना है,
जो उत्तर नहीं– राहत खोजने आती है।

हर दस्तक के साथ
कभी बीते हुए समय की खामोशी मिलती है,
और साथ ही आती है
मेरी दबी हुई झुंझलाहट–
क्यूँ इतना समय लगाया तुमने आने में?

मैं जानती हूँ,
माँ ने लड़ाई लड़ी होगी–
समाज से, घर से, खुद से।
पर अंदर कहीं ग़ुस्सा भी उठता है–
क्यों नहीं की थेरपी जैसे कहा था?

फिर याद आता है,
हर थेरपी एक संघर्ष है,
हर एक्सरसाइज़ एक युद्ध।
घर में कोई मदद नहीं,
समाज पूछता है,
पर समझता नहीं।

एक कोने में बैठा पिता–
जैसे उसकी दुनिया ही रुक गयी हो।
और माँ–
आँखों में आँसू, पर आवाज़ में हिम्मत।
मैं उनकी पीड़ा देखती हूँ,
और फिर खुद को संभालती हूँ।

क्या यह बच्चा कभी दौड़ेगा?
क्या बोलेगा?
क्या दुनिया इसे अपनाएगी?
सच नहीं जानती – शायद हाँ, शायद नहीं,
फिर भी कहती हूँ–
“हमें उम्मीद है।"

उम्मीद.
जो कभी हकीकत बनती है,
और कभी बस एक फीकी सी मुस्कान बनकर रह जाती है।
और उस एक मुस्कान में
मैं फिर से विश्वास बुनती हूँ।

फिर एक दिन दोनों आते हैं
पिता- "बस घर के काम में लगी रहती है,
बच्चे को टाइम ही नहीं देती!"
माँ तड़ से – "और आप? मोबाइल में
बच्चा वहीं एक कोने में
ब्लॉक्स जोड़ रहा होता है–
शायद वो समझ चुका है,
"इन दो के बीच मेरा नम्बर सबसे बाद में आता है!"
मैं बीच में... जैसे कोई रेफरी–
“फाउल दोनों तरफ़ से है, अब बच्चा संभालिए प्लीज़!”

और एक दिन, दरवाज़ा फिर खुलता है–
पर इस बार डर नहीं होता,
एक मासूम मुस्कान होती है।
वो चहकता है–"डॉक्टर मैडम!"
"अब मैं स्कूल जाता हूँ, पढ़ता हूँ, बोलता हूँ!"
माँ की आँखों में गर्व की चमक,
पिता के होठों पर शांति।

मेरा कमरा एक संतुलन है –
उम्मीद और नाउम्मीदी के बीच,
प्रेम और अनुशासन के बीच,
गुस्से और करुणा के बीच।

मैं कभी थकी हूँ-- हाँ,
कभी-कभी टूटी भी,
पर ऐसे ही पलों के लिए
हर सुबह फिर से
उसी दरवाज़े तक पहुँचती हूँ–
नए चेहरे, नई उम्मीदों के साथ।

यह मेरा कमरा है,
जहाँ हर दिन
एक नई कहानी जन्म लेती है–
थोड़ी अधूरी,
थोड़ी चमकती हुई।

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Transform your life with Yoga Physical, Mental and Spiritual benefits

For doctors mental and physical stress is a given in today's hectic lifestyle. Yoga offers a powerful solution. By committing to yoga just four days a week, we can enhance our physical and mental well-being, reducing the risk of chronic conditions like hypertension, diabetes, anxiety disorders, and behavioral issues.

Yoga is a transformative practice that harmoniously integrates physical postures (asanas), breathing techniques (Pranayama), and meditation to cultivate overall well-being. By embracing yoga as a lifestyle choice, individuals can experience significant benefits in managing chronic conditions like hypertension, diabetes, and anxiety disorders. Regular practice enhances physical, mental, and emotional well-being, leading to a better quality of life.

While yoga some similarities with gymnastic it's focus on flexibility, balance, and inner peace distinguishes it from other exercises. This holistic practice builds strength, flexibility, balance, and coordination while promoting mental clarity, calmness, and stress relief. Yoga also fosters inner peace, self-discipline, and cardiovascular health, slowing the aging process and deepening the connection between body, mind, and spirit.

Combining yoga with activities like gymming, running, cycling, swimming and meditation creates a powerful synergy for a healthy lifestyle. This integrated approach offers numerous benefits, including:

- Improved physical flexibility and balance
- Enhanced mental clarity and focus
- Reduced stress and anxiety
- Increased self-awareness and self-discipline
- Better cardiovascular health
- Improved overall well-being and quality of life

By incorporating yoga and complementary practices into your daily routine, you can unlock a more balanced, resilient, and fulfilling life."

Dr. Devajit Sharma
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Happiness in the virtual world- The Dopamine trap

"I would urge parents to limit the amount of social media that children watch because they're being programmed by a dopamine-maximising AI,"- Elon Mask
Have you ever noticed if you scroll and view a reel or video on social media, the videos of similar taste and content keep coming to you? Be it food recipes, sports, bodybuilding or explicit content, whether you have watched them by accident or choice, similar videos will keep coming to you till you become fatigued. We all know Artificial Intelligence (AI) is watching us day and night, our likes and dislikes, and trying to influence us based on our choices and interests. But are you aware that the AI is trying to alter the level of dopamine, the feel-good hormone, in our body? It is like drugging, showing content that make us more and more euphoric.

Adolescents seek instant gratification, acknowledgement and reward. AI is taking advantage of this weakness and makes content that will make them happy all the time and this acts as a drug. All the likes and comments that they get, give them the gratification and recognition that they are seeking all the time.
Before elaborating let me explain what is neurotransmitter and what is dopamine.

Neurotransmitters are chemical messengers of our body. Their job is to carry chemical signals ("messages") from one nerve cell to the next target cell. The next target cell can be another nerve cell, a muscle cell or a gland. The body has a vast network of nerves, that send and receive electrical signals from all over the body. The nervous system controls everything from the mind to the muscles, as well as functioning of the organs. In other words, nerves are involved in everything we do, think and feel. Dopamine the "feel-good" hormone, is a neurotransmitter that's an important part of our brain's reward system. Dopamine has a role to play in controlling memory, mood, sleep, learning, concentration, movement and other body functions. If dopamine levels become low or higher than normal in our body, we suffer from many neurological and mental disorders. The body normally produces enough dopamine, but the level may become low in erratic modern stressful lifestyles and some illnesses. Low levels of dopamine make us depressed and we don't feel like doing anything meaningful in life, at the same time high dopamine levels can make us aggressive and impulsive. We might associate increased levels of dopamine to the feeling of craving for something. When you finally get the thing you've been craving for, your brain triggers another burst of dopamine that reinforces your actions. Illegal drugs, such as cocaine and heroin, are so addictive in part because they trigger a massive dump of dopamine.

Social media platforms are designed to maximise user engagement by leveraging the brain's reward system, through dopamine. AI uses vast amounts of data to learn users' preferences, behaviours, and interests.

By presenting content tailored to individual users, AI keeps users engaged and coming back for more, creating a vicious cycle of anticipation and reward that releases dopamine.
Data from 2019, showed that nearly 66 percent of Indian children aged 5-11 years have access to the internet, especially through smartphones. This early exposure to AI-driven content raises alarms about its long-term effects on young minds. Children and adolescents are naturally curious, the anticipation and unpredictability of new content generated by electronic media, gets children hooked to social media platforms and makes them dependent enough to keep coming back for more. The dopamine release then enhances the effect, akin to gambling mechanisms.

We do know that the proper use of internet can create lots of opportunities and it is very helpful when it comes to education and in giving us a global perspective, making us global citizens. AI is being successfully used for the treatment of Attention Deficit Hyperactivity disorders and Autism too. Thus it is a double edged sword, to be used with care.

We must hence create screen ethics at home right from the start. We must have a net-free zone, net free time and family time in our own homes. We must sit and talk with our teenage children in a friendly, calm and cool environment. Handling teenagers is not an easy job. It can go either way and become detrimental if we are not careful. We should always start discussions with an open mind and should never be judgmental. We should let our children open up and should give them time to start the conversation. Children follow us, rather than just listening to us. We should practice what we preach. We should limit and restrict ourselves from using social media at home, especially when children are watching. Most guidelines say screen time should be restricted to a maximum of 2 hours a day for children and adolescents. But no study has conclusively showed that using two hours a day of internet is safe. Rather than counting hours' onscreen, we should start counting hours of net free time and give importance to the content of internet that is being seen. From early childhood, we should promote outdoor games, family time, storytelling, book reading, sky watching, bird watching etc. All these activities, make us happy, and we can create happiness in our minds, there will then be bursts of dopamine in the brain to keep us motivated and elated. If we can make our children happy in the real world in such a way then why will there be a need to search for happiness in the virtual world?

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Immunity: Your Body's Personal Army

Immunity is the body's defence system that protects us from diseases. Think of it as an invisible shield that works day and night to keep you healthy. It involves a complex network of cells, tissues, and organs, with white blood cells playing the role of frontline soldiers.

There are two main types of immunity:

1. Innate Immunity: This is the first line of defence, something we're born with. It responds quickly and fights anything that seems foreign. This includes skin, mucus, stomach acid, and certain white blood cells.

2. Acquired (Adaptive) Immunity: This is the immunity we build over time by being exposed to diseases or through vaccines. It's like your body learning to recognize specific enemies and developing weapons to destroy them. Vaccines, for example, train your immune system without making you sick.

Immunity in the Indian Context: A Common Man's Concern

For the average Indian, immunity is not just about scientific definitions—it's about daily survival and health in the face of pollution, limited access to clean water, crowded living conditions, and rising lifestyle diseases like diabetes and hypertension. The COVID-19 pandemic, for example, made many Indians suddenly interested in "immunity boosters," from turmeric milk to kadha.

Common Factors Affecting Immunity in India:

1. Nutrition: Many people in India face malnutrition or imbalanced diets. Deficiencies in vitamins like D, C, and minerals like zinc weaken immunity.
2. Pollution: Air quality in cities like Delhi severely impacts respiratory health, making people more prone to infections.

1. Sanitation: Poor sanitation in rural and urban slums leads to higher rates of water-borne diseases like typhoid and cholera.

2. Healthcare Access: Delayed treatment, self-medication, and antibiotic misuse can compromise the immune system over time.

3. Traditional Remedies: Ayurveda and home remedies play a strong cultural role. While many are beneficial, not all are scientifically proven.

Interesting facts about Immunity (With an Indian Touch)

· **India has the world's largest immunization program.** The Universal Immunisation Programme (UIP) protects over 27 million newborns and 30 million pregnant women annually.

·**Your gut houses 70% of your immune system.** This makes traditional Indian foods like curd (rich in probiotics) important for immunity.

· **Despite abundant sunlight, many Indians have Vitamin D deficiency,** affecting immunity. Urban lifestyles and indoor work culture are major reasons.

·**Vitamin C-rich foods like amla (Indian gooseberry) and lemon are natural immunity boosters.** One amla contains as much Vitamin C as 20 oranges!

·**Yoga and meditation, rooted in Indian tradition, help regulate stress hormones,** which directly impact immune function.

·**India was polio-free by 2014,** a major public health victory made possible by consistent vaccination efforts.

What Can the Common Man Do to Stay Immune-Strong?

1. Eat a balanced diet: Include seasonal fruits, vegetables, whole grains, nuts, and probiotics.
2. Practice hygiene: Simple handwashing can prevent numerous diseases.
3. Exercise regularly: Even walking or doing yoga boosts immune function.
4. Sleep well: Poor sleep reduces immune response.
5. Avoid smoking and excessive alcohol: Both severely weaken your defences.
6. Get vaccinated: It's the easiest and safest way to build immunity.

Conclusion:

Immunity is more than just a buzzword; it's a silent warrior inside all of us. For India's common man, staying healthy often means relying on a mix of tradition, nature, and modern science. Understanding and improving immunity is not just a personal choice—it's a public health responsibility. And it starts with small, consistent actions.

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SCENE AT PEDIA CLINIC

एकाध गोद में चिपके neonate
कुछ कपड़े उठाकर दिखाते हुए पेट
दो चार बच्चे रोते चिल्लाते हुए
घुसने से पहले ही फड़फड़ाते हुए

पिछला इंजेक्शन याद रखने वाले
कुछ अचरज से शक्लें तकने वाले
एक्जामिनेशन टेबल पर यूँ ही लेटे हुए
कुर्सी छोड़ डस्टबिन पर बैठे हुए

पर्दे फाइलों की धज्जियाँ उड़ाते हुए
फ्रिज के पीछे छिपते छिपाते हुए
उल्टी-दस्त में लॉलीपॉप खाने वाले
मोबाईल देख भाप लगवाने वाले

कुछ का आते ही मासूम सलाम
या जय जिनेंद्र, नमस्ते, राम राम
चेहरे पर पूरे टाइम स्माइल
बंदर-टोपी में मारते स्टाइल

कुछ घर से ही सोच के आएंगे
के आज डाॅक्टर को लूट के आएंगे
खिलौने-चाॅकलेट की रिश्वत मिलेगी
तो ही मालिक चैकअप करवाएंगे

किसी को दवा चाहिए मीठी वाली
किसी को बोतल करनी है खाली
कोई चाइनीज़ में बात करने वाला
कोई बापू की शर्ट कुतरने वाला

किसी का प्रेशर क्लिनिक में बनता है
कोई बहती हुई नाक में सनता है
किसी को बस स्टेथोस्कोप चबाना है
किसी को बार बार वज़न कराना है

कुछ जो क्लिनिक में डाॅन से आते हैं
सीधे ही स्टूल पर तशरीफ जमाते हैं
गल्ले को खोल कर अवलोकन करते हैं
ना डाॅक्टर ना उसके बाप से डरते हैं

पैन, सैनेटाइज़र, टार्च और रैक
एक के बाद सब पर अटैक
पटर पटर घर के राज़ बकने वाले
104 डिग्री में भी ना थकने वाले

गर ऐसे बच्चों को आपने डराया तो
कहेगा 'ओऐ मुझे इंजेक्शन लगाया तो'
'चालान काट दूँगा,खोपड़ी तोड़ दूँगा'
'मुक्का मार दूँगा, बम फोड़ दूँगा'

गोया इलाके के गुंडे मवाली हों
या हमसे खानदानी दुश्मनी पाली हो
उनसे उलट कुछ सुस्ती की दुकान
लटकी शक्ल, रोतले और बेजान

बोले तो क्लिनिक कम चिड़ियाघर ज्यादा
इसी में जीवन निकलना है आधा
बोर होने का कोई सवाल नहीं
पीडियाट्रिक्स लेने का कोई मलाल नहीं

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मरीज़ आजकल :

डॉक्साब गूगल पे टाईम 9-12 दिखा रहा है, हम 12:30 आ जाएंगे, आप जाना मत।

'भाईसाब' आपने 'दुकान' खोल ली क्या??
'अंकल' आप 'शॉप' पे कितने बजे तक रहते हो?
'भैया', यार मुझे समझ नहीं आ रहा था तो सोचा आपसे ही पूछ लूँ।
अरे ये देखो बेटा, 'डॉक्टर मामा' के क्लिनिक पे आ गये, मामू को हाय बोलो।

डॉक्साब आपका भाई जिस स्कूल में पढ़ा है, हमारे बेटे के साले का भतीजा भी उसके सामने वाली स्कूल में पढ़ता है, हमसे थोड़े ही फीस लोगे।

"डॉक्साब घर पे एक चार महीने और अठारह साल की बच्ची को भी यही दिक्कत है, उनको भी यही दवाई दे दें??"
"डॉक्साब मेरी भी दवाई इसी पर्ची के पीछे लिख दो।"
"डॉक्साब आगे भी हर बुखार में ये सारी दवाई दे सकते हैं??"

डॉक्साब आपने तीन दिन की दवाई बोली थी, पर हमने सोचा अभी तो बॉटल भरी पड़ी है, तो 6-7 दिन और दे दी, अब खत्म हुई है। पर डॉक्साब अब इस दवाई से इसके दस्त लग गये, कोई एसी दवाई दो जिसका साइड-इफेक्ट ना हो।

डाक्साब बुखार आ रहा है, बार बार उल्टी दस्त जा रहा है, वजन नही बढ रहा, पॉटी में कीड़े निकलते हैं, चमड़ी पर दाने निकल रहे है। पर डाक्साब दवाई ज्यादा मत लिखना, ये लेता नहीं है।

(लीवर फेल हो चुका मरीज) : डॉक्साब भर्ती मत करो, सुबह शाम इंजेक्शन से काम नहीं चल जाएगा?

डॉक्साब आज ससुराल आई हुई हूँ, फोन पे दवा बता दो।
डॉक्साब आज शिमला आए हुए थे, फोन पे दवा बता दो।
डॉक्साब आज कोई लाने वाला नहीं है, फोन पे दवा बता दो।
डॉक्साब बारिश हो रही है, फोन पे दवा बता दो।
डॉक्साब बस छोटी सी दिक्कत है, फोन पे दवा बता दो।

(रात 11 बजे, घर की घंटी बजाकर) : डाक्साब पीछे वाली गली में ही रहते हैं, बच्चे को चार दिन से जुकाम था, हमको लगा आप घर पे ही तो होंगे, इसलिए आ गए, पडोसी होने का यही फायदा है, कभी भी जगा सकते हैं।

डाक्साब आपने सुबह फ्रूट्स खिलाने का बोला था, कीवी खिला दें??
(थोड़ी देर बाद): डॉक्साब, नारियल पानी की जिद कर रहा है, पिला दें क्या??
(थोड़ी देर बाद) : डॉक्साब, और कुछ खा नहीं रहा, एक दो चम्मच चाऊमीन दे दें क्या??

(जुकाम की दवा लेने के दस दिन बाद, जिसमें बीच में एक भी बार फॉलो-अप पर ना आए हों) : डॉक्साब, अच्छी दवाई लिखो थोड़ी, इस दवाई से तो कुछ आराम ही नहीं है, खाँसी वैसी की वैसी है।
डॉक्टर: बीच में थोड़ी ठीक थी खाँसी?
मरीज़: हाँ बस 3-4 दिन आराम पड़ा था
डॉक्टर: कुछ ठंडा खाया इन दिनों?
मरीज: बस एक दिन आइसक्रीम खाई थी, परसों इसकी बहन का बर्थडे था तो जरा सा केक खाया था, फ्रिज का पानी तो चुपके से पी जाता है डाक्साब, मानता नहीं है, इसे समझाओ। एसी के बिना तो डाक्साब इसे नींद ही नहीं आती। आप तो दवाई बढ़िया लिखो, एक दिन में तैयार ही जाए।

डॉक्साब ये तो रोज़ 100 रूपये के कुरकुरे, चॉकलेट खा जाता है। पिज्जा बर्गर तो बहुत ही पसंद है। रोज खिलौने लाता तोड़ता है। अरे पर डॉक्साब 200 रूपये फीस तो ज्यादा है, हम तो रेगुलर मरीज हैं, आपको सौ ही देंगे।

Dr Vishnu Pansari
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State Trainer, Childhood Tuberculosis

Childhood Tuberculosis -Some newer things in NTEP Guidelines

According to Global tuberculosis report for 2024 TB Burden in India accounts 24 % of the Global Childhood tuberculosis means it is a major public health problem. Surprisingly missed case gap is highest in <5 year of age group because TB control strategy not so well equipped for diagnosis of TB among children.

Symptom Characterization for suspecting TB

Definition-

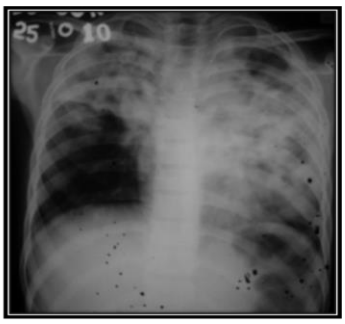
- Persistent fever for > 2w without a known cause
- Unremitting cough for > 2w
- Weight loss of 5% or no weight gain in past 3m despite adequate nutrition or failure of nutritional rehabilitation in babies with SAM with or without contact with patient with pulmonary TB in past 2 years

Initial screening test-

Chest X ray suggestive of tuberculosis

Hilar or paratracheal L.N

Milliary



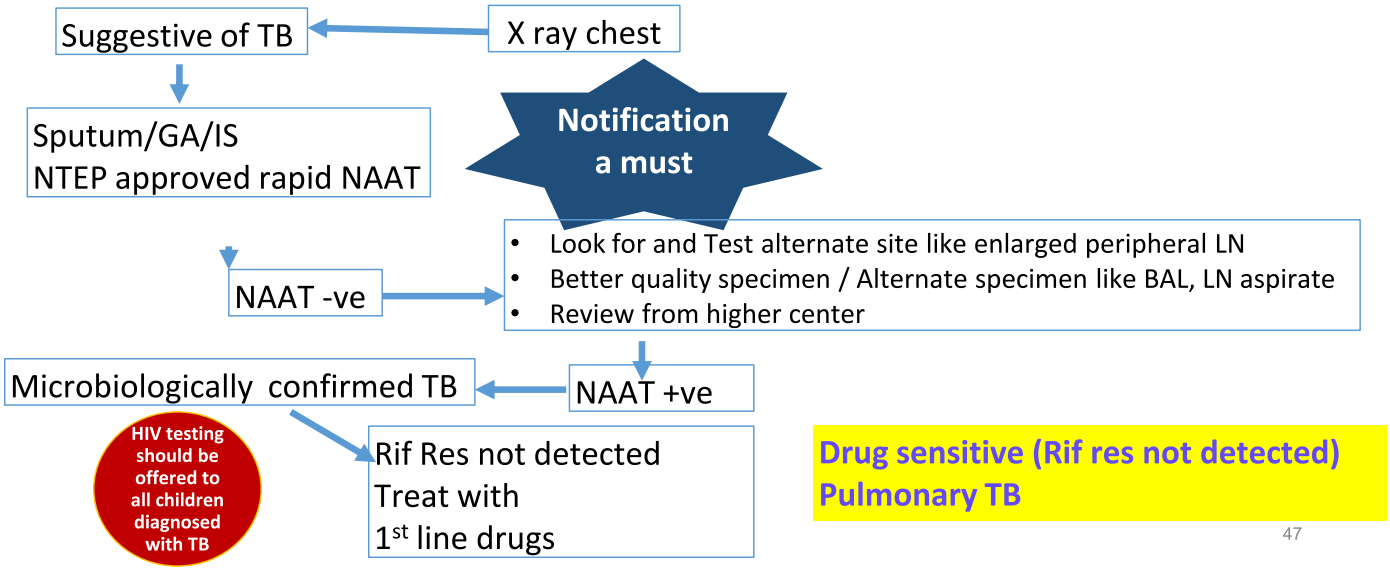
Fibrocavitary

Microbiological diagnosis -Confirmed diagnosis means either showing presence of pathogen (smear or NAAT).

Complete diagnosis: means knowing about rifampicin resistance (at least).

Currently all cases of TB must tested for presence of Rifampicin resistance (RRTB) upfront, to appropriately align therapy.

Only NTEP approved rapid NAAT test should be used.



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Regimen for TB (RS TB)

IAP NTEP guidelines 2019

Type of patient[a]	Regimens
New microbiologically confirmed RS Pulmonary TB New Clinically diagnosed Pulmonary TB (probable RSTB) New microbiologically confirmed RS extra-pulmonary TB New Clinically Diagnosed extra-pulmonary TB (probable RSTB) Drug sensitive Previously Treated TB[c] (Recurrent, Treatment after loss to follow up, Treatment after Failure)	2HRZE+ 4HRE[b]

a. Molecular testing shall be done in all new cases in children with suspected TB at diagnosis and RSTB (Rifampicin resistance not detected) cases included in this regimen

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b. In case of Neuro and spinal TB the continuation phase is extended to 10 months

c. All these category of children shall be evaluated as DR TB suspects and evaluated as per DR TB Algorithm. DST based treatment shall be followed. In case they are found to be Rifampin (and INH) sensitive, they shall be re-started on the regimen as for a new case. This group was earlier treated with CAT II regimen which is now withdrawn from NTEP.

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"Future Genes, Present Laughs"

1. In 2050:
"Sir, your DNA shows you are not suitable for marriage. Too much 'mommy issues' gene."
"But I love her!"
Sorry, emotional damage is hereditary.

2. In 2070, kids will say:
"Mom, did you and dad fall in love?"
Mom: "No beta, we just had a 96% DNA match."

3. In the future, parents won't ask "What does he do?"
They will ask:
"Beta, show me his DNA. Does he have the 'stability' gene?"

4. Infection Alerts (Future Smartwatch):
"My smartwatch just told me I am 83% likely to catch a cold from my coworker."
Mine just told me I am 100% related to the virus. Apparently, it mutated from my own cells.

5. Doctor: "The bad news is you are infected."
Patient: "And the good news?"
Doctor: The infection is 47% genetically compatible with your DNA. You are now family.

6. Future Hospital Visit:
Nurse: "The infection mutated."
Patient: "Into what?"
Nurse: Into your identical twin. We are not sure which one of you is the original anymore.

Dr. Sumita Nayak
Senior Consultant
President IAP Bengaluru

Tree of Life

Jaipur Pida MID TERM 2025

PEDIATRIC INFECTIOUS DISEASE ACADEMY

HOSTED BY IAP JAIPUR

Date : 05th & 06th July 2025 | Venue : Rajasthan International Centre (RIC) Jaipur

PIDA MIDTERM 2025

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