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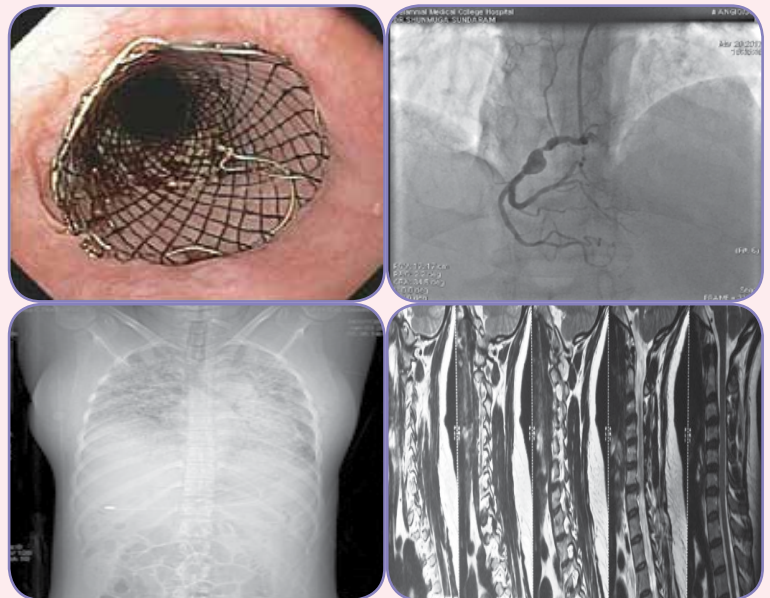


EVENTS

- * **Valaikappu Function**
- * **Madurai Liver Congress 2017**
- * **World Environment Day**
- * **World Schizophrenia Day**

HIGHLIGHTS OF SCIENTIFIC SECTION

- * **Tuberculous tracheoesophageal fistula treated with endoscopic self expandable metal stent (SEMS)**
- * **Coronary artery aneurysm – an entity to be reckoned with**
- * **Rare case of interstitial lung disease complicating pregnancy**
- * **Minimally invasive spine surgery (MISS)**



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GUEST EDITORIAL**Sustainable Development Goals in India
The way forward**

The Sustainable Development Goals (SDGs) are a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity.

In September 2015, at the Sustainable Development Summit of the United Nations, India has signed the declaration on the 2030 Agenda for sustainable development, showing its strong commitment to the implementation of 17 Sustainable Development Goals. SDGs are extension of Millennium Development Goals (MDGs) which were adopted by India during 2000-2015 and have shown the remarkable progress in several areas. The under-five mortality rate (U5MR) has come down from 126 (1990) to 48 comprising of 1.2 million deaths in 2015. India achieved a maternal mortality rate (MMR) of 167 (2011-2013), the target of safe drinking water has been achieved in rural areas and the target of sanitation is likely to be achieved in urban areas.

The SDGs include 17 goals and 169 targets of which the third goal — “ensure healthy lives and promote well-being for all at all ages” is a health related goal. However addressing other goals like poverty, hunger, education, gender equality, clean water and sanitation is crucial as these are the important social determinants of health and disease.

Health is a state's subject in India and hence their role is crucial in designing and achieving convergence across all parameters. For the achievement of health related SDG, focus will have to be paid to prevention of disease, provision of health care infrastructure and human resources, financial resources and quality health care. More public health investment is required for improving the maternal and child health services, confronting neglected tropical diseases, eliminating communicable diseases like Malaria, AIDs, Hepatitis and Tuberculosis. Provision of universal primary health care and the involvement of private sector are vital to achieve these targets.

“The goal of sustainable development cannot be achieved globally without India and the world will be watching how India will implement its new strategic directives”.

Dr. Samir Bele

Professor, Community Medicine, VMCH&RI, Madurai

Editor

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CHAIRMAN'S MESSAGE

Dear all,

Greetings!

As we enter into the second half of the year, I hope all of you are on track in pursuing your goals for the year 2017. The students of Velammal Medical College have excelled in their first and second clinical year examinations with a pass percentage of over 95%. At this juncture, I would like to emphasise the importance of in-depth knowledge about their discipline over rote learning. We stress upon practical, problem-based learning that encourages the student to actively participate in the learning process. The teaching and learning activities at the institute have been designed in such a way as to impart skills and knowledge.

Given the nature of the profession, students should be capable to actively understand and participate in the decision making process in patient management. Besides the examinations, our students have regularly been winning laurels in various conferences and other academic competitions. I encourage more students to participate in these forums. I also encourage the faculty and staff to take up newer initiatives and towards increasing the quality of the education. These initiatives should be long term commitments and mainstreamed with the routine.

Students should also explore learning and research related opportunities available nationwide and worldwide, to widen their horizon of knowledge. Such in-depth learning will also improve their chances of securing a postgraduate seat in a discipline of their choice. Besides being knowledgeable, Velammal Medical College trains students to be empathetic and ethical doctors.

This hospital and institute was born out of the dream of a mother and her son to provide affordable healthcare to the needy people. I hope all students and staff of this institute shall work efficiently and dedicatedly towards the realisation of this dream.

Regards,

M.V. Muthuramalingam,

Chairman, Velammal Educational Trust.



TUBERCULOUS TRACHEOESOPHAGEAL FISTULA TREATED WITH ENDOSCOPIC SELF EXPANDABLE METAL STENT (SEMS)

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ABSTRACT

Tracheoesophageal fistula (TEF) due to benign disorders was treated with surgery conventionally. Nowadays self expandable metal stent (SEMS) are placed endoscopically for such fistulae. Our index patient presented with cough immediately after taking food and diagnosed to have TEF. The etiology of TEF was found to be tuberculosis. He was treated with endoscopic SEMS placement and anti-tuberculous treatment which resulted in complete resolution of his symptoms.

INTRODUCTION

Tracheoesophageal fistula (TEF) can be congenital or acquired. Most of the acquired TEF are due to malignancy of the esophagus or tracheobronchial tree. But rarely TEF can occur due to benign causes.¹ The benign TEF occurs due to infections including tuberculosis, syphilis, actinomycosis. Apart from infections, penetrating and crushing injuries can lead to TEF. Rarely chemical ingestion, foreign body ingestion and esophageal diverticulum can also lead to TEF. Previously surgery used to be the only treatment modality for TEF due to benign disorders. Now, endoscopic self expandable metal stents (SEMS) placement is being used for treatment of these fistulas.² We report a patient with benign TEF of tuberculous etiology, who was successfully treated with SEMS.

CASE REPORT

A 56-year-old man presented to the out-patient department with history of fever, cough with expectoration, weight loss of 3 months duration. He also had the history of coughing immediately after taking food or liquids. Baseline investigations showed anemia of chronic disease, raised ESR, bilateral upper lobe infiltrates in chest X-ray. Sputum analysis showed Acid-fast bacilli. Upper Gastrointestinal endoscopy showed a fistulous opening in the mid esophagus. Water soluble contrast study showed tracheoesophageal fistula.

We placed a fully covered SEMS (Cook Medical, USA) of 10 cm length, through the endoscope, covering the fistula. He was also

started on Anti-tubercular therapy (ATT). We kept the stent in the esophagus for two months for the fistula to heal. After two months, the stent was removed by endoscopy with a rat-tooth forceps. Repeat water soluble contrast study of the esophagus and repeat endoscopy did not show any evidence of the fistula. The patient completed the course of ATT and the fistula was completely healed.

DISCUSSION

Tracheoesophageal fistulae, which may be congenital or acquired, have been rarely reported in literature and their etiology has been associated with cancer, trauma, and infections. The latter includes tuberculosis, histoplasmosis, syphilis, and actinomycosis. Tuberculosis is the most common cause of infective Tracheoesophageal fistula.

Conventionally Tracheoesophageal fistulae have been managed with surgery with increased morbidity. Self expandable metal stents (SEMS) have been used for a long time for malignant strictures and fistula associated with malignancy. The stents were uncovered and could not be removed.

Recently, newer stents have been introduced which are fully covered SEMS which can be placed and removed by endoscopy. Such removable SEMS are used for benign tracheoesophageal fistula and they are left in place for 4 to 12 weeks. Simultaneously, the treatment for the primary pathology is given for the patient (anti-tuberculous treatment in this case).³ Then the stent can be removed and the patient is reassessed for the presence of residual fistula.

CONCLUSION

Benign Tracheoesophageal fistula due to various etiologies, which have been conventionally treated with surgery, can now be treated with endoscopic placement of self expandable metal stents. These stents can also be removed endoscopically after the healing of fistula.

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Figure 1. Endoscopy showing Tracheoesophageal fistula



Figure 2. Self expandable metal stent in esophagus

CORONARY ARTERY ANEURYSM – AN ENTITY TO BE RECKONED WITHVijayakumar K¹, L. Mohanakrishnan², Shanmugha Sundaram³, P.Selvakumar⁴, E.Balaji⁵, Manfred Fernando⁶¹Consultant Cardiac Surgeon, ²Director of Cardio Thoracic and Vascular Surgery, ³Consultant Cardiologist, ⁴Director of Medical Services and Head of Cardiac Anaesthesiology Department, ⁵ Consultant Cardiac Anaesthesiologist, ⁶Resident Cardiac Surgery, Velammal Speciality Hospital, Madurai.**INTRODUCTION**

Coronary artery aneurysms (CAA) are not very uncommon as its prevalence is between 0.3 -5% of coronary angiograms.¹ Post coronary angioplasty with implantation of drug eluting stents too is now postulated to produce CAA even without injury.² Hence the incidence of CAA can logically be predicted to increase in coming years. We are hereby presenting this case to create an awareness of this entity.

CASE REPORT

A 62 years old gentleman, known hypertensive for the last 2 years, had an acute coronary episode one month back. It was diagnosed as Inferior wall myocardial infarction and was thrombolysed in a peripheral centre. Once stabilised, he was referred to this centre for further evaluation and management. Coronary angiogram revealed normal left main coronary, but left anterior descending artery (LAD) showed a mid, near total occlusion. Circumflex had mild proximal disease, but a tight ostial lesion in second obtuse marginal artery (OM2). Right coronary artery (RCA) showed proximal 80% stenosis followed by focal aneurysm (Figure 1). Echo revealed moderate to severe mitral regurgitation.

His treatment plan was coronary artery bypass grafting surgery with mitral valve repair and to excise the coronary aneurysm, which was an incidental finding. CAA is not a culprit lesion here, but having diagnosed incidentally needs to be tackled.

Surgery was done in the routine way. Left internal mammary artery (LIMA) and saphenous veins were harvested. LIMA was anastomosed to LAD and saphenous vein was anastomosed to OM. The coronary aneurysm was then identified (figure 2) and tackled. The aneurysm was opened and was found to be filled with clots (figure 3). The clots were evacuated. The proximal and distal opening of coronary artery from aneurysmal sac was identified (Figure 4). Saphenous vein was used to anastomose, end to end with the coronary distal to aneurysm (figure 5). The proximal communication of the coronary with aneurysm was closed. Subsequently his mitral valve was repaired by exposing the valve through left atrium. The left atrium was then closed and the proximal anastomoses of the vein grafts were completed to the aorta. He had an uneventful recovery.

DISCUSSION

In this patient the presence of clots in aneurysm may be a potential source of thromboembolism which can cause myocardial ischaemia and infarction. Whether that has caused his symptoms cannot be established as he had extensive atherosclerotic lesions. The cause of his CAA can be pinpointed to atherosclerosis which is the commonest cause of CAA. The surprise finding of CAA is the commonest way of presentation of most of this entity.

Coronary artery enlargement can be of two types - aneurysms and ectasia. Aneurysm is defined as a segment that has a diameter, exceeding the neighbouring segment or the diameter of the largest coronary artery of the patient by 1.5 times. Secondly it should involve only less than 50% of the length of the vessel.³ Whereas in ectasia the coronary has to be 1.5 times larger than the normal size but involves more than 50% of the total length.



Figure 1: The angiographic picture of aneurysm of Right coronary artery



Figure 2: The aneurysm opened up showing clots



Figure 3: The aneurysm opened up showing clots



Figure 4: The proximal and distal openings identified and a small tubular shunt is introduced into it



Figure 5: The saphenous vein graft is anastomosed to the distal coronary opening in the aneurysm

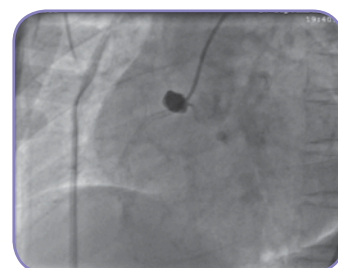


Figure 6: Angiographic picture of a post stent implantation aneurysm of right coronary artery. The stent can be seen immediately after the aneurysm.

Aneurysms can be classified in three ways (1) based on composition of wall – true aneurysms and pseudo aneurysms (secondary to trauma including iatrogenic), (2) shape of aneurysms - saccular and fusiform and (3) based on size as - giant aneurysm (size more than 2cm) or small ones.

The commonest cause of aneurysm in adults is atherosclerosis. Other causes include Kawasaki disease, autoimmune disease, trauma, infection, dissection, congenital malformation, post angioplasty (figure 6).² Post-angioplasty CAA without trauma has also been reported. The possible explanations for this entity are beyond the scope of this article.

Rarely CAA itself may be the cause for symptoms and in majority it is an incidental finding. The complications that can possibly arise out of aneurysms are thrombosis in the dilated part and later on leading to embolism causing infarction and angina. It can also in very rare situations rupture and cause tamponade or form fistulas. Giant CAA producing pressure effect causing RV failure has also been reported.⁵

All symptomatic cases have to be treated surgically as those with obstructive disease, and those with fistula or rupture. Large aneurysms need surgery to prevent rupture and also to avoid pressure effects. In many situations the surgery is for the accompanying disease rather than for CAA, but during the procedure CAA has to be tackled. For small asymptomatic CAA, with the accompanying condition not warranting surgery then anticoagulation will suffice.

CONCLUSION

CAAs are not very rare and their number is predicted to go up with more coronary interventions. Awareness of this entity and a consensus on the plan of treatment is therefore essential.

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RARE CASE OF INTERSTITIAL LUNG DISEASE COMPLICATING PREGNANCY

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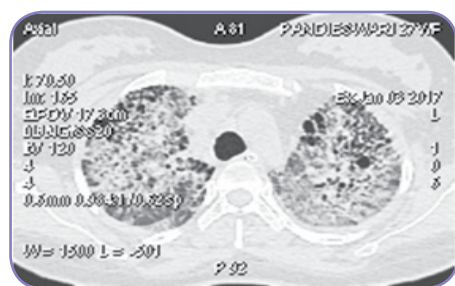
INTRODUCTION

Interstitial lung disease (ILD) is a misnomer as it affects more of parenchyma of lungs than the interstitium hence called as Diffuse Lung Parenchymal Disease. Its incidence ranges from 3-26/1,00,000 per year. Prevalence of preclinical and undiagnosed ILD is estimated to be 10 times that of clinical recognized disease. Though rare, one of the major indirect causes of maternal deaths. Pregnancy is a unique physiological state during which changes occur in all systems of the body to meet metabolic needs of both the mother and growing foetus. Enlarging uterus and increasing hormonal levels cause changes in volumes and mechanics of lungs.

CASE REPORT



Chest X Ray



HRCT

A 27 year old primi gravida conceived after long period of infertility, desperate to continue pregnancy at 25-26 weeks who is a known case of Interstitial Lung disease was admitted with complaints of breathlessness past 2 weeks. She was previously booked outside and immunized. She was admitted 1 month back for breathlessness in IMCU, was treated with parenteral steroids, and upon being symptomatically better, she was discharged with oral steroids. No other significant past and family history.

On examination patient was conscious, oriented, dyspneic, afebrile. No pallor, icterus, cyanosis, clubbing or lymphadenopathy. Pulse:124/min, BP:140/80mm of Hg, RR: 28/min, Spo2: 93% CVS: S1 S2 heard, RS: B/L crept present, P/A: uterus 24 weeks, relaxed, FHR good. Patient was started with oxygen 2 liters, oral and nasal steroids. Treatment was continued for a week under supervision of pulmonology

department. Decreased fetal movements were observed due to oligohydraminos and was treated with IV fluids and astymin drip. She also developed oral candidiasis and was given flucanazole, and candid paint.

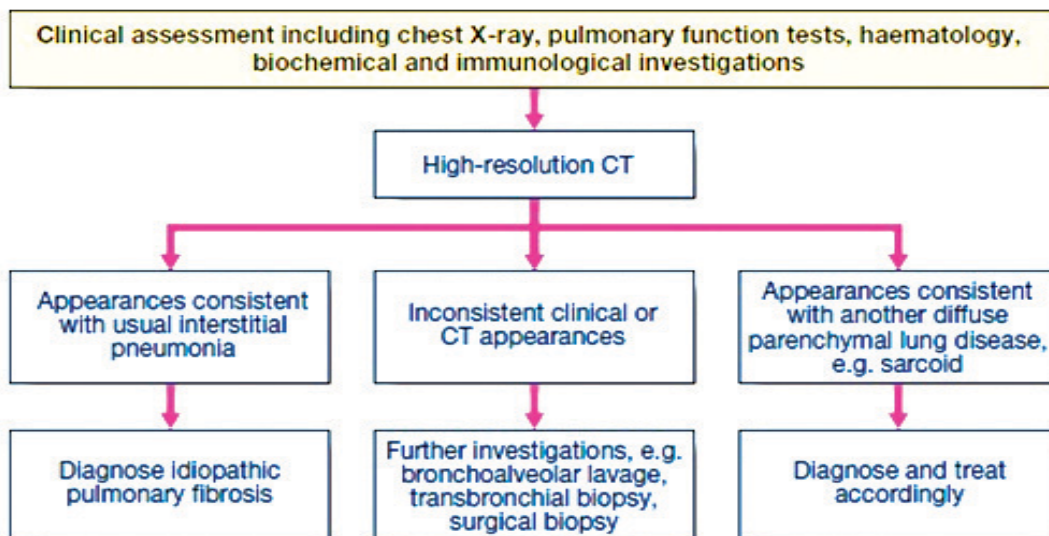
After a week she developed severe dyspnea with RR-37/min, SpO2-89% and required 15Lit of O2, hence patient was shifted to RICU. Patient had respiratory alkalosis, and was started on IV antibiotics (piptaz and azithromycin) and parenteral steroids. Dermatologist's opinion was sought for steroid induced acneform eruptions. On 28.12.16 patient was put on NIV with FIO2-70% along with treatment for oligohydraminos. At (29 weeks 1 day) emergency LSCS was planned in view of primi, breech presentation, severe oligohydraminos, IUGR, ILD with type I respiratory failure with deteriorating lung function.

LSCS was done under trans abdominal plane block with low dose spinal anesthesia and delivered alive girl baby weighing 865 gm which later was shifted to NICU. Patient was doing well till POD III with high flow oxygen mask. On POD III, she developed severe respiratory distress with desaturation, and she was ventilated. ECHO and venous doppler of lower limbs were normal. HRCT showed : Minimal left pleural effusion, mild dilatation of main pulmonary artery, no evidence of thrombus, diffuse ground glass opacity with interlobar septal thickening and honey combing and bronchiolectic changes in B/L lung parenchyma. On 5.1.17 she was started on imipenam and cyclophosphamide as patient was going for type II respiratory failure. Patient subsequently requested discharge against medical advice. Three days following discharge she succumbed to the illness.

DISCUSSION

Diffuse parenchymal lung diseases can be subdivided into five major groupings¹

- (1) Idiopathic interstitial pneumonias
- (2) Diseases associated with systemic conditions, including rheumatological disease
- (3) Diseases caused by environmental triggers or drug ingestion
- (4) Granulomatous diseases
- (5) Other diffuse lung diseases



Algorithm for the investigation of patients with interstitial lung disease following initial clinical and chest X-ray examination.

The chronic diffuse parenchymal lung diseases can be broadly sub classified into five patterns of longitudinal disease behavior², based upon cause, severity, the relative degree of inflammation and fibrosis, and observed change in the short term. Each clinical pattern is associated with a separate approach to management

- Self-limited inflammation—responds to withdrawal of an offending agent, and other therapy is unnecessary.
- Stable fibrotic disease — Treatment is not required, but monitoring of serial pulmonary function tests is needed.
- Major inflammation, with or without supervening fibrosis — Treatment with corticosteroids is usual, initially at high dosage.
- Slowly progressive fibrotic disease, in which stabilization is a realistic goal — Aggressive initial treatment is usually warranted to ensure optimal control of disease activity. Long-term therapy is often required.
- Inexorably progressive fibrotic disease—the hallmark of IPF, Long-term treatment may slow disease progression, but initial high-dose therapy achieves nothing in known IPF and may cause unnecessary drug toxicity.

Diagnosis based on lab investigations³

- Full blood count: lymphopenia in sarcoidosis; eosinophilia in pulmonary eosinophilia and drug reactions; neutrophilia in hypersensitivity pneumonitis.¹
- Ca²⁺: may be elevated in sarcoidosis.
- Serum angiotensin-converting enzyme: non-specific indicator of disease activity in sarcoidosis.
- ESR and CRP: non-specifically raised.
- Autoimmune screen: autoantibodies may suggest connective tissue disease.
- Arterial Blood Gas Analysis (ABG), Tuberculin test—negative in 2/3 of sarcoidosis patients, BRONCHOALVEOLAR LAVAGE- cellular profile special stains or studies.
- Lung biopsy- Trans Bronchial Biopsy, Open Lung Biopsy.

Management

Principal aim of management is to remove exposure to injurious agents, to suppress inflammation to prevent further destruction of

the pulmonary parenchyma, and to palliate the manifestations of these diseases.

Drugs used are

- Corticosteroids: Prednisolone 1 mg/kg, gradually tapered (5 mg/week) over several months to a maintenance dose.
- Immunosuppressive agents: Cytotoxic agents (Cyclophosphamide) or immunosuppressive agents (Azathioprine) may be used in patients who do not improve on steroid therapy or who cannot tolerate corticosteroids.^{3,4}
- Recent advances: Colchicine(0.6-1.2mg) for 6-12 months-safe, D-penicillamine, N-acetyl cysteine and Pirfenidone with variable results. Lung transplant has been advocated in advanced end stage disease. Single lung transplantation is suffice in most patients.⁴

Prognosis

Five-year survival is reported in up to 40% of patients, Course of ILD is progressive and fatal in most patients of primary IPF and median survival of IPF is about 4 years. No improvement in survival observed for last 40 to 50years^{1,2}.ILD's secondary to systemic diseases or other causes follow the course of the underlying disease.

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MINIMALLY INVASIVE SPINE SURGERY (MISS)

Dr. Maria Subison, MS, MCh

Consultant Neuro Surgeon, Velammal Medical College Hospital and Research Institute, Madurai

It is the novel method of spine surgery where we can avoid long incision, extensive muscle retraction. As a result we can avoid post operative muscle pain, muscle atrophy.

Advantages of MISS

Less blood loss, less post operative pain, low infection rate, shorter recovery time...shorter hospital stay, tiny scars...better cosmesis and less cost. Advantage is more in MIS spine fixation (e.g.: lumbar TLIF) compare to conventional open spine fixation.

Instruments for MISS: Table mounted retractor system, serial dilators, operating microscope, micro-instruments.

Procedure

Operating table should be inverted v shape so that interlaminar space will be increased. Incision should be marked at the symptomatic side (around 2cm lateral to midline). Incision site is marked under c arm guidance. Incision size is approximately 2 cm. Incision is deepened upto lumbar fascia. Serial dilators are inserted. Muscles are just split in this technique and are not cut. Dilator inserting site (docking site) is lamino facet junction for discectomy and foraminotomy. Docking site for TLIF (Trans foraminal lumbar interbody fusion) is facet joint. Bone defined. Rest of the procedure is same as open method.

A total of 4 cases were done in the last 3 months at VMCH&RI out of which 3 were lumbar cases and 1 was a case of cervical foraminotomy. All the 3 lumbar patients improved immediately after surgery. Patient can be discharged in the same day (day care surgery).

CERVICAL FORAMINOTOMY CASE

Why cervical foraminotomy?

Normally for cervical disc we used to do anterior approach in which we use to remove the normal disc and bone to approach the pathology and fuse the vertebrae. In selected cases where patient have radiculopathy and MRI shows lateral disc bulge with root compression without cord compression, we can do posterior foraminotomy and decompress the nerve in which normal disc is untouched. Unnecessary fusion and motion loss is also avoided.

Indication for foraminotomy

Patients who have only radiculopathy symptoms and MRI shows lateral disc.

Contraindication for foraminotomy

Patients who have myelopathy symptoms and MRI shows myelopathy features

Case History

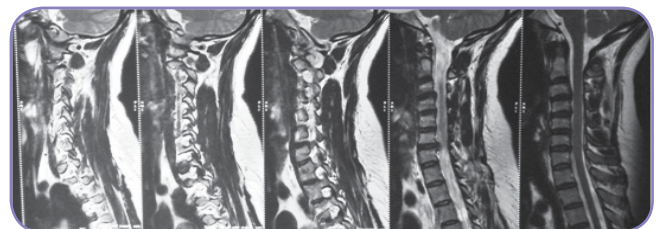
A 36 year old female patient admitted with the h/o neck pain radiating to right upper limb-3 months. Numbness was present in the right C7 dermatomes since 3 months and patient was unable to flex the right index finger since 1 week. Patient was operated in MIS technique and she improved immediately after surgery.



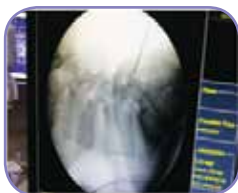
MIS Instruments



Lumber case: Position of the patient



Sagittal



Site of the incision confirmed with c arm



Small paramedian incision made on the symptomatic side



Photo showing table mounted retractor system



Axial

CONCLUSION

Minimally invasive spine surgery is technically demanding surgery. In south Tamil Nadu only our hospital has this system. With good result we will achieve new milestones in coming days.

PHARMACOVIGILANCE

Pharmacovigilance programme of India (PvPI) is the emerging field in the search of adverse drug reactions. It not only concentrate on the adverse effects of drugs but also to the reactions due to blood transfusion, vaccines and various materials used in medicine and surgery both for investigation and therapy.

In Velammal Medical College Hospital and Research Institute the Pharmacovigilance unit is fast growing with reporting 5 to 11 adverse reactions per month & we are approved as reporting unit through vigiflow which even many Government Medical colleges have not achieved. So far we have reported blood transfusion reactions and attributing to the study on bladder cancer? induced by Pioglitazone. In future we are proposing to study the teratogens and carcinogens with the utilization of drugs by retrograde study on pregnancy and adulthood respectively.

We are here to report the adverse reactions sent by the physicians practicing nearby in private clinics also So the private practioners can utilize our service for reporting the adverse reactions from their private clinics also and serve the National programme of PVPI. Except for filling the attached form genuinely the reporters are not liable for any other enquiries regarding their reports by anybody. But by contributing the adverse drug reactions the practioners are serving the community a lot!

Practioners can report all well known reactions such as gastritis due to iron and NSAIDS since it will be useful to update the incidence of the particular reaction. However even trivial reactions such as itching and rashes can be reported because for one person it may be trivial which may produce a severe allergic reaction for others. So reporting such reactions may caution the physician while using the same drug.

We are looking specially for the adverse reactions due to vaccines, anti tubercular drugs, drugs for rheumatology & drugs used in diseases of long duration such as leprosy, epilepsy, malignancy & HIV.

**“LET US SERVE THE COUNTRY BY REPORTING ADVERSE DRUG REACTIONS
SAVE THE LIFE OF PEOPLE FROM ADVERSE DRUG REACTIONS”**

To report adverse drug reactions:


Toll free No: 1800 180 3024

Email: info@velammalmedicalcollege.edu.in

Submitted by, Department of Pharmacology,

VMCH&RI Madurai

ADR REPORTING FORM



SUSPECTED ADVERSE DRUG REACTION REPORTING FORM
For VOLUNTARY reporting of Adverse Drug Reactions by Healthcare Professionals

Version-1.3

National Coordination Centre
Pharmacovigilance Programme of India
Ministry of Health & Family Welfare,
Government of India
Sector -23, Raj Nagar, Ghaziabad-201002
Tel.: 01120-2783400, 2783401, 2783392
Fax: 01120-2783311
www.ipc.nic.in

Pharmacovigilance Programme of India for Assuring Drug Safety

INDIAN PHARMACOPOEIA COMMISSION (National Coordination Centre-Pharmacovigilance Programme of India) Ministry of Health & Family Welfare, Government of India Sector-23, Raj Nagar, Ghaziabad-201002										FOR AMC/NCC USE ONLY			
Report Type <input type="checkbox"/> Initial <input type="checkbox"/> Follow up										AMC Report No. _____ Reg. No./IPD No./OPD No./ICR no. _____			
A. PATIENT INFORMATION										Worldwide Unique No. : _____			
1. Patient Initials _____	2. Age at time of Event or Date of Birth _____	3. M <input type="checkbox"/> F <input type="checkbox"/> Other <input type="checkbox"/>	12. Relevant test/ laboratory data with dates _____							4. Weight _____ Kgs			
B. SUSPECTED ADVERSE REACTION										13. Relevant medical/ medication history (e.g. allergies, race, pregnancy, smoking, alcohol use, hepatic/renal dysfunction etc.) _____			
5. Date of reaction started (dd/mm/yyyy)										14. Seriousness of the reaction: No <input type="checkbox"/> if Yes <input type="checkbox"/> (please tick anyone)			
6. Date of recovery (dd/mm/yyyy)										<input type="checkbox"/> Death (dd/mm/yyyy) <input type="checkbox"/> Congenital-anomaly			
7. Describe reaction or problem _____										<input type="checkbox"/> Life threatening <input type="checkbox"/> Required intervention to Prevent permanent			
										<input type="checkbox"/> Hospitalization/Prolonged impairment/damage			
										<input type="checkbox"/> Disability <input type="checkbox"/> Other (specify) _____			
										15. Outcomes <input type="checkbox"/> Recovered <input type="checkbox"/> Recovering <input type="checkbox"/> Not recovered			
										<input type="checkbox"/> Fatal <input type="checkbox"/> Recovered with sequelae <input type="checkbox"/> Unknown			
C. SUSPECTED MEDICATION(S)													
S.No	8. Name (Brand/Generics)	Manufacturer (if known)	Batch No. / Lot No.	Exp. Date (if known)	Dose used	Route used	Frequency (OD, BD, etc.)	Therapy dates		Indication	Causality Assessment		
								Date started	Date stopped				
i													
ii													
iii													
iv													
9. Action Taken (please tick)										10. Reaction reappeared after reintroduction (please tick)			
As per	Drug withdrawn	Dose increased	Dose reduced	Dose not changed	Not applicable	Unknown	Yes	No	Effect unknown	Dose (if reintroduced)			
i													
ii													
iii													
iv													
11. Concomitant medical product including self-medication and herbal remedies with therapy dates (Exclude those used to treat reaction)													
S.No	Name (Brand/Generics)	Dose used	Route used	Frequency (OD, BD, etc.)	Therapy dates		Indication						
					Date started	Date stopped							
i													
ii													
iii													
Additional Information: _____										D. REPORTER DETAILS			
										16. Name and Professional Address: _____			
										Pin: _____ E-mail: _____			
										Tel. No. (with STD code) _____ Signature: _____			
										Occupation: _____			
										17. Date of this report (dd/mm/yyyy): _____			

ADVICE ABOUT REPORTING

A. What to report

- Report serious adverse drug reactions. A reaction is serious when the patient outcome is:
 - Death
 - Life-threatening
 - Hospitalization (initial or prolonged)
 - Disability (significant, persistent or permanent)
 - Congenital anomaly
 - Required intervention to prevent permanent impairment or damage
- Report non-serious, known or unknown, frequent or rare adverse drug reactions due to Medicines, Vaccines and Herbal products.

Note- Adverse Event Following Immunization can also be reported in Serious AEFI case Notification Form available on <http://ipc.nic.in/showfile.asp?lid=650&Enchid=>

B. Who can report

- All healthcare professionals (Clinicians, Dentists, Pharmacists and Nurses) can report adverse drug reactions

C. Where to report

- Duly filled Suspected Adverse Drug Reaction Reporting Form can be send to the nearest Adverse Drug Reaction Monitoring Centre (AMC) or directly to the National Coordination Centre (NCC).
- Call on Helpline (Toll Free) 1800 180 3024 to report ADRs.
- Or can directly mail this filled form to pvpi@ipcindia.net or pvpi.ipcindia@gmail.com
- A list of nationwide AMCs is available at: <http://www.ipc.gov.in>, http://www.ipc.gov.in/PvPI/pv_home.html

D. What happens to the submitted information

- Information provided in this form is handled in strict confidence. The causality assessment is carried out at AMCs by using WHO-UIC scale. The analyzed forms are forwarded to the NCC through ADR database. Finally the data is analyzed and forwarded to the Global Pharmacovigilance Database managed by WHO Uppsala Monitoring Centre in Sweden.
- The reports are periodically reviewed by the NCC-PvPI. The information generated on the basis of these reports helps in continuous assessment of the benefit-risk ratio of medicines.
- The information is submitted to the Steering committee of PvPI constituted by the Ministry of Health & Family Welfare. The Committee is entrusted with the responsibility to review the data and suggest any interventions that may be required.

E. Mandatory field for suspected ADR reporting form

- Patient initials, age at onset of reaction, reaction term(s), date of onset of reaction, suspected medication(s) and reporter information.

For ADRs Reporting Call on PvPI Helpline (Toll Free)

1800 180 3024

(9:00 AM to 5:30 PM, Working Days)

Confidentiality: The patient's identity is held in strict confidence and protected to the fullest extent. Programme staff is not expected to and will not disclose the reporter's identity in response to a request from the public. Submission of a report does not constitute an admission that medical personnel or manufacturer or the product caused or contributed to the reaction.

SZIRACON

The city of the Nizams, Hyderabad, hosted the 4th Annual South Zone IRA Conference, SZIRACON. The final year MBBS students viz. Yuva, Dhivya, Harish and Jane had the opportunity to present posters in this 3 day conference. The preconference CME, symposium and seminars served knowledge to those gathered on the various rheumatological conditions and their management trends at present. The cultural activities and the inaugural dinner were a feast to the eyes and the palates of the audience.

We are proud to share the excitement and applause we received when we got the first and second best posters – Yuva and Dhivya. All students expressed their gratitude to guide Dr. Subramanian Nallasivan, Rheumatologist, Velammal Medical College Hospital and Research Institute, Madurai. His talk about ‘Biologics in Rheumatology: Data from South Tamil Nadu’ also opened up eyes on the growth of Velammal institution and therapeutic efficacy of newer world class treatment.

Tips to publish research, career guidance and startups in rheumatological practice proved useful to the competitive and young part of the audience.

Following are the topics we presented.

SN	Topic	Presenter	
1	Diversity of rheumatology patients in a newly established paediatric rheumatology unit in medical college hospital	Yuva Vishalini Ravindran	1 st Prize
2	Plasma exchange still very effective for pulmonary hemorrhage in Anca Vasculitis	T. Dhivya	2 nd Prize
3	Unusual presentation of Dermatomyositis/ Polymyositis	T Harish Kumar	
4	Cyclophosphamide is still the gold standard for lupus nephritis? study of patients with sle and nephritis in a tertiary care hospital	Yuva Vishalini Ravindran	
5	Lymphatic TB and C1q nephropathy	Jane Sathiyavadi	



WORLD LUPUS DAY

LUPUS or SLE- (Systemic Lupus Erythematosus) is one of the commonest autoimmune diseases affecting young women of child bearing age. It is a multisystem disease and if untreated, it can cause significant morbidity and mortality. World lupus day is celebrated on 10th May all over the world, in order to raise awareness among the public, patients and doctors.

Velammal Medical College Hospital and Research Institute, Rheumatology department had conducted “Patient Awareness Programme” and Q/A session by Dr. Subramanian, Dr. Ramanujam Professor and HOD of Psychiatry and Dr. Vikram Sagar, Nephrologist on 16th May 2017. There was a family meet too with little children of patients with SLE attended. Dr. Subramanian thanked all for participating in the Lupus Day meet.



108 SENSATIZATION



A health awareness program was conducted by GVK EMRI, Tamil Nadu and department of Community Medicine VMCH&RI, Madurai on 17/06/17 between 2 PM - 3 PM. Around 150 medical students attended the program. The program included orientation and exhibition of various services available by 104 and 108 to medical students.

BABY SHOWER FUNCTION

Valaikappu function is an important traditional samskara in south Indian states. From the day of the fetus formation in its mother's womb, a child grows in different stages, each with a stipulated time frame. The brain formation completes by seventh month of pregnancy and thus the unborn child can record sounds and vibration from its surroundings, helping for uplifting fetal brain growth. It is an ancient ritual celebrated for the pregnant woman and the baby by the elders for safe delivery. We OBG department conducted this auspicious function for our Velammal Antenatal mothers for the second year. We also invited other pregnant women in and around Madurai. Our chief guest was our beloved chairman Shri. Mr. M. V. Muthuramalingam. Our honorable madam Mrs. Kunjaravalli Muthuramalingam started the baby shower function and blessed the Antenatal mothers. More than 160 pregnant women participated in this function and received the blessings. We also conducted a small cultural program followed by lunch with 5 different variety rice. The festival ended by honoring the pregnant women with gifts (A Kit containing a Saree, Nutrient Powder and Iron supplements).



INTERNATIONAL NURSES DAY CELEBRATION AND INAUGURATION OF STUDENT NURSES' ASSOCIATION UNIT OF VELAMMAL SCHOOL & COLLEGE OF NURSING - 12.05.2017

International Nurses Day was organized and celebrated by nursing fraternity of Velammal Medical College Hospital and Research Institute, Velammal Specialty Hospital, principal, faculty and students of Velammal School & College of Nursing on 12.05.2017 along with the inauguration of Student Nurses' Association Unit of Velammal School & College of Nursing. The event took place at Velammal Medical College Hospital and Research Institute Auditorium in the presence of Honorable Chairman Shri. M.V.Muthuramalingam, Velammal Educational Trust, Chief Guest Dr. Gnana Sambantham, Dr. R.M. Raja Muthaiah, Dean, Dr. S. Somasundaram, Medical Superintendent, Dr. Selvakumar, Director of Medical Services, Mr. Peter Kennady, Chief Operative Officer and Prof. Dr. S. Chandrakala, Principal, Velammal School & College of Nursing had given a warm welcome, staff nurses from VMCH&RI and VSH lit the Kuthuvilakku, honorable chairman Shri. M.V. Muthuramalingam, gave a special address about the Contribution of Nurses in providing holistic care for the upliftment of patient welfare, Dr. Gnana Sambantham expressed his happiness in participating in this programme and also highlighted about the role of nightingale in development of modern nursing practice. As a part of celebration cake cutting was done by all the dignitaries along with Mrs. Jamima Jothi, NS,VSH. Mrs. Anitha Ani Bai, Nursing Director, introduced the theme for International Nurses Day - 2017 "A voice to lead, Achieving the Sustainable

Development Goals". Staff nurses and students made the day colorful by performing cultural programme. On behalf of nurses day celebration, sports and cultural competitions held in Velammal School and College of Nursing. The events were evaluated by doctors and teaching faculties from Velammal Medical College hospital and Research Institute and Velammal School and College of Nursing. I & II Prize for each event, Individual performer and the championship were distributed for the students on nurses day celebration in VMCH & RI Auditorium by the dignitaries. The Programme ended with the vote of thanks by Mrs. Nandhini, NS, VMCH&RI.

Report submitted by - Principal,
Velammal School & College Of Nursing, Madurai.



Congratulations

WINNERS OF QUIZ COMPETITION AND POSTER PRESENTATION HELD IN MADURAI LIVER CONGRESS 2017 ON 22.04.17 TO 23.04.2017, ORGANIZED BY THE DEPARTMENT OF GASTROENTEROLOGY, VELAMMAL MEDICAL COLLEGE HOSPITAL & RESEARCH INSTITUTE, MADURAI

QUIZ COMPETITION 1ST PRIZE WINNERS



Arun M
III MBBS



Arun Kesav M
III MBBS



Chandrapriyan TS
III MBBS

QUIZ COMPETITION 2ND PRIZE WINNERS



Swetha T S
III MBBS



Nivetha T S
III MBBS



Nivetha A
III MBBS

WINNERS OF POSTER PRESENTATION



Venkatesh K
III MBBS (1st Prize)



Krishnika R
IV MBBS (3rd Prize)

RECEIVED SECOND PRIZE FOR CLINICO PATHOLOGICAL CASE PRESENTATION IN AXON 2017 HELD ON 2ND - 4TH JUNE 2017 AT PSG INSTITUTE OF MEDICAL SCIENCE & RESEARCH, COIMBATORE



Shivani Baskar Kuttuva

WINNERS AND PARTICIPANTS OF POSTER PRESENTATION IN SZIRALCON 2017 (4TH ANNUAL SOUTH ZONE INDIAN RHEUMATOLOGY ASSOCIATION CONFERENCE) HELD ON 19TH, 20TH & 21ST MAY 2017 AT HYDERABAD, ORGANISED BY RHEUMATOLOGY ASSOCIATION HYDERABAD CHAPTER

PRIZE WINNERS



Yuva Vishalini R
(1st Prize)



Dhivya T
(2nd Prize)



Jane S Sathivadivu



Harish Kumar T

PRESENTED POSTER



Dr. N. Subramanian

Consultant Rheumatologist and Assistant Professor,
Department of medicine and rheumatology, VMCH & RI

Congratulation Dr. N. Subramanian.....

He has been honored as one of the best citizens of India by International Publishing House. In addition, he has received Bharat Jyoti Award from India International Friendship Society for his meritorious services, outstanding performance and remarkable role.



Congratulations Dr. Jeyashree K Assistant Professor, Department of Community Medicine, VMCH&RI

She had collaborated with the UNION (International Union for TB and Lung Diseases) and mentored a project with China CDC at WHO-SORT IT course, Colombo. The results of the project are now published in Plos One.

“Comparing yield and relative costs of WHO TB screening algorithms in selected risk groups among people aged 65 years and over in China, 2013”.



JULY

- 1 July - Dr. D. Sriramulu, Consultant, Nephrology
Dr. J. Caroline, Sr. Resident, Ophthalmology
- 2 July - Dr. R. Venkatesh Kumar, Sr. Resident, Anesthesiology
Dr. M. Deepika, Jr. Resident, Cardiology
Dr. V. Ramar, Professor, Orthopedics
- 4 July - Dr. M. Angu Vijayam, Associate Professor, General Medicine
Dr. M.J. Muralikannan, Sr. Resident, General Surgery
Dr. S.S. Vignesh Kumar, Jr. Resident, Speciality
- 7 July - Dr. M. Azam, Jr. Resident, ENT
- 9 July - Dr. R. Lavanya, Sr. Resident, Anesthesiology
- 10 July - Dr. S. Mahesh Kumar, Consultant, Cardiology
Dr. C. Sivagami Sundari, Sr. Resident, OBG
- 12 July - Dr. Malarvani, Medical Officer, Urban Center, Community Medicine
- 14 July - Dr. N. Padmavathi, Jr. Resident, General Medicine
- 15 July - Dr. J.X.A. Manfred Fernando, Sr. Resident, Cardio Thoracic & Vascular
Dr. C. Azad Gowri Mukunthan, Medical officer, General Medicine
- 16 July - Mr. M. Ramkumar, Tutor, Anatomy
- 17 July - Dr. A. Visali, Jr. Resident, Paediatrics
- 19 July - Dr. B. Vishnu Varthan, Sr. Resident, General Medicine
- 21 July - Dr. N. Kannappan, Assistant Professor, Orthopaedics
- 22 July - Dr. N.S. Mani, Professor & HOD, Radiology
- 23 July - Dr. M.J. Krishna Kumar, Sr. Resident, Orthopaedics
- 24 July - Dr. A. Vijaya Sethupathi, Jr. Resident, Neurology
- 27 July - Dr. R. Vadivelu, Assistant professor, Cardiology
- 29 July - Dr. R. Deepa Vinitha Rani, Assistant Professor, Ophthalmology
Dr. G. Mathevan, Professor, Paediatrics

AUGUST

- 1 August - Dr. R.M. Sathish Kumar, Assistant Professor, General Surgery
- 3 August - Dr. M. Saravanan, Assistant Professor, Paediatrics
- 4 August - Dr. R. Ganesan, Professor, General Surgery
- 5 August - Dr. C. Praveen Kumar, Sr. Resident, General Medicine
- 7 August - Dr. N. Uwaraja, Emergency Physician, Casualty
- 8 August - Dr. L. Ramya, Jr. Resident, General Medicine
- 9 August - Dr. R. Gnanasekaran, Assistant Professor, Dermatology
Dr. T. Gomathy, Professor, Pathology
- 10 August - Dr. S. Dhivya, Sr. Resident, Paediatrics
- 11 August - Dr. S. Raja Sankar, Professor, Anatomy
- 13 August - Dr. V. Sandhya, Sr. Resident, General Medicine
Dr. A.G. Santhana Krishnan, Consultant, Neurology
- 14 August - Dr. J. Mohan, Associate Professor, Pharmacology
- 15 August - Dr. R. Sundarajan, Medical Officer, TAFE
- 16 August - Dr. L. Ramya, Jr. Resident, General Medicine
- 17 August - Dr. J.N.C. Hamilton, consultant, Anaesthesiology
Dr. M. Rani Solai, Associate Professor, General Medicine
- 18 August - Dr. S. Yogaraj, Assistant Professor, Radiology
- 19 August - Dr. R. Sakunthala, Sr. Resident, Dermatology
Dr. A. Ramesh, Associate Professor, Microbiology

- 20 August - Dr. Sabita Singh, Assistant Professor, Anatomy
- 22 August - Dr. S. Rajarajeshwari, Professor, Gynaecology
- 24 August - Dr. B. Renuka Devi, Assistant Professor, Gynaecology
- 25 August - Dr. P. Ramadevi, Sr. Resident, Anaesthesia
Dr. S. Sindhu Bharathi, Jr. Resident, Speciality
- 26 August - Dr. A.S. Krishnam, Professor, Dermatology
Dr. T. Karthikraj, Assistant Professor, Paediatrics
- 29 August - Dr. P. Sasikala, Associate Professor, Anatomy

SEPTEMBER

- 2 September - Dr. B. Nisha, Assistant Professor, Anaesthesiology
Dr. J. Vinoth, Jr. Resident, General Medicine
- 4 September - Dr. L. Mohana Krishnan, Consultant, cardiothoracic surgeon
- 5 September - Dr. C. Swaminathan, Jr. Resident, Speciality
- 7 September - Dr. S. Harikrishnan, Sr. Resident, Chest & TB
- 9 September - Dr. P. Raj Kumar, Jr. Resident, Speciality
- 10 September - Dr. R. Narendranath, Jr. Resident, Gastroenterology
- 14 September - Dr. M. Saranya, Jr. Resident, General Medicine
- 15 September - Dr. A.C. Arun, Sr./Assistant Professor, General Medicine
- 16 September - Dr. R. Anandha Kumar, Assistant Professor, General Medicine
- 18 September - Dr. A. Dhanyan Harshidan, Assistant Professor, ENT
Dr. Laxmi.C.C, Associate Professor, Physiology
- 20 September - Dr. P. Suresh, Consultant, Anaesthesiology
- 21 September - Dr. M. Vijay Anand, Assistant Professor, Anaesthesiology
Dr. M. Gobinath, Professor, General Surgery
- 24 September - Dr. G. Saravana Kumar, Assistant Professor, Radio diagnosis
- 26 September - Dr. C. Ramanan, Sr. Resident, General Medicine
- 29 September - Dr. S. Janani, Jr. Resident, General Medicine
Dr. M. Mithran, Assistant Professor, Orthopaedics

WELCOME TO THE VELAMMAL FAMILY

Dr. S. Rajan	Assistant Professor - Forensic Medicine
Dr. U. Sridhurga	Assistant Professor - Pediatrics
Dr. Mamata T Shenoy	Assistant Professor - Biochemistry
Dr. S.V. Saranya	Assistant Professor - Community Medicine
Dr. V. Tamilarasan	Assistant Professor - Radiology
Dr. R. Ramanarayanan	Assistant Professor - Anaesthesia
Dr.(Major)L. Rupakumar	Anaesthesia - Senior Consultant
Dr. B. Shifa Babu	Radiology Consultant
Dr. Duvuru Amareswar Reddy	Hepatology Consultant
Dr. R. Gayathri	Emergency Physician - Senior Resident
Dr. M.S.P.S. Rajavel	Anaesthesia - Senior Resident
Dr. A. Asaithambi	ENT - Senior Resident
Dr. Jaiganesh	General Medicine - Senior Resident
Dr. Betsy Sherba	Physiatry - Senior Resident
Dr. V. Meenakshi Sundaram	Pediatrics - Senior Resident - General Surgery

AN UPDATE ON ECMO



A CME was conducted upon "AN UPDATE ON ECMO" @ 1ST FLOOR BOARD ROOM, on 10/6/17 Saturday between 2 pm to 5 pm. The Program was presided by The Dean Mr Rajamuthaiah Sir, Medical Superintendent Prof Dr.Soma Sundaram.

All Cardio thoracic Surgeons, Emergency Doctors, ICU & OT Technicians, Senior Staffs and Perfusionists attended the program.

The main theme of the CME is to demonstrate upon EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO) or EXTRA CORPOREAL LIFE SUPPORT(ECLS) is a highly advanced life support therapy used to treat critically ill patients with respiratory and or cardiac failure.

The program was organised by Dr P.Selvakumar, Director of Medical Services and 50 members attended the program.

MADURAI LIVER CONGRESS 2017

“Madurai Liver Congress 2017” conference was conducted in Velammal Medical College Hospital and Research Institute on 22nd & 23rd of April 2017, organized by the Department of Gastroenterology with supports from the Honorable Chairman, the Dean, Medical Superintendent, Vice Principal and Director of Medical Services. The theme of the conference was “Everything about Liver in 2 days”. The conference was inaugurated by Dr. T. Prabhushankar, IAS, Sub Collector, Cheyyar. The conference was well attended by Gastroenterologists, Professors of Medicine & Surgery, Post graduates and Undergraduates of various Medical colleges of Tamil Nadu and neighboring states. Dr A. C. Arun welcomed the gathering and Dr. N. Sudhan delivered the vote of thanks.

The eminent faculties who delivered the lectures were Dr. Subrat Acharya (AIIMS), Dr. Usha Dutta, Dr. S. K. Sinha (PGI, Chandigarh), Dr. V. K. Dixit (BHU, Varanasi), Dr. P. Advaitam, Dr. T.S. Chandrasekar, Dr. V. Jayanthi, Dr. L. Venkatakrishnan (PSG), Dr. L. Thayumanavan, Dr. A. S. A. Jegannathan. The topics covered ranged from “Basic Clinical Approach to Jaundice” to “Liver Transplantation”. There was also quiz and poster competition about Liver disorders for UG and PG students. The conference was an eye-opener about the recent advances in Liver disorders for both the practicing clinicians and medical students. The conference was supported by IMA, API and ASI of Madurai and neighboring districts.

- Dr. A. C. Arun, MD., DM,

Consultant Gastroenterologist, VMCH & RI.

WORLD SCHIZOPHRENIA DAY

May 24 marks the World Schizophrenia Day. The week preceding—May 14th to 21st is observed as the World Schizophrenia week world wide. On these days mental health personnel around the globe organise activities and educational programmes for patients and families affected by the illness – Schizophrenia.

In Velammal Medical College Hospital, the department of psychiatry conducted an awareness programme on the topic of Schizophrenia for around 160 patients with the illness.

The programme was conducted on 30th May 2017 in the hospital auditorium. Around 270 beneficiaries which included the family members of the patients attended the programme, which was graced by Chief Guest Dr. G. Ramanujam MD (Psychiatry), Professor and Head, Department of Psychiatry, Tirunelveli Medical College. The head of the department of psychiatry Dr. V. Ramanujam introduced the chief guest following which the chief guest gave an educative talk in the local language about the illness and the treatment issues. The major part of the programme was an interactive question and answer session, where the patients and their families clarified their doubts and shared their experience with the group. Patients who had been successfully fighting the illness and remaining functional in spite of all odds and stigma were identified and prizes were distributed by the Dean Dr. Raja Muthaiah and Medical Superintendent Dr. Somasundaram of VMCH&RI. The family members who have set an example to the others through their unconditional support and efficient care giving were also identified. Their contribution in ensuring the drug compliance of patients was appreciated and they were also given prizes. The programme ended with a vote of thanks by Dr. Sugapaneetharan and lunch was provided for all the patients and family members.

WORLD ENVIRONMENT DAY

World environment day is also known as the Environment Day, Eco Day. It has been one of the great annual events for years which is being celebrated worldwide by the people aiming to protect the unique and life nurturing nature on every 5th June. Every year celebration is planned according to the particular theme and slogan of the year to bring effectiveness in the campaign all through the world. This year's theme was “Connecting People to Nature”.

In view of this theme of world environment day, Velammal Medical College Hospital and Research Institute's students, who are NSS volunteers, conducted awareness activity for out patients and general population, on basis of following subject matter: “Planting Trees, Rain Water Harvesting, Avoiding Plastics and Polythene and Preserve Ground Water”.

The chairman of Velammal educational trust, Shree. M. V. Muthuramalingam started the event in the presence of Dean of

VMCH & RI, Dr. R. M. Raja Muthiah, Medical Superintendent Dr. S. Somasundaram, Vice Principal Dr. P. K. Mohanty and Chief Operating Officer Mr. Peter Kennedy. Dr. Dhaval, Associate professor, department of Community Medicine and the NSS Coordinator of VMCH & RI, organised the entire events.

Students gathered in front of main gate of hospital with flex banners and placards demonstrating how to preserve ground water and environment, need to plant more trees and significance of harvesting rain water. Students also demonstrated and explained the threats of global warming and the need to completely banning plastics and polythene articles. Further students also explained about importance of obeying traffic rules, adverse effects of emission from vehicles through placards. The general population who accompanied out patients in their waiting times raised doubts regarding how to preserve the environment, which were clarified by the students.

XPERANZA 2K17

Xperanza 2k17 – An intracollege cultural and sports meet of Velammal Medical College Hospital and Research Institute was held between May 8 and June 7. With Professors turning judges and students showing active participation in various extra-curricular activities – it really had been a memorable time for everyone of us here in Velammal. The Off stages competitions like Poetry (English), Poetry (Tamil), Creative Writing, Script Writing, Face Painting, Nail Art, Mehendi, Rangoli, Flameless Cooking, Bridal Make up, Flower decoration, Gym dashers and Painting. There was also trending games such as Mini Militia, 8 ball pool, Dubsmash and Mannequin Challenge. The grand finale was on June 6 & June 7 and it was the cherry-on-the-top. The cultural night was filled with music and dance and cherishing moments.



EVENTS



Madurai Liver Congress



World Schizophrenia Day



World Environment Day