SANTACRUZ MEDICAL SOCIAL ASSOCIATION

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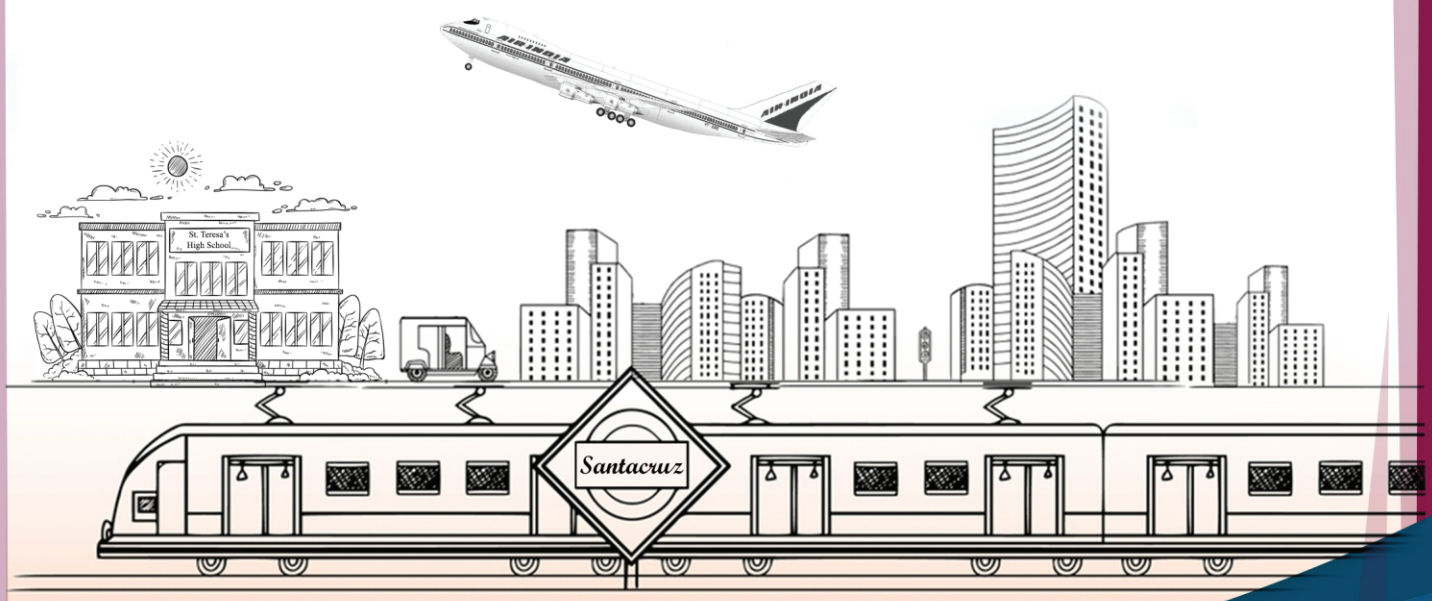
SMSA Samvaad

MEDICAL BULLETIN

2026



Happy

New Year

SMSA SAMVAD

SMSA NEWS LETTER

INDEX

Dear SMSA Family,

It gives us immense joy presenting to you the next edition of Samvaad — our very own platform for communication, connection, and continuous learning.

This initiative beautifully reflects the vibrant spirit of SMSA — where camaraderie meets curiosity, and where we continue to learn, share, update ourselves and grow together as a family of dedicated medical professionals. Each edition of Samvaad brings forth valuable insights from our talented members, simplified updates from diverse fields of medicine, and practical perspectives that enrich our clinical practice.

More than just a newsletter, Samvaad embodies the very essence of who we are as a community — committed, compassionate, and constantly evolving.

My heartfelt appreciation to our editorial team for their dedication and creativity in bringing this edition to life. Your efforts ensure that Samvaad remains a vibrant bridge connecting every member of our SMSA family.

Here's to continued learning, shared success, and lasting togetherness — the true spirit of Samvaad, and of SMSA itself.

With warm regards,
Dr. Nisha Chaturvedi
President, SMSA (2025–26)

We are pleased to announce the publication of the latest edition of Samvaad.

This publication serves not only as a newsletter but also as a vital conduit for fostering continuous learning regarding advancements in the global medical field. It represents a unifying element for all members of the SMSA family. I extend my sincere congratulations to the Samvaad team for their dedication in producing this edition, which truly embodies our collective pursuit of knowledge.

I wish the entire team continued success in the years ahead.

With warm regards,
Dr. Sunny Rungta
Secretary, SMSA (2025–26)

NEWER ADVANCES IN THE MANAGEMENT OF DRY EYES

Introduction:

Dry eyes, as the name suggests, deals with the various conditions that can lead to dryness of the ocular surface. The underlying pathology in dry eyes is inflammation of the ocular surface. In some patients, it may present as red inflamed eye while in others the eye appears quiet but has underlying "white inflammation."

Classification of Dry Eyes

Dry eyes have been broadly classified into three types:

1. Aqueous tear deficiency (ATD)
2. Meibomian gland disease (MGD)
3. Mixed type

Aqueous tear deficiency (ATD) is due to inadequate secretion of tears leading to poor availability of tears on the ocular surface. In Meibomian gland disease, the meibum secreted by the meibomian glands is abnormal, leading to early breakdown of the tear film and symptoms of dryness and irritation. Patients belonging to the mixed group have both pathologies co-existing. ATD is commonly associated with collagen vascular diseases, most commonly rheumatoid arthiritis. This condition is termed as Sjogren's syndrome and may be associated with dry mouth. Cicatrizing conjunctivitis like Stevens Johnson Syndrome, Mucous membrane pemphigoid and others are more severe form of dry eyes & may lead to severe morbidity.

Symptoms

The various symptoms of dry eye include irritation, foreign body sensation, redness, burning, photophobia. Some patients of dry eyes experience watering from their eyes due to reflex tear secretion. Eye strain, headache, fatigue etc may also be experienced. Patients with Sjogren's syndrome may experience dry mouth along with dry eyes and symptoms such as joint pains, skin rashes, etc. due to associated collagen vascular disease. Chronic use of eye drops such as drops for glaucoma can also lead to symptoms of dry eyes.

Diagnosis

Diagnosing dry eyes requires a holistic approach. Diagnosis should not be made based on symptoms alone. Multiple questionnaires like OSDI, DEWS, etc. are available which help in understanding the magnitude of the problem. A good clinical examination including slit-lamp evaluation of the cornea and ocular surface including eye lids and tear film are mandatory in arriving at the correct diagnosis. Staining of the ocular surface using vital dyes like sodium fluorescein, rose bengal and lissamine green help in

grading the severity of ATD. Advanced diagnostic tools can help in determining parameters like Non-invasive tear breakup (NiBUT), Meibography, Tear meniscus height and others.

These advanced and detailed tests help in determining the type as well as magnitude of dry eyes. They also help in differentiating dry eye cases from those with digital eye strain, neuropathic pain, eye allergy, uncorrected refractive errors, which can mimic symptoms of dryness.

Systemic blood investigations are often required to rule out any systemic pathologies like collagen vascular disease, nutritional deficiency, allergy etc. If blood tests reveal any auto-immune pathology, consultation with immunologist is required to start adequate systemic therapy. Nutritional deficiencies like Vitamin D, Vitamin B12 etc need to be corrected, when present.

Treatment of Dry Eyes

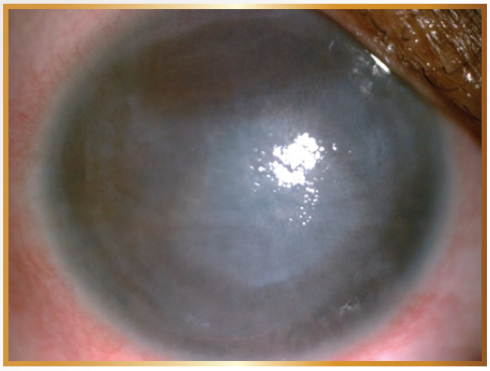
As dry eyes are an important inflammatory disease, treating with lubricants or artificial tears alone will not provide complete relief. Although, lubricant molecules like carboxy-methyl cellulose, sodium hyaluronate, poly-vinyl alcohol, etc. help stabilise the tear film, these do not work against the underlying inflammation. Topical immune-modulators like Cyclosporin A, Lifitegrast, Trehalose help in suppressing ocular surface inflammation and provide long term relief. Oral Pilocarpine therapy is useful in patients with Sjjogren Syndrome. Patients with co-existent collagen vascular disease need systemic therapy with DMARD's, immune-modulators and biologics for control of systemic disease. Intense pulse light therapy (IPL) and Low-level light therapy (LLLT) are recommended in meibomian gland disease. Interventions like Punctal occlusion help in preservation of tear film in ATD. In severe ATD, scleral contact lens is recommended to stabilise the ocular surface and prevent photophobia. Patients on long term glaucoma therapy should use preservative free formulations.

Various life-style modifications like screen breaks, use of humidifiers, UV protection, omega-3 rich diets, avoidance of smoking, avoidance of pollutants etc are advocated as these factors worsen dry eye disease. Adequate counselling of individuals who have prolonged screen time is required to explain about computer vision syndrome and its prevention. Appropriate glasses should be prescribed to individuals with uncorrected refractive error to address complaints of eye strain.

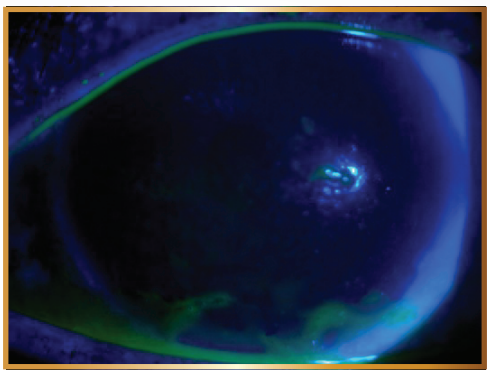
Conclusion:

To summarize, dry eyes is a commonly occurring condition that can be treated in a holistic way with the help of newer diagnostic and therapeutic modalities.

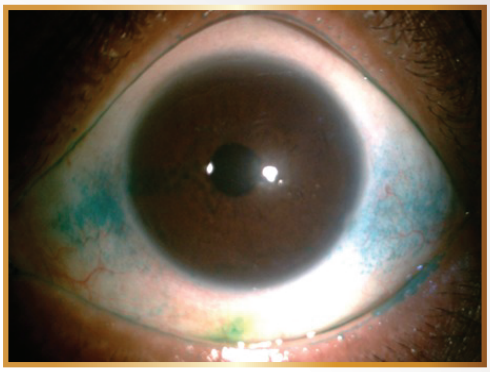
Below are a collection of photographs taken to describe different facets of dry eyes.



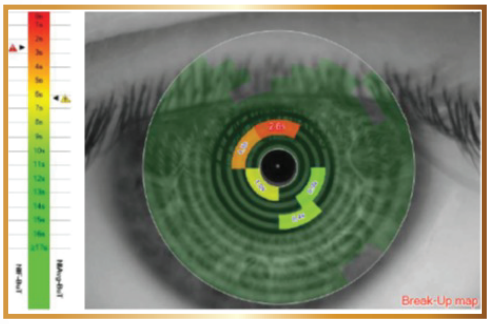
Dry, lustreless cornea in Sjogren's Syndrome



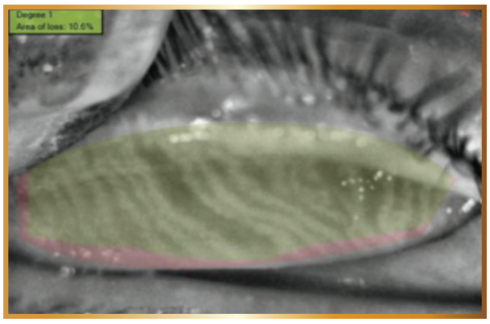
Abnormal corneal surface on staining with Sodium fluorescein



Conjunctival surface staining with lissamine green



Non-Invasive Tear Breakup Time



Meibography

Dr. Sushmita Shah
Ophthalmologist - Cornea, Lasik & Cataract Surgeon
Director, Eye Life Hospital
Santacruz. Member - SMSA

SCREEN ADDICTION AND ITS MANAGEMENT

The excessive and compulsive use of digital devices in the form of smart phones, tablets, computers, television to name a few, interferes with daily life.

Over the past decade, screens have become a central part of a child's life, with schools teaching on tablets and assigning homework on laptops. Although digital tools can enrich learning, children easily slide into overuse and then experience behavioural addiction. This screen addiction is characterised by compulsive screen checking, loss of interest in non-digital activities and emotional distress when screens are removed:

Children are especially vulnerable due to neurobiological factors and environmental factors as follows:

1. The pre-frontal cortex, responsible for impulse control is not fully matured till their mid-twenties
2. Dopaminergic reward pathways are hyper-responsive in childhood
3. Identity formation in adolescence is increasingly tied to social media feedback
4. FOMO (Fear Of Missing Out) as online peer pressure causing fear of 'cost' of disconnection.
5. Dual income parents facing reduced traditional support in child upbringing along with time constraints leading to a rising screen dependency among their children
6. Dearth of open spaces for outdoor play
7. Marketing gimmicks with kids versions of various apps

ADVERSE EFFECTS ON CHILD'S HEALTH

1. Sleep disruption, due to blue light, which affects melatonin production adversely
2. Sedentary lifestyle leading to OBESITY, poor posture and eye-strain
3. Emotional disturbances like anxiety and depression
4. Behavioural problems like aggression and impulsive behaviour
5. Impaired social skills, with difficulty in face to face interactions
6. Reduced attention span leading to a decline in academic performance. Studies using EEG show reduced sustained-attention spans after exposure to 30 minutes of fast-paced cartoons.
7. Language delays in toddlers with more than 2 hours/day of screen exposure

INTERVENTIONS

1. Psychoeducation

* Recommended screen time limit

< 2 year - avoid screen completely

2-5 year - < 1 h/d, high quality content

> 6 year - consistent limits to be set, ensuring sleep, study , physical activity not affected

2. Behavioural Strategies

* Digital hygiene routines - device free meals, no screen 1 hr before going to bed
* Parental modelling- mindful use by parents
* Reward system- reinforce offline play
* Screentime rules to be set with consequences
* Use gradual detox- reduce screen time by 5-10% per week
* Let the child be part of the planning set rules as they are more likely to follow them

3. Psychological Intervention

* CBT- Cognitive Behavioral Therapy- addresses maladaptive thoughts and behaviour
* Family Therapy -restructure dynamics and improve communication.
* Mindfulness techniques- enhance self-regulation

4. Medical Management

* Treat comorbid conditions like ADHD, depression and anxiety
* Eye Strain - follow 20-20-20 rule to reduce eye strain - every 20 minutes look at some thing at least 20 feet away for 20 seconds. This allows eye muscles to relax and helps prevent symptoms like dryness, blurred vision and headaches.

5. School and Community Intervention

* Digital literacy and education
* Structured extracurricular activities – at least 1hr outdoor play on a daily basis.
* Awareness programs for parents and teachers

CONCLUSIONS

Urbanisation, economic shifts and changing social attitudes have transformed Indian families from joint to nuclear structures, with more dual income parents and more single parent families. Balancing working hours with quality family time leads to many a parent experiencing guilt over child upbringing.

A cognitively stimulating home that promotes play, reading, conversation and exploration boosts curiosity and skills development. Despite constraints parents can nurture language, social skills, problem solving and creativity through thoughtful planning.

Early identification and family centred interventions are crucial. The goal is not to eliminate screens but to integrate them in ways that serve children's development rather than hijack it. By combining neuroscience-informed limits, design tweaks, and community support, we can raise a generation that is digitally fluent without being digitally dependent. Thus the GOAL is balanced tech use, and not abstinence .

Dr. Priti Parikh (MD, DCh)
Consultant Pediatrician and TNMC Alumnus, Bandra, Mumbai.
Past President, SMSA

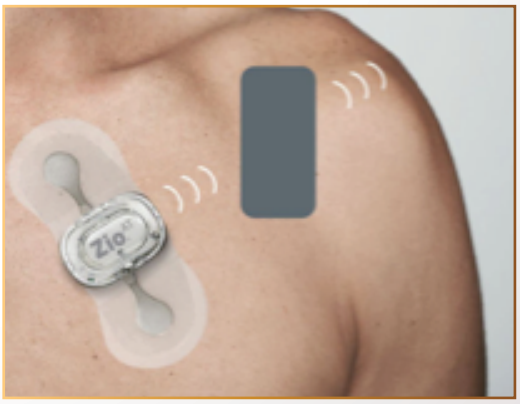
INNOVATION & TRANSLATIONAL MEDICINE

Across laboratories and hospitals worldwide, a profound disconnect persists. Researchers make ground-breaking discoveries—elegant mechanisms of disease, promising therapeutic targets, and innovative technologies. Yet many of these discoveries never reach the patients who desperately need them. This gap between scientific achievement and clinical application represents one of the most pressing challenges in modern medicine. The solution lies in embracing translational medicine and the systematic approaches like bio-design that flip the traditional research model on its head, moving from patient needs first to solutions that actually reach the bedside.

The Traditional Research Pipeline: From Lab To... Nowhere

To understand translational medicine, we must look at the traditional research model: basic scientists identify mechanisms, pharma/med-tech companies develop solutions, regulators evaluate safety, and treatments finally reach patients. However this approach takes roughly 15 years, and most discoveries fail. The National Institute of Health (NIH, USA) identifies two barriers: T1, where basic findings never reach clinical trials due to funding or regulations, and T2, where proven treatments aren't adopted into standard practice. This gap is the "valley of death," where projects perish between discovery and care. It is particularly treacherous for academic and small biotech researchers, as only 3% of venture capital supports early-stage drug discovery. Consequently, a graveyard of promising ideas is created, never seeing the light of clinical practice.

Why Research Gets Stuck: The Fundamental Problem



The traditional model's core weakness stems from its starting point: researchers typically begin with a scientific question or a laboratory observation. Stanford University's "Bio-design" addresses the issue by flipping this paradigm. Instead of starting with scientific curiosity, Bio-design begins by identifying genuine, unmet clinical needs directly at the bedside. It fosters collaboration between businessmen, engineers, doctors, and other providers. Moreover, this process demands deep, early-stage analysis of the solution's impact on all stakeholders—patients, payers, providers, scientists, and regulators. In the past, neglecting these commercial and regulatory realities created a graveyard of failed inventions. By incorporating these constraints into the design process from day one, Bio-design transforms potential afterthoughts into foundational requirements, dramatically increasing the likelihood that an innovation will successfully reach patient care.

Examples of Translational Medicine in Action: When Bio-design Changed Lives

The power of the bio-design approach becomes undeniable when examined through real-world examples.

Consider cardiac arrhythmia monitoring. Over 2.7 million US patients experience abnormal rhythms annually and is no . Per the standard of care, patients wore diagnostic devices like Holter (ECG) monitors for 24–48 hours. These devices are cumbersome, uncomfortable, and often failed to capture intermittent arrhythmias that occurred outside the monitoring window. The team working in this area directly observed this clinical reality; patients removing their monitors prematurely because the devices interfered with daily life and professional work. They watched clinicians frustrated by incomplete diagnostic data and the need for repeat testing. The unmet need was clear: a cardiac monitor that patients would actually wear for longer periods, that captured more diagnostic data, and that was comfortable enough not to disrupt daily life. The result was the Zio Patch. It is a small, single-use ECG monitor that adheres to the skin, can be worn continuously for up to 14 days (versus 48 hours for conventional monitors), remains functional during showering and normal activities, and provides comprehensive cardiac rhythm data. The patch combines superior diagnostic accuracy with exceptional patient experience—patients actually wear it because it doesn't burden them. The clinical impact has been substantial. Today, the Zio service is used in over 400 facilities, diagnosing hundreds of thousands of patients and significantly reducing unnecessary repeat testing.

Another compelling example is the SNaP Wound Care System. While negative pressure wound therapy (NPWT) accelerates healing, traditional devices were noisy, electrically powered pumps that restricted patient mobility. Fellows observed that most chronic wounds (like diabetic ulcers) were small, yet the bulky equipment prevented patients from maintaining active lives. Responding to the need for a portable solution, the team created the SNaP system. It is mechanically powered—requiring no electricity—and ultra-portable. Clinical evidence validated this design: randomized trials showed that wounds treated with SNaP were twice as likely to achieve 50% closure at 30 days compared to electric pumps. Beyond clinical metrics, the device dramatically improved quality of life, allowing patients to work and exercise while receiving treatment.

Broader Impact of Bio-design-Inspired Innovation

These are not isolated successes. Since the Bio-design & sister programs like BioInnovate Ireland, they have founded more than eighty companies, and their technologies have helped more than 21 million patients worldwide. Some of these innovations address dramatic problems—a device to improve peritoneal dialysis safety, wearable therapy for hand tremors, minimally invasive urinary implants to prevent incontinence—while others address what might seem like small but clinically meaningful issues, such as safe earwax removal tools and portable infection-detecting technology for dialysis patients. The common thread: each began with direct

observation of an unmet clinical need, involved physicians as full team members from the outset, and maintained focus on implementation barriers from the earliest stages. The result is medical technology that actually gets used, that actually helps patients, and that actually reaches the market rather than languishing in the "valley of death."

The importance of translational medicine extends beyond labs and start-ups; it is a necessity for modern healthcare systems facing aging populations, rising disease burdens, and constrained resources. Allowing discoveries to languish in the "valley of death" is no longer tenable. The COVID-19 pandemic powerfully demonstrated the potential of accelerated translation. Vaccine platforms, diagnostic tests and therapeutic strategies moved from concept to clinical deployment in months, not years, because translational infrastructure and resources were rapidly mobilized. The same speed and focus must be applied to other critical healthcare challenges. Translational medicine is therefore not a luxury, but an imperative to deliver better outcomes to patients who cannot wait decades for discoveries to reach them.

The message to practicing physicians is unambiguous: innovation is an imperative, and their participation is irreplaceable. Healthcare's evolution—driven by technology, artificial intelligence, and resource limitations—forces a critical choice: will physicians shape the future of care, or merely react to it? Their clinical insights are vital and irreplaceable, offering a detailed understanding of the clinical ecosystem including patient experience, specific treatment failures, and the realities of daily care that engineers often miss. Engineers may create devices that are technically sophisticated with impractical clinical implication and entrepreneurs may chase markets that do not exist. The misalignments waste resources and delay solutions that may help patients. Physicians can engage across the entire spectrum, serving as expert advisors, leading user testing, holding formal leadership roles (like CMOs), or pursuing their own ventures as medical entrepreneurs. Physicians therefore have a professional responsibility—and a unique opportunity—to actively shape the technologies and care models their patients will depend on.

The Power of Flipped Thinking: Bio-design versus Traditional Research

The significance of translational medicine extends far beyond laboratories and start-up companies. The contrast between the traditional research model and the bio-design approach illuminates why translational medicine is so critical: the bio-design flip doesn't eliminate rigorous science or thorough clinical validation. Rather, it ensures that rigorous science is directed toward solving problems that actually matter to patients and that implementation barriers are understood and addressed throughout development rather than discovered belatedly. The bio-design process and translational medicine

more broadly recognises physician expertise as fundamental and not supplementary. The evidence is powerful and the approach has been proven scalable, generating dozens of successful companies and technologies impacting millions of patients.

Thus, healthcare innovation is truly accelerating – through electronic health records, artificial intelligence, remote monitoring technologies, or novel therapeutics and the pace of change is unprecedented. Rather than hoping that laboratory discoveries will eventually reach patients, these novel approaches start with patient needs and further evolve with physician input as full partners right from the beginning and address barriers preventing clinical application. Innovation is thus necessary for physician satisfaction and professional relevance. The innovation process, when structured around patient needs and clinical reality, aligns naturally with physician values of improving patient care and advancing the field. The future of medicine will be shaped by those who engage in innovation today!

Dr. Shashwat Hora (MBBS, MBID)
Translational Medicine Expert
Member, SMSA

The Modern Age Conundrum Of Anti-Obesity Medications (AOMs): To Take Or Not To Take?

In a 3-series article, we wish to share the science behind weight loss and the use/ misuse/isuse of the new anti-obesity agents.

The obesity prevalence is exploding world-over and India too is in the middle of this publichealth crisis. Recent reports suggest that one in four adults in India are either overweight or obese; overall, 24% of adult women and 23% of adult men are overweight/obese in India.The prevalence of childhood and adolescent obesity has alarmingly increased in parallel too and is a massive concern for the future health of these individuals.
Obesity used to be dismissed earlier as a cosmetic issue, or a behavioural problem or lack of will-power, later on a co-morbidity or complication but never a disease. It was only in the year of 1997, that the World Health Organization labelled it as a disease. This move anticipated improved and early diagnosis and management of the same by qualified professionals rather than being left to the mercy of half-cooked approaches. Although a continuous or lifelong struggle for many, the disease has once again come under the spotlight as for the first time there appear to be solutions to the "long-term" management of obesity, with the introduction of the GLP-1 therapies or the Incretin-based drugs. Nevertheless, they have opened up the pandora's box and let out a multitude of questions for all.

Thus, weight management has been a challenge for clinicians as well as people living with overweight/ obesity for decades with the most exciting solutions falling short of expectations. Finding sustainable weight management solutions to offer patients has been the holy grail for researchers, clinicians, bariatric surgeons, nutritionists and all stakeholders involved. Many have questioned the metabolic surgery and also the use of drugs, referred to as anti-obesity medications (AOMs) for weight loss and continued use of the same. There is a popular belief that weight gain is equal to more calories in than out and thus, loss would result from tilting the equation in the opposite direction. This may be only transiently true as the hormonal changes that set in with chronic weight gain, render this disease as a chronic, complex, relapsing progressive disease process in which abnormal or excess body fat or adiposity impairs health, increases the risk of long-term medical complications and reduces lifespan.

Understanding the biology of appetite regulation is central to developing strategies for sustained weight loss. Appetite is normally regulated by a complex interplay of different signals from different areas in the brain. Thus, the brain has a central role in controlling eating behavior and appetite.

Weight is determined and regulated by a unique, three-layer appetite system in the brain:

• Homeostatic eating is eating based on hunger and is a balance between feelings of satiety and hunger. It is mainly under hypothalamic control with some other areas as well. Key hormones mediating satiety are GLP-1, peptide YY, oxyntomodulin, pancreatic polypeptide, amylin, insulin, leptin and POMC (Pro-opiomelanocortin) while ghrelin mediates and increases hunger.

• Hedonic eating involves eating for pleasure with the centre in the mesolimbic and other areas of the brain. This is a function of the balance between Wanting (dopaminergic) and Liking (endogenous opioid and cannabinoid systems). The neurotransmitter, dopamine controls Wanting or the motivation or drive to eat and the opioid and cannabinoid receptors control Liking or the pleasure associated with food.

• Lastly the executive function involves the decision to eat and the seat of control is in the prefrontal cortex of the brain.

Normally, long term energy balance is centrally regulated by the brain with peripheral inputs from the adipose tissue, pancreas, gut on the energy stores and nutritional state via the neural and hormonal pathways. The imbalance in energy intake and expenditure (leading to obesity) can result from changes in the peripheral signals, from genetic predisposition or even medications or environmental, societal and psychological factors.

We know that lifestyle modifications e.g. dietary restriction, physical activity or exercise lead to weight loss up to 5-10% of their baseline body weight. However, it is nearly impossible to sustain the dietary restriction and also maintain weight loss. Thus, there is weight regain no matter how much effort has been put in and how much weight has been lost. The peripheral factors like increased orexigenic (ghrelin, NPY, AgRP) and decreased anorexigenic (leptin, insulin, CCK, GLP1, PYY) peptides convey a state of nutritional deprivation to the brain triggering increased hunger and food cravings with a low level of satiety. Simultaneously, due to the diet-induced weight loss, there is a significant decrease noted in the total daily energy expenditure as the resting metabolic rate and the thermic effect of food often decrease. Thus, exercise energy expenditure and non-exercise activity thermogenesis are both reduced. The enhanced hunger and decreased energy expenditure thus lead to weight regain, particularly when the individual is exposed to an obesogenic environment with easy availability of calorie-dense foods and no opportunity for physical activity.

Hold on.....the story will be continued in the next article in this series.

Dr. Purvi Chawla
MBBS, MS (Pharm Sci, USA), PG (Diabetology, UK), PG (Endocrinology, UK)
Consultant Diabetologist & Director of Clinical Research
Past President – SMSA

DOCTOR'S DAY SPECIAL

Ever since I can remember, whenever I was asked, what I wanted to become when I grew up, without a moment's hesitation, I would reply, "Doctor".
And I did do that!
And I am glad I did it!
And so, if I demand respect for myself and my fellowmen, it is because we have very well earned it.

LIKE NO OTHER JOB

I picked up the scalpel and slaughtered the demons
The OT floor was splashed in a myriad of colours and.....
Who says I don't play Holi!

I spent hungry days and sleepless nights
The constant tick-tick of the monitor ringing in my ears and.....
Who says I don't fast for Navratri!

My heart sang a carol and danced
The lusty cry of a newborn brought me to my knees and.....
Who says I don't rejoice at Christmas!

My family kept the candles lit and waited
Till I came home late at night for dinner and.....
Who says I didn't celebrate Diwali!

Dr. Rekha Ambegaokar
Director and Head of Department - Obstetrics and Gynecology
Nanavati Max Hospital, Mumbai.
Past President, SMSA

IMPORTANCE OF SCREENING MAMMOGRAPHY IN BREAST CANCER

The big C (Cancer) is very common these days and so the dialogue around it also has to evolve. The diagnosis often fills the patient and the family with despair and they ask – Why me! Did I do something wrong? The family members ask if it can be prevented....

Yes, indeed with caveats! For preventing cancers, good lifestyle measures are paramount but nothing can completely prevent them from developing as there are myriad of contributory factors. The next best option is to look for early signs and screen for common cancers. Breast cancer, cervical cancer, oral cancer and lung cancer are some of the common ones.

Let me emphasise on one of the most preventable and treatable cancers i.e. breast cancer. October is the breast cancer awareness month hence sharing some important information about it is critical. Screening and early detection of breast cancer is helpful.

Much to contrary belief, breast cancer is no longer a disease restricted to older women and it has been seen that a significant proportion of Indian cases are that of young breast cancer. So how do we tackle it – using two very important tools - self-examination of the breast and screening mammography, both are effective in helping us pick signs early on. Clinically, it is well-known that the earlier the diagnosis, the better the patient responds and lesser treatment is required.

Hence, what we all need is a little motivation and persistence. If we make it a point to talk about breast self-examination and screening mammography to all the female patients visiting our clinics - I am sure the thought process of the masses will change and people will become more “Breast Aware”.

Breast self-examination entails visual examination and physically examining one’s breasts once a month – one week after periods are over or on a fixed date in case of post-menopausal women. It should start as early as 20 years of age. The idea is to teach the women to appreciate how normal breasts feel like and if there are any new changes then they may be picked up early. Women should look for lumps, nipple discharge, skin changes, armpit lumps or nipple changes. Any changes that persist should prompt an examination by a specialist.

Screening mammography should ideally start at the age of 40 in females at average risk and should be repeated every 12-18 months. After 40 years of age, a good quality X-ray mammography is a must and an ultrasound of the breast alone does not suffice. With advancing technology, a 3D mammography has become the gold standard of diagnosis as it can find lesions even in dense breasts. MRI of the breast is a troubleshooting tool only with very specific indications and is not recommended as a routine procedure. These two basic measures if adopted can shift the cancer detection to early stage and drastically improve outcomes.

Many rumours exist about the safety of mammography and the link with inducing cancer. The truth is radiation exposure in mammography is approximately four times that of exposure with an X ray. When the risks versus the benefit ratio is assessed, the benefits far outweigh the risks. Hence it is an approved recommendation. Whenever a mammography is done and an ultrasound of the breast is also ideally included, to improve sensitivity.

These measures will empower women and help women prioritise their health and well-being. We need to increase awareness and educate them about the importance of these measures. Also a dialogue about health, wellness and disease should be encouraged- as this will also help spread the word around.

Hopefully this message finds its way into our day to day practice. If we take just a few minutes to spread this awareness – I think it will mark a huge step in our fight against this menace of increasing breast cancer.

Dr. Niharika Garach
MBBS, MS, MCh Surgical Oncology
Fellowship Peritoneal Surface Oncology
Specialist – Breast, Gynaec and Peritoneal Surface Oncology
Member, SMSA.

CHILDHOOD OBESITY: THE BURDEN OF TOMORROW, TODAY

Childhood obesity is a growing epidemic in India, particularly in high and middle-income populations, is expected to account for 11% of the global burden of child obesity by 2030.

What Is Childhood Obesity?

Childhood obesity is defined as BMI (Body Mass Index at or above 95th percentile for age and sex in children aged 2 years and older.)

Risk factors:

- **Eating habits** - Frequently eating foods with loads of added sugar, saturated fat or sodium can lead to weight gain in children. These include fast foods, baked goods and vending machine snacks, candies, desserts, sodas, fruit juices and sports drinks.
- **Not enough movement** - Too much time spent being inactive also plays a crucial role in weight gain. Examples include watching the screen for hours. TV and online shows may also feature junk food commercials or ads further encouraging the consumption of the same. If your child is 2 years old or more, limiting leisure screen time not used for schoolwork to no more than two hours a day will be helpful. If your child is younger than 2 years, then the ideal is no screen time at all.
- **Mental health factors** – Both personal and family stresses can raise a child's risk of obe sity due to high levels of cortisol in the blood, leading to feelings of increased hunger.
- **Certain medicines** - Some prescription medicines can also raise the risk of obesity. They include prednisone, lithium, amitriptyline, paroxetine, quetiapine, carbamazepine, olanzapine and risperidone given for different reasons under the supervision of a quali fied professional.
- **Family factors** - If your child comes from a family of people who tend to gain weight easily, your child may be more likely to put on weight.
- **Genes and hormones** - Sometimes, mutations in certain genes can play a part in child hood obesity; so can conditions linked with hormones imbalance, hypothyroidism etc can lead to weight gain.

Long-term Effects: Not Kid Stuff

Obesity in childhood does not just fade away with time and ends up making its presence felt, well into adulthood, as per many studies.

- Physical Health: Children with obesity are at increased risk of developing type 2 diabetes, hypertension, fatty liver disease, early puberty, orthopedic complications and even asthma.
- Psychosocial Impact: Beyond physical ailments, childhood obesity has been linked to low self-esteem, depression, and social stigmatization.
- Chronic Adult Diseases: Sadly, obese children often become obese adults, increasing their risk of heart disease, stroke, and certain cancers.

Prevention: An Ounce of Wisdom

Prevention is not just the job of clinicians; it's a family affair—best to think of it as teamwork.

- Balanced Diet: Encourage a mix of whole grains, fruits, and vegetables.
- Portion Control: Teach children about healthy portion sizes and mindful eating, entire family should eat healthy food together.
- Regular Activity: Children should be engaged in at least 60 minutes of physical activity daily—let them run, dance, play.
- Screen Time Management: Limit time spent on screens. If kids spend half as much energy running as they do flipping through apps, childhood obesity statistics would look different.

Parental Guidance: The Secret Sauce

Prevention is most effective when parents lead by example. Families that cook together, eat together and play together, stave off obesity

- Model healthy behaviors and attitudes.
- Involve children in meal planning and preparation (bonus points for themed salad nights).
- Make active play a family routine, not a chore.

Conclusion: Small Steps, Big Leaps

Childhood obesity is not a sprint—it's a marathon where good habits outrun genetics, and family wisdom jumps hurdles better than a superhero's sidekick. With thoughtful guidance and a sense of humor, general practices, and especially vigilant parents, can nurture healthier, happier children who grow into adults with fewer ailments and fonder memories of mealtime fun.

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GENITAL HYGIENE, AN IMPORTANT STEP TO PREVENT UTI IN FEMALES

Urinary Tract Infections (UTIs) are among the most common health issues affecting women. The higher propensity towards increased infection in women is attributable to the shorter urethra and proximity to the vagina and anus.

Nevertheless, with maintenance of proper genital hygiene, the same may be prevented. So let us learn more.

What is a UTI?

A UTI occurs when bacteria enter the urinary tract and grow inside when the milieu is conducive.

What are the symptoms?

- Burning or pain while passing urine
- Increased urge to urinate
- Cloudy or foul-smelling urine
- Lower abdominal pain

If left untreated, infections can spread to the kidneys and cause serious complications.

How to prevent it?

Prevention is the key as repeat infections can also cause a significant deterioration in the quality of life of the patient. Here are some tips for routine care and prevention of infection:

1. Maintain Proper Washing Habits

- Clean the genital area daily with lukewarm water; it can be done while taking bath
- Use mild, unscented soap
- Always wash front to back — never back to front — to prevent bacteria from the anal area from reaching the urethra

2. Avoid Over-washing or Harsh Products

- Over-washing can disturb the natural vaginal flora
- Avoid using douches, antiseptic washes, or perfumed sprays. These can disr upt the healthy bacterial flora

3. Wear Breathable Underwear

- Choose cotton underwear instead of synthetic fabrics
- Avoid tight clothing or prolonged use of wet garments which can trap mois ture and encourage bacterial growth

4. Change Sanitary Products Regularly

- During menstruation, change pads or tampons every 4–6 hours
- Wash hands before and after changing sanitary pads or cups
- Consider menstrual cups or breathable pads to reduce irritation

5. Practice Safe Sexual Hygiene

- Urinate before and after intercourse to flush out bacteria
- Clean the genital area gently after sexual activity
- Avoid using spermicides or lubricants with harsh chemicals

6. Stay Hydrated

- Drink 6–8 glasses of water daily to help flush bacteria out of the urinary system
- Avoid excessive caffeine and alcohol

7. Empty Bladder Regularly

- Don't hold urine for long periods
- Pass urine every 3-4 hourly as it reduces bacterial multiplication in the urinary tract

8. Manage Underlying Conditions

- Women with diabetes or recurrent infections should maintain good glyce mic control and consult their doctor regularly
- Consider probiotic supplements or yogurt to support vaginal health

If you are using common toilets, use cleaners or sprays to sanitise toilets seat covers. E.g. peesafe spray.

When Should One See A Doctor?

Meet your Doctor immediately if you have :

- Persistent burning during urination
- Blood in urine
- Recurrent UTIs
- Fever or back pain

Prompt treatment helps prevent kidney involvement and chronic infections.

Takeaway:
Good genital hygiene is not about excessive cleaning — it is about gentle, regular care that supports the body's natural defense system.

With simple daily habits, you can protect yourself from discomfort, infection, and long-term complications.

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24