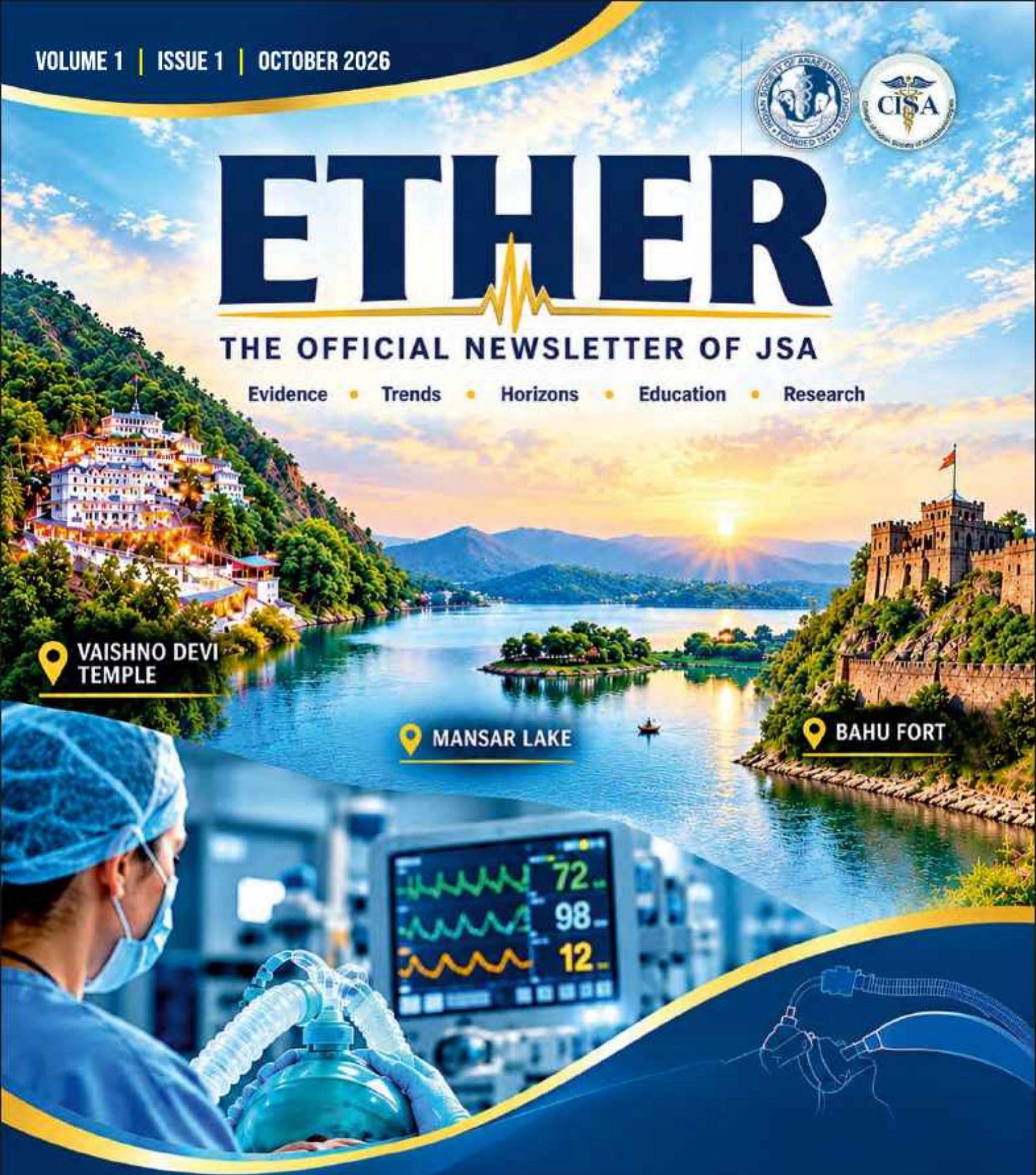
VOLUME 1 | ISSUE 1 | OCTOBER 2026

ETHER

THE OFFICIAL NEWSLETTER OF JSA

Evidence • Trends • Horizons • Education • Research



VIGILANCE TO RESILIENCE:
THE EVOLVING IDENTITY OF THE ANAESTHETIST

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PRESIDENT'S MESSAGE



Dear Esteemed Members of Jammu Society of Anaesthesiologists,

It gives me great pleasure to present the 1st News Letter of Jammu Society of Anaesthesiologists. As President, it is my honour to reflect on the last productive year and a period of steady progress, renewed academic enthusiasm and strengthened professional bonding within our fraternity. I express my sincere appreciation for your dedication and teamwork. United in our mission, we have reached new milestones and supported each other in both challenges and at difficult times.

I am a firm believer in the power of three virtues—honesty, sincerity and hard work—which I strive to imbibe in every task and every responsibility that has been entrusted upon me.

Last year, and this year, our branch has conducted several academic programmes, CMEs, public awareness programmes, North Zone PG assembly for postgraduate students, and collaborative events that enriched both our knowledge and community outreach. Our participation in World Anaesthesia Day with cultural programme celebration, Walkathon with anaesthesia sports day last year, helped educate the public about the vital role of anaesthesiologists in healthcare and fitness.

I deeply appreciate the dedication of our Executive Committee members, the enthusiasm of our members and support of our senior mentors. Your collective efforts keep this branch vibrant and forward-looking. Let us keep striving for excellence, fostering a culture of mutual learning and collaboration, and expanding our outreach.

Thank you all for your support during my tenure, and let us move forward together, upholding the values and spirit of Jammu Society of Anaesthesiologists. Wishing you all a successful and fulfilling year ahead.
Long Live JSA, Jai Hind.

Dr Ashwani Kumar
President
JSA

SECRETARY'S MESSAGE



Dear Esteemed Members and Colleagues,

It gives me immense pleasure and pride to present the inaugural edition of Ether, the first-ever newsletter of the Jammu Society of Anaesthesiologists (JSA). This is not merely a record of activities, but a reflection of our collective commitment and vision to take the Society to newer heights.

The journey of JSA began in 1993 under the chairmanship of Dr Pramila Sharma, former HOD Anaesthesia GMC Jammu and was formally registered in 2014 under the leadership of Dr Nandita Mehta. Building on this legacy, I had the privilege of taking over as Secretary in 2024, following the first-ever online election involving anaesthesiologists across Jammu Division — a significant milestone in our democratic journey.

The tenure that followed was demanding, hectic, and immensely fulfilling. JSA worked tirelessly to strengthen its functioning and expand its academic, professional, and social outreach. From CMEs, awareness campaigns, COLS training, postgraduate quizzes and Pro and Con debates to trauma and disaster management workshops, sports day, walkathon, and online webinars, our calendar remained vibrant. Each initiative reflected our determination to promote learning, collaboration, and excellence. The celebration of World Anaesthesia Day was particularly remarkable and emerged as a defining moment for JSA.

As Secretary, I have sincerely endeavoured to discharge my responsibilities in the best interests of the Society. I am deeply grateful to the entire elected team for their hard work and cooperation. My heartfelt gratitude to our President, Dr Ashwani Kumar, for his constant guidance, unwavering support, and active involvement in every major decision. His encouragement has been my greatest strength.

A key initiative of the present elected body has been our commitment to ensure that the JSA Constitution is implemented in its true spirit. We believe sustainable progress is possible only when constitutional provisions, democratic principles, and institutional responsibilities are upheld. Though challenging, this step was taken in the larger interest of JSA.

Our vision is to build a stronger, more transparent, and inclusive Society where anaesthesiologists from GMCs, peripheral institutions, and all sectors across Jammu — especially our young colleagues — find meaningful representation and participation.

With warm regards and best wishes,

Dr Updesh Kumar
Secretary
JSA

VICE PRESIDENT'S MESSAGE



Dear Esteemed Colleagues,

It gives me immense pleasure and privilege to address you through this edition of the Jammu Society of Anaesthesiologists Newsletter.

Anaesthesiology has evolved remarkably over the years and today occupies a central position in modern healthcare. Our responsibilities extend far beyond the operating room to include perioperative medicine, critical care, emergency and resuscitation services, acute and chronic pain management, and anaesthesia for procedures outside the operating theatre. This expanding role places upon us an even greater responsibility towards patient safety, professional excellence, ethical practice and continuous learning.

As a professional society, the Jammu Society of Anaesthesiologists provides an important platform for academic exchange, continuing medical education, research and professional development. We must continue to promote evidence-based practice, high standards of monitoring and documentation, multidisciplinary teamwork and the adoption of advances in anaesthesia and critical care.

I especially encourage our young colleagues and postgraduate students to actively participate in academic activities, research, workshops and scientific discussions. Their enthusiasm, dedication and innovative ideas will play a vital role in shaping the future of our specialty.

We should also work collectively to address the challenges faced by our fraternity and strive to improve the quality and safety of anaesthesia and perioperative care in our region. Collaboration with surgeons, intensivists, emergency physicians, nursing professionals and other healthcare teams is essential to achieving this goal.

I sincerely appreciate the leadership and efforts of our President, Dr. Ashwani Kumar, and Secretary, Dr. Updesh Kumar, along with all office bearers and members of the Society. I also congratulate the editorial team and all contributors for their valuable efforts in bringing out this newsletter.

May this newsletter serve as a platform for knowledge sharing, professional interaction, recognition of achievements and strengthening the bonds within our fraternity.

Let us continue to learn, collaborate and lead, keeping patient safety and professional excellence at the heart of our practice.

With warm regards and best wishes to all members for continued growth and success.

Dr. Mushtaq Ahmed Wani
Vice President
JSA

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Events and Activities
More Events
More Connections
A Brighter Community

CME / PANEL DISCUSSION ON CURRENT SCENARIOS AND CHALLENGES OF ANAESTHESIA AND CRITICAL CARE SERVICES IN JAMMU DIVISION AND WAYS TO IMPROVE THE SERVICES
4th JAN 2025

























AWARENESS CAMPAIGN ON LABOR ANALGESIA
SMGS HOSPITAL JAMMU
10TH FEB 2025











PPF MEETING
15TH FEB 2025





NORTH ZONE PG ASSEMBLY, GMC JAMMU
21ST - 23RD MARCH 2025













Principal, GMC Jammu, Dr Ashutosh Gupta being honoured during a program organized by Anaesthesia Department.

GMC Jammu hosts successful North Zone PG Assembly on Anaesthesiology







AWARENESS CAMPAIGN ON
KNOW YOUR ANAESTHESIOLOGIST AND ANAESTHESIA SERVICES
GOVT. HOSPITAL GANDHI NAGAR, JAMMU
29TH SEP 2025













PROS- CONS DEBATE AND QUIZ COMPETITION ON OCCASION OF WORLD ANAESTHESIA DAY 4TH OCT 2025













CME AND WORKSHOP ON TRAUMA
GOVT MEDICAL COLLEGE, UDHAMPUR
10TH OCT 2025





















COLS (COMPRESSION ONLY LIFE SUPPORT)
SMGS HOSPITAL JAMMU
14TH OCT 2025











KNOW YOU ANAESTHISIOLOGIST & ANAESTHESIA SERVICES AWARENESS CAMPAIGN AT ASCOMS HOSPITAL 29TH OCT 2025













SPORTS DAY CELEBRATION
GMC JAMMU
22ND NOV 2025











2025








ISA JAMMU
SPORTS DAY





WALKATHON, GMC JAMMU
23RD NOV 2025















WOMEN'S DAY CELEBRATION BY JSA IN SUPER SPECIALITY HOSPITAL
8TH MARCH 2026
















SIMPLE STEPS TO SAVE A LIFE


WE CARE FOR YOU
WHEN YOU'RE
NOT AWARE






FIRE YARD
HYDRANT

WORLD ANAESTHESIA DAY CELEBRATIONS
16TH OCT 2025




















WORLD
ANAESTHESIA DAY
2025


WORLD
2025




WORLD
ANAESTHESIA DAY
2025




ANAESTHESIA DAY


ANAESTHESIA DAY
2025

JSA AWARDS 2025
WORLD ANAESTHESIA DAY



LIFE TIME ACHIEVEMENT AWARD









JSA AWARDS 2025
WORLD ANAESTHESIA DAY

















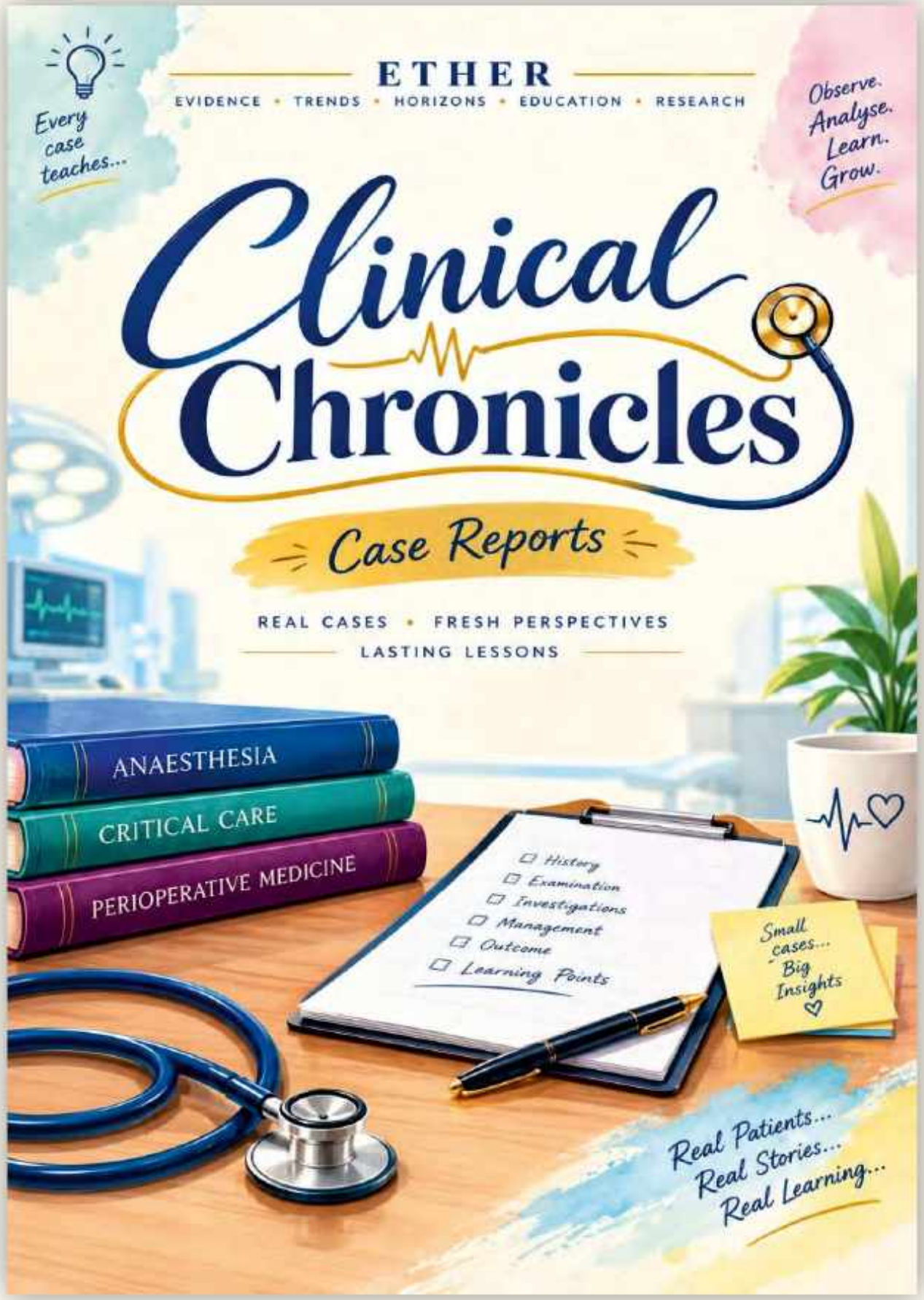
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COMBINATION OF ULTRASOUND- GUIDED ERECTOR SPINAE PLANE BLOCK WITH INTERSCALENE BLOCK AS PRIMARY ANAESTHETIC TECHNIQUE FOR MODIFIED RADICAL MASTECTOMY IN A PATIENT OF COMPROMISED CARDIORESPIRATORY STATUS: A CASE REPORT.



Dr Rajesh Angral, (Associate Professor, Anaesthesia, GMC Kathua)
Dr Neha Chajgotra (Senior Resident, Anaesthesia, GMC Kathua)

ABSTRACT

Anaesthetic management of elderly patients with significant comorbidities undergoing breast cancer surgery is challenging. Regional anaesthesia can reduce systemic effects, provide effective analgesia, and minimize opioid use. We report an 80-year-old woman with coronary artery disease, hypertension, and hypothyroidism who underwent modified radical mastectomy with axillary clearance under ultrasound-guided erector spinae plane and interscalene blocks as the sole anaesthetic technique.



INTRODUCTION

Modified radical mastectomy (MRM) with axillary lymph node dissection (ALND) is a standard breast cancer procedure, typically performed under general anaesthesia (GA)[1]. However, regional anaesthesia (RA) offers a safe alternative by providing adequate surgical anaesthesia and postoperative analgesia while decreasing perioperative complications in high risk patients in whom GA poses significant challenges [2]. We report the successful use of ESPB combined with IBPB as the sole anaesthetic technique for MRM with ALND in an elderly woman with multiple comorbidities, demonstrating effective perioperative management.

CASE PRESENTATION

An 80-year-old woman with advanced right breast cancer, CAD, hypertension, and hypothyroidism was scheduled for MRM with ALND. Despite prescribed medications, compliance was poor. Baseline investigations were largely unremarkable except for elevated TSH (31.86 mIU/L). ECG showed inferior ischemic changes, while echocardiography revealed an EF of 40% with basal inferior wall hypokinesia. Chest X-ray showed COPD changes. Given her condition, ESPB combined with IBPB was selected as the primary anaesthetic technique. After informed consent, standard monitoring was instituted. Baseline HR, BP, and SpO were 70 bpm, 150/85 mmHg, and 88% on room air, respectively; oxygen was administered at 6L/min via face mask. UnderUSG guidance, IBPB was performed with 10 mL local anaesthetic, followed by a right T4 ESPB using 20 mL of a solution containing ropivacaine 0.5% (140 mg) and dexamethasone 8 mg. A sensory block from T1–T7 and the axilla was achieved.



Low-dose dexmedetomidine (0.3 μg/kg/h) was used for sedation. Surgery proceeded uneventfully with stable haemodynamics.

Postoperatively, VAS remained <3 for approximately 24 hours. The patient was comfortable, alert, mobilized early, and experienced no complications.

DISCUSSION

This case demonstrates the successful use of ESPB combined with IBPB as the sole anaesthetic technique in a high-risk patient. The approach avoided the cardiovascular depressant effects of GA, maintained haemodynamic stability, and reduced opioid requirements, thereby minimizing respiratory and cardiac stress while providing effective perioperative analgesia.

Although continuous thoracic epidural and paravertebral blocks have been used for breast surgery, their application in extensive procedures involving ALND may be limited by technical complexity and potential complications.

Due to the complex innervation of the breast and axilla, combined regional techniques are often required for adequate coverage. Approaches such as thoracic PVB with PNB, SAPB with PNB, and thoracic PVB with IBPB have been explored, but each has limitations. [3,4].

The ESPB, a relatively newer RA technique, provides effective analgesia for thoracic and breast surgeries by targeting the dorsal and ventral rami of spinal nerves [5].

Several studies have explored the combination of ESPB with various RA techniques like ESPB with selective brachial plexus block (SBPB) and ESPB with PEC 2 block but each of these approaches comes with its own limitations [6,7]. The combination of ESPB and IBPB has not been previously reported; hence, this case highlights its feasibility and effectiveness.

CONCLUSION

Combining an ESPB with IBPB offers a safe and effective alternative to GA for high risk patients with multiple comorbidities, undergoing MRM with ALND by providing adequate surgical anaesthesia, excellent postoperative analgesia and facilitating early recovery.

AIRWAY MANAGEMENT OF PALATOGLOSSAL BANDS AND CLEFT PALATE IN AN INFANT IN A RESOURCE LIMITED SET UP – A CHALLENGE TO AN ANAESTHESIOLOGIST: A CASE REPORT



Meenakshi Devi, Ashwani Kumar, Mushtaq Ahmed Wani, Heena Saini, Sanjay Dhar
Deptt. of Anaesthesia, Intensive Care and Pain Medicine, GMC Jammu

Abstract
Palatoglossal bands are rare congenital anomalies with few reported cases. They may cause feeding difficulties or respiratory distress requiring surgical intervention. Anaesthetic management is challenging due to difficult conventional laryngoscopy, associated cardiac or digital anomalies, and limited availability of pediatric flexible fibreoptic bronchoscopy. We report the anaesthetic management of a one-year-old infant presenting with recurrent upper respiratory infections, cough, poor weight gain, and feeding difficulties.

Introduction



Palatoglossal bands are rare congenital anomalies with very few reported cases. [1] They present with either respiratory distress at birth or feeding difficulties. They are usually associated with a variety of congenital defects such as cleft lip and palate, microglossia, micrognathia and temporomandibular disorders. [2] The cause of these bands is still unknown and presumed to be genetic, teratogenic, or mechanical insult in early gestation [3]. These defects are commonly associated with many congenital syndromes such as Moebius' syndrome, hypoglossia–hypodactylia syndrome, Hanhart's syndrome, cleft palate medial synechiae syndrome etc. [4,5] Our patient was a case of nonsyndromic palatoglossal bands and cleft palate as she did not have any other associated congenital anomaly. The definitive surgery includes excision of palatoglossal bands under anaesthesia. [6]

Case Presentation
A one-year-old female presented with recurrent respiratory infections, feeding difficulties, vomiting, and poor weight gain. Examination revealed palatoglossal bands with tongue–palate fusion (Figure 1), delayed motor milestones, left maxillary hypoplasia, and left microphthalmos with absent eyeball. MRI suggested cleft palate; echocardiography and abdominal ultrasound were normal. After informed consent and difficult-airway preparation, anaesthesia was induced with sevoflurane while maintaining spontaneous ventilation. Direct laryngoscopy with a Miller blade, external laryngeal manipulation, and neck extension enabled successful placement of a 3.5-mm uncuffed ETT without muscle relaxation. Anaesthesia was subsequently maintained with isoflurane, nitrous oxide, oxygen, fentanyl, paracetamol, and atracurium. The bands were released, followed by VWK palatoplasty and intravelar veloplasty. The child was extubated uneventfully and had good postoperative recovery and feeding. Maintaining spontaneous ventilation and direct visualization during intubation minimized airway trauma and bleeding. Nasotracheal fibreoptic intubation is considered ideal for palatoglossal bands. [7] However, a pediatric fibreoptic bronchoscope was unavailable in our setup.

Discussion



Airway management is critical in patients with intraoral pathologies and anticipated difficult intubation. Supraglottic airway devices may be unsuitable, making failed intubation potentially life-threatening. In our case, an ENT specialist was kept on standby for emergency tracheostomy. Palatoglossal synechia is a rare congenital anomaly of unknown etiology. Pandey et al. reported uneventful fibreoptic-guided intubation under spontaneous ventilation [8]. As a flexible fibreoptic nasopharyngoscope was unavailable in our setup, conventional laryngoscopy under sedation was performed with the ENT team on standby. Although adhesion release under local anaesthesia has been described for emergencies, it was avoided due to the risk associated with an unprotected airway. Thorough preoperative evaluation is essential, as the severity of palatoglossal synechia can pose significant anaesthetic challenges.

Conclusion
To conclude, in a resource limited setting, where the pediatric flexible fibreoptic bronchoscope may not be available, the conventional laryngoscopy through one side of the band under adequate sedation without muscle relaxation can be a feasible alternative for securing a definitive airway.

CASE REPORT: ANAESTHETIC MANAGEMENT OF ACUTE MYOCARDIAL INFARCTION IN PREGNANCY



Rajdeep Kour, Rishu Parihar, Ashwani Kumar, Updesh Kumar and Vanya Tripathi
Deptt. of Anaesthesia, Critical Care & Pain Medicine, GMC Jammu)

ABSTRACT

Myocardial infarction is encountered rarely during pregnancy, but when it occurs the event is life threatening to both mother and fetus. Data on maternal and fetal outcome are limited, but overall maternal mortality approaches 35% to 40% of deaths occur during the third trimester. We present a case of myocardial infarction at 36 weeks of gestation, and discuss the anaesthetic management of the problems encountered during the delivery.

INTRODUCTION

Myocardial infarction is encountered rarely during pregnancy, but when it occurs the event is life threatening to both mother and fetus. Data on maternal and fetal outcome are limited, but overall maternal mortality approaches 35% to 40% of deaths occur during the third trimester. We present a case of myocardial infarction at 36 weeks of gestation, and discuss the anaesthetic management of the problems encountered during the delivery.

CASE REPORT

A 28 year old multigravida with 36 weeks period of A 36-week pregnant woman presented with chest pain and a single episode of syncope. ECG showed ST elevation

in I and aVL with reciprocal ST depression in II, III, aVF, V4 and V5, suggestive of acute inferolateral MI; Troponin-T was positive. USG showed reduced umbilical artery diastolic flow, necessitating emergency LSCS. Hb was 9 g/dL; coagulation profile and ABG were normal. In the OT, she developed monomorphic

VT (HR 210/min) with hypotension and loss of consciousness, successfully treated with 200-J DC cardioversion and IV amiodarone. Emergency LSCS was performed under GA with RSI using midazolam, etomidate and succinylcholine. Immediately after delivery, she developed pulseless VT, requiring CPR and 200-J DC shock, with successful resuscitation. Neonatal APGAR was 10/10 at 1 min.

She remained intubated and was shifted to ICU. Aspirin, clopidogrel, enoxaparin, beta-blocker and atorvastatin were initiated. She was extubated uneventfully on postoperative day 1. Echocardiography showed global hypokinesia, mild MR and EF 35–45%, suggestive of peripartum cardiomyopathy. She was transferred to cardiology on day 5 for further management.

DISCUSSION

IHD in pregnancy is uncommon (~1 in 10,000 deliveries), with AMI more frequent in multigravidas >33 years, particularly in the third trimester (Dwyer et al., 2005; Roth and Elkayam, 1996). Pregnancy is procoagulant with increased cardiovascular stress, and untreated AMI carries 37–50% mortality (Thorne, 2006). In the absence of fetal distress, delivery should preferably be delayed for ≥3 weeks after MI (Duarte et al., 2011). PPCM presents in late pregnancy or early puerperium and may mimic normal pregnancy with fatigue, oedema and dyspnoea; its hallmark is new- onset LV systolic dysfunction (Ramachandran et al., 2011; Dutt et al., 2013). For emergency LSCS, GA may be preferred in decompensated or significantly symptomatic patients, while stable patients may undergo RA; significant anticoagulation contraindicates RA (Ramachandran et al., 2011; Mellor and Bodenham, 1996). Anaesthetic goals are maintenance of oxygenation, acid-base balance, haemoglobin and haemodynamic stability, with careful fluid management. Aspirin and heparin are considered relatively safe when indicated (Sebastian et al., 1998). Multidisciplinary management with close maternal and fetal monitoring is essential (Ray et al., 2004). In resource-limited settings, a high index of suspicion and early diagnosis are crucial for optimal maternal and fetal outcomes.

RECOGNITION AND MANAGEMENT OF PERIOPERATIVE ANAPHYLAXIS



Dr. Ajay Gupta,
Professor
Deptt. of Anaesthesia, Critical Care & Pain Medicine, GMC Jammu

Anaphylaxis is a serious systemic hypersensitivity reaction that is usually rapid in onset and may cause death if not recognized early and treated promptly.

Anaphylaxis is highly likely when any one of the following 2 criteria are fulfilled:

1. Acute onset of an illness (minutes to several hours) with simultaneous involvement of the skin, mucosal tissue, or both (eg, generalized hives, pruritus or flushing, swollen lips-tongue-uvula)

AND AT LEAST ONE OF THE FOLLOWING:

a. Respiratory compromise (eg, dyspnea, wheeze-bronchospasm, stridor, reduced PEF, hypoxemia)

b. Reduced BP or associated symptoms of end-organ dysfunction (eg, hypotonia [collapse], syncope, incontinence)

c. Severe gastrointestinal symptoms (eg, severe crampy abdominal pain, repetitive vomiting), especially after exposure to non-food allergens

2. Acute onset of hypotension[a] or bronchospasm[b] or laryngeal involvement[c] after exposure to a known or highly probable allergen[d] for that patient (minutes to several hours), even in the absence of typical skin involvement.

Management of perioperative anaphylaxis

General measures:

i. Withdrawal of the culprit drug if known

ii. Temporary discontinuation or lightening of the depth of anaesthesia may help resuscitation efforts as the cardiovascular disturbances of anaphylaxis are exacerbated by the depressant effects of general anaesthetics-waking up patient should be considered, depending on the circumstances.

iii. Use of the Trendelenburg position or leg raising manoeuvres .

iv. Call for help early. Therapeutic measures:

v. Epinephrine i.v, titrated to effect

vi. Liberal infusion of i.v fluids- 20-50ml/kg depending upon the severity of the reaction.

vii. Support to the airway with 100% oxygen

EPINEPHRINE

AGE	IM DOSE	IV DOSE	IV INFUSION DOSE
Adults	0.5mg(500µg)	10-100µg bolus (depending upon severity of reaction can be escalated up to 200µg	0.05-0.1µg/kg/min (titrated to effect)
>12 yr	0.3mg (300µg)	Same dose as in adults (titrated to effect)	Same dose as in adults (titrated to effect)
<12 yr	0.01mg/kg (10µg/kg)	1-10µg/kg	Same dose as in adults (titrated to effect)

In cardiac arrest 1mg IV epinephrine is given as per ACLS guidelines.

Proceeding with surgery after a reaction

Individualize according to severity, haemodynamic /respiratory stability and urgency. If time-critical and stabilized, surgery may proceed while avoiding all suspected triggers.

Antihistamines & steroids

Not first-line treatment and must never delay adrenaline/fluids. Antihistamines are mainly for persistent cutaneous symptoms. Steroids have no proven benefit in routine acute anaphylaxis; may be considered in refractory reactions per local protocol.

Diagnostic tests in acute anaphylaxis

- Serum mast-cell tryptase supports retrospective diagnosis. Take a sample as soon as practical after initial resuscitation, another about 1–4 h after onset, and a baseline sample ≥ 24 h later.
- Compare acute and baseline tryptase; normal tryptase does not exclude anaphylaxis.

Post-operative workup

- Refer to specialist allergy/immunology service.
- Review anaesthesia chart + perioperative exposures; skin testing/in-vitro tests ± drug provocation when appropriate.
- Document confirmed/suspected culprit and safe alternatives; provide patient information/alert documentation for future anaesthesia.

PERIOPERATIVE ANXIETY IN CHILDREN



Dr Anuradha Bali
Consultant Anaesthesia
JK Health Services

Perioperative anxiety, characterised by tension, apprehension and increased autonomic activity, is common in children undergoing surgery. Parental separation, pain, unfamiliar surroundings and masked personnel can trigger it. It may prolong induction and recovery and cause emergence delirium, nightmares, sleep disturbances, enuresis and eating disorders that may persist for up to a year. Children aged 1–5 years are particularly vulnerable.

Risk Factors

- Child-related: Young age, previous negative medical experience, shy temperament and limited developmental maturity.
- Parent-related: High parental anxiety, separation/divorce and previous surgical experiences.
- Environment-related: Sensory overload and conflicting information.

Non-pharmacological Management

1. Education and preparation: Age-appropriate information, OT and PACU orientation, and equipment familiarisation reduce fear. Children >6 years benefit most when preparation is done 3–4 days prior.
2. Behavioural techniques: Distraction with toys and games diverts attention.
3. Parental presence at induction (PPIA): Calm parents reduce anxiety and improve cooperation, while anxious parents may increase distress.
4. Complementary approaches: Music therapy, hypnosis and acupressure may help.
5. Technology: Audiovisual aids, virtual reality and web-based apps reduce preoperative anxiety.

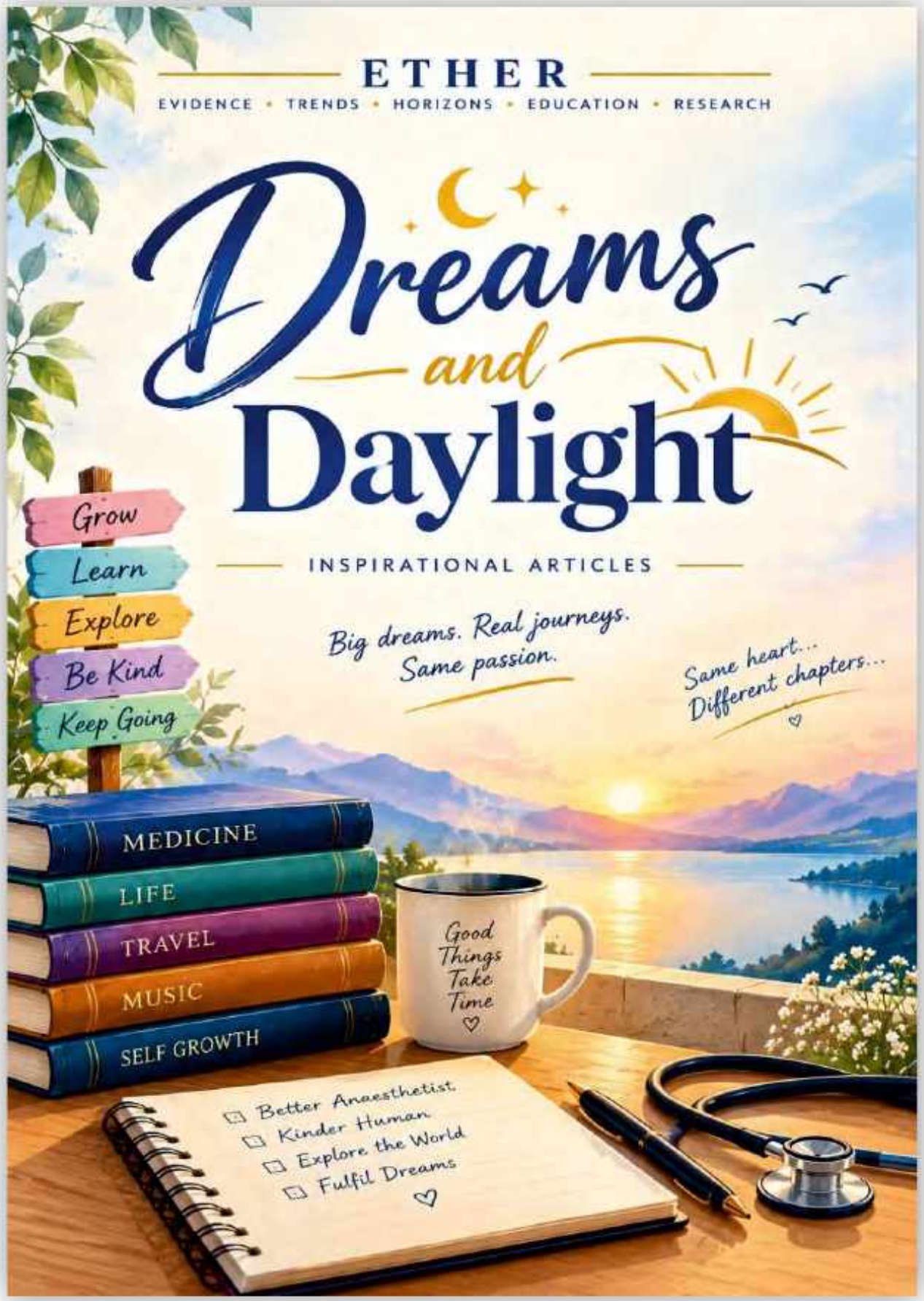
Pharmacological Management

Premedication can be given orally, intranasally, intramuscularly or rectally.

- Midazolam: Short-acting benzodiazepine with rapid onset.
- Fentanyl (OTFC): Provides sedation and analgesia; may cause pruritus, respiratory depression and nausea.
- Ketamine: Provides sedation, analgesia and dissociation with limited respiratory depression; may cause hypersalivation, rigidity and emesis.
- Clonidine: Alpha-2 agonist with sedative and analgesic properties; may cause postoperative psychomotor impairment.

Conclusion: Individualised, child-centred care combining psychological preparation and judicious pharmacological intervention is essential to minimise perioperative anxiety.

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Kinder Human
Explore the World
Fulfil Dreams

My Journey In Anaesthesiology : From Primitive To Ai



Dr Gurmeet Singh Reen
Retd. Senior Anaesthesiologist
JK Health Services

Thirty-four years back, I joined as a reluctant MD student in Anaesthesiology at GMC Jammu, and since then I have not looked back and carried on the flag with my head held high, without succumbing to the whims and undue pressure from the surgical fraternity.

I was fortunate enough to get the love and support from my colleagues and senior faculty who were responsible for changing my uncertainty to a postgraduate who started liking the speciality. My whole perception toward Anaesthesia changed when I was blessed with Dr. Daljit Singh Charak as my guide, who groomed me with his teachings, techniques and approach to patients that helped me to become a balanced and composed Anaesthesiologist.

When I started working, to begin with, the constraints were too many, not the academics, as we had a galaxy of excellent faculty to teach us and fortunately we were only 2 PG students at that time. At that time we had no monitors and limited drugs, most of them are part of history now, so we had to rely on clinical sense and judgement and even on God's blessings at times to come out of a crisis. We used to give spinal anaesthesia with 18G needles, not disposable ones but autoclaved or boiled multiple-use steel needles, slowly graduating to 24G needles by the time I retired.

I personally learned from my seniors, colleagues, my juniors and even from senior technicians and incorporated all of it to try to give a balanced, complete and tailor-made anaesthesia to each patient. This approach fulfils the needs of the patient, the surgeon and even yourself for a better and safe outcome from anaesthesia.

As for the role of AI in our speciality, personally I have not relied much on it because every patient is different and behaves differently to the drugs used.

My advice to all Anaesthesiologists: upgrade your knowledge and skills periodically by reading textbooks, journals and attending workshops and conferences sincerely. And if you want to excel in the speciality, love it, be proud of it and perform your work with full commitment, dedication and no shortcuts to achieve your goals.

Long live ISA and Anaesthesiology!



My Journey

From the Operation Theatre to Head of the Department of Anaesthesia

Dr. Anita Vig Kohli, Ex-HOD and Professor,
Deptt. of Anaesthesia, Critical Care & Pain Medicine, GMC Jammu.



I am Dr. Anita Vig Kohli, and my professional journey in anesthesiology has been defined by dedication, continuous learning, perseverance, and profound gratitude. Reflecting on my career—from standing beside the operating table as a young anesthesiologist to serving as the Head of the Department of Anesthesia at Government Medical College (GMC), Jammu—I am filled with a deep sense of fulfilment and humility.

The operating theatre has always represented more than a workplace to me. It is an environment where knowledge, precision, teamwork, and compassion converge. During the early years of my career, every case presented an opportunity to learn, and every patient offered valuable lessons about medicine, responsibility, and, above all, the sanctity of human life. Although anesthesiologists often work behind the scenes, they bear an immense responsibility: safeguarding patients during some of the most vulnerable moments of their lives.

> *"My journey continues with the same commitment with which it began: to serve, to learn, to teach, and to care."*

Over the years, I have witnessed significant advances in anesthesiology. Developments in technology, monitoring, critical care, regional anesthesia, and perioperative medicine have transformed the specialty. Keeping pace with these changes has required continuous professional development and a willingness to adapt. Alongside my clinical responsibilities, teaching young doctors and collaborating with colleagues have become equally important aspects of my professional life. I have always believed that medicine advances when knowledge is shared.

My tenure at GMC Jammu has been enriched by the many individuals with whom I have had the privilege of working: senior mentors who provided guidance, colleagues who offered support during challenging situations, nurses and technicians whose contributions are indispensable, and generations of students and residents who brought enthusiasm, curiosity, and fresh perspectives to the department. Their trust and cooperation have been among the greatest strengths of my career.

In time, I was entrusted with the responsibility of serving as Head of the Department of Anesthesia. Moving from the operating table to the position of Head of Department represented far more than a change in designation. It marked a transition from focusing primarily on individual patient care to assuming responsibility for the department, its personnel, academic standards, and future development. Leadership taught me that a department is not built by one individual; it is strengthened collectively through teamwork, mutual respect, discipline, and a shared commitment to excellence in patient care.

As I reflect on my career, I see not merely a progression of professional roles, but a journey shaped by countless patients, teachers, colleagues, students, and experiences. The operating theatre taught me courage and precision; teaching taught me patience; and leadership taught me humility.

Today, I remain deeply grateful for the opportunity to serve my profession and institution. The position of Head of Department is not the destination of the journey; rather, it represents another responsibility, another opportunity to learn, and another avenue through which I can contribute to the noble cause of medicine.

Palliative Care at GMC Jammu: Restoring Comfort, Dignity and Hope



Dr Rajesh Mahajan
Professor & Head
Deptt. of Anaesthesia, Critical Care & Pain Medicine, GMC Jammu

Government Medical College (GMC), Jammu has emerged as a pioneer in the field of palliative care, providing compassionate, patient-centred services to individuals with life-limiting illnesses. Since its inception in 2021, the palliative care unit at GMC Jammu has offered a daily outpatient department, dedicated indoor ward facilities, and round-the-clock services, benefiting more than 1,000 patients to date. The unit functions under the close supervision of experienced faculty, ensuring safe, ethical, and evidence-based care tailored to individual patient needs.

While the service primarily caters to cancer patients, palliative care at GMC Jammu extends its scope to several other areas requiring symptom-focused and supportive care. These include advanced neurological disorders such as stroke, motor neuron disease, Parkinson's disease, dementia, and multiple sclerosis; end-stage organ failures including chronic kidney disease, congestive heart failure, chronic liver disease, and advanced respiratory illnesses like COPD; progressive infectious and inflammatory diseases; severe trauma, spinal cord injuries, and debilitating musculoskeletal conditions; and geriatric patients with frailty, multimorbidity, and chronic pain syndromes.

The availability of round-the-clock services with all classes of opioids, analgesics, and adjuvant medications allows effective control of pain and other distressing symptoms, significantly reducing patient suffering. Palliative care also promotes psychosocial counselling, spiritual support, caregiver education, and continuity of care, reducing unnecessary interventions and hospitalizations. By facilitating advance care planning and end-of-life discussions, the service ensures care aligned with patient values. In essence, palliative care at GMC Jammu integrates medical expertise with empathy, offering dignity, comfort, and holistic support across a wide spectrum of serious illnesses.





Is Superspeciality a Must After MD Anaesthesia? - A Jammu Perspective

Dr Sanjay Kalsotra
Professor & Head
Deptt. of Anaesthesia & Critical Care, GMC Kathua



MD Anaesthesia remains a complete qualification, but the question of DM/DrNB after MD is increasingly relevant, even in Jammu.

The Changing Ground Reality

Anaesthesia is no longer just OT-based. With Super-speciality Hospital Jammu, AIIMS Vijaypur, and private ICUs expanding, there is growing demand for focused expertise in cardiac, neuro, paediatric, critical care, and pain. For GMC faculty posts and corporate hospitals outside J&K, a DM now carries clear weight.

Why Consider DM?

1. Academic Edge: For GMC Jammu, Rajouri, Doda, Kathua faculty and for corporate jobs in Delhi/Chandigarh, DM in Cardiac, Neuro, Paediatric or Critical Care gives priority.
2. Expertise: Complex cases like paediatric cardiac or transplant referrals need focused training.
3. Niche Practice: Pain clinic and critical care are emerging as independent lucrative avenues in Jammu.

Why DM Scores Extra: DM offers national recognition, faster promotions, eligibility to start superspeciality courses in Jammu, access to research funding, and a distinct identity beyond OT services — transforming you from a service provider to a leader and opinion-maker.

Why MD is More Than Enough in Jammu

1. Huge Demand: Jammu Division — from GMCs to District Hospitals — needs competent general anaesthesiologists. Freelance anaesthesia, private nursing homes, and intensive care depend on MDs.
2. Fellowships Work Better: Instead of 3-year DM, a 1-year fellowship in critical care, paediatric anaesthesia, or USG-guided regional anaesthesia is more practical and cost-effective for our setup.
3. Reality of Practice: Surgeons and hospitals here value availability, safety, and airway/regional skills — not DM tags.

Bottom Line: If you aim for metros or academic super-speciality, DM helps. If you plan to serve and grow within Jammu Division, become a skilled MD with strong ICU, ultrasound, and pain skills. In Jammu, competence matters more than certificates.



Keeping the Ignited Flame of Academics and Research Burning in Anaesthesiology

Dr Sunana Gupta
Professor & Head
Deptt. of Anaesthesia & Critical Care , AIIMS Jammu



In the rapidly evolving world of modern medicine, anaesthesiology stands as one of the most dynamic and demanding specialties. Where patient safety, precision, and rapid decision-making are paramount, continuous learning and active research are not just beneficial, but indispensable for every anaesthesiologist aiming to provide safe, effective, and evidence-based care.

Expanding Horizons Beyond the OT

Anaesthesiology is expanding beyond the operating room into perioperative medicine, critical care, pain management, and trauma. Recent advances like ultrasound-guided regional blocks, point-of-care ultrasound (POCUS), advanced airway devices, depth-of-anaesthesia monitoring, AI-assisted decision tools, safer drug delivery systems, and personalised anaesthesia approaches have significantly strengthened patient safety, precision, and perioperative outcomes. These advances emphasize the need for continuous learning and adaptation.

Active academic participation keeps anaesthesiologists updated with latest guidelines, safety protocols, and evidence-based practices. It improves decision-making through adoption of new clinical pathways, algorithms, monitoring standards, and modern technologies like POCUS and regional techniques, ultimately enhancing patient safety, quality of care, and professional competence.

AI and the Future of Anaesthesia

Artificial intelligence is reshaping anaesthesia practice through predictive monitoring, automated drug delivery, clinical decision support, and early detection of complications. Staying updated is essential to integrate these emerging technologies safely and effectively into clinical practice.

Evidence-Based Practice: The Cornerstone

Evidence-based practice ensures clinical decisions are based on reliable and updated scientific evidence. With rapidly advancing technologies, evolving guidelines, and increasing patient complexity, research helps refine protocols, improve drug safety, and enhance perioperative outcomes. It reduces variability in care, minimises complications, and supports adoption of best practices such as updated airway algorithms, BLS and ACLS updates, ERAS pathways, and advanced monitoring standards.

Continuous research fosters innovation, validates new therapies, and keeps anaesthesiologists aligned with global standards. Ultimately, it strengthens patient safety, optimises efficacy, and drives the specialty's evolution.

In an era where medicine advances at incredible speed, commitment to lifelong learning is both a professional responsibility and a moral obligation, ensuring every patient receives the safest, most advanced, and evidence-based care.



Critical Care Medicine: Saving Lives, Setting Standards

Dr Vanilla Chopra,
Senior Consultant & Head
Deptt. of Critical Care , SMVDU



Critical care medicine is at the forefront of saving lives, managing patients with life-threatening illnesses in the Intensive Care Unit (ICU). It integrates continuous monitoring, advanced diagnostics, and complex interventions to support vital organs failing due to cardiac, respiratory, neurological, renal, hepatic, or metabolic dysfunction, providing both immediate resuscitation and sustained organ support.

Evolving as a Superspeciality in India

In India, critical care has matured into a recognized superspeciality. The DM in Critical Care Medicine, a three-year NMC-approved program, is offered at premier institutes like AIIMS New Delhi, Tata Memorial Hospital Mumbai, and SGPGIMS Lucknow. The DrNB in Critical Care by the National Board of Examinations offers parallel training across many accredited hospitals.

Complementing these are ISCCM programs - IDCCM and IFCCM - for physicians and anaesthesiologists seeking to build expertise. Online and hybrid fellowships have made advanced training more accessible for working professionals, combining practical exposure with academic rigor.

ISCCM: Driving Training, Standards, and Advocacy

Established on October 9, 1993, the Indian Society of Critical Care Medicine (ISCCM) is the backbone of India's critical care community, with over 100 branches. It organizes conferences, workshops, develops India-specific guidelines, promotes patient safety, and facilitates research and education.

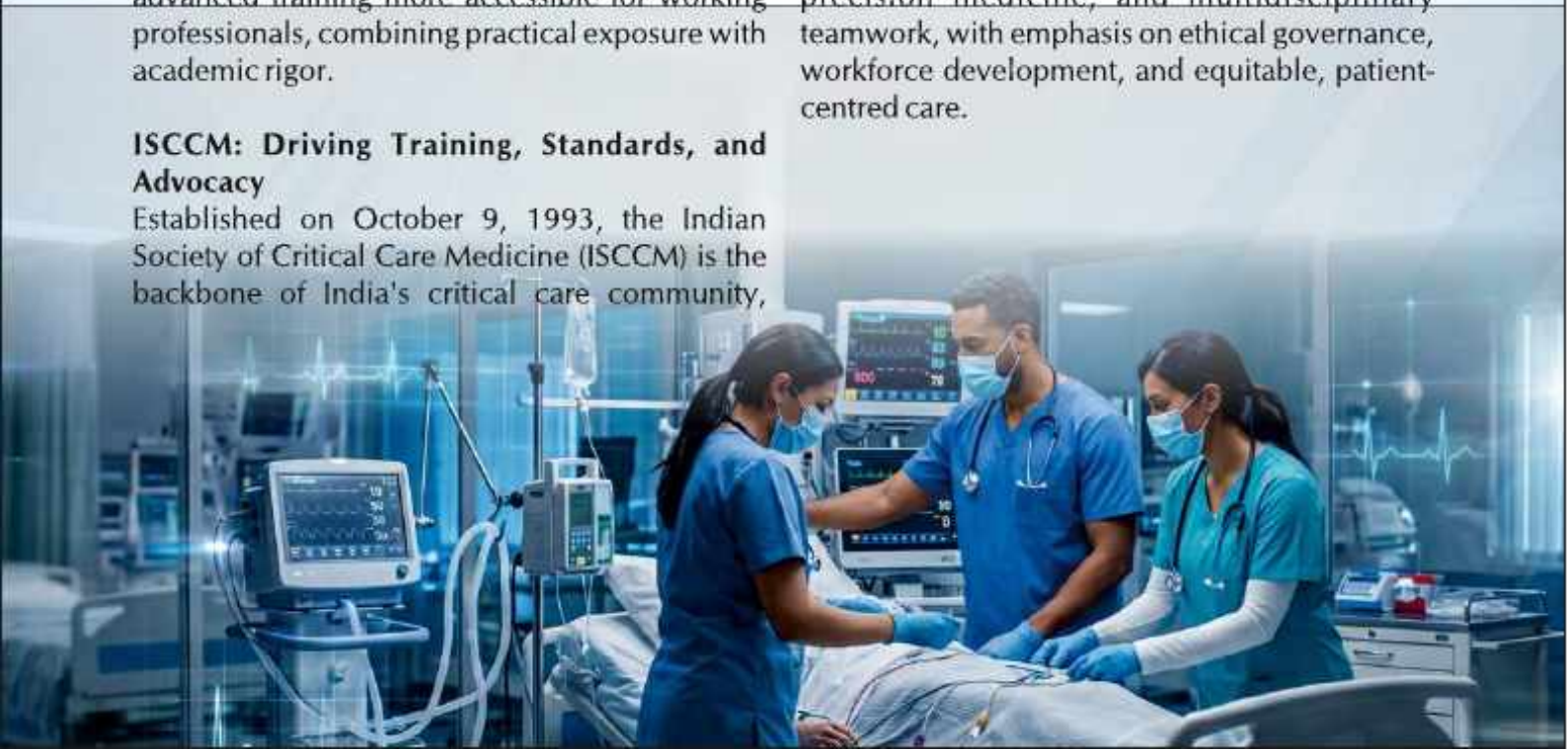
The Jammu Branch, inaugurated in October 2023, exemplifies this expansion. Through CMEs, outreach programs, and skills training, it is strengthening regional critical care services and ensuring quality standards reach beyond metros.

Challenges and Opportunities Ahead

Despite growth, challenges persist - inadequate infrastructure, unequal access, workforce shortages, and financial burden on patients. Many regions still face limited ICU beds and trained staff, compounded by ethical dilemmas and high out-of-pocket costs.

Innovation Shaping the Future

The future is being reshaped by technology. AI-driven analytics, tele-ICU for remote support, robotic rehabilitation, and advanced extracorporeal therapies are enhancing outcomes and extending specialist reach. The next decade will focus on digital integration, precision medicine, and multidisciplinary teamwork, with emphasis on ethical governance, workforce development, and equitable, patient-centred care.



Yoga For Anaesthetists



Dr. Madan Lal Katoch
Professor
Deptt. of Anaesthesia, Critical Care & Pain Medicine, GMC Jammu

Anaesthetists often face high stress, long hours, static posture, and mental fatigue. Yoga can help reduce stress, improve posture, prevent back/neck pain, and enhance focus & breathing control—all essential for your profession.

BENEFITS OF YOGA FOR ANAESTHETISTS

Area	Yoga Effect
Stress & anxiety	Activates parasympathetic system → calm mind
Focus & alertness	Improves concentration & breathing
Neck/back strain	Corrects posture, stretches spine
Long standing hours	Improves circulation & prevents varicose veins
Mental fatigue	Enhances mindfulness & recovery
Emotional health	Reduces burnout

KEY YOGA COMPONENTS

1.Asanas (Postures)–for posture & muscular relief

2.Pranayama (Breathing) – for calmness & oxygenation

3.Meditation–for focus & emotional balance

RECOMMENDED YOGA ASANAS

A) For Neck & Back Pain (OT posture)

- Tadasana – improves posture
- Bhujangasana (Cobra pose)
- Marjariasana (Cat-Cow stretch)
- Setu Bandhasana (Bridge pose)
- Shashankasana (Child's pose)
- Ardha Matsyendrasana (Spinal twist)

B)For Long Standing Hours & Circulation

- Viparita Karani (Legs up the wall)
- Pawanmuktasana (ankle/knee rotation)
- Utkatasana (Chair pose)
- Vrikshasana (Tree pose) – improves balance & concentration

C)For Shoulder & Wrist Strain (IV insertion, laryngoscopy)

Gomukhasana – stretches shoulders Garudasana arms stretch
Wrist rotation & palm extension exercises

PRANAYAMA (BREATHING TECHNIQUES)

Technique	Benefit
Anulom Vilom	Calms mind, reduces stress
Bhramari	Relieves tension headaches
Box breathing (4-4-4-4)	Used by military—improves focus
Kapalbhati	Keeps lungs clear & active

MIND RELAXATION / MEDITATION

Mindfulness meditation – focus during OT Body scan meditation – for relaxation after duty Yoga Nidra – excellent for post-duty fatigue
5-minute "breathing break" before entering OT – highly recommended



Anaesthetic Challenges In Renal Transplant Patients



Dr. Ashwani Kumar
Professor
Deptt. of Anaesthesia, Critical Care & Pain Medicine, GMC Jammu

Renal transplantation presents significant anaesthetic challenges due to end-stage renal disease and dialysis-related physiological disturbances, with the primary goal being protection of the new graft.

Renal transplant programme in Super speciality Hospital, GMC Jammu was started on 30th April 2022 and till date 37 live renal transplant cases has been done . A dream that began in 2016 , has now become a reality, offering a new lease of life to the people of J&K.

The members of first ever Renal transplant team were Dr Smriti Gulati (Prof & Head of the deptt) , Dr Ashwani Kumar (Associate Professor) , Dr Anjali Mehta (Associate Professor) , Dr Amit Manhas (Assit Prof), Dr Neha Dang (Lecturer) , Senior resident Dr Megha Gandotra, Dr Abhilasha Gupta respectively .

Various challenges we faced:

Preoperatively:

Patients often have fluid and electrolyte abnormalities including hyperkalaemia, metabolic acidosis, sodium and calcium/phosphate imbalance, and may be either hypovolaemic after dialysis or fluid overloaded, along with anaemia, hypertension, LVH, ischaemic heart disease, cardiomyopathy, arrhythmias, and uraemic complications like platelet dysfunction with bleeding tendency, pericarditis and encephalopathy. This requires careful assessment of volume status, potassium and acid-base after dialysis, protection of the AV fistula from BP cuffs or cannulation, and review of medications including immunosuppressants.

Intraoperatively:

Fluid management is critical to maintain adequate allograft perfusion without causing pulmonary oedema, avoiding both hypovolaemia and fluid overload, maintaining blood pressure and cardiac output with judicious balanced crystalloids and vasopressors if needed, while avoiding prolonged hypotension, severe hypertension and excessive vasoconstriction, and monitoring ECG, ABGs and electrolytes for hyperkalaemia, acidosis and hypocalcaemia. Drug dosing must be adjusted for impaired renal function by preferring atracurium/cisatracurium for neuromuscular blockade, avoiding accumulation of renally excreted opioid metabolites like morphine, and avoiding nephrotoxic drugs. Surgical factors include graft placement in the iliac fossa with vascular anastomosis to iliac vessels, risk of major bleeding, graft vessel thrombosis, haemodynamic changes from vascular clamping and reperfusion-related hypotension, requiring adequate volume status around reperfusion. Immuno suppression with tacrolimus/ cyclosporine, mycophenolate and steroids brings risks of infection, drug interactions, nephrotoxicity, hypertension, hyperglycaemia and need for steroid supplementation.

Postoperatively:

Challenges include delayed graft function, acute tubular injury, acute rejection, hyperkalaemia, fluid imbalance, bleeding, infection, cardiovascular and respiratory complications, and the need for adequate analgesia without opioid accumulation.



Thoracic Segmental Spinal Anaesthesia: My Personal Experience



Dr Renu Wakhloo
Professor
Deptt. of Anaesthesia, Critical Care & Pain Medicine, GMC Jammu

Thoracic segmental spinal anaesthesia involves administration of a small volume of intrathecal local anaesthetic at a selected thoracic level to achieve a restricted block covering dermatomes required for surgery. By targeting required segments, it aims to limit sympathetic blockade and minimise haemodynamic fluctuations. This approach is appealing in selected patients with respiratory comorbidities to avoid general anaesthesia, although pulmonary outcomes depend on multiple factors. It has been explored for intra-abdominal, thoracic, breast surgery and awake thoracoscopy.

My experience has been challenging but rewarding. The presence of spinal cord at thoracic puncture site is a major consideration, and potential for neurological injury must never be underestimated. Another challenge is variability in extent and spread, as intrathecal drug distribution cannot always be predicted.

There is no universally accepted fixed dose. Dose requires clinical judgement, experience, intended sensory distribution, local anaesthetic used, and patient-specific factors. Patient physiology, expected duration, extent of surgery, and availability of alternative plan must be considered.

I emphasise mastering preprocedural ultrasound to understand thoracic anatomy, identify appropriate space, and plan needle trajectory. Steeply angled spinous processes and narrow interlaminar spaces make landmark approach demanding. Patient positioning should be optimised for access, comfort and safety.

Needle advancement must be controlled, with attention to patient feedback. Injection must not proceed with unexpected paraesthesia or resistance. Technique should be undertaken by trained anaesthesiologists in carefully selected patients, with suitable monitoring and discussion with surgeon.

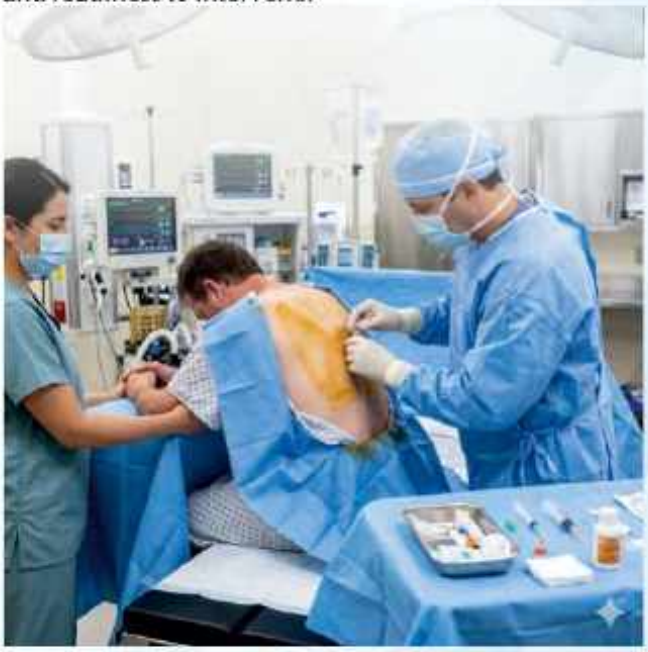
Minimum effective dose should be pursued while ensuring adequate anaesthesia and safety. Standard monitors, IV access, vasopressors, resuscitation drugs, and readiness for immediate conversion to general anaesthesia must be available.

I share my experience in modified radical mastectomy with axillary clearance. After thorough evaluation of cardiopulmonary reserve, coagulation and medications, informed consent was obtained explaining benefits, risks and alternatives.

With standard monitoring and sitting position, TSSA was performed at T5–T6 using 1.2 mL of 0.75% ropivacaine (9 mg) with 5 micrograms dexmedetomidine as off-label adjunct. Sensory block was assessed by pinprick, with attention to T1–T2 and axillary field. Medial forearm loss suggested T1 involvement. Motor assessment included handgrip and intrinsic muscle movements.

As block extended cephalad, patient complained of mild breathlessness with SpO2 drop from 99% to 95%, possibly due to intercostal weakness or anxiety. Oxygen via Venturi mask and reassurance improved symptoms. Haemodynamics remained stable with ~10% BP reduction. Midazolam 1 mg IV was given for sedation.

Surgery lasted 90 minutes, sensory block persisted 3 hours. TSSA is promising but technically demanding, requiring right patient, drug, dose and technique. Success is not merely achieving level, but safe, effective, patient-centred anaesthesia with vigilance and readiness to intervene.



Disruptive Clinical Behaviour In Operation Theaters



Dr Laughi Bhan
Consultant Anaesthesia
JK Health Services

Introduction
Disruptive clinical behaviour refers to disrespectful conduct towards colleagues, sometimes escalating to bullying. Such unpleasant events are frequently encountered in daily practice, particularly in operation theaters (OTs), and are a growing concern that needs identification and intervention.

Teamwork is the essence of OT functioning, which gets jeopardized by disruptive behaviour. Literature provides ample anecdotes and real-life experiences showing that many OR professionals indulge in disruptive behaviour, knowingly or unknowingly, with a distinct rank order. It is an accepted fact that such behaviour increases patient morbidity and mortality. Hence, introspection and control of one's own behaviour is vital to maintain a healthy OT environment.

Definition and Forms of Disruptive Behaviour
Disruptive behaviour encompasses a range of unacceptable clinical actions including incivility, bullying and harassment. Examples include dismissive and derogatory comments, insensitive attitude, inappropriate language, threats, demeaning conduct, aggressive behaviour, verbal outbursts, and reluctance to answer questions. In essence, any behaviour that makes the victim feel intimidated or threatened and impairs their ability to provide patient care is disruptive behaviour.



Causes
Causes can be categorized as Intrapersonal such as personality traits and psychological conditions; Organisational like production pressure, mismanagement and administrative inefficiencies; and Interpersonal like perception of status hierarchy.

Consequences
Disruptive behaviour undermines colleagues' rights and adversely affects patient care through poor communication, impaired teamwork and reduced knowledge transfer due to rudeness. Help-seeking behaviour is also affected.

Many anesthesiologists may resort to lying to colleagues out of fear of being blamed for untoward incidents. Strained teamwork due to manipulative, competitive and dominant strategies creates an unhealthy atmosphere. This ultimately leads to occupational stress, sleep deprivation, burnout, depression and low self-esteem. Victims of bullying have poorer mental health, frequently avail sick leave and may leave the workplace. Increased absenteeism brings disrepute and poor ratings to the institution.

Strategies for Prevention and Management
Four-step strategies are advised for prevention and management.

1. Setting Standards: Set expected behavioural standards through oaths, laws, code of conduct and mandatory institutional curricula.

2. Education and Support: Equip and educate clinicians to meet standards via professional wellness programs. Identify at-risk clinicians and provide peer support and mentorship.

3. Monitoring and Reporting: Monitor compliance while maintaining anonymity. Staff should be aware of the reporting mechanism.

4. Remedial Measures: Adopt staged remedial measures. Corrective actions must be fair and prompt. Institutes must have a healthy policy and committee. For the 10% with disruptive behaviour, start with informal meetings, counselling, awareness and supervisor intervention, followed by department head and high-level disciplinary action if needed.

Conclusion
Study of disruptive behaviour in ORs is essential. While all OR professionals are implicated, surgeons remain the most common instigators. Ongoing monitoring through regular performance feedback and soft-skills development is needed. Understanding this phenomenon and devising preventive intervention strategies is imperative.

Medical Skill Enhancement In Jammu

Dr Shelly Mahajan
Anaesthetist, JK Health Services
National Master Trainer for Basic Emergency Course (BEC)



Medical skill services refer to educational programs and facilities that provide training in healthcare skills. These include technical programs like basic and advanced life support, delivered through simulation labs, online platforms, and certificate courses. They are designed for students, practicing professionals, youth aspiring to enter healthcare, and non-medical citizens willing to save lives at home and workplace.

Types of medical skill services

Simulation and skill labs: Dedicated facilities that provide a safe environment to practice clinical skills before handling patients. They use manikins, simulated scenarios, and modern equipment like VR labs to mimic real-world environments.

Training and up-skilling initiatives: Programs designed to help practicing doctors and nurses up-skill in technical and soft skills, including communication, leadership, and patient care. They include partnerships with hospitals for clinical apprenticeships and hands-on experience.

Basic Life Support (BLS)

BLS comprises a set of crucial medical skills used to sustain life during emergencies such as cardiac arrest, respiratory failure, and choking until advanced medical help arrives. It is a required certification for healthcare professionals and first responders.

Key Skills and Services in BLS Training

BLS courses teach prompt recognition of life-threatening emergencies and effective interventions:

- Cardiopulmonary Resuscitation (CPR): High-quality chest compressions and rescue breaths for adults, children, and infants, with minimal interruptions.
- Automated External Defibrillator (AED) Usage: Proper and early use of AED to restore normal rhythm during sudden cardiac arrest.
- Airway Management: Techniques for relieving foreign-body airway obstruction (choking) in all age groups.
- Team Dynamics: Effective communication and role assignment during multi-rescuer resuscitation.
- Special Considerations: Opioid-associated emergencies and basic first aid for injuries, depending on provider.

Who Needs BLS Certification? Physicians, nurses, paramedics, EMTs, dentists, therapists, firefighters, police officers, nursing and medical students, lifeguards, and school professionals.

Certification Details: Reputed providers include American Heart Association (AHA) and American Red Cross. Training is available in-person, online, or blended format with hands-on skills session. Initial course takes 3.5 to 6 hours, valid for two years. Periodic renewal is vital as skills decline over time.

Skill Center Nagrota

Societies are being transformed into first responders. In UT of J&K, Jammu Skill & Simulation Centre (JSSC) at RIHFW Nagrota, Jammu, under the Director, Health Services Jammu, conducts Basic Emergency Course (BEC) by ICRC, BLS, ALS, and First Aid for medical, paramedical staff, university and college staff, police, traffic police, fire and emergency services and volunteers.

The institute trained 4,666 participants during 2022-25 and is empowered to sign an MoU with NCC for extending training to NCC cadets of UT of J&K.



Anaesthetic Challenges in J&K Health Services: Working Against the Odds

Dr Ravinder Gupta
Consultant Anaesthesia
JK Health Services



Anaesthesiologists serving in Jammu and Kashmir Health Services face unique challenges, particularly in far-flung and resource-limited healthcare facilities. Shortages of trained staff, inadequate equipment, limited ICU facilities and the absence of oxygen plants compromise perioperative safety. The absence of sanctioned posts for anaesthesia technicians in the Health Services sector further increases workload and hampers the delivery of safe anaesthesia services.

The unavailability of dialysis facilities when urgently required, along with the lack of cardiologists and other super-specialists for timely consultation, complicates the management of high-risk patients. Anaesthesiologists are often compelled to make critical decisions with limited support while managing emergencies.

Administrative and local pressure to undertake surgical procedures despite inadequate infrastructure and support facilities creates additional challenges. Anaesthesiologists face the difficult task of balancing healthcare needs with their ethical and professional responsibility to prioritise patient safety.

These circumstances contribute to considerable mental stress, professional isolation and medico-legal vulnerability. Addressing these challenges requires strengthening peripheral healthcare infrastructure, creating sanctioned posts for anaesthesia technicians, ensuring adequate staffing and essential equipment, and establishing reliable referral systems with timely specialist support.

Patient safety must remain paramount. No healthcare professional should be compelled to undertake procedures beyond the safe capabilities of their institution. Recognising these challenges and implementing appropriate measures are essential to protect patients, support anaesthesiologists and strengthen healthcare delivery across Jammu and Kashmir.



From Burnout To Balance: Mental Health Stratergies For Modern Anaesthesiologist



Dr Jyoti Sakral
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Deptt. of Anaesthesia & Critical Care, ASCOMS Jammu

As anesthesia professionals, we are confronting challenging times. Our specialty is experiencing a period of mergers, rapid consolidation of practices, and a trend toward employed providers that has dramatically a□ected our autonomy.

Burnout is a pattern of symptoms with extremely low physical and emotional energy levels, cynicism, and decreased work e□ort. This can lead to significant consequences, both personally and professionally.Professionals with burnout are less productive, have a higher likelihood of turnover, and are more likely to reduce their work e□ort in the coming years. Not surprisingly, this can have a significant impact on patients.

The prevalence of burnout among anaesthesiologists has reached concerning levels, with recent studies reporting rates as high as 68%. This underscores an urgent need to address the multifaceted contributors to professional distress, including prolonged working hours, unpredictable scheduling, high-stakes decision-making, and emotional fatigue. Left unaddressed, burnout not only jeopardizes clinicians' mental health but also compromises patient safety and care quality. Medical burnout among anesthesia providers is absolutely preventable and reversible.



Reversing this trend requires a dual approach targeting both individual resilience and systemic change. Clinicians are encouraged to adopt evidence-based strategies such as mindfulness meditation, cognitive behavioral techniques, and strict adherence to sleep hygiene and physical wellness routines. Establishing professional boundaries and engaging in supportive peer relationships further fortify mental well-being.

Equally critical are organizational measures promoting sustainable workloads, adequate sta□ng, and flexible scheduling. Leadership commitment to fostering a transparent culture that destigmatizes mental health care and facilitates confidential access to psychological support is essential. Peer support programs and mentorship also contribute meaningfully to a sense of community and shared purpose.

Ultimately, restoring balance is a professional imperative that safeguards both clinician well-being and patient outcomes. By integrating personalized self-care with systemic interventions, modern anaesthesiologists can sustain the resilience necessary to meet the complex demands of contemporary practice. This holistic paradigm from burnout to balance represents not only a pathway to improved mental health but a crucial dimension of professional excellence within anesthesiology.

"If health care providers aren't well, it's hard for them to heal the people for whom they are caring."

Establishing Relationship with fellow colleagues and OT staff – Advantages of Working Together



Dr. Isha Gupta,
Associate Professor
Deptt. of Anaesthesia, Critical Care & Pain Medicine, GMC Jammu

As an Anaesthetist, we often find ourselves at the forefront of patient care, working closely with surgeons, nurses and other healthcare professionals in the operation theatre. While our expertise is crucial, it is equally important to recognise the value of building strong relationships with our fellow colleagues and OT staff. In this article, I'll share my views on advantages of working together and offer tips on establishing a collaborative culture.

Benefits of Collaboration :

Improved Patient Care : When we work together, we share knowledge, expertise, and ideas, leading to more effective patient management and better outcomes.

Enhanced Teamwork : Collaboration promotes a sense of belonging, encouraging team members to support each other and work towards a common goal.

Increased Effieciency : Clear communication and defined roles streamline OT processes, reducing delays and improving workflow.

Professional Growth : Working with colleagues from diverse backgrounds and disciplines expands our knowledge, skills, and perspectives, enhancing our professional development.

Tips For Building Relationships :

Take time to introduce yourself : Establish a personal connection with OT staff and colleagues.

Attend OT meetings and huddles : Participate in team discussions to stay informed and build relationships.

Offer Help and Support : Be approachable and willing to lend a hand.

Communicate Effectively : Clearly articulate your needs, concerns and expectations.

Show appreciation : Express gratitude for your colleagues hard work and dedication.

By fostering a culture of collaboration, we can create a positive, productive and patient centric OT environment. Let's work together to build bridges and achieve goodness!



The Dilemma of the After-Hours Case: An Anaesthesiologist's Perspective



Dr Neha Sharma
Associate Professor,
Deptt. of Anaesthesia, Critical Care & Pain Medicine, GMC Jammu

The End of a Long Day
It is 4:45 PM. After a long day on our feet ensuring the OT runs smoothly, we see the surgeon approaching. Silently, we hope, "Please, no more cases now."

The "Small" Emergency
But he insists, "It's just a small case, won't take long, maybe five minutes, and it's an emergency."

Is it really just small? For the surgeon, perhaps. He will operate and leave. For us, the work has just begun. We must evaluate the patient, check investigations, prepare drugs and machine, manage anxiety, induce, monitor, reverse, shift to recovery, stabilize vitals, and complete paperwork. The tasks extend far beyond the surgeon's five minutes.

The Anaesthesiologist's Dilemma
Decision-making at this hour is never easy. Experience has taught us two truths: it is never just a small case, and the label of "emergency" is often used loosely to fit another case into the day.

Our minds race: Is this a genuine emergency or a routine case pushed to the end? If it truly was an emergency, why was it left till now?

We must make a fair, balanced decision. We weigh the patient's needs against team exhaustion, safety risks, and personal commitments - children to be picked up, classes to attend, buses to catch, and OT staff waiting to set up for tomorrow.

If we postpone, the patient may stay longer, attendants incur extra cost, and if it is a true emergency, the condition could worsen. The pressure is real and palpable.

A Test of Professional Judgement
Should we risk being the villain for the surgeon or the hero for our OT staff? It is a test of judgement that considers patient need, team fatigue, and hospital schedule.

Sometimes we oblige, even if it means going home late, keeping family waiting, and making a long day longer. Other times, when it is clearly not an emergency and delay will not matter, we must say "No." A tired team rushing an unprepared patient compromises safety.

The Ultimate Priority: The Patient
Sometimes the surgeon's request prevails, sometimes the anaesthesiologist's judgement stands. Ultimately, it does not matter who wins, as long as the patient does not lose - because it is never just five minutes.



Obstetric Intensivist:
The Need of the Hour



Dr Sandeepika Dogra
Assistant Professor,
Deptt. of Anaesthesia & Critical Care, AIIMS, Jammu

Global maternal health has improved significantly, yet disparities remain profound. High-income countries report maternal mortality ratios (MMR) as low as 10–12 per 100,000 live births, while developing nations have MMR of 200-250 per 100,000 live births contributing over 99% of global maternal deaths. ICU admissions also mirror this inequality—2–4 per 1000 deliveries in developed nations versus 4–16 per 1000 in low- and middle- income regions.
The leading global causes of obstetric ICU admission include postpartum haemorrhage, severe pre-eclampsia/eclampsia, sepsis, cardiac disease, respiratory failure, and multi-organ dysfunction.

India reflects this global pattern. Although the SRS 2020–22 reports an improved national MMR of 88, the variation across states remains stark:
Kerala, Maharashtra, Tamil Nadu: MMR 30–60
Assam, UP, MP, Rajasthan: MMR > 150

These disparities stem from inconsistent ICU preparedness, delayed escalation, and limited use of structured obstetric emergency protocols. In many settings, critically ill parturients deteriorate rapidly due to late presentation, inadequate antenatal screening, and the absence of early-warning systems.

At the same time, India's maternal demography is undergoing a major shift. Increasing numbers of women are conceiving at advanced maternal age, and pregnancies affected by diabetes, hypertension, renal disease, obesity, autoimmune disorders, congenital heart disease, and thyroid dysfunction are now routine. Survivors of childhood cardiac surgeries and chronic illnesses are also reaching reproductive age. These high-risk pregnancies carry greater chances of sudden decompensation, further stressing the need for specialised obstetric critical care.

This is where the 'Obstetric Intensivist' becomes paramount to modern maternal safety.

Caring for a critically ill parturient demands simultaneous mastery of pregnancy physiology and advanced critical care. The Obstetric Intensivist provides this essential blend, offering:

- Pregnancy-specific hemodynamic and ventilatory management.
- POCUS-guided evaluation of airway, cardiac function, and volume status.
- Leadership of rapid-response Obstetric Medical Emergency Team (OMET) activation and stabilisation.
- Protocol-based management of haemorrhage, hypertension, sepsis, and cardiac events.
- Seamless coordination between obstetrics, anaesthesia, ICU, neonatology, and nursing teams.
- Establishment and oversight of dedicated obstetric HDUs/ICUs for high-acuity care.



In a country where most maternal deaths are preventable, Obstetric Intensivist stands as the missing link between expeditious maternal deterioration and safe deliveries.
For India's journey towards improved maternal safety, Obstetric Intensivists are not optional—they are indispensable, and the time to strengthen this speciality is NOW.

Shaping Identity: The Resident to Consultant Evolution



Dr Rumani Ruku
Assistant Professor
Deptt. of Anaesthesia, Critical Care & Pain Medicine, GMC Jammu

The journey from resident to consultant represents far more than a change in title; it marks a profound evolution of identity, responsibility and professional maturity. While residency lays the groundwork for clinical skills and medical knowledge, the consultant stage completes the transformation into an independent, reflective and authoritative practitioner. This evolution is not merely about gaining seniority; it is about discovering one's professional character and voice.

Residency is characterized by intense learning, structured supervision and constant refinement of clinical judgement. It is a period of building competence under guidance while being shaped by mentors, experiences and the demands of patient care. Yet, within this demanding environment, the foundations of a consultant's identity begin to take form.

As residents we learn to navigate uncertainty, manage complex cases, collaborate with multidisciplinary teams and engage with diverse patient populations. Resident identity is shaped by continuous learning and adaptation. Each challenging case, sleepless night and discussion with mentors adds valuable insight, but decisions are still validated by seniors. While autonomy increases gradually, the safety net of supervision remains. This stage fosters humility, resilience and curiosity, qualities essential for the next phase.

The shift from resident to consultant is both empowering and daunting. Suddenly, responsibility for clinical decisions rests on one's own judgement. Consultants not only treat patients but also shape the clinical environment through leadership, mentorship and strategic decision making. This transformation requires confidence, accountability and clarity of purpose. Responsibility transforms identity, encouraging decisiveness, self-assurance and unwavering commitment to patient welfare and safety.

This evolution also involves redefining relationships within healthcare systems. Former supervisors become colleagues, and junior trainees look up for direction and guidance. This shift demands effective communication, emotional intelligence and the ability to balance empathy with authority. Furthermore, the consultant identity includes a broader holistic vision of healthcare with focus on long-term planning, quality improvement, ethical decision making and collaboration across departments and specialties.

Ultimately, this is a transformative journey shaped by experience, reflection and growth, an evolution from dependence to autonomy, from learning to leading, and from seeking guidance to offering it. It marks professional advancement and symbolizes fulfillment of a lifelong commitment to serve with expertise, integrity and compassion.



The First Five Minutes Of A Perioperative Crisis

Dr. Suhail Bandey
Professor & Head
Deptt. of Anaesthesia & Critical Care, GMC Rajouri



The first five minutes of any perioperative crisis are the most decisive. As an anaesthetist, my initial response is to stop, verbalise the problem out loud, and call for help early rather than struggling alone. I secure the airway and confirm oxygenation and ventilation first, since hypoxia kills faster than almost any other derangement. Simultaneously, I check the circuit, gas supply, and monitors to rule out equipment failure before assuming a patient-related cause.

I switch to 100% oxygen, ensure IV access is patent, and get a rapid set of vitals — pulse, blood pressure, ETCO2, SpO2 — to form a working diagnosis. Communication with the surgical team is essential: they must pause or adjust the procedure if needed. Assigning roles to the team (drawing drugs, documenting, fetching equipment) prevents chaos.

Above all, following a structured algorithm — rather than relying on memory alone — keeps the response systematic under pressure.

Five Small Habits That Can Make A Difference In The Operating Room

Small habits. Safer practice. Better patient care.

Dr. Sucheta Hans
Assistant Professor
Deptt. of Anaesthesia & Critical Care, GMC Kathua



A safe operating room depends not only on advanced technology but also on consistent everyday habits. The Indian Society of Anaesthesiologists (ISA) emphasizes vigilance, preparedness, monitoring, and teamwork for safer anaesthesia.

1. The 5-Minute Machine Physical Check (Using the MSMAIDS Mneumonic):
   - Machine
   - Suction is functioning
   - Monitors
   - Airway cart
   - Iv line
   - Drugs
2. Strictly Enforce The 2-4-6 Fasting RULES
3. Implement the Pre-Induction "Sign-In" and "Time-Out" Huddle:
   - Patient Identity and Consent
   - Allergies and comorbid clearances
   - Anticipated blood loss or difficult airway warnings
   - Antibiotic and DVT prophylaxis
4. Continuous Clinical Monitoring:
   - Physical monitoring
   - Cross-referencing visual assessments with pulse oximeter, ETCO2.
   - Communicate clearly with the OT team and share concerns
5. Standardized Post-Anaesthesia Care Unit (PACU) Hand Off:
   - Cultivate the habit of delivering a structured verbal hand off

Remember: Small checks can prevent big problems. Safety begins with consistency.

Group Practice Adaptability and Advantages in Anaesthesiology: A Jammu Perspective

Dr Kunal Sharma
Assistant Professor
Deptt. of Anaesthesia, Critical Care & Pain Medicine, GMC Jammu



Anesthesiology has evolved from a predominantly individual, procedure-oriented specialty into a comprehensive discipline encompassing perioperative medicine, critical care, emergency resuscitation, pain management, trauma care, and multidisciplinary decision-making. These expanding responsibilities have increased the need for collaborative models of professional practice.

Group practice in anesthesiology refers to a structured arrangement in which two or more anesthesiologists work together as an organized team to provide anesthesia and perioperative care, sharing clinical responsibilities, professional expertise, while maintaining individual clinical accountability. Its principal strength is the integration of individual expertise into a coordinated system capable of delivering more reliable services, facilitating professional growth and supporting consistent standards of patient care.

In Jammu province, where government medical colleges, private hospitals, tertiary referral centres, and peripheral healthcare institutions operate within a diverse geographical and socioeconomic environment, group practice offers an opportunity to improve service delivery, strengthen professional collaboration, and expand access to specialised anaesthesia services.

Modern anaesthesia involves advanced airway management, ultrasound-guided regional anaesthesia, haemodynamic monitoring, critical care, and management of perioperative complications. Collaborative team based practice makes it easier to share expertise and manage surgical complexity, obstetric emergencies, trauma, and high-risk patients.Anaesthesia is a specialty in which uncommon but critical events may demand immediate assistance. Group practice facilitates access to professional assistance during difficult airways, major haemorrhage, cardiac arrest and other perioperative emergencies.

A shared roster enables equitable distribution of elective operating lists, emergency calls, night duties and leave which will improve work–life balance.Group practice can accommodate anaesthesiologists with focused interests in cardiac, paediatric, obstetric, neuroanaesthesia, regional anaesthesia, pain medicine and critical care.Collaboration encourages clinical discussions, continuing education, research and the adoption of evidence-based practices

For Jammu, the opportunity lies in developing a model suited to local clinical demand, workforce availability, institutional diversity and geographical realities. Group practice can transform anaesthesia practice from an isolated, individual-dependent model into a coordinated and sustainable professional arrangement, balancing clinical excellence, financial viability, professional independence and quality patient care.



A Day That Never Ends:

THE REALITY OF 24-HOUR SHIFTS IN GOVERNMENT ANAESTHESIA PRACTICE



Dr Supriya Gandotra
Ex- Senior Resident
Deptt. of Anaesthesia, Critical Care & Pain Medicine, GMC Jammu

Introduction

Inside the operating theatre, time loses its familiar rhythm. What seems like a normal day to the outside world stretches endlessly for an anaesthetist on a 24-hour shift. The government hospital setting—marked by patient overload, sudden emergencies, and resource constraints—turns these shifts into marathons of endurance. While the idea of long duty hours is often presented as a test of dedication, real-world evidence tells a different story: **fatigue is not a badge of honour—it is a risk.**

The Experience: When One Shift Becomes Three

For a government hospital anaesthetist, a 24-hour shift is not a single stretch of time. It unfolds in phases:

Morning: Predictability and Routine- Elective cases dominate the schedule. The team operates efficiently, and there is still mental clarity.

Afternoon: The Unpredictable Begins- Emergencies start arriving—polytrauma, obstetric collapses, septic patients, or sudden decompensations. Meals are missed, breaks dissolve, and stress begins to accumulate.

Night to Early Morning: The Silent Toll- It is during these hours that fatigue peaks. Reflexes slow, eyes burn, and even basic cognitive tasks demand effort. Yet emergencies continue relentlessly. This is when errors become more likely—not due to incompetence, but simply human biology.

Endurance or Excess? The Debate Resurfaces



1. The Case for Endurance

Supporters of long shifts argue that emergencies require someone always available. Government hospitals often lack adequate staff, making extended duty hours a necessity. Continuity of care is also easier when one anaesthetist manages preoperative, intraoperative, and postoperative phases.

2. The Case for Excess

However, evidence overwhelmingly shows that **fatigue compromises clinical judgment**, increases complication rates, and threatens patient safety. Anaesthesia requires minute-to-minute vigilance. Any lapse—even seconds long—can be catastrophic. Long shifts also contribute to emotional exhaustion, burnout, and an overall decline in the clinician's well-being.

What the Poster Symbolizes



The poster captures a harsh truth:
"A 24-hour shift tests not our dedication, but our biology."
The imagery—a masked, fatigued anaesthetist holding their head in distress—highlights the human cost of the current system. It reflects high patient load, continuous emergencies, and the silent burden carried by government healthcare workers.
The message is clear: **a tired anaesthetist is a safety risk—for the patient and for themselves.**

Conclusion

The experience of a government hospital anaesthetist reveals a profound truth: 24-hour shifts push professionals beyond physiological limits. What appears to be endurance is often an unsustainable struggle fought silently behind the OT doors. It is time to rethink the narrative. Fatigue is not dedication. Rest is not a luxury. And safety—both for patients and clinicians—must always come first.

Guidance Beyond Duty:
The Enduring Teacher- Student equation

Dr. Zahida Aziz
Senior Resident
Deptt. of Anaesthesia, Critical Care & Pain Medicine, GMC Jammu



"It is the supreme art of the teacher to awaken joy in creative expression and knowledge," wrote Albert Einstein, and nowhere does this truth resonate more deeply than in anaesthesia, a specialty where clarity, vigilance, and decisive action determine the course of a patient's life. For a resident, the teacher student relationship becomes a cornerstone of training, shaping not only clinical ability but also temperament, confidence, and ethical grounding. In the operating room, where moments can stretch or collapse under pressure, the presence of a guiding mentor is often the difference between hesitation and assured action.

Throughout my residency, I have realised that what we seek most from our teachers is guidance that extends beyond obligatory instruction. We look for reassurance during a difficult airway, measured words during unexpected hypotension, and a calm presence that transforms anxiety into clarity. The ideal anaesthesia teacher is one who sees a resident not just as a learner of techniques but as a developing clinician who needs nurturing of mind, discipline, and emotional balance. Nietzsche's reflection, "The essence of all great mentorship is to awaken in another the capacity to surpass oneself," beautifully captures the spirit of such mentorship. True guides do not impose their ways; they help us discover our own strengths.

> **"The essence of all great mentorship is to awaken in another the capacity to surpass oneself,"**

My own experiences highlight how transformative this guidance can be. I recall moments when a consultant paused amidst a packed OT schedule to break down a complex concept, or when a senior quietly stepped beside me during my first challenging airway, offering steady direction without undermining my autonomy. These small acts, though subtle and often unseen, shaped my growth far more meaningfully than any structured lesson. Aristotle's assertion that "Educating the mind without educating the heart is no education at all" holds special weight in anaesthesia, where empathy, patience, and composure are indispensable.

Yet mentorship is never one-sided. Residents bring curiosity, fresh viewpoints, and the willingness to question established patterns, enriching the teacher's own understanding. Seneca's observation, "He who teaches learns twice," reminds us of this reciprocity, while Confucius' belief that "Education breeds confidence; confidence breeds hope" underscores how genuine guidance can transform a hesitant trainee into a confident anaesthesiologist.

Ultimately, guidance beyond duty in anaesthesia becomes a quiet but powerful force; one that shapes safe practitioners, strengthens professional values, and ensures that the wisdom of one generation inspires the excellence of the next.

The Pain Healer : A Conversation With

Dr Rohit Lahori
MBBS, DA, FIPM, FIAPM
IDIPM (S Korea Medical University & Montipillar University France)
Ph.D(s) Pain Medicine
Pain Specialist, Govt Hospital Gandhi Nagar, Jammu



1. What inspired you to choose Pain Medicine as your field?

During my anaesthesiology practice, I saw patients suffering from agonizing, intractable pain — advanced cancer, trigeminal neuralgia, severe spine disorders — where conventional medicines offered little relief. I realized pain relief is not just supportive care, but a fundamental human right. This conviction inspired me to specialize in Interventional Pain Medicine and Palliative Care, to bring structured interventional relief and compassionate end-of-life care to those who felt they had no options left.

2. What was the biggest challenge you faced while establishing yourself as a pain specialist in Jammu?

The main challenge was lack of awareness. Pain Medicine was new to the region and chronic pain was seen as an inevitable part of aging or illness. Establishing the Pain and Palliative Care Department at Govt. Hospital Gandhi Nagar and The Pain Clinic at Talab Tillo required consistent advocacy, educating referring physicians, and proving that MIPSI procedures — Minimally Invasive Pain and Spinal Interventions — could drastically improve quality of life without major surgery.

3. Was there ever a moment when you thought of giving up and what kept you going?

Working in a government setup, procuring advanced equipment and establishing palliative services across J&K was administratively and logistically challenging. I am thankful to the J&K administration for recognizing the need and supporting the specialty. Quitting, however, was never an option. The relief on a patient's face after years of pain, a bed-bound patient walking again, or a cancer patient resting comfortably — that is what kept me going.

4. How has your journey from an anaesthesiologist to a renowned pain specialist changed your approach to patient care?

An anaesthesiologist focuses on acute, real-time stability in the OT. Pain Medicine shifted my focus to holistic, long-term care. Chronic pain impacts not just the body, but the emotional, psychological and financial health of the whole family. My approach evolved from treating a symptom to understanding the patient's complete story, combining precise interventions with empathetic communication and continuous support.

5. What is the most satisfying or memorable patient experience of your career?

Managing trigeminal neuralgia — called 'the suicidal disease' where even a breeze triggers excruciating facial shocks — is most memorable. Performing minimally invasive procedures like radiofrequency ablation or balloon compression and seeing a patient who couldn't eat or speak wake up pain-free is profoundly gratifying. It shows the life-changing power of interventional pain techniques.

6. Pain clinics are still not easily accessible to many patients. What are the biggest challenges you face in bringing modern pain treatment to them?

Challenges are awareness, accessibility and infrastructure. Many in rural and remote areas don't know such services exist and present late. Integrating pain and palliative care into primary and secondary health centres needs workforce training, coordination and sustained resources. Outreach projects and partnerships with district hospitals are key to bridging this gap.

7. What role do you see anaesthesiologists playing in the future of Pain Medicine?

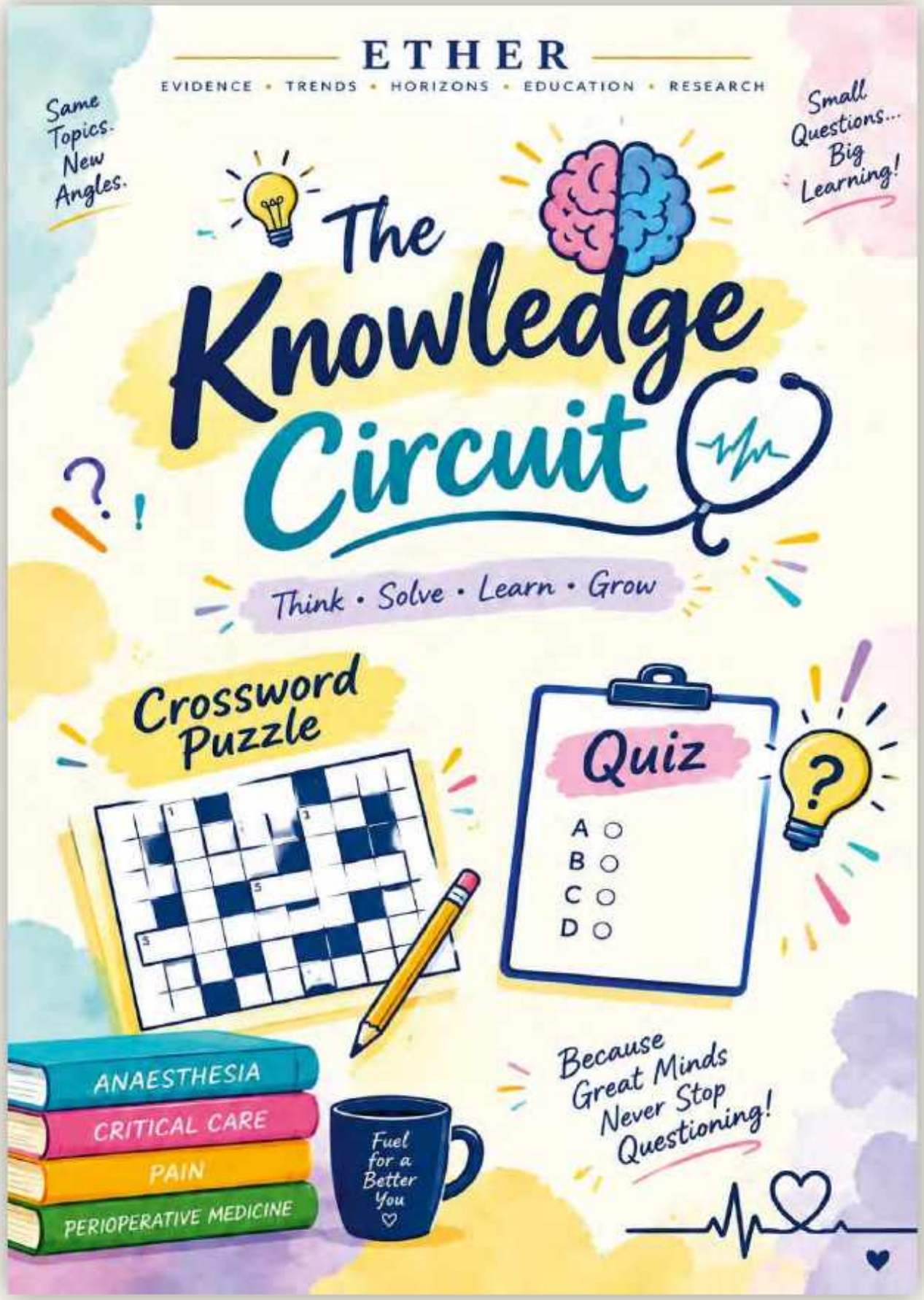
Anaesthesiologists are the natural architects of Pain Medicine due to their expertise in pharmacology, physiology, critical care and nerve blocks. In future they will: pioneer advanced interventions like neuromodulation and regenerative therapies; lead multidisciplinary pain and palliative teams; advance precision medicine using AI and genomics for personalized care; and champion opioid stewardship through multi-modal, non-opioid strategies.

8. If you could give one message to young anaesthesiologists who want to enter Pain Medicine, what would it be?

Move from managing fleeting intraoperative physiology to walking with patients through long-term suffering. Technical skill with a needle is only half the job; the true art lies in empathy, meticulous listening and restoring hope. Treat the whole person, not just the symptom — your impact will be measured by the dignity and comfort you restore.



Dr. Heena Saini
Assistant Professor
Anaesthesia, GMC Jammu


ETHER
EVIDENCE • TRENDS • HORIZONS • EDUCATION • RESEARCH
Same Topics. New Angles.
Small Questions... Big Learning!
The Knowledge Circuit
Think • Solve • Learn • Grow
Crossword Puzzle
Quiz
A
B
C
D
ANAESTHESIA
CRITICAL CARE
PAIN
PERIOPERATIVE MEDICINE
Fuel for a Better You
Because Great Minds Never Stop Questioning!

25 ANAESTHESIA RESIDENCY AND DUTY HACKS

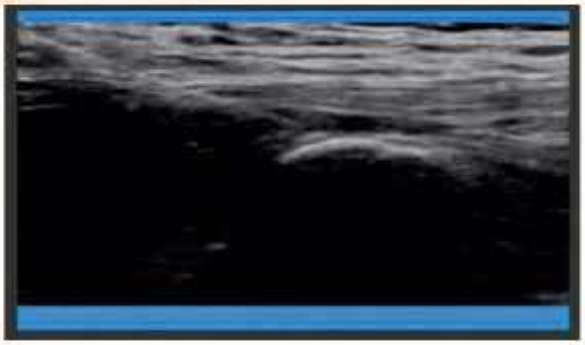
Dr. Aneesha Gupta
(M.D. Anaesthesiology and Critical Care, GMC Jammu.)



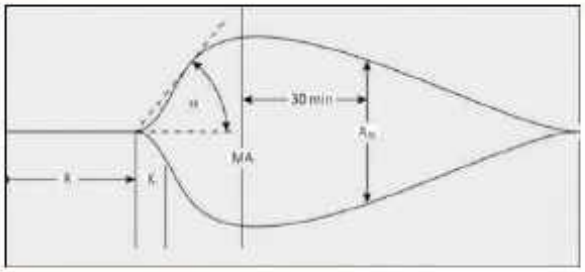
1. When senior tells you to load a syringe fast — put some air in the vial before loading; saves time *and wrist strength.* 💉 💉
2. Respect your OT staff. They can make your day heaven… or sterile hell. 😈 🤢
3. For glass ampoules that refuse to break — tap the neck with a syringe tip before snapping. Saves your fingers *and your temper.*
4. Can't find the vein? Lower the hand below heart level and wait 20 seconds — gravity works better than ultrasound sometimes. □ □
5. Adjust the OT table height *before* starting spinal — your back will thank you after residency. 👍 □ 👍
6. If you're inserting a spinal in a difficult patient — make sure the light's perfect; shadows make your aim philosophical.
7. Don't put your pen down anywhere near the OT table — it's lost to gravity forever.
8. Always keep a backup IV — the working one fails exactly when you give sux.
9. For paediatric tube size — smaller is safer; leaks are kinder than tears. 😶 😶
10. "Anticipate and prepare" beats "react and panic" every single time.
11. Night duty rule: never say "it's quiet tonight." The universe is listening, and it's cruel. 🌎 □ 🌎
12. Before heading to ICU, pocket two pens — one will vanish before your first ABG. 🖊 🖊
13. For cold theatres — two OT gowns = one happiness. 😊 😊
14. Label your extensions before you connect them — guessing which one has norad is not a game you want to play.
15. Keep your airway trolley arranged *the same way every time* — muscle memory saves lives faster than memory recall. 💪 💪
16. Always keep a drape or towel under the circuit — it cushions the patient and your ego if something falls. □
17. When the surgeon says "just 10 minutes more," mentally multiply by π. 😝
18. When things go south — first look at the *patient,* not the monitor. Machines panic faster than humans. 👀 👀
19. When the surgeon asks "Is the patient relaxed?" — smile and say, "More than me, sir." □ 👍
20. When in doubt, call for help early. Even legends start as juniors who knew when to shout "SIR!" 🙋 🙋
21. Night-duty starter pack – stethoscope, torch, pen, caffeine, and faith. 🩺 ☕
22. For sleepy nights, set small goals: one round, one sip of water, one check of gases. Momentum beats fatigue. 👍
23. Write legibly, even at night — your 7 a.m. handwriting shouldn't look like a P wave.
24. Always, *always* carry a smile under your mask — calm anaesthetist, calm theatre. 😊
25. After night duty when the sun rises — deep breath, small stretch, one proud smile: you kept everyone breathing. Mission accomplished. 🩺 ✅ 😎

PHOTO QUIZ

Q1. Which USG block is it



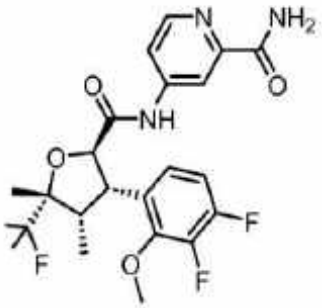
Q2. Which parameter of TEG trace reflects clotting factor activity



Q3. Identify the ultrasound image.



Q4. Identify this structure of an approved oral non-opioid analgesic.



Q5. The 2026 Nobel Prize in Medicine was awarded for which discovery?



Q.6 Identify the catheter.



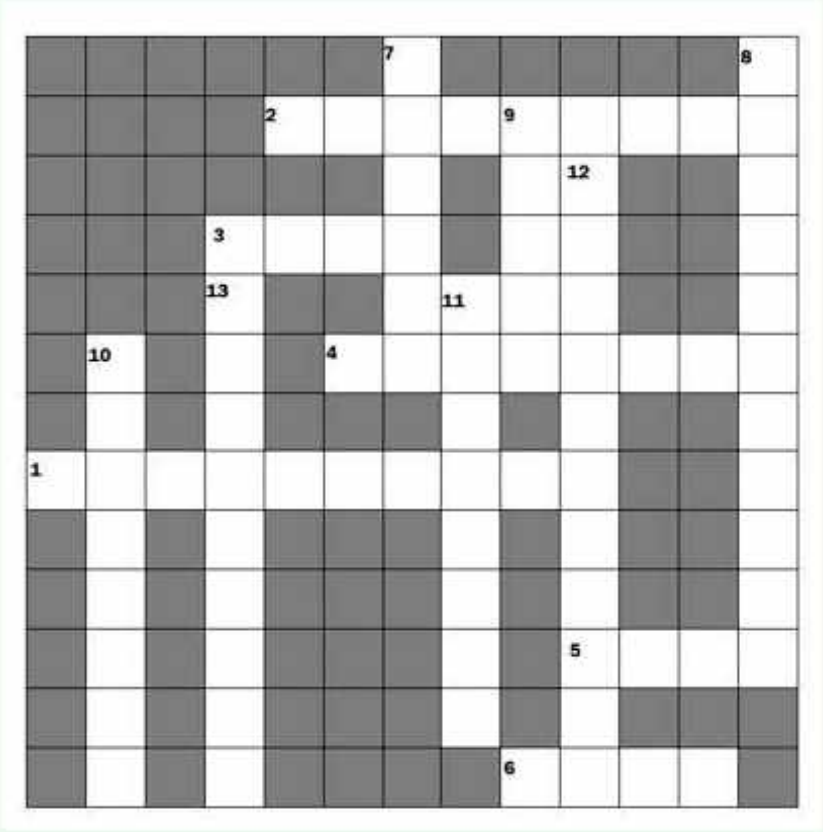


Dr Mehak Gul
Assistant Professor
GMC JAMMU

ANSWER KEY: Q1.Erector spinae plane block. Q2. R time: reaction time Q3.Gastric antral ultrasound
Q4. Suzetrigine Q5. Light-gated ion channels and optogenetics. Q6.A Fogarty arterial embolectomy balloon catheter

CROSSWORD PUZZLE

Author: Dr. Aneesha Gupta



CLUES:

ACROSS

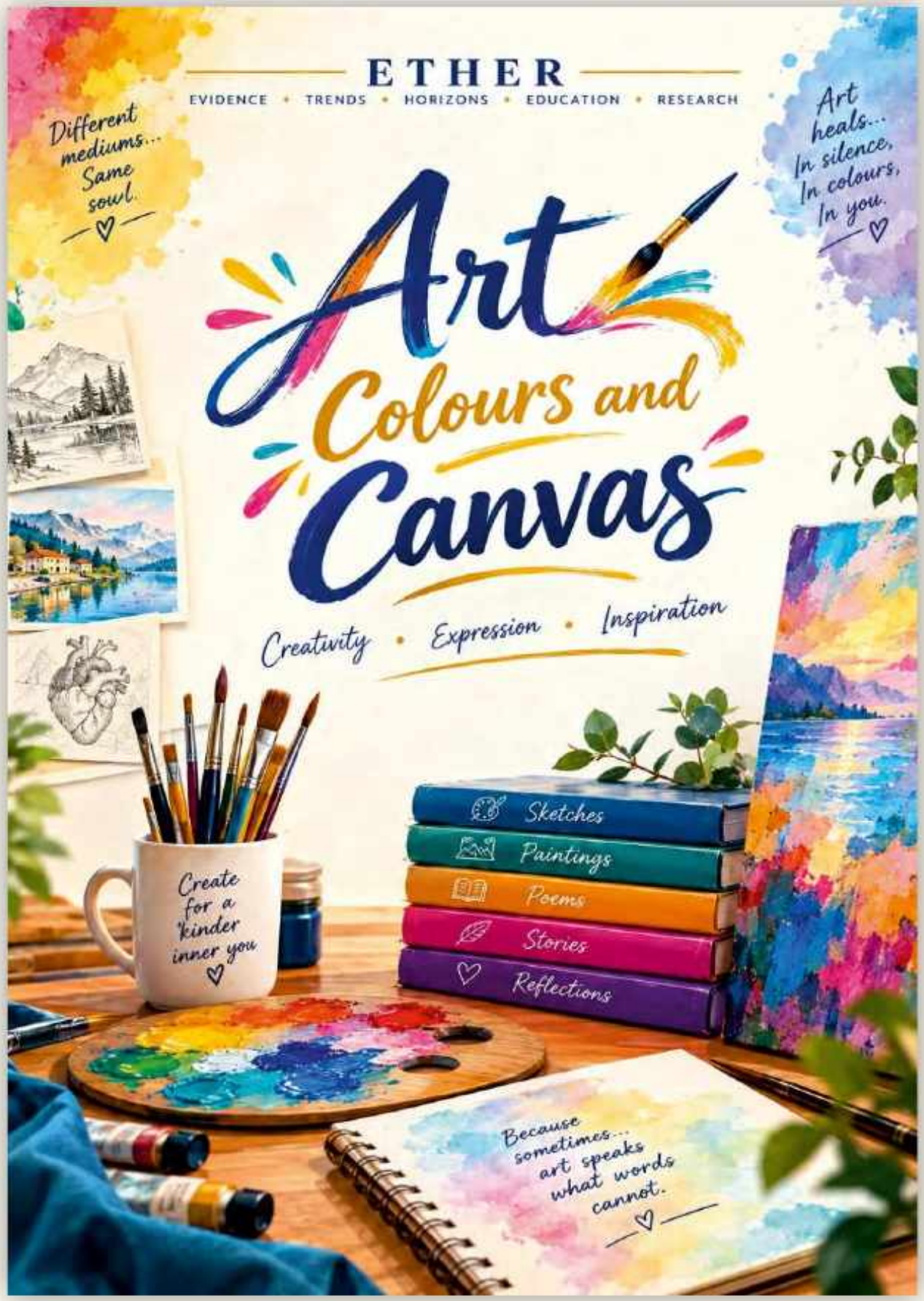
1. BENZODIAZIPINE REVERSAL (10)
2. ART IN CHEMISTRY- BOTH ESTER AND AMIDE (9)
3. LAUGHING GAS CYLINDER COLOUR (4)
4. DREAMLAND'S MILKY WHITE (8)
5. BAG REVIVES LIFE (4)
6. VAPOURIZER OF A SWEET GAS (4)

DOWN

7. EITHER WAY- IT FIRST KNOCKED US OUT (5)
8. LIFE SUPPORT MACHIENE (10)
9. SEAL OF PROTECTION (4)
10. OPIOID ANTIDOTE (8)
11. HE KEPT LONDON COOL (8)
12. SWEET BREATH OF CALM (11)
13. MAINTAIN CARDIAC OUTPUT DURING INDUCTION (9)



ANSWER KEY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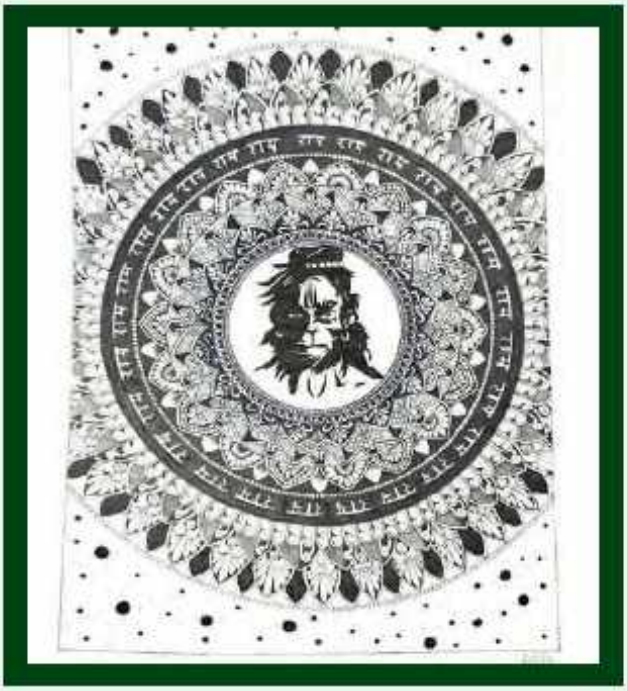
Different mediums... Same soul.
Art heals... In silence, In colours, In you.
Art
Colours and
Canvas
Creativity • Expression • Inspiration
Sketches
Paintings
Poems
Stories
Reflections
Create for a kinder inner you
Because sometimes... art speaks what words cannot.

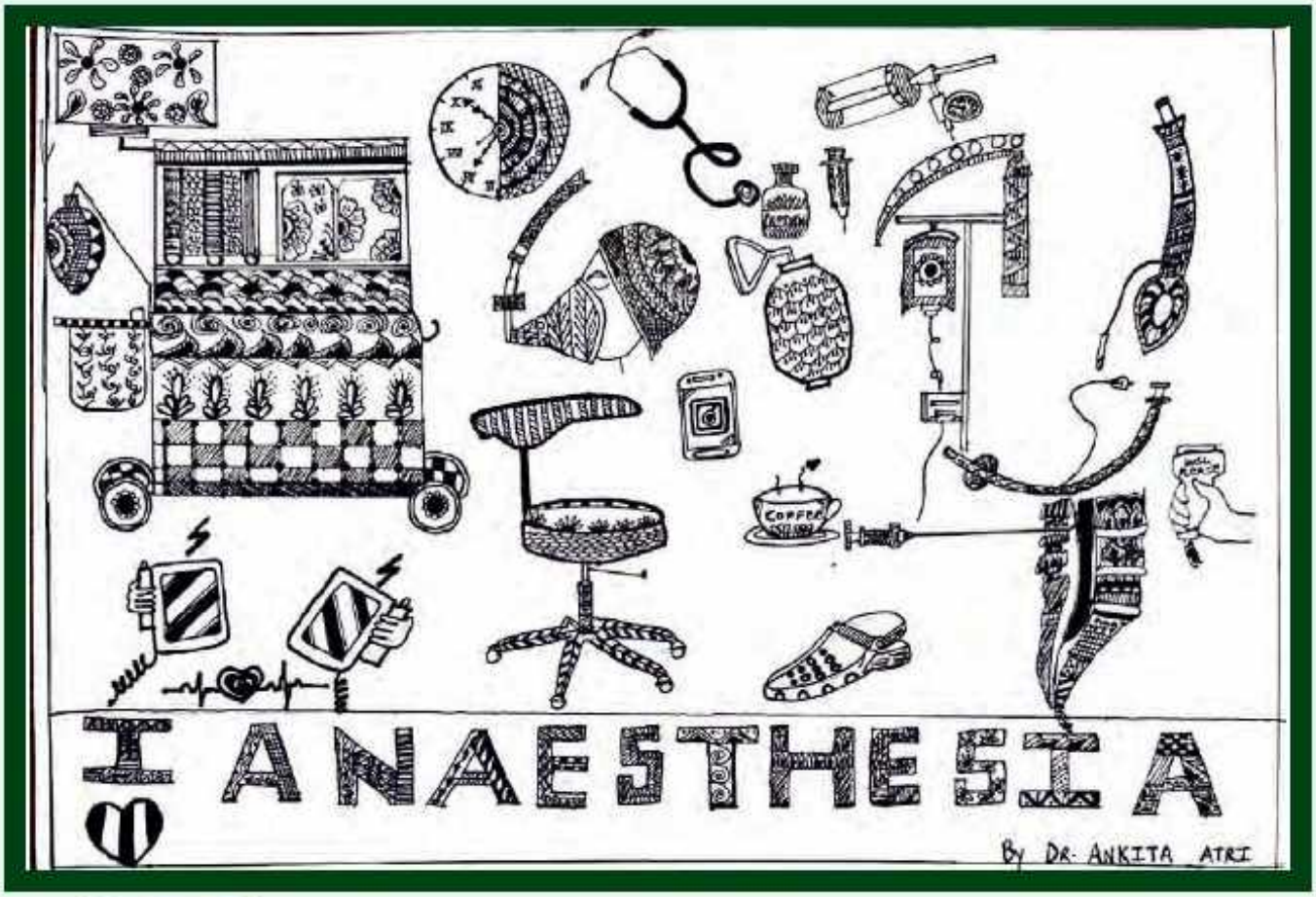






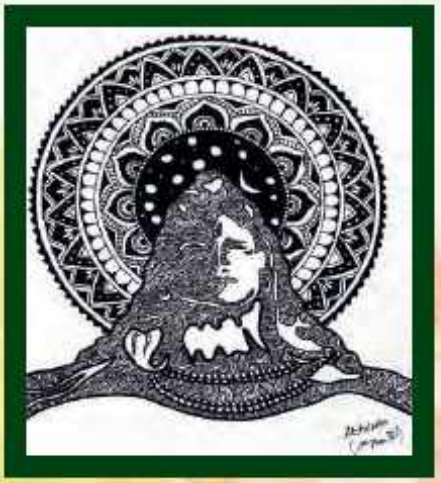


Painting by Dr. Ashwani Kumar
Deptt. of Anaesthesia, Critical Care & Pain Medicine, GMC Jammu





Art by Dr. Ankita Atri
Anaesthesia GMC Udhampur

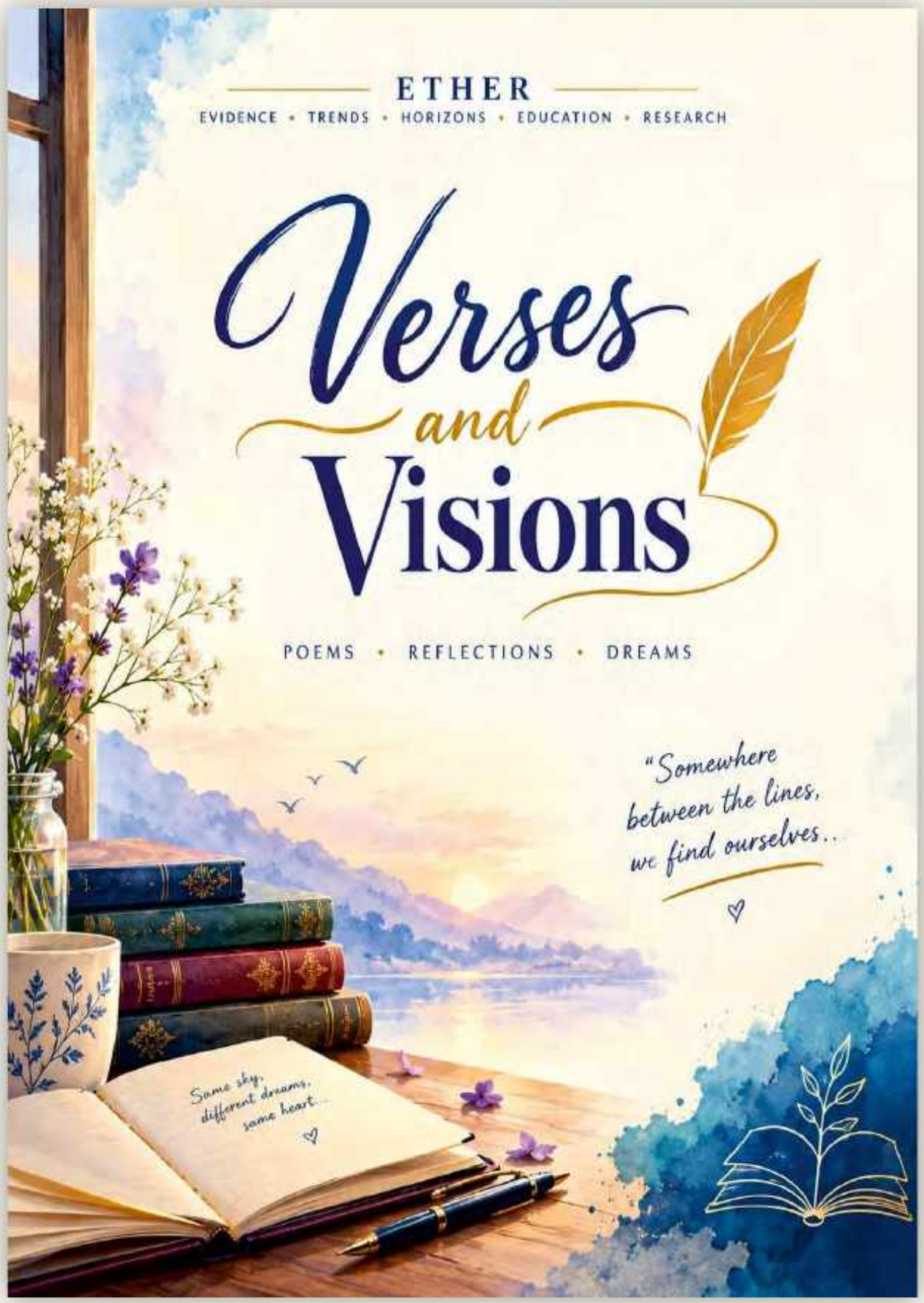






Art by Dr. Abhilasha Gupta
Anaesthesia GMC Jammu




ETHER
EVIDENCE • TRENDS • HORIZONS • EDUCATION • RESEARCH
Verses and Visions
POEMS • REFLECTIONS • DREAMS
"Somewhere between the lines, we find ourselves..
Same sky, different dreams, same heart.

जब दर्द असह्य हो जाता है

जब दर्द असह्य हो जाता है,
जब जीवन संकट में आता है,
जब शल्य-कक्ष में हर पल,
मृत्यु से संघर्ष हो जाता है—
तब मौन खड़ा एनेस्थीसियोलॉजिस्ट,
जीवन का प्रहरी बन जाता है!

न हम शोर मचाते हैं, न यश के गीत सुनाते हैं,
हम रोगी को सुलाकर भी, जीवन की लौ जलाते हैं!

सर्जरी की सफलता, ICU की हर साँस,
पेन क्लिनिक में राहत, पुनर्जीवन में विश्वास—
हर धड़कन की निगरानी, हर संकट का समाधान,
एनेस्थीसिया के ज्ञान से सुरक्षित होता इंसान!

याद रखना, ऐ दुनिया! हमारी खामोशी को कमजोरी मत समझना,
हमारी कला को केवल बेहोशी मत समझना!
हम वह विज्ञान हैं, जो दर्द को विराम देता है,
और जीवन को मृत्यु के द्वार से वापस लाने का पैगाम देता है!

सोलह अक्टूबर का यही उद्घोष,
मानवता का यही सम्मान—
जहाँ जीवन की आशा है, वहाँ एनेस्थीसिया का योगदान!
हम केवल नींद के रखवाले नहीं—
हम सुरक्षित जीवन के अनकहे रखवाले हैं!



Dr Satyadev Gupta
Professor & Ex-HOD
GMC, Jammu

तिलिस्म-ए-बेहोशी

ये तिलिस्म सा हरसू क्या है।
अनगिनत कनों की फुहार सी क्या है।
आँख ख़ामोश बंद, आसमां में हूँ मैं।
सब दुःख-दर्द, तकलीफ से मौन हूँ मैं॥

अब तक जितने थे दर्द बेशुमार ।
शरीर पे घाव थे जो बेमिसाल ।
तकलीफ जहन्नुम माफिक थी जो घेरे मुझे।
अचानक क्या हुआ कोई हर ले गया इसे ॥

महसूस ऐसा होता, जैसे मैं हूँ ही नहीं ।
आसमान में हूँ उड़ता, शरीर है ही नहीं ॥
सब अच्छा-अच्छा लगता, तकलीफ है ही नहीं ।
कैसा ये चमत्कार, पर जादूगर तो कोई है ही नहीं॥

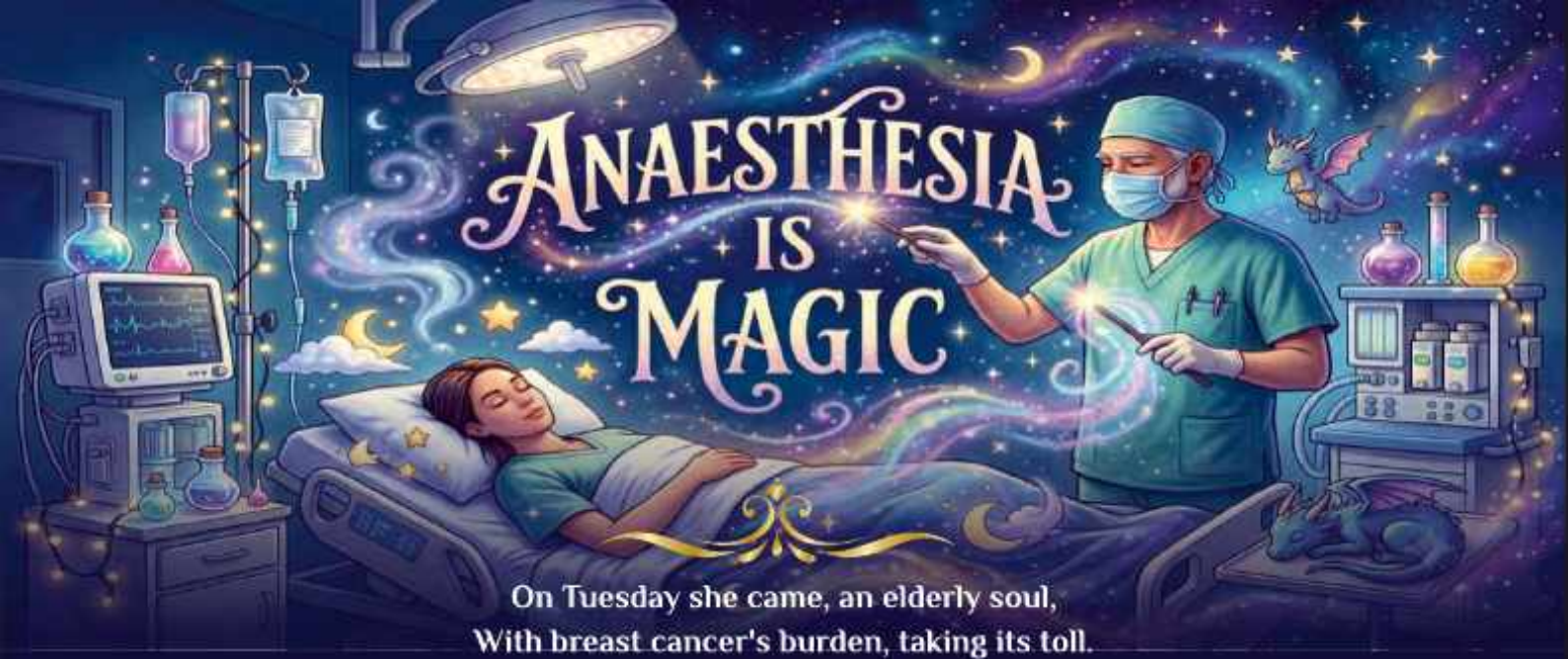
सलाम ऐसे हाथों को ।
सलाम ऐसी फनकार को ।
दर्द से निजात दिला दी जिस शख्स ने ।
सच है कि देख नहीं पाऊंगा उसको ।
ज्यों ही तिलिस्म ख़त्म, वो शख्स जा चुका होगा ॥

पर सदा दुआ है उन सबके लिए ।
जो देवता बन ऑपरेशन में आते ।
सब रोगों से, सब तकलीफों से मुक्ति दिलाते ।
विघ्नहर्ता आसपास है एहसास दिलाते॥

रहो तुम सलामत सदा ।
यही दुनिया को बताऊँगा ।
परदे के पीछे किरदार था बड़ा बेमिसाल ।
निस्वार्थ सेवा-भाव, सदैव अडिग, सदैव तत्पर।
खत्म करने दर्द-तकलीफ का हर एक कतरा ।
इंसान के वेष में है फरिश्ता कोई उतरा ॥



डॉ विशाल कांत
असिस्टेंट प्रोफेसर
जीएमसी उधमपुर



On Tuesday she came, an elderly soul,
With breast cancer's burden, taking its toll.
So many comorbidities, fear in every eye—
Most said "Not safe... don't even try."

But courage whispers where doubt grows loud,
And hope must rise above the crowd.
I chose a thoracic epidural's grace,
To bring calm and comfort to her fragile space.

She felt no sensation, no surgical pain,
Just gentle stillness, like cool, soft rain.
Awake she remained, serene and aware,
As the theatre filled with devotional prayer.

Play my favourite bhajan," she said so mild,
A simple request, as tender as a child.
Krishna's songs flowed pure and deep,
She was awake while her body asleep.

For two and a half hours the surgery went on—
But fear and suffering were beautifully gone.
When it ended, tears shimmered in her gaze,
Not of pain, but gratitude's quiet blaze.

And in my eyes, tears gathered too—
Not sympathy alone, but joy shining through.
For in that moment, it became so clear:
Anaesthesia is magic—I wish to tell all of you here.



By- Dr Raksha Kundal,
Associate Professor, AIIMS JAMMU

Life Between The Beeps

"A poem by an exhausted anesthesiologist"

My life begins with "BP is low!"
And ends when seniors say, "Let's go!"
A cup of chai, my only dream,
Interrupted by the monitor's beep.

I haven't slept, I haven't eaten,
Yet somehow I'm still calmly treating

"Just one more case," they always say,
And there goes my entire day.

The surgeon asks, "Can we start now?"
I smile politely — don't ask me how!

The pulse ox drops, my heart rate climbs,
Who needs horror films when you work these times?

I dream of weekends, peace, and rest,
But night duty puts that dream to test.

My friends go dancing dressed to impress,
I'm counting drops and managing stress.

No red carpet, no fancy gown,
Just scrubs, a mask, and a tired frown.

But when the patient wakes up right,
It makes the longest shift feel light.

So here I stand, between the beeps,
Running on chai and stolen sleeps.

Anesthesia: where heroes quietly stay, Keeping patients safe —
one beep at a time, each day!
"We don't always get applause, but we keep the rhythm alive."



Dr Neha Khullar
Senior Resident
GMC Jammu

ANESTHESIA
THE NINJA OF OT

Anesthesia sneaks in like a soft ninja breeze,
Whispering, 'Time to nap,' with professional ease.
You swear you'll resist, you bargain and fight,
But—oops—you're gone before counting to five feels right.



Surgeons get busy, humming their song,
While you dream nonsense all surgery long.
You wake up smiling, half-confused, half proud
'Did I snore?' you ask the entire crowd.
Don't worry—everyone does. It's allowed!



DR SUPRIYA GANDOTRA

From the Kitchen



As the chilly winter months set in, our bodies naturally crave foods that provide warmth and sustained energy. Dry fruits—such as almonds, walnuts, cashews, dates, and figs—are packed with healthy fats, vitamins, and minerals that help boost immunity, improve digestion, and keep us energized all day long. Including these nutrient-rich gems in your diet not only supports overall health, but also adds a delightful natural sweetness to seasonal desserts like these wholesome dry fruit laddus.*

DRY FRUIT LADDU RECIPE

INGREDIENTS

- 15 soft dates (deseeded and chopped)
- 5 dried figs (chopped)
- 20 raisins
- 25 almonds (toasted and roughly chopped)
- 10 cashews (toasted and broken)
- 20 pistachios (toasted and chopped)
- 1.5 tablespoon mixed nuts (walnuts/ hazelnuts, optional)
- 1 teaspoon melted ghee
- 1/4 teaspoon cardamom powder
- 2 tablespoons desiccated coconut (optional)

METHOD

- Prepare the Dry Fruits: Toast almonds, cashews, and pistachios on low flame until lightly golden and aromatic. Allow them to cool, then chop roughly.
- Blend Fruits: In a mixer, pulse the dates and figs until a soft, sticky mixture forms. Add raisins and blend again briefly for texture.
- Combine & Saute: In a nonstick pan, heat ghee, then add the blended fruit mixture. Sauté on low for 4-5 minutes until it turns glossy and soft. Sprinkle cardamom powder for fragrant flavor.
- Add Nuts: Mix in the toasted nuts and optional desiccated coconut.
- Stir well and cook for 1 more minute, ensuring all ingredients are combined.
- Shape Laddus: Allow the mixture to cool slightly, then divide into equal portions.
- Roll gently into bite-sized balls using lightly greased palms.
- Garnish (Optional): Roll finished laddus in finely chopped pistachios or coconut for an extra touch.
-

PRESENTATION TIP

Place each laddu in a mini cupcake liner for an elegant look. Garnish with a single slivered pistachio or edible gold leaf atop each, and serve in a decorative box for gifting.

Storage

Dry fruit laddus keep well in an airtight container for up to a week at room temperature. These laddus are naturally sweetened, rich in wholesome nuts and dried fruits, and perfectly healthy for festive occasions or everyday snacks. Their vibrant colors and irresistible aroma make them a treat for both the palate and the eyes. Feel free to adjust the nut or fruit selection to suit your taste, and enjoy presenting this delightful recipe!



Dr. Naine Bhadrala
Professor Anaesthesia,
GMC, Jammu

Medical Astrology: Health and Healing

In Vedic Science, medical astrology studies how planetary positions influence the body, immunity, mental state, and disease tendencies. Planets are seen as symbols and systems of energy that give deeper insights into our character and life path. From a psychological standpoint, the natal chart is a symbolic mirror of our character and soul.

A natal chart is calculated from date of birth, accurate birth time, and place of birth to determine precise planetary positions at birth.

In a birth chart, there are 12 houses and each house and planet depicts a part of the human body. For example, Aries governs head and face, Taurus governs throat and neck, Sun is linked with heart and spine, Moon governs emotions and fluids. Each sign reflects strengths and weaknesses.

Important: It doesn't replace modern medicine. Astrological interpretations should not substitute for clinical assessment, lab investigations, imaging, screening or evidence-based treatment, and should not be used to start, stop or delay treatment for serious conditions. Think of it as a health map showing areas to nurture carefully.

By studying a medical astrology chart, one can identify: health strength, weak organs or systems, chronic disease tendencies, periods of vulnerability and preventive remedies.

Planets and Their Role in Our Health

Sun - Vital Energy and Immunity: Represents inner strength and life force. Well-placed Sun means strong immunity; weak Sun may relate to low vitality, heart or bone issues.

Moon - Mind and Emotional Balance: Controls mood, mind and body fluids. Unstable Moon may cause anxiety, hormonal imbalance or sleep issues.

Mars - Blood and Muscles: Governs courage, blood and muscle strength. Imbalance may lead to inflammation, high BP or low drive.

Mercury - Nervous System: Linked with speech, nerves and skin. Weak Mercury may cause anxiety, skin allergies or poor focus.

Jupiter - Liver and Growth: Represents growth, digestion and wisdom. Strong Jupiter brings healthy metabolism; imbalance indicates overindulgence.

Venus - Hormones and Beauty: Governs reproductive organs, sugar balance and skin. Disturbed Venus may bring hormonal or sugar-related issues.

Saturn - Bones and Chronic Illnesses: Related to bones, joints and chronic conditions. Disciplined lifestyle keeps Saturn steady.

Rahu and Ketu - Hidden Issues: Shadow planets pointing to sudden health changes, addictions, or mysterious ailments. Grounding practices help.

Our body is not separate from the universe. Medical astrology is not about fear or fate, but insight. It helps us take charge of our health in a more conscious way and brings us closer to nature and rhythm.



Dr Neha Dang
Assistant Professor
Anaesthesia

The Eternal Love Triangle: Anaesthetist, Surgeon & The Clock

Dr. Preeti Sharma



The eternal triangle: the anaesthetist waits, the surgeon operates, and the clock just laughs. "Almost done!" says the surgeon — spoken in every era since anaesthesia began. Meanwhile the anaesthetist silently titrates propofol like a hostage negotiator, while the clock, smug and unbothered, ticks toward lunch.

The anaesthetist watches vitals, the surgeon watches the wound, and the clock watches neither — it just keeps ticking toward the next case. "Two more stitches!" has been surgery's most reliable lie since 1846. Meanwhile the anaesthetist mentally negotiates with reversal agents, and the clock, utterly heartless, refuses everyone's request for overtime.

Surgeon: "Just closing up!" Clock: laughs in minutes. Anaesthetist: already charting the next patient's premedication out of sheer optimism. It's not a love triangle, it's a hostage situation — except everyone agreed to be there, nobody's getting a ransom, and the coffee got cold two hours ago.

Bad Habits as Anaesthetists We Should Skip—but Somehow Can't

Dr. Salma Mariyam



Bad Habits as Anaesthetists We Should Skip—but Somehow Can't

Checking the monitor every 10 seconds, saying "just one more case," surviving on chai, and calling 4 hours of sleep "enough." We promise to stop procrastinating documentation, but somehow the OT list always wins. And yes, we still carry our stethoscope like a superhero cape—because apparently, anaesthesia runs on caffeine, chaos, and confidence!

"Things that never taught us in residency but should have"

Dr. Madhan Kumar & Dr. Sivashree SP





Residency taught us how to manage patients, emergencies and uncertainty—but not how to manage ourselves after a 24hour duty!

It never taught us how to survive on chai, function without sleep, decode "just one small case," or stay calm when someone says, "Doctor, the patient is crashing!"

Somewhere between sleepless nights, emergency calls, endless paperwork, failed IVs, cancelled cases and "sir/mam is calling," we learnt resilience, teamwork, friendship and the art of surviving residency—with a smile! ♥

Surgeon says 5 min- Anaesthetist hears "Cancel Dinner"

Dr. Madhvi Gupta

When a surgeon says "5 minutes", Even Google Translate fails to interpret it correctly; But Anaesthetist's brain decodes it instantly as - **"BETA, DINNER CANCEL KAR DO."**



Because we know:

Surgeon's 5 min = Finding one more adhesion, debating anatomy, asking for one more mop, suddenly remembering a lymph node he forgot or wrong anastomosis he repaired.

Meanwhile Patient is waking up, tube is becoming a chewing gum and our stomach is growling louder than the monitor.

That 5 minutes is enough to watch one episode, rethink my career choice of MD Anaesthesia, and realize why surgeons wear watches but anaesthetists watch time.

The Half Sedated Confessions That Nobody Ask For



Dr. Sonica Dogra

The half-sedated patient suddenly reveals family secrets, hidden crushes, and lifelong grudges.

The anaesthetist gets free entertainment, unsolicited confessions, and occasionally a marriage proposal! Best part?

The patient remembers nothing, but the entire OT staff now knows EVERYTHING!

The coffee to case ratio that keeps anaesthesia alive

Dr. Shipra Gupta

One case = one coffee. Two cases = two coffees. Emergency case = coffee running at 100 mL/hr.



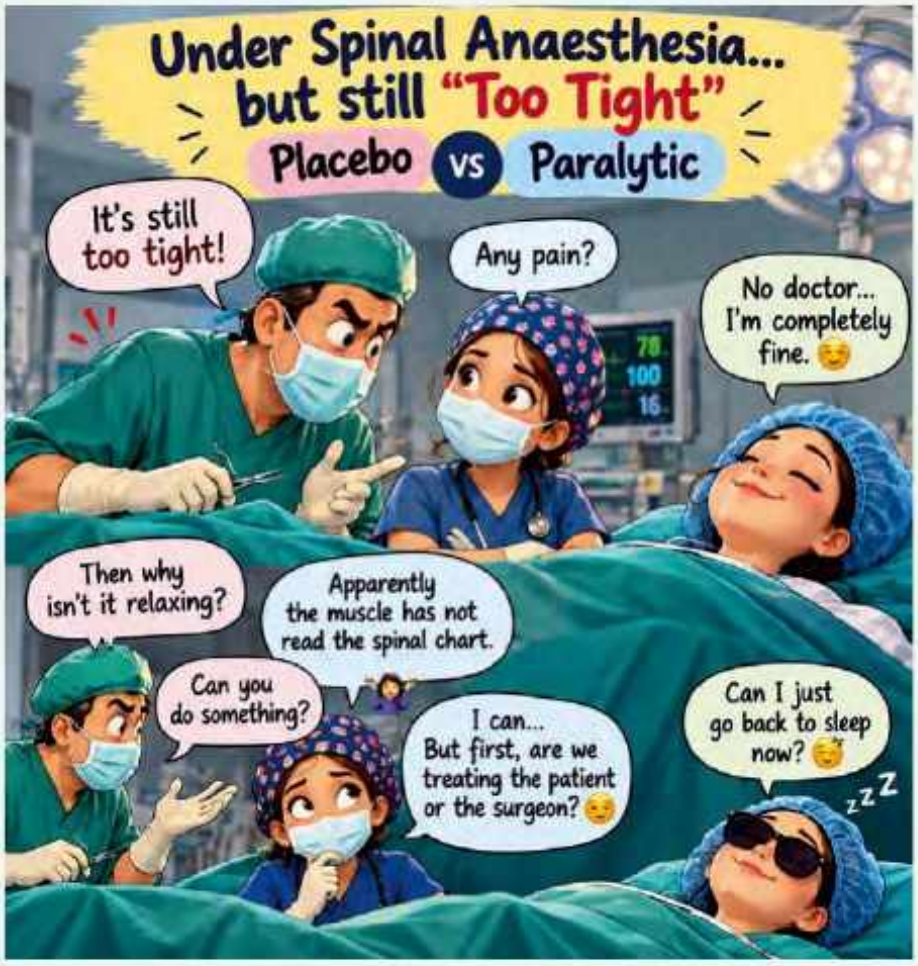
Propofol induces sleep, sevo maintains it, but only coffee keeps the anaesthetist conscious.

Monitor ECG, SpO_2, $EtCO_2$... and the coffee cup level. The last one predicts the anaesthetist's survival.

The surgeon asks, "Is the patient ready?" The anaesthetist replies, "Is the coffee ready?"

No coffee, no induction. No second coffee, no maintenance. No third coffee, no emergence... of the anaesthetist!

Coffee is our first fluid bolus, second-line vasopressor, and definitive treatment for Monday mornings





Dr. Sanam Kassana



Dr. Santosh Rajput



TRIBUTE TO A REMARKABLE SOUL
PROF. DR. ANJALI MEHTA



In fond remembrance of Prof. Dr. Anjali Mehta — a beacon of professionalism, competence, and warmth, whose absence continues to be deeply felt.

Prof. Mehta was a proud product of GMC Jammu, where she completed her post-graduation (2004-2007) and registrarship, and served as faculty since 2011, rising to the rank of Professor in the Department of Anaesthesiology. She was a guide and mentor to generations of postgraduates.

An active and dedicated member of the Jammu Society of Anaesthesiologists, she served with distinction as Governing Council Member and Vice President, JSA. Her organisational acumen was exemplary. She played a vital role in the success of the North Zone ISA Conference 2024.

She was the architect and driving force behind the concept of the PG Assembly — a dream she envisioned and initiated with great zeal. The successful PG Assembly held in March 2025 at GMC Jammu under the banner of JSA was the fruition of her vision.

She was the successful Organising Secretary for many CMEs and workshops and served as National Faculty for AMF (Airway Management Foundation).

Her presence was uplifting, her laughter contagious, and her generosity boundless. Even during her courageous battle with cancer, she exemplified grace and resilience.

Her legacy as a teacher, leader, and compassionate anaesthesiologist will live forever.

— Jammu Society of Anaesthesiologists

Contributed by:
Dr. Arti Mahajan
Associate Professor
Anaesthesia, GMC Jammu

EDITOR-IN-CHIEF'S NOTE



Dear Esteemed Members and Colleagues,

It gives me immense pleasure to present the inaugural edition of Ether, the first-ever newsletter of the Jammu Society of Anaesthesiologists (JSA). This marks a new chapter in our Society's journey — a platform to celebrate our achievements, share knowledge, and preserve our collective legacy.

Every society has a story to tell, and Ether endeavours to bring JSA's story to life, capturing not just our academic activities but also the enthusiasm and spirit that unites us.

Beyond updates on CMEs, workshops, and conferences, we aim to feature clinical insights, articles, quizzes, OT experiences, and creative contributions reflecting the human side of our profession. We especially invite young anaesthesiologists and postgraduates to contribute actively.

Bringing this first issue to fruition has been both an honour and a responsibility. I thank the Society's leadership, editorial team, and all contributors for their support in making this vision a reality.

May Ether strengthen bonds across institutions, foster academic excellence, inspire young minds, and chronicle the evolving story of anaesthesiology in Jammu.

With warm regards,

Dr Updesh Kumar
Editor-in-Chief, Ether
JSA



INVITATION TO CONTRIBUTE

'ETHER', the official newsletter of the Jammu Society of Anaesthesiologists invites contribution of articles originally written by JSA members (Life and associate) for the next edition of Newsletter. The articles can be in the form of interesting case reports for discussion, articles on topics of current clinical relevance, photo-essays, articles on medicolegal /health/ financial/extracurricular issues of interest to the anaesthesiologists. Original literary works such as poems, funny cartoons or paintings on topics of anaesthesia are also welcome. Information about extraordinary achievements/experiences of JSA members, book publication can be sent. The articles should be brief and written in font Times New Roman 12-14 size and presented in Microsoft office word document (rtf/doc files). Plagiarism and violation of copyrights should be strictly avoided. The articles should be e-mailed to isajammu65@gmail.com with a covering letter addressed to the Honorary Secretary JSA.

Dr Updesh Kumar
Editor-in-Chief
ETHER
(The official newsletter of the JSA)

Disclaimer:

The information and opinions presented in this newsletter reflect the views of the authors. The editorial team of the newsletter and the Jammu Society of Anaesthesiologists (JSA) will not be responsible for the statements made by the authors. Publication does not mean endorsement by the JSA.

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