ISA Indian Society of Anaesthesiologists

Eternal Vigilance

UTTAR PRADESH STATE BRANCH

Nishchetak

The official newsletter of ISA UP State

"Mentors in White, Warriors in Green: A Tribute to Teachers and Defence Anaesthetists

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UTTAR PRADESH STATE BRANCH

Nishchetak

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Message from President, ISA UP State

A Year of Academic Excellence, Professional Unity, and Collective Progress

Dear colleagues,

It gives me immense pleasure and deep satisfaction to reflect on the past year of the Indian Society of Anaesthesiologists, Uttar Pradesh State Branch (ISA UP). It has been a year of collective endeavour, academic enrichment, professional collaboration, and renewed commitment to advancing the speciality of anaesthesiology and critical care.

As I look back on this remarkable journey, I am reminded that our society's true strength lies not only in the activities we organise, but also in the knowledge we share, the relationships we nurture, and the lives we touch through professional excellence.

Strengthening Academic Excellence and Continuing Medical Education

One of our foremost priorities has been promoting academic excellence through conferences, continuing medical education programmes, workshops, webinars, and scientific deliberations. We have continued to create opportunities for knowledge exchange, professional development, and meaningful interaction among senior faculty members, practising anaesthesiologists, and postgraduate students.

These initiatives have reinforced the importance of evidence-based practice, research, innovation, and lifelong learning. We remain committed to empowering our younger colleagues with the knowledge, skills, and confidence they need to meet the evolving challenges of modern anaesthesiology.

Nurturing Young Talent and Building Professional Unity

The future of our speciality rests in the hands of young anaesthesiologists. Through academic postgraduate assemblies and various other initiatives for postgraduate students, ISA UP has continued to encourage young professionals to participate in scientific activities and assume active leadership roles.

Our commitment goes beyond academic learning to include mentorship, professional camaraderie, and an inclusive environment where every member feels valued and inspired.

UPISACON 2026: A Celebration of Knowledge and Fellowship

A major milestone this year was the successful organisation of the 48th Annual Conference of ISA UP, UPISACON 2026, in Varanasi from 2-4 October 2026. The three-day academic gathering brought together more than 350 delegates and 150 faculty members from across India, creating a vibrant forum for scientific exchange, clinical learning, and professional fellowship.

The conference explored the expanding horizons of anaesthesiology, including perioperative medicine, critical care, pain management, patient safety, and emerging healthcare innovations. Distinguished academicians and experts enriched the scientific discussions and reaffirmed the value of collaboration in advancing our speciality.

For us in Varanasi, hosting this prestigious conference was both an honour and an opportunity to strengthen ISA UP's academic legacy.

Expanding Our Academic Vision

As we move forward, ISA UP remains committed to strengthening its academic framework, encouraging research and publications, supporting faculty development, and expanding opportunities for structured continuing medical education.

Our vision is to build a society that not only responds to the profession's changing needs but also actively shapes the future of anaesthesiology through innovation, collaboration, and academic leadership.

Gratitude: The Foundation of Our Success

No achievement is the work of one individual. Every success comes from collective dedication, teamwork, and a shared sense of purpose.

I extend my sincere gratitude to ISA's national leadership, our senior mentors, past presidents, executive committee members, city branch office-bearers, faculty members, organising teams, and every member of ISA UP. I especially acknowledge the enthusiasm of our younger colleagues and postgraduate students, whose energy and participation continue to strengthen our society.

I am also grateful to our institutional leadership, collaborators, and industry partners for their valuable support in advancing our academic mission.

As my tenure as President draws to a close, I look back with deep gratitude and forward with optimism. True leadership is not about individual accomplishments; it is about building institutions, nurturing people, and leaving a stronger foundation for those who follow.

ISA UP's journey must continue with renewed determination, greater inclusivity, scientific integrity, and an unwavering commitment to patient safety.

Let us continue to learn, grow, and serve together. May ISA UP reach greater heights of academic excellence and professional distinction while remaining steadfast in its commitment to the welfare of our members and the patients entrusted to our care.

Together, let us transform knowledge into competence, collaboration into progress, and professional commitment into better patient outcomes.

"The true measure of leadership is not what we achieve during our tenure, but the strength of the legacy we leave behind."

With warm regards and best wishes,

Rajeev Kumar Dubey

Dr. Rajeev Kumar Dubey



Message from Secretary, ISA UP State

Taking Indian Airway Expertise to the Global Stage

My Experiences at International Airway Conferences in the USA and Malaysia

Representing India at two prestigious international airway conferences in September 2026 was both an honour and an enriching academic experience. I had the privilege of participating as an invited speaker at the Society for Airway Management (SAM) Annual Meeting in Boston, USA (17–20 September) and the Regional Airway Meeting in Malaysia (25–27 September). These platforms brought together leading airway experts from across the world, offering opportunities to exchange ideas, discuss innovations and reflect upon the evolving science of airway management.

At the SAM conference in Boston, I presented my work on retrograde intubation, highlighting the continued relevance of this technique in managing difficult airways, particularly in resource-limited settings. At the Regional Airway Meeting in Malaysia, I spoke on airway management in giant anterior mediastinal tumours, addressing the challenges of maintaining airway patency and ensuring patient safety in complex clinical situations. Both presentations provided opportunities to showcase clinical experience from India and engage with international colleagues on practical approaches to challenging airway scenarios.

What made these experiences particularly meaningful was the opportunity to demonstrate that Indian anaesthesiologists have much to contribute to global medical education. Our clinical diversity, adaptability and experience in managing challenging cases offer valuable perspectives to the international scientific community. I returned with new ideas, professional connections and a renewed conviction that academic exchange must be a two-way process. International conferences are not merely opportunities to learn from the world; they are opportunities to share what the world can learn from us. I hope such interactions encourage more young anaesthesiologists to pursue research, innovation and international academic collaboration.

Dr. Tanmay Tiwari



Editor's Note, Nishchetak

Dear Colleagues,
It gives me immense pleasure to present the July-September edition of our newsletter, a reflection of the collective wisdom, achievements, and enduring spirit of our anaesthesia fraternity.

This edition celebrates "Mentors in White, Warriors in Green", a tribute to two remarkable pillars of our profession—our teachers, who shape generations of anaesthesiologists, and our defence anaesthetists, whose commitment to healing transcends the boundaries of comfort and circumstance.

Anaesthesiology is a specialty where excellence often unfolds away from the spotlight. Yet, behind every successful intervention lies a legacy of mentorship, perseverance, innovation, and quiet courage.

Through these pages, we hope not merely to document accomplishments, but to celebrate the people, experiences, and values that define our professional journey.

For knowledge makes us competent, experience makes us confident, but compassion and commitment make us truly worthy of the trust placed in us.

I extend my heartfelt gratitude to all our contributors and readers for keeping this dialogue of learning and inspiration alive.

Warm regards,

Dr Bhavya Naithani Dube

ISA Indian Society of Anaesthesiologists

UTTAR PRADESH STATE BRANCH

wholeheartedly welcomes the new executive committee of ISA Uttar Pradesh



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2025-2028
DR RAJNEESH MISHRA



2025-2028
DR ANKIT KUMAR



2026-2029
DR HIMANSHU PRINCE

ISA UP State News & Activities



Operation Theatre Se Janta Tak - Episode 1

- Branch - ISA UP State
- Date - 2026-08-12
- Venue - Facebook Live
- Description - Episode 1 - Organ Donation
- 12th August 2026 | 7 PM Onwards | Facebook Live
- Together, Let's Spread Awareness Because One Donor Can Save Many Lives



Anaesthesia Awareness Program - On Air with Akashvani

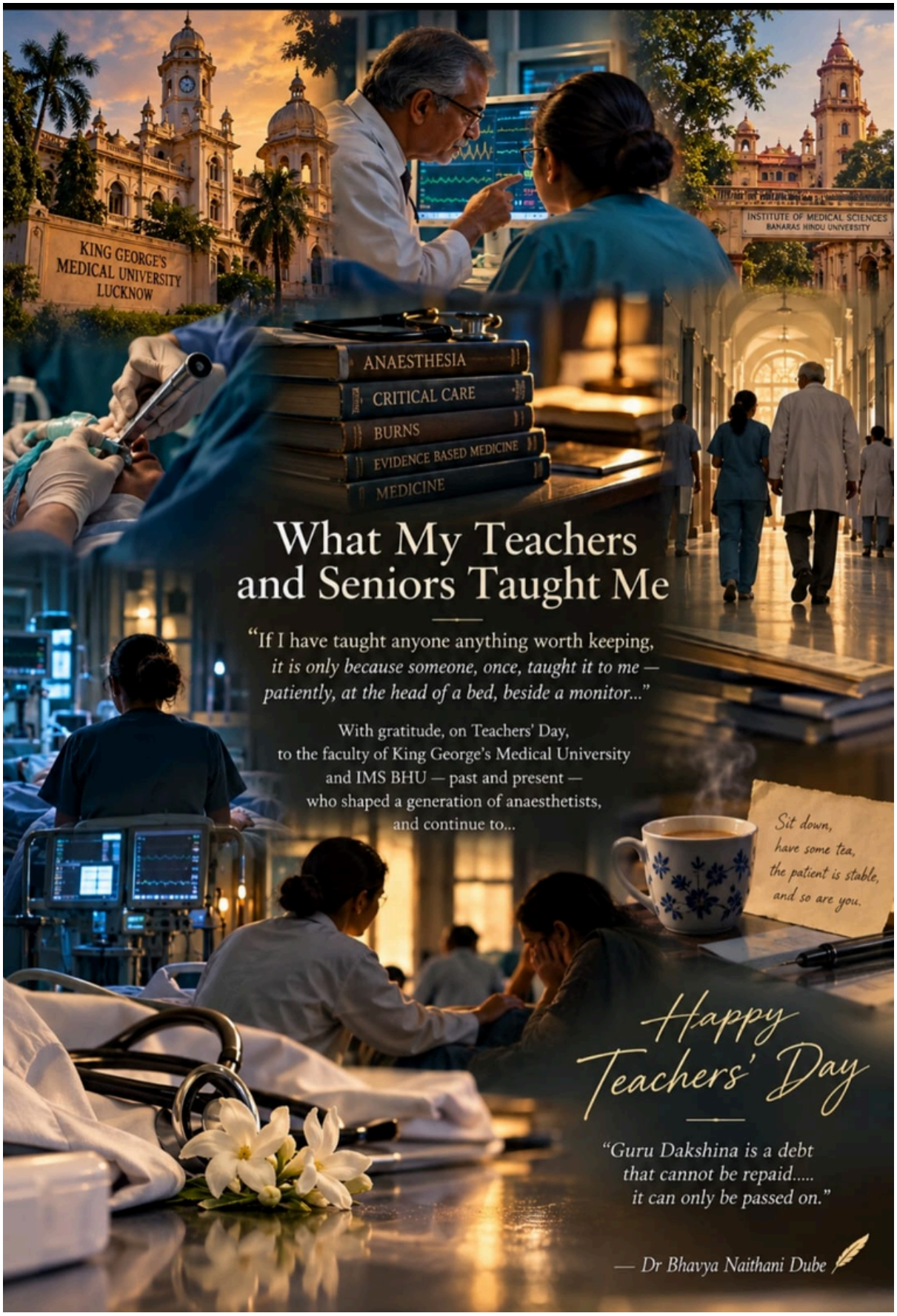
- Branch - ISA UP State
- Date - 2026-08-22
- Venue - Akashvani Radio Station
- Description - Explaining the Myths & Facts related to Anaesthesia

ISA UP State News & Activities



ISA UP State PG Case Series - Aug 2026

- Branch - ISA UP State
- Date - 2026-08-06
- Venue - Virtual
- Description - Case 1- Anaesthetic considerations in a case of mitral stenosis. Case 2- Anaesthetic considerations in a case of obstructive jaundice


KING GEORGE'S MEDICAL UNIVERSITY LUCKNOW
INSTITUTE OF MEDICAL SCIENCES BANARAS HINDU UNIVERSITY
ANAESTHESIA
CRITICAL CARE
BURNS
EVIDENCE BASED MEDICINE
MEDICINE
What My Teachers and Seniors Taught Me
"If I have taught anyone anything worth keeping,
it is only because someone, once, taught it to me —
patiently, at the head of a bed, beside a monitor..."
With gratitude, on Teachers' Day,
to the faculty of King George's Medical University
and IMS BHU — past and present —
who shaped a generation of anaesthetists,
and continue to...
Sit down,
have some tea,
the patient is stable,
and so are you.
Happy Teachers' Day
"Guru Dakshina is a debt
that cannot be repaid.....
it can only be passed on."
— Dr Bhavya Naithani Dube

What My Teachers and Seniors taught me

Dr Bhavya Naithani Dube

If I have taught anyone anything worth keeping, it is only because someone, once, taught it to me — patiently, at the head of a bed, beside a monitor ....
With gratitude, on Teachers' Day, to the faculty of King George's Medical University and IMS BHU— past and present — who shaped a generation of anaesthetists, and continue to.....

They taught me to stand at the head of the bed before I touched the patient — to look first at the whole person, at the colour of the lips, the rise of the chest, the small tremor of a hand on the sheet. The monitor, they said, will tell you numbers. The patient will tell you everything else, if you know how to look.

They taught me the language and secrets of the pulse

They taught me the airway. Not as a chapter, but as a discipline. That the moment you assume it will be easy is the moment it will not be. That you check your equipment before you check your confidence. That the difficult airway is not an emergency if you have already imagined it, three times, on the way to the operating room.

They taught me to be afraid, correctly. Not the fear that freezes, but the fear that makes you double-check the drug, the dose, the side, the consent. Fear, they said, is not the opposite of competence. Carelessness is.

They taught me to write clearly in the case sheet — because someone will read it at three in the morning, tired, and their decision will rest on your sentence. A vague note is not humility. It is a small act of abandonment.

They taught me to say I don't know. To say it in front of juniors, in front of seniors, in front of the family. And then to go and find out, and come back, and say it again — this time, with the answer.

What My Teachers and Seniors taught me

They taught me the ward round as a form of respect. That you do not lean on the bed of a patient who cannot lean back. That you speak to the person, not across them. That you introduce the youngest resident to the oldest patient, because both of them are learning something today.

They taught me the burns ward — the smell that does not leave your coat, the dressings that take longer than the surgery, the mother sitting outside for the eleventh day. They taught me that resuscitation is arithmetic and that recovery is patience, and that between the two lies almost everything a doctor is asked to do.

They taught me the ICU at night. The small blue light of the ventilator. The nurse who has been there longer than you and knows more than you and will, if you are wise, tell you so without saying it. They taught me to listen to her.

They taught me to break bad news slowly. To sit down. To use the patient's name. To let the silence be long. To not fill it with statistics. To offer water, a chair, a hand — whichever the family reaches for first.

They taught me to teach. That the resident watching you intubate is learning not only the manoeuvre but the manner. That how you speak to the theatre technician is part of the lesson. That a teacher is always, whether they wish it or not, being copied.

They taught me the library and the journal club. That an opinion is not an argument, and an argument is not evidence, and evidence is not certainty. That you read the paper, then the methods, then the funding, then the paper again.

They taught me the corridor conversations — the real curriculum. What to do when a colleague is struggling. When to escalate. When to protect a junior. When to stand your ground with a surgeon, and how to do it without breaking the case.

What My Teachers and Seniors taught me

They taught me the long white corridors themselves — the marble worn smooth by generations of hurried footsteps, the notice boards layered with decades of announcements, the trees in the courtyard older than any of us. KGMU is not only a place. It is a lineage. To wear its coat is to inherit something you did not earn alone.

They taught me that medicine is not what you know on the day of the exam. It is what you remember at four in the morning, when the exam is a patient, and the only invigilator is your own conscience.

And some of them — the ones I still carry — taught me by the smallest things. The way a professor paused before entering the ICU, as if gathering himself. The way another always thanked the ward boy by name. The way a third, on the worst night of my first year, put a hand on my shoulder and said only, sit down, have some tea, the patient is stable, and so are you. That is what my teachers at KGMU taught me. Not a syllabus. A way of standing in the world, in a white coat, at the head of the bed, when someone else's life is briefly, entirely, in your hands.

I forget the doses sometimes. I do not forget them.

GURU DAKSHINA is a debt that cannot be repaid.....it can only be passed on
#happpyteachersday

ISA UP
City Branches
News & Activites

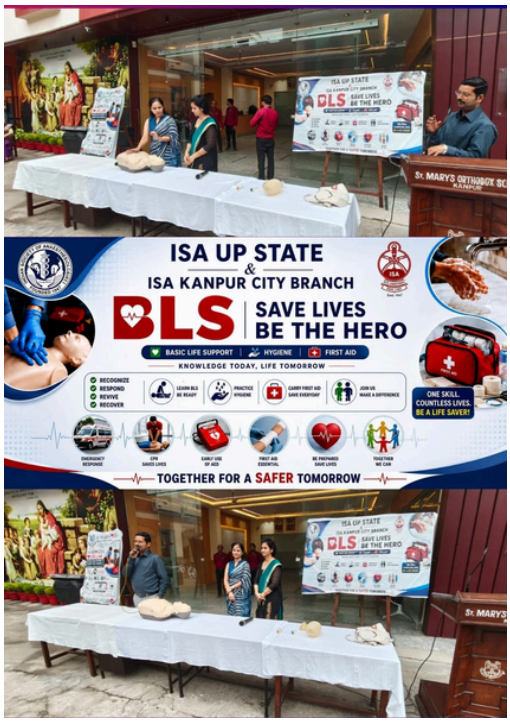
ISA Gorakhpur



ONCOS 1.0 2026

- Branch - ISA Gorakhpur
- Date - 2026-08-01
- Venue - AIIMS Gorakhpur
- Description - Theme: Newer Clinical, Operative and Supportive (Palliative) Strategies in Oncology ONCOS 1.0, 2026 brought together experts in anaesthesia, surgery, oncology, intensive care, palliative care, nursing, and research to discuss advances in comprehensive perioperative cancer care. The conference attracted over 100 delegates from across the country.

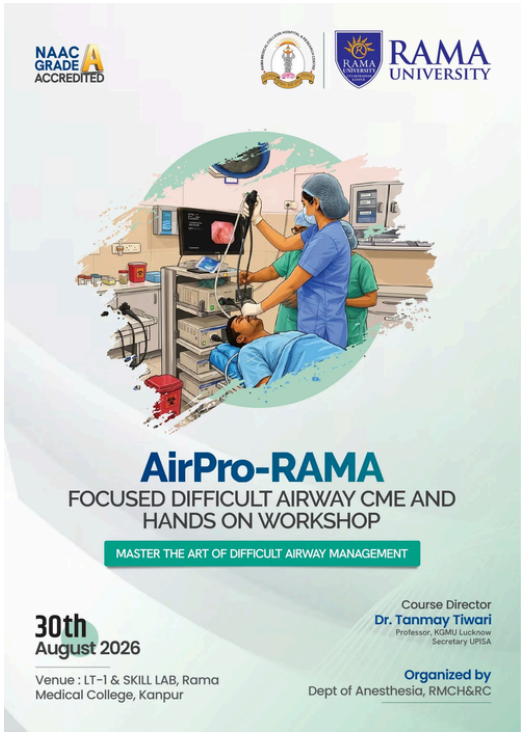
ISA Kanpur



Basic Life Support (BLS)

- Branch - ISA Kanpur
- Date - 2026-08-19
- Venue - St. Mary's Orthodox School, Kanpur
- Description - ISA UP STATE & ISA KANPUR CITY BRANCH | BLS AWARENESS ACTIVITY "SAVE LIVES. BE THE HERO." The Indian Society of Anaesthesiologists (ISA) - UP State & ISA Kanpur City Branch conducted an impactful Basic Life Support (BLS), First Aid & Hygiene Awareness Programme at St. Mary's Orthodox School, Kanpur on 19 th August 2026

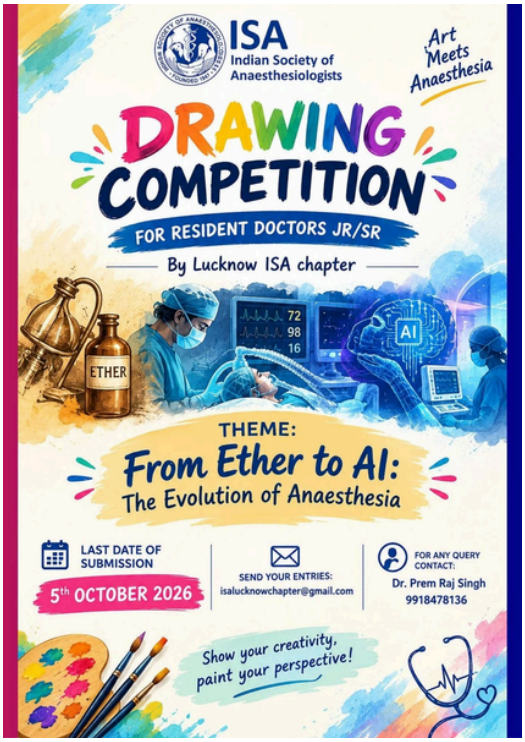
ISA Kanpur



AirPro-RAMA

- Branch - ISA Kanpur
- Date - 2026-08-30
- Venue - Rama Medical College, Kanpur
- Description - ISA Kanpur and ISA UP State presents AirPro-RAMA Focused Difficult Airway CME & Hands-on Workshop Master the Art of Difficult Airway Management

ISA Lucknow



DRAWING COMPETITION - FOR RESIDENT DOCTORS

- Branch - ISA Lucknow
- Date - 2026-10-05
- Venue - Virtual
- Description - The Lucknow ISA Chapter invites all Resident Doctors (JR/SR) to participate in a creative Drawing Competition. Theme: "From Ether to AI: The Evolution of Anaesthesia" Express your creativity and imagination through art, depicting the remarkable journey of Anaesthesia—from the era of Ether to the age of Artificial Intelligence.

ISA Lucknow



Case Presentation for PG Students

- Branch - ISA Lucknow
- Date - 2026-08-25
- Venue - RMLIMS, Lucknow
- Description - 2:30 PM onwards

ISA Noida



Monthly CME: August 2026

- Branch - ISA Noida
- Date - 2026-08-18
- Venue - Venue- Zoom (virtual)
- Description - Peripheral nerve blocks for hip surgeries

ISA Noida



ISA Panchrakshak 2.0 - Social Outreach Program

- Branch - ISA Noida
- Date - 2026-08-25
- Venue - Noida Stadium
- Description - A special and heartfelt thank you to ISA National Headquarters for conceptualizing and organizing this wonderful Social Outreach Program and for creating such an informative and easy-to-understand educational video. Using this initiative and the video, we were able to demonstrate the five life-saving skills to a number of people at Noida Stadium. It turned out to be a small but very meaningful and effective awareness program.



Radio Talk

- Branch - Noida
- Date - 2026-07-01
- Venue - Radio
- Descripiton - Dr Ankita Sharma, Executive Member of ISA NOIDA, G. B Nagar got the opportunity to be on air at 92.7 bigfm on the occasion of Doctor's Day on July 1st 2026.

She was interviewed by RJ Khurafati Nitin on -

1. What it feels to be a Doctor?
2. How and when has it happened that you had to sacrifice your family for being a Doctor?
3. Are you a First Generation Doctor of your family?

ISA Noida



ISA Panchrakshak 2.0 - On Teachers' Day

- Branch - ISA Noida
- Date - 2026-09-12
- Venue - First Cry Intellitos, Noida Sector 50
- Description - On Teachers' Day Celebrations -12th September 2026

The Literary Ledger

The Grace of Life Beyond Goodbye

Dr Divya Srivastava, MD, PDCC Organ transplant anesthesiology
Additional professor
Sanjay Gandhi post graduate institute of medical sciences, Lucknow

As the world, including Indian Society of Anaesthesiologists (ISA) observes Organ Transplant Week, between 3 rd to 13 August , share a poem that explores perhaps the most difficult decision a parent could ever make.
As doctors, we witness the extraordinary gift of organ donation. We celebrate the lives saved, the second chances granted, and the miracles made possible by medical science.

But behind every transplant is another story—one of unimaginable loss, extraordinary courage, and a family that chose to give when life had taken everything from them.
The Grace of Life Beyond Goodbye is written from the perspective of a mother who must let her son go, yet finds the strength to allow parts of him to live on in others.

Because sometimes, the greatest act of love is not holding on, but allowing life to continue beyond goodbye.



Poem by Dr Divya Srivastava



Poem by Dr Divya Srivastava



The Grace of Life Beyond Goodbye

So I place my trembling hand
upon your forehead
and give the only answer
love has left me.

Yes.

Take his heart.
Let it thunder in a stranger's chest
when mine has learned
the slow language of grief.

Take his lungs.
Let some child run into the morning
and waste his breath on laughter.

Take his eyes.
Let someone see the face of
the mother who has waited
years to be seen.

Take his liver —
let it cleanse the blood of someone
who has been waiting too long
for the body to forgive itself.

Let it return colour to a waning face,
appetite to a child's mouth,
ordinary mornings to a family
that had begun to measure time
in hospital corridors
and whispered prayers.

Let another mother watch her son
rise from a bed
I cannot bring mine back from.
Let her hear him ask for food,
complain about school,
leave his shoes in the doorway —
all the small, unbearable mercies
I would surrender heaven
to witness again.

Take what still knows how to heal.
Take all that can still be given —
not because I am brave,
but because you were kind.

Organ donation can offer grieving families a meaningful positive outcome while giving patients another chance at life; in India, a deceased donor may save up to eight lives, subject to medical suitability and allocation.

Tonight, one mother will return
to a room that still remembers you.
She will touch the shirt you last wore,
hold the pillow that has forgotten your warmth,
and weep with the terrible knowledge
that no miracle will make you hungry again,
or late again,
or young again.

But somewhere, other mothers will wake
to sounds they thought they had lost forever:
a steadier heartbeat,
a deeper breath,
a child calling from another room,
a future opening its frightened hands.

Let them smile.
Let them hold their children
with the fierce, astonished gratitude
of those who have been given back
what they were learning to bury.

I will keep the part of you
that no surgeon can recover:
your first cry,
your crooked smile,
the weight of your sleeping head
against my shoulder.
I will carry the silence.
I will carry your absence
like a second body within me.

But you —
you will not be only gone.
You will beat.
You will breathe.
You will see.
You will heal in another body.

My son,
I could not keep you,
so I gave the world
what remained of my heart.

— Dr Divya Srivastava
Additional Professor
Transplant Anaesthetist
Sanjay Gandhi Postgraduate Institute
of Medical Sciences (SGPGIMS), Lucknow

Obesity



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In the world, food grains are available in due season; every crop has a specific harvest time. Consequently, we store these grains so that they may serve us when needed. Similarly, our bodies possess fat cells—located in various regions—that store dietary fat (in the form of triglycerides) so that it can be utilized during times of necessity. In an emergency, our body converts this stored fat into energy, enabling us to fast for several days. However, when fat is consumed in excessive quantities—and compounded by modern unhealthy lifestyles, genetic predispositions, and other complex physiological issues—it begins to harm the body. It then manifests as the disease known as obesity, which, in turn, triggers the onset of various other ailments. The World Health Organization (WHO) officially recognized obesity as a disease in 2004, when it had reached epidemic proportions.

So, what exactly is obesity? Obesity is defined as the excessive accumulation of body fat in various locations throughout the body. It is not merely a matter of being "overweight," as body weight can also be attributed to muscle mass. Obesity is not bound by age, race, gender, or any other demographic factor; it can occur at any stage of life. It has now become increasingly prevalent among children as well, serving as an open invitation to a host of diseases: high blood pressure, diabetes, heart disease, respiratory and pulmonary disorders, various liver ailments, joint diseases, cancer, sleep disorders, mental health issues, and—particularly in women and young girls—various disorders affecting the uterus and ovaries, as well as infertility and other reproductive health issues.

Due to urbanization and improved economic conditions, modes of transportation have become readily available, resulting in physical activity levels dropping to near-zero. Furthermore, the easy availability of processed foods—which are high in caloric content but contain very few, if any, essential nutrients—inevitably leads to an increase in waist circumference.

Obesity

How to Evaluate (Assess) Obesity:
Assess the condition based on five key parameters:

1. Information regarding the individual's history of obesity.
2. A comprehensive physical examination of the individual.
3. Diseases or ailments associated with obesity.
4. Parameters of physical fitness.
5. The individual's willpower.

Every affected individual must understand the critical importance of comprehending and treating obesity—particularly in the context of lifestyle modifications. It is essential to listen attentively to the individual's entire narrative, including their daily routine, dietary habits, other health issues stemming from their obesity, and—fundamentally—whether the individual (be it a woman, man, or child) genuinely desires to overcome their obesity. One must ascertain the specific type of assistance they require, the amount of time they can commit, and whether they perceive obesity as a distinct disease and a root cause of other ailments.

Causes of Obesity: The primary causes are related to dietary habits—specifically, the timing of meals, the quantity consumed, and the quality of the food (i.e., the proportion of proteins, fats, carbohydrates, minerals, vitamins, etc., present in the diet).

Obesity stems from a multitude of factors. The principal cause is an imbalance in dietary intake. Furthermore, factors such as age, gender, genetics, hormonal balance, and stress play a significant role in the development of obesity. Contemporary diets frequently feature fast food and high-calorie beverages. Moreover, individuals suffering from obesity often experience persistent hunger—feeling hungry again shortly after having consumed a substantial meal.

Genetics: Genes play a pivotal role in the body's metabolism and distribution of fat. Obesity frequently runs in families. This phenomenon is not solely due to heredity; it also arises because family members often share identical cooking methods and eating habits. If one or both parents are obese, the risk of their child inheriting obesity is significantly higher.

Emotions: Emotions such as boredom, anger, and depression can lead individuals to overeat, even when they do not feel physically hungry. Stress plays a critical role in the onset of obesity; when individuals are unable to cope effectively with stress, they often turn to consuming high-calorie foods as a coping mechanism.

Obesity

Gender – Women tend to gain more weight compared to men, even when their caloric intake is equivalent to that of men. Men possess a higher muscle mass, and muscles burn more calories.
Age – As age increases, both the metabolic rate and caloric requirements decrease; this results in a loss of muscle mass and an increase in body fat.

Health Conditions – Certain health conditions—such as depression, Cushing's syndrome, and Polycystic Ovarian Syndrome (PCOS)—can contribute to obesity. Furthermore, certain medications—including contraceptive pills, antidepressants, and steroids—can promote overeating and contribute to weight gain.

Lifestyle Choices – Certain lifestyle choices—such as an unhealthy diet, physical inactivity, smoking, and alcohol consumption—can lead to obesity. An unhealthy diet, particularly one that includes fast food (which is high in calories and low in fiber—i.e., fruits and vegetables), promotes weight gain. Physical inactivity and a sedentary lifestyle hinder fat burning and contribute to weight gain. Weight gain is directly proportional to the number of hours spent sitting in one place while using a phone, tablet, or laptop. Excessive consumption of alcohol and sugary soft drinks can be directly linked to obesity. High-calorie beverages, when consumed alongside fast food, rapidly accelerate the onset of obesity.

Obesity in Children

Obese children are at a higher risk of developing various other disorders, including:

- Type 2 Diabetes (excessive sugar levels in the blood)
- Hypertension (high blood pressure)
- High Cholesterol (excessive fat levels in the bloodstream)
- Fatty Liver Disease (excessive fat accumulation in the liver, which can lead to liver dysfunction)
- Obstructive Sleep Apnea (breathing difficulties during sleep that can impair concentration and focus during the day)
- Vitamin D deficiency
- Precocious puberty (especially in girls) and advanced skeletal age
- Polycystic Ovary Syndrome (in girls)
- Joint pain (particularly hip/knee pain)
- Behavioral/mental health-related concerns

Obesity

These potentially serious issues can begin in childhood and persist into adulthood. Studies tracking children through to adulthood have shown that children who are obese typically remain obese as adults. Some doctors conduct fasting blood tests and collect urine samples to screen for elevated glucose and cholesterol levels. Additionally, for some children and adolescents, blood tests may be performed to assess liver function, pubertal status, and Vitamin D levels.

Additional strategies to help improve your child's eating habits and physical activity include:

1. Caregivers as Role Models: You play a highly influential role in shaping your children's attitudes toward food and exercise. If you consume healthy foods and engage in daily physical activity, your child is likely to adopt similar eating habits and exercise routines.
2. Create a Positive Food Environment: Make fruits, vegetables, and nutritious foods readily available. To minimize temptation, avoid keeping unhealthy snacks and beverages at home.
3. Establish Structured Meals and Snacks: Encourage your child to eat three meals a day, along with two small, healthy snacks between meals. Discourage skipping meals, as this can lead to overeating. Furthermore, grazing—or frequent, unstructured eating—can heighten hunger and diminish feelings of satiety, potentially resulting in overconsumption. Establishing specific meal times is crucial for maintaining a healthy dietary routine. Ideally, meals should serve as social family gatherings.
4. Involve your child in grocery shopping and meal preparation.
5. Minimize eating out and consuming outside food.
6. Limit screen time and avoid eating while using screens.
7. Aim to have at least one family meal together each day.
8. Do not use food as a reward or a punishment.
9. Make physical activity fun. Find activities that your child enjoys.
10. Encourage better sleep habits. On average, children require 9-11 hours of sleep per night. Screens should be turned off at least 30-60 minutes before bedtime.

Obesity Management and Treatment:

1. Management
2. Treatment
3. Medications
4. Weight Loss Surgery (Bariatric)

Obesity

Management: When discussing weight loss, we invariably emphasize the importance of a healthy diet and exercise. A third, crucial element—which is often overlooked—is adequate sleep. Adequate sleep does not simply mean getting 6 to 8 hours of sleep at any random time of the day; more importantly, it refers to *when* you sleep. Adhering to your biological clock is the key to good health and well-being. Altered sleep patterns—specifically, sleeping at irregular hours—contribute to eating at inappropriate times, which in turn disrupts metabolism. Getting 7-9 hours of sleep daily at the right time is essential. Irregular sleep schedules encourage late-night eating—often involving high-calorie, processed junk foods. Furthermore, the lack of physical activity following such eating results in the body storing these calories as fat during sleep. Consequently, the individual typically wakes up late the next morning and feels lethargic throughout the day.

And then, the very next day, that same routine begins anew; within this cycle, a few hundred grams of weight are gained each day—an increase we often fail to even notice. If an individual is doing nothing wrong with their diet yet still observes their weight increasing, they might be surprised to learn that sleep, too, can play a significant role in this process. In fact, getting less than seven hours of sleep can diminish—or even completely negate—the benefits derived from diet and exercise. Sleep deprivation, in turn, triggers food cravings—specifically for calorie-dense foods.

Treatment : The initial and most critical aspect of treating obesity focuses on education regarding healthy food choices and regular physical activity. Treatment plans typically include detailed recommendations for modifying eating habits and incorporating exercise. A healthy diet consists of a variety of vegetables and fruits; whole grains (such as barley, bulgur, quinoa, and whole-grain bread); lean proteins (including fish, skinless chicken, beans, and nuts); and low-fat or fat-free dairy products (such as milk, yogurt, and cheese). The consumption of sugary beverages—such as juices, sodas, sweetened teas, chocolate milk, or strawberry milk—should be either strictly limited or eliminated entirely. Furthermore, the intake of carbohydrates (such as chips, cookies, cakes, and candy) should be restricted.

The energy content of food is typically expressed in terms of calories per specific serving size (measured by weight or volume). For most individuals, reducing daily caloric intake constitutes a vital component of their treatment plan. Controlling portion sizes lies at the very heart of healthy eating. A nutritionist can engage in a discussion with you and your child to provide education on healthy dietary practices. Through this dialogue, a personalized, healthy meal plan can be developed specifically for your child.

Obesity

Meal plans, dietary regimens, and nutritional supplements are widely available. Social media platforms and the internet also offer various tools and resources for weight loss. However, it is crucial to note that certain plans may not be safe or suitable for children. Moreover, not every plan works effectively for every individual.

Exercise and physical activity are essential for good health and can aid in weight loss. Children aged 3 to 5 years should remain physically active throughout the day. Children aged 6 to 17 years should engage in at least 60 minutes of moderate-to-vigorous physical activity daily. However, without making changes to dietary habits, exercise alone will not result in significant weight loss.

Key Medications for Obesity:

- Semaglutide
- Tirzepatide
- Liraglutide
- Orlistat
- Phentermine-Topiramate
- Naltrexone-Bupropion

Medications: While diet and exercise are often helpful, some children and adolescents are unable to achieve significant weight loss. For these individuals, medications to treat severe obesity may be incorporated into their lifestyle. The use of such medications is restricted to children over the age of 12. To date, Orlistat, Liraglutide, Semaglutide, and Phentermine/Topiramate have been approved by the FDA for use in children over the age of 12. These medications carry potential side effects and must be used in conjunction with a healthy lifestyle to be effective.

What About Weight Loss (Bariatric) Surgery? Weight loss (bariatric) surgery has proven effective for certain adults and adolescents suffering from severe obesity. Currently, the American Academy of Pediatrics recommends considering bariatric surgery for children over the age of 12 who have Class 2 obesity accompanied by comorbidities (such as diabetes, fatty liver disease, hypertension, dyslipidemia, or sleep apnea), or those with Class 3 obesity alone. However, complications—such as weight regain, micronutrient/vitamin deficiencies, and gallbladder issues—are common.

Obesity

Consult a physician regarding these medications and surgery.

Conclusion : So, let us all launch a campaign against obesity right now—starting with ourselves and our own families. And let us ensure that no one falls victim to this condition. I am an Anaesthetist. Obesity is our enemy; administering anesthesia to an obese patient and performing surgery on them is extremely difficult.

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Dr. K. Sudha Rao is a distinguished anaesthesiologist and healthcare administrator with over 33 years of service in the Indian Railway Medical Services. An alumna of Lady Hardinge Medical College, New Delhi, she pursued postgraduate training in Anaesthesiology at King George's Medical University, Lucknow, and an M.Phil. in Hospital and Health Systems Management from BITS Pilani. She served in several senior clinical and administrative positions, culminating in her appointment as Chief Medical Director, North Central Railway, Allahabad. A former two-term President of the Railway Forum of Anaesthesiologists, she has made significant contributions to medical education, public health, hospital administration, and professional development. Following her retirement, she continues to remain actively engaged in academic and charitable medical initiatives.

An Army Wife

She stands beside the station gate,
With trembling hands, yet calm in state;
The whistle blows, the train moves slow,
And carries half her heart to go.
At dawn she watches crimson spill
Across the distant, silent hill;
The bugle's mournful, measured cry
Sends half her living heart nearby.
She smiles and waves, says, "Do not fear,"
Though every goodbye draws a tear.
He wears the uniform, proud and bright,
She wears her courage every night.
He leaves in olive, stern and proud,
While grief is veiled beneath the crowd;
She lifts her chin, serene, composed,
Though every trembling fear is closed.
She checks the phone, she waits for news,
She learns to hide her lonely blues.
A sudden ring, a message small,
Can make her heart begin to fall.
She dwells where absence takes its throne,
Yet makes each transient house a home;
She manages a home alone,
Makes every unfamiliar place her own.
She tells the children, "Papa is strong,
He will be home before too long."
She holds them close when nights are cold,
And turns her worry into gold.
Through monsoon rains and winter's chill,
Her steadfast spirit does not still;
From desert towns to mountains high,
She learns to live, but not ask why.
When festivals arrive with lamps aglow,
She keeps one flame for him to know:
Though miles may lie from door to door,
Her love will reach the distant shore.
She guards the lamp on festive nights,
Its golden flame a vow of light;
Across the miles, through frost and sand,
Her prayers accompany his hand.
No medals hang upon her chest,
No bugle calls her sacrifice blessed.
Yet every day, through joy and pain,
She stands through sunshine, storm, and rain.
No laurel crowns her quiet brow,
No trumpet honours her sacred vow;
Yet in the hush behind the fame,
She bears the weight without a name.
She knows the tyranny of delay,
The fragile comfort of a "safe today";
A phone that rings, a letter brief,
Can summon hope—or sharpen grief.
And when he comes in uniform,
Safe again from every storm,
Her waiting heart begins to sing—
For love has conquered everything.
When he returns from storm and strife,
She welcomes back her heart, her life;
Behind each soldier, proud and free,
There stands a strength the world may not see.
For every soldier at the line,
There is a heart that keeps the shrine:
An army wife—unseen, unsung—
Whose valour lives upon her tongue.
An army wife, both soft and brave,
Whose love becomes the light he saves;
She guards his world with loyalty,
And serves the nation silently.

Dr. Bhavya Dube
Department of Anaesthesiology & Critical Care
King George's Medical University, Lucknow



The Defence Anaesthesiologist

Dr (Lt Col) Nimish Gaur
Cl Spl Anaesthesiology
Department of Anaesthesiology and Critical Care: MH Ahmedabad

One uniform.
Two arenas.
The same duty.

IN PEACE: The Preparation

In peacetime we run the operation theatres and intensive care units of military hospitals. We take soldiers, veterans and their families safely through surgery, and we sit through long nights with the critically ill.
We also teach and we rehearse: damage-control resuscitation, mass casualty drills, evacuation and handover between each level of care. We do it until it is reflex, because the chain is only as strong as its weakest link.

IN THE FIELD: The Test

When the guns are hot, the work changes in form but not in purpose. We work in forward medical echelons with limited sources. In a wounded soldier's first hour, the anaesthesiologist often decides what the next ones will look like.
As an anaesthesiologist in uniform, I learned that readiness begins long before the call to duty. The Surgical Strikes of 2016 and Operation Sindoor in 2025 remind us of the importance of being prepared for the unexpected.
My experience during brutal civil unrest in Democratic Republic Of CONGO, 2022, goes far beyond. In Congo, the brutality had no front line to hide behind. Mobs turned on the very bases and hospitals that were meant to be sanctuary, and the violence came in waves of stones, tear gas and fear. The wounded were brought to us bleeding and broken: peacekeepers, local security personnel, and civilians who had nowhere else to go. We worked through it with the sound of the crowd outside the walls, never certain the hospital itself would hold. Yet the ventilators kept running and the tables were never empty, because someone had to stay steady at the head of the bed while the world outside lost its head.
Our teams stood ready for exactly that.

THE COMMON THREAD

The Army teaches us to stay calm in disorder. Anaesthesia teaches us to respect the thin margin between stable and crashing. Together they make a doctor who neither panics nor hesitates.
There is little applause in this work. A soldier who wakes up comfortable and rejoins his unit rarely knows how much could have gone wrong and did not. That is how we prefer it.
We train in peace so that we can serve without fail in war.
The uniform stays the same. So does the responsibility.



The Unbroken Chain: Anaesthesia from the Forward Post to the Base Hospital

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Introduction

In civilian practice the patient comes to us. In uniform, we often have to go to the patient, build the theatre around the patient, or accompany the patient through a night sky. I have come to think of the defence anaesthesiologist less as a person in a theatre than as a link in a chain, and the chain holds only if every link does. I follow it here in the order the patient travels, drawing on the teachings and publications of my senior defence anaesthesiologists, who taught me that the lone anaesthesiologist carries responsibility for both theatre and intensive care, and that service comes before self.

The Lone Officer

Isolation is not new. Our seniors still speak of being the only anaesthesiologist for miles, on duty "24 hours and 7 days a week" and in charge of the intensive care unit (ICU) as well. There is a particular solitude in that position, because every decision is yours. There is also a particular pride in knowing that the patient depends on you and that you are prepared.

The Dug-in Theatre

The experience of Operation Sindoor further underscored the operational value of this approach. In forward areas, multiple damage-control surgeries were undertaken close to the point of injury, with the aim of controlling haemorrhage, stabilising critically injured casualties and preserving life and limb before evacuation to higher echelons. These interventions demonstrated how a capable forward surgical team, supported by sound anaesthetic resuscitation and critical care, can make the difference between a casualty surviving the immediate phase of injury and succumbing before definitive care. The forward theatre differs from the one we train in as anaesthesia trainees. It must be set up quickly, move with the troops, and work in whatever space the terrain and the tactical situation allow. Our base hospitals are fully equipped, and in the field the anaesthesiologist adapts the theatre and the technique to the setting. Forward trauma care was traditionally a "scoop and run" exercise. As infrastructure in dug-in OTs and forward surgical stations has developed, it is shifting towards "stay and play": the casualty is resuscitated, receives damage control surgery close to the point of injury, and is held there until the tactical situation allows evacuation. The dug-in OT brings its own working conditions:

- Space. The table, machine, suction, monitors and team share a few square metres, so the team works in close coordination.
- Ventilation. Air exchange in a sheltered space is limited, so we plan for long hours and for infection control.
- Temperature. Unlike in a routine OT, we cannot hold the theatre at a set temperature. We guard against hypothermia, one arm of the lethal triad, by warming the patient directly.
- Power. Mains supply cannot always be relied on, so we are ready to continue by manual means.
- Oxygen. Supply has to be planned, so cylinders are counted and technique is chosen to use oxygen carefully



Beyond the Operating Theatre: Lessons in Service and mentoring

Surg Cdr Markose L Paret, DM(Cardiothoracic and vascular Anaesthesia)

As a cardiac anaesthesiologist in the Armed Forces, I have learnt that our profession extends far beyond the operating theatre. It is a unique intersection of science, discipline, teamwork, and compassion, where every decision carries profound responsibility and every heartbeat reminds us of the trust placed in our hands.

Cardiac anaesthesia teaches us to remain calm amid uncertainty, anticipate crises, and make decisions when seconds matter. Military service adds another dimension—adaptability, resourcefulness, and an unwavering commitment to duty. Yet, the greatest lesson has been that no achievement in cardiac surgery is ever individual. Surgeons, anaesthesiologists, perfusionists, nurses, and technicians succeed only when they work as one team.

Our mentors shape not just our clinical skills, but also our character. From a senior's composure during a crisis to a teacher's willingness to explain a difficult decision, the most enduring lessons are often learnt by observation. As we become mentors ourselves, our responsibility is to nurture independent thinking, encourage questions, and teach with both compassion and accountability. Its our duty to pay forward what ever good mentoring one receievd ahead to new generation of professionals.

Not every case has the outcome we hope for, but every experience reminds us of the importance of preparation, vigilance, and humility. The most rewarding moments are often quiet ones—a patient getting discharged after complex surgery who has something important in life to look forward or a family receiving a second chance at hope.

The white coat represents our commitment to healing; the uniform, our commitment to service. Together, they remind us that true leadership lies not in rank or recognition, but in responsibility, integrity, and the ability to inspire others.

Ultimately, our legacy is not measured merely by the lives we save, but also by the lives we touch, the teams we strengthen, and the next generation of clinicians we prepare to serve.

The Unbroken Chain: Anaesthesia from the Forward Post to the Base Hospital

Over all of this, the threat of enemy action is always present. Working with that awareness, while keeping full attention on the patient, is part of the job. The key to setting up such a theatre at short notice is equipment that depends less on power and uses less oxygen. This is a deliberate choice, right for the place. Blood, People and Partnership Blood. In our military hospitals blood is readily available, and soldiers come forward to donate willingly. In forward areas, blood and blood products are now airlifted from rear hospitals to forward surgical stations for life-saving transfusion.

In the forward theatre, every decision about surgery is also a decision about blood. An Unfamiliar Team. The team may be assembled in a hurry, with equipment unfamiliar to all. Our training prepares us for this, covering triage, battlefield critical care, damage control surgery, resuscitation and the transport of priority-one patients to higher echelons. Even so, the anaesthesiologist must brief the team and check every device personally, because there is no shared habit to fall back on.

The Surgeon. If a single sentence captures what the forward theatre is like, it is this: In the forward theatre, the anaesthesiologist is the surgeon's only assistant, and the surgeon is the anaesthesiologist's only assistant.

There are seldom extra hands. The surgeon says what is needed, the anaesthesiologist says what is possible, and together they choose a damage-control operation that the patient can survive, in keeping with the tenets our seniors insist on: “know your limitations” and carry out “only urgent surgeries”. This mutual dependence is not a compromise. It is the purest expression of service, resting on a trust that crosses rank and specialty.

The Base Hospital

At a base hospital the virtue is order. The trauma theatre is kept ready at all times, and every arrival is handled through a standard three-priority protocol of resuscitation, monitoring and surgery, with the most urgent cases taken first. The aim throughout is to bring the casualty to surgery quickly and safely, and to keep the operation within what the patient can survive. What time has taught us is that a rehearsed system, with equipment ready and decisions made in advance, saves lives that improvisation alone cannot.

Where the Air is Thin

Many colleagues serve far from any base hospital. During the Kargil conflict of 1999, troops operated at altitudes of up to 18,000 feet (about 5,500 metres), with temperatures that can fall below -30°C. Casualties in such terrain may have high-altitude pulmonary or cerebral oedema, acute mountain sickness, frostbite or hypothermia. At 18,000 feet the oxygen pressure in the air is about half that at sea level (81 mmHg compared with 159 mmHg), and the low atmospheric pressure also changes how anaesthetic drugs act. We therefore titrate drugs carefully and often prefer regional techniques, which have fewer systemic effects and protect breathing.

The Unbroken Chain: Anaesthesia from the Forward Post to the Base Hospital

When the Patient Cannot Leave

The chain depends on weather, terrain and the enemy, and decisions on evacuation are taken case by case. When a patient who needs transfer must stay, the anaesthesiologist becomes an intensivist without an ICU, keeping the patient ventilated, warm and comfortable through the night, ready to move the moment the window opens. Those nights are rarely written about, but they are among the longest we spend.

In the Air

When the window opens, the journey is itself a test. The patient faces falling air pressure, lower oxygen, noise, vibration and cold, dry air, and the anaesthesiologist must anticipate each of them. At a cabin altitude of 8,000 feet, gases expand by about 35%, so tracheal cuffs are filled with saline rather than air and a pneumothorax must be drained before flight. The fall in oxygen pressure can lower saturation to about 90% even in a healthy patient, so supplemental oxygen is essential. Noise makes auscultation nearly impossible, so we rely on visual alarms, and vibration and motion sickness add to the patient's distress. Aircraft are often not designed as medical platforms, so we carry our own airworthy resuscitation and ventilation equipment and oxygen. Purpose-built patient transfer units, which carry a ventilator, monitor, defibrillator and infusion pumps on a single trolley, are now available to us.

What Binds the Chain

Asked once about the key human factors in defence anaesthesia, one of our most senior teachers did not mention drugs. The answer was empathy, connection with the troops, service before self, and the welfare of troops, which is always paramount. It is these qualities that hold the chain together. In forward areas, the anaesthesiologist resuscitates and stabilises the casualty. In the dug-in theatre, the anaesthesiologist provides anaesthesia for limb- and life-saving surgery. When evacuation is delayed, the anaesthesiologist holds the patient through the night, and when the window opens, accompanies the patient on the journey by road or air. At the base hospital, the anaesthesiologist receives the patient and carries the care on through surgery and intensive care. At every step the patient is handed on safely and no link is left unattended. This continuity, from the first resuscitation to the base hospital, is what makes the chain unbroken.

Conclusion

Civilian and defence anaesthesia share the same purpose: to save lives and restore function. However, the demands of modern warfare require defence anaesthesiologists to combine clinical excellence with adaptability, preparedness and the ability to deliver care in challenging and rapidly changing environments. The future of military medical care lies in strengthening the continuum of care from the point of injury to the base hospital. Well-equipped forward surgical facilities, trained teams, effective resuscitation and timely evacuation enable life-saving interventions to be delivered closer to the point of injury. The ability to sustain treatment when evacuation is delayed further strengthens this continuum.

The Unbroken Chain: Anaesthesia from the Forward Post to the Base Hospital

Operation Sindoor highlighted the operational value of forward surgical care and the expertise of teams working together to save lives and preserve function. The decision to operate, continue treatment or evacuate remains guided by clinical judgement and the prevailing circumstances. Ultimately, the unbroken chain of care rests on more than equipment and infrastructure; it rests on preparedness, teamwork, adaptability and an unwavering commitment to the casualty. From the forward post to the base hospital, the anaesthesiologist remains a vital link in this journey, ensuring that care continues wherever the mission demands.

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Quiz

By - Col Mallikarjun Dube , MD

Defence Anaesthesia
History and Equipment
QUIZ: TEN QUESTIONS

1. In which year were the Indian Armed Forces Medical Services constituted as a unified organisation?
2. Which historical anaesthesia device was designed to deliver ether using atmospheric air in remote surgical settings?



3. Who introduced the Macintosh curved laryngoscope blade in 1943?
4. Which two gases were used in the original Boyle's anaesthesia machine introduced in 1917?
5. True or false: Oxford Inflating Bellows can provide manual positive-pressure ventilation without a compressed gas supply?



6. Which anaesthesia pioneer developed endotracheal techniques while working with facial-injury casualties during World War I?
7. Which features are advantages of draw-over anaesthesia systems?
8. Which historical breathing system associated with Ralph Waters incorporated carbon dioxide absorption?
9. True or false: The EMO inhaler was introduced before World War I and used in 1914.
10. Which institution in Pune is a major centre for postgraduate medical training in the Indian Armed Forces?

Defence Anaesthesia
History and Equipment



ANSWERS AND EXPLANATIONS

1. **Answer:** 1948
Explanation: The Armed Forces Medical Services were constituted on 1 May 1948.

2. **Answer:** EMO (Epstein–Macintosh–Oxford) inhaler
Explanation: Developed in the 1950s, this draw-over ether inhaler could function without compressed gas cylinders, making it useful in remote and field settings.

3. **Answer:** Sir Robert Macintosh
Explanation: He introduced the Macintosh curved laryngoscope blade in 1943. The blade is positioned in the vallecula to lift the epiglottis indirectly.

4. **Answer:** Oxygen and nitrous oxide
Explanation: The original Boyle's anaesthesia machine (1917) used oxygen and nitrous o and helped establish continuous-flow anaesthesia delivery.

5. **Answer:** True
Explanation: Oxford Inflating Bellows can be operated with ambient air, allowing manu positive-pressure ventilation without a compressed gas supply, which is useful in austere and resource-limited settings.

6. **Answer:** Ivan Magill
Explanation: His work with Harold Gillies on facial-injury casualties during World War contributed to modern endotracheal anaesthesia.

7. **Answer:** Ambient air as carrier gas; reduced dependence on compressed gases; suitability for remote facilities
Explanation: Draw-over systems use atmospheric air as the carrier gas, reducing dependence on cylinder supplies and are useful in remote and field environments. They do not automatically deliver 100% oxygen; supplemental oxygen is needed for enrichi

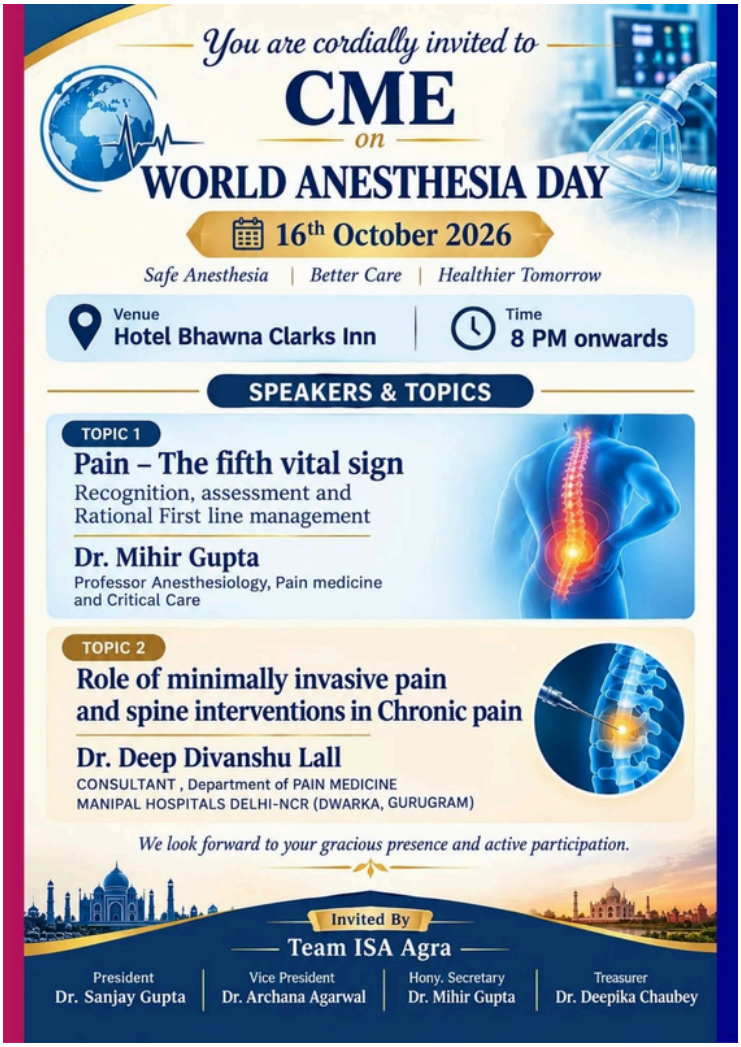
8. **Answer:** Waters to-and-fro system
Explanation: The Waters system incorporated a carbon dioxide absorber, enabling rebreathing and conservation of anaesthetic gases.

9. **Answer:** False
Explanation: The EMO inhaler was developed in the 1950s, not before World War I and not used in 1914.

10. **Answer:** Armed Forces Medical College (AFMC)
Explanation: AFMC, Pune was established in 1948 and is a major centre for postgradu medical training in the Indian Armed Forces.

Upcoming Events & Activities


Asian and Oceanic Society of Regional Anaesthesia and Pain Medicine
AOSRA-PM
WEBINAR SERIES
22nd October 2026 (Thursday)
7:00 pm (IST)
8:30 pm (ICT)
9:30 pm (MYT)
SPEAKERS
Dr. Amrita Rath
Prof. BHU, Varanasi, India
Topic:
Newer and Evolving Fascial Plane Blocks
TAPA & MTAPA Block, EOICPB, SIPB, BRILMA & SPSPIB Block
Dr. Sivashanmughan
Prof. JIPMER, Puducherry, India
Topic:
Thoracic and Lumbar Spine Ultrasound: Anatomical Nuances, Scanning Windows and Clinical Applications
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You are cordially invited to
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on
WORLD ANESTHESIA DAY
16th October 2026
Safe Anesthesia | Better Care | Healthier Tomorrow
Venue
Hotel Bhawna Clarks Inn
Time
8 PM onwards
SPEAKERS & TOPICS
TOPIC 1
Pain – The fifth vital sign
Recognition, assessment and Rational First line management
Dr. Mihir Gupta
Professor Anesthesiology, Pain medicine and Critical Care
TOPIC 2
Role of minimally invasive pain and spine interventions in Chronic pain
Dr. Deep Divanshu Lall
CONSULTANT , Department of PAIN MEDICINE
MANIPAL HOSPITALS DELHI-NCR (DWARKA, GURUGRAM)
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Anesthetists: The Unsung Heroes Guarding Every Breath, Sustaining Every Beat

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