Celebrating 20 YEARS

TRAUMA & EMERGENCY
TEAMS
ACADEMIC MEDICINE SENTINEL

Proclaiming & Promoting Academic Leadership

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Operation Sindoor: A Parent's Perspective

As a parent, you prepare your children for school, exams, heartbreaks, and success. But nothing prepares you for the moment when your child is caught in the despair of war.

When the news broke that conflict had erupted and students were trapped, our world came crashing down. Each day was a torment—uncertainty hung heavy in the air. We tried not to show our panic to our younger children. We stayed glued to the television and our phones, desperate for any news, any sign that the government was doing something.

And we, as parents, had no answers. How do you explain to a child what terrorism is? How do you convince them they're safe, when even you aren't sure anymore? How do you help them sleep, when they flinch at the sound of a pressure cooker or a passing truck?

While Operation Sindoor was launched to bring justice—swift, strategic, and precise—it also served as a balm for millions of parents like us. We saw our armed forces not just as soldiers, but as protectors of childhood. The missiles they launched weren't just weapons—they were shields for innocent lives, like our daughter's.

We watched in real time as our nation stood up—not with panic or vengeance, but with purpose, precision, and strength. We saw our armed forces act not just as soldiers, but as protectors of our children. They struck deep into the roots of terror, not for glory, but so that no child would ever again have to hide under a school desk in fear.

We were not just watching a military operation. We were watching our nation declare: "We will not let our children live in fear. Not on our soil. Not on our watch."

Yes, we are broken by what our daughter experienced.

We are proud—proud to be citizens of a country that protects its young.

Proud of every brave jawan who stood between our children and chaos.

Proud that in the face of darkness, India rose—not with fear, but with fire.

Dr. A.P. Singh
Dean
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Sri Amritsar

Official Voice of
Academic College of Emergency Experts (ACEE)
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Neonatal Resuscitation: Summary of Updated Guidelines and Key Practice Points

Dr Neha Thakur Rai

Introduction: The latest neonatal resuscitation guidelines incorporate significant updates based on recent systematic reviews and evidence. Key updates include umbilical cord management, oxygen administration, temperature regulation, and ventilation strategies. The recommendations emphasize individualized care based on the infant's gestational age and clinical condition.

Key Updates in Neonatal Resuscitation

- ☑ **Umbilical Cord Management:** Delayed cord clamping is now recommended for both term and preterm infants. The 2023 update includes guidance on intact umbilical cord milking (Yamada et al., 2024).Specific timing recommendations for preterm infants have been included (Liley et al., 2017).
- ☑ **Oxygen Administration:** For term and late-preterm infants (≥35 weeks gestation) requiring respiratory support, resuscitation should start with 21% oxygen. For preterm infants (<35 weeks gestation), oxygen should be initiated at 21–30% and titrated based on oxygen saturation targets (Escobedo et al., 2019).This marks a shift from the previous routine use of 100% oxygen for resuscitation.
- ☑ **Temperature Control:** Maintaining normal body temperature is crucial to improving outcomes. Assisted ventilation should be initiated within the first minute for infants with absent or ineffective breathing (Liley et al., 2017).
- ☑ **Ventilation Strategies:** New guidelines provide recommendations on device selection and interfaces for administering positive-pressure ventilation (Yamada et al., 2024).Routine intubation and tracheal suctioning are no longer recommended for non-vigorous infants born through meconium-stained amniotic fluid (Liley et al., 2017; Weiner & Zaichkin, 2022.

Key Points for Clinical Practice

- ☑ **Care of the Well Newborn:** Early skin-to-skin contact is beneficial for healthy newborns who do not require resuscitation. Term newborns with good muscle tone and effective breathing should be placed on their mother's chest immediately. Routine suctioning (oral, nasal, pharyngeal, or endotracheal) is not recommended due to lack of benefit and potential risk of bradycardia. Delayed cord clamping (>30 seconds) is recommended for both term and preterm infants who do not require resuscitation. In term infants, delayed clamping increases hematocrit and iron levels without increasing the risk of phototherapy, NICU admission, or mortality. In preterm infants, it reduces the need for vasopressors or transfusions. Cord milking is not recommended for preterm infants due to the risk of intraventricular haemorrhage.
- ☑ **Initial Resuscitation Steps:** Newborns without muscle tone or effective breathing should be placed under a radiant warmer for resuscitation. Maintain newborn temperature between 36.5°C and 37.5°C (97.7°F - 99.5°F) to reduce mortality and morbidity, especially in preterm and low-birth-weight infants. Suctioning should be performed only if the airway is obstructed by fluid. Tactile stimulation should be limited to drying the infant and rubbing the back or soles of the feet.
- ☑ **Heart Rate Assessment and Oxygen Therapy:** Heart rate should be assessed by auscultation; ECG is preferred if available as it detects heart rate faster than a pulse oximeter. Positive-pressure ventilation (PPV) should begin immediately for infants who are apneic, gasping, or have a heart rate <100 bpm within the first 60 seconds of life.Every 30-second delay in ventilation increases the risk of mortality or prolonged NICU admission by 16%.PPV should be provided at 40-60 breaths per minute with a peak inspiratory pressure of 30 cm H_2O for term infants and 20-25 cm H_2O for preterm infants.Positive End- Expiratory Pressure (PEEP) up to 5 cm H_2O may help maintain lung volume.For infants who are breathing but experiencing labored breathing or persistent cyanosis, continuous positive airway pressure (CPAP) is beneficial.In preterm infants (<30 weeks gestation), CPAP reduces the risk of bronchopulmonary dysplasia or death.In infants ≥35 weeks gestation, resuscitation with 21% oxygen is optimal, while preterm infants should start with 21-30% oxygen and adjust as needed.
- ☑ **Chest Compressions and Medications:** If the heart rate remains <60 bpm despite 30 seconds of PPV, chest compressions should begin using a two-thumb encircling technique (3:1 compression-to-ventilation ratio).Ventilation should be optimized before starting chest compressions, including endotracheal intubation if necessary. Epinephrine should be administered if the heart rate remains <60 bpm after 60 seconds of chest compressions and adequate ventilation. IV epinephrine is preferred (0.01-0.03 mg/kg) over endotracheal administration due to faster plasma levels. Epinephrine dosing may be repeated every 3-5 minutes if needed.
- ☑ **Post-Resuscitation Care:** Infants requiring prolonged resuscitation should be monitored in a NICU or triage area. Hypoglycemia is common and should be managed promptly to prevent neurological damage. Newborns ≥36 weeks gestation should be assessed for hypoxic-ischemic encephalopathy. Therapeutic hypothermia is beneficial in term/late preterm infants with moderate-to-severe encephalopathy and intrapartum asphyxia, reducing major neurodevelopmental disabilities and mortality.
- ☑ **Discontinuing Resuscitation:** The decision to stop resuscitation should be based on gestational age, fetal condition, available resources, and parental wishes. Viability is typically considered at 22-24 weeks gestation. If the fetal heart rate remains undetectable after 20 minutes, resuscitation efforts should be reconsidered in discussion with the care team and parents.

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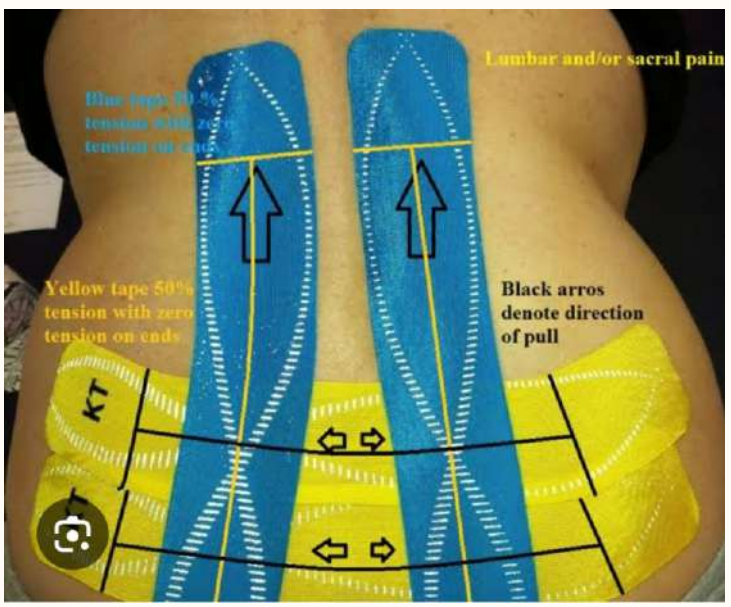
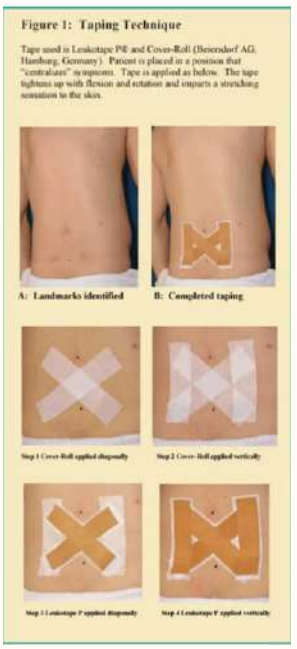
Lower Back Pain

Dr Aditya Sood

Introduction: Lower back pain is a common but debilitating problem affecting millions worldwide and often encountered in Emergency department. It is the result of poor posture, muscle strain, or underlying medical conditions (eg. Diabetes mellitus, thyroid conditions, age related degenerative changes, inflammatory conditions like Rheumatoid arthritis). While management and treatment have to be done as per underlying condition but a supportive care is required to alleviate discomfort and enhance mobility. Techniques like Rigid taping has emerged as short-term measure for pain relief till definitive specialized management. RT provides support to the muscles in the back, which may help reduce strain and improve function. This article explores the application, and



effectiveness of rigid taping for individuals presenting with moderate to severe lower back pain in emergency. 1 In an emergency department setting, rigid taping, can be a helpful adjunct to other treatments for acute lower back pain,



potentially reducing pain and improving function, though more research is needed to fully understand its role.

Here's a more detailed explanation:

Understanding Rigid Taping 1

Rigid taping, also known as athletic taping, involves the use of non-elastic tape to stabilize and support muscles and joints. Unlike kinesiology tape, which allows for flexibility, rigid tape restricts movement to prevent further injury and provide structural reinforcement. It should not be considered a primary treatment for lower back pain, but rather as an adjunct to other interventions.

It's important to educate emergency medicine physicians about the potential benefits and limitations of RT, as well as proper application techniques

Benefits of Rigid Taping for Lower Back Pain 1

Pain Relief: By limiting excessive movement, rigid taping helps reduce strain on the lower back muscles, alleviating pain.

Postural Support: It encourages proper posture, preventing additional stress on the spine.

Enhanced Stability: The tape provides external support, reducing the risk of sudden movements that may worsen the condition.

Improved Healing: By restricting movement, rigid taping allows injured tissues to recover more effectively.

Application of Rigid Tape 2

Correct application of rigid tape is important for its effectiveness. Here's a step-by-step guide:

Preparation: Clean the skin and ensure it is dry before application.

Positioning: The individual should maintain a neutral spine posture.

Tape Placement: Apply strips of rigid tape along the lower back, ensuring firm but comfortable adhesion.

Securing the Tape: Additional strips may be used to reinforce stability.

Monitoring: The tape should be checked regularly for signs of irritation or discomfort.

Effectiveness and Considerations 2

Rigid taping is a temporary solution and should be used alongside other treatments such as physical therapy and exercise. It's essential to consult a professional before using rigid taping, especially for severe cases of lower back pain.

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Limited to limitless- capitalising on resources in a developing country

Dr. Nisha Toteja

Emergency rooms (ER) are places notorious for their disparate and desperate clamour for resources, particularly in developing nations like India. Yet, these areas can also opportunistically become role models of the limitless resources in a crisis.

A rejoinder for this was serendipitously brought forward by our first encounter dealing with an unfortunate mass casualty incident. This incident happened at around 8 PM in the ER of a newly established Institute of National Importance, which is still in the embryonic stage of development compared to a fully functional ER of a tertiary care hospital. In its nascent stage, this institute struggles with a handful of supplies, limited manpower, limited beds, and no mechanism to meet or expand surge capacity. But as Murphy's law states," anything that can go wrong will go wrong".

This law is based on entropy, a natural law that states that systems in our universe tend to end up in disorder and disarray. Entropy, the second law of thermodynamics, as luck would have it, came with full fury at the inconvenient time of the approaching night shift in the ER. Nearly 15 critical patients, who were victims of an unfortunate LPG cylinder blast in a slum dwelling, were brought to our centre, which was manned by skeletal staff and limited supplies. At this very moment came our reckoning to do our best considering the situation. Emergency alert signals were sent through WhatsApp groups, and nursing officers from all over the hospital rushed into the ER without any qualms, and so did the residents from Anaesthesia, Pediatrics, Medicine, and Surgery. However, even the most well-oiled machinery collapses in the face of a disaster. We, too, faced several challenges, such as running out of emergency supplies like laryngoscopes, ambu bags, bandages, medicines, intravenous lines, ventilators, etc.

What did we do? Though there was absolute chaos initially, we chinned up and formed teams of 2-3 per patient under the guidance of a Pediatric faculty trained in trauma care. The remaining members, or whoever we could spare after procedures, ran errands and mobilised supplies from other areas. A trauma-trained nurse did the rapid triaging and provided first aid for green and yellow patients along with junior residents on duty. Red patients, almost 6-7 in number, all having >50% burns, including an infant and a 7-year-old, were managed by Neonatology and Pediatric faculty, assisted by multidisciplinary speciality residents. After a marathon of lifesaving endotracheal intubations, central venous access insertions, fluid resuscitations, and paraffin dressings, a semblance of order was established in the chaos. The nursing officers managed the floor efficiently, and all patients were given the golden hour management despite their critical status Emergency Ambulance services were activated, and one by one, all six critical and intubated patients were transported to the nearest dedicated Burn Centre after prior communication and accompanied by adequate supporting staff with well-established definitive airways and venous access (central and peripheral) with intravenous fluids on flow. Slowly, the chaos and cacophony abated, and we sighed a sense of relief. The healthcare professionals who accompanied the sick patient during transport went home far beyond their shift timings into the dead of the night, with tired bodies but spirits high from having done the best with all the limited or limitless resources we had. Of course, there is always room for improvement and nagging doubts about not having done enough. We still have miles to go from this state towards having an optimal Disaster Response System, Incident Command Centre and the need for a more specialised Burn ICU within our facility. Still, on this day, with the given restraints and resources, no loss of life occurred on our watch, and the resourcefulness of our human resources shone through. Entropy may not be all bad, as it reveals resilience, strength and courage in our systems that we never knew existed.

Midnight Brew in Emergency Medicine

The ER is usually a whirlwind of alarms and urgent voices, but occasionally, it slips into a deceptive quietness. In emergency medicine, such stillness is rarely comforting, as it may be the calm before the inevitable storm. As fatigue takes hold, manifesting in gritty eyes and a slowing mind, the midnight brew provides a much-needed boost.

A comforting tradition during my residency was our faculty's habit of offering us tea or coffee and a small snack during moments of pause. These breaks became more than just time for refreshment—they were opportunities to reflect on the challenges of the shift and share stories.

The 'what if' scenarios were the most engaging part of our break-time discussions. I recall one instance where we were puzzling over a patient's unexplained unresponsiveness. Someone suggested a snake bite, despite the initial absence of visible marks on our examination. Later, a colleague, prompted by that 'what if,' discovered a subtle bite on the patient's scalp. This led to the correct treatment and the patient's recovery.

A simple break-time discussion between an intern and my faculty proved transformative. During a break, one of our interns approached a faculty member, expressing his uncertainty about choosing a postgraduate specialty. The significant impact of that conversation was evident when the intern's path ultimately led him to become a successful emergency physician.

Looking back, those late-night coffee breaks were surprisingly productive. They fostered a strong sense of teamwork, encouraged valuable reflection on our goals as residents, and, as I later found, provided a unique window into my residents' challenges and stresses. In essence, these breaks transformed into a rich environment for team building, focused learning, process improvement brainstorming, career guidance, and the exchange of crucial patient management pearls.

And so, the cycle repeats.

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DSH – A Case Series

Dr. Linu Sekhar

Today I discuss a case series of deliberate self-harm patients who attended my department. The case series substantiates my previous write up on the changing trends in the toxicological landscape (vol 18; edn 4, TEAMS) where I discussed how the trend of poisoning has changed with increased incidence of polypharmacy and club drugs /intoxicants.

Case - 1: 60Yr old male patient was brought to our department with Alleged history of Deliberate Self Harm –consumption of Tab Bisoprolol 5 mg (15), Tab Telvas 40 mg (15), Tab Clopitab CV Gold 20 mg (unknown quantity) and Tab Etizolam 0.5 mg (Unknown quantity) around 11:00 pm from residence. Gastric lavage and other supportive measures were done in ED. He was a known hypertensive and dyslipidemic patient for past 10 yrs. He was hypotensive and bradycardic on arrival and hence he was started on intravenous glucagon infusion. He was admitted into the critical care unit with continuous ECG monitoring to rule out heart blocks. After 24 hours glucagon infusion was stopped and patient was shifted to step down ICU for further care. He was later discharged after a week of hospital stay.

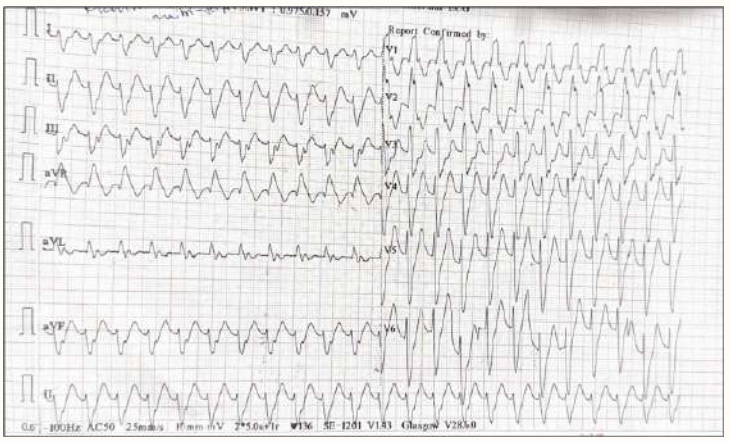
Case - 2: 57yr old female was brought to SGMC ED with alleged history of Deliberate Self Harm - ingestion of Tab Thyronorm (1 bottle of 100 mcg, 1 bottle of 75 mcg and half bottle of 50 mcg). Gastric lavage was done from ED. She was a known case of hypothyroidism, Systemic hypertension, & dyslipidemia for the past several years. On arrival to our department, she was conscious oriented, hemodynamically stable and saturation maintained in room air. She was monitored for signs and symptoms of thyroid storm. She was started on Inj Dexona and oral propranolol. I.V potassium correction was given and patient was shifted to Critical care for further management. She was shifted to step down ICU after 2 days and discharged after 5 days of hospital stay.

Case - 3: 27yr old male brought to ER in an intoxicated condition. He had breath smell of alcohol and was in a violent mood. He was sedated and started on supportive medications. He was the son of case 1 & 2 and both the cases were due to a sudden quarrel between these three people which resulted in this gentleman exhibiting a violent and outrageous act which involved breaking of a glass furniture in front of the parents and as a retaliatory measure they both suddenly embarked on the misadventure of Deliberate Self Harm which resulted in an unnecessary hospital stay and expenses for the entire family. We had a tough time in managing these 3 patients who presented at the same time and there was no sane by stander present at the arrival time with them. Later when this 27yr old patient's wife came, she gave the history of the addictive nature of her husband and the frequent quarrels at the house. The incident should be an eye opener for all Emergency Departments as we need to anticipate more of such instances in the near future due to the ever changing trends in the toxicological landscape .

Naman's ECG corner

Case arrival: A 76-year-old male was brought to the emergency with acute shortness of breath. He had a history of severe aortic stenosis and HFrEF for which he was on irregular medications. He had baseline shortness of breath of mMRC grade 2 and was brought to the ED now with acute worsening of symptoms for 1 day. He had a pulse rate of 180/min and BP of 110/70. ECG was obtained. Attempt to interpret the ECG by yourself.

Discussion: Differentiating ventricular tachycardia (VT) from supraventricular tachycardia (SVT) with aberrancy in a regular wide complex tachycardia (RWCT) can be challenging but is useful due to different treatment strategies. Certain key ECG features and clinical clues can help in this distinction.



Key Clinical & ECG Features Favoring Ventricular Tachycardia (VT):

- Patients with a history of prior myocardial infarction, heart failure, or cardiomyopathy are significantly more likely to have VT as the cause of a wide complex tachycardia. In adults presenting with wide complex tachycardia, VT is the cause in over 80% of cases, and this percentage is even higher in those with known structural heart disease (over 90%).
- While not exclusive to SVT, paroxysmal SVTs (AVNRT and AVRT) often terminate abruptly with vagal maneuvers or adenosine, which act to block AV nodal conduction.
- **Atrioventricular (AV) Dissociation:** The presence of AV dissociation, where the atria and ventricles are paced independently, is highly specific for VT. Look for P waves that are not related to the QRS complexes. However, the absence of overt AV dissociation does not rule out VT.
- **Capture Beats:** Occasionally, the sinus node may transiently capture the ventricles, producing a QRS complex with a normal duration. This 'normal' beat comes in between the run of WCT and is highly suggestive of VT as the cause of WCT
- **Fusion Beats:** A hybrid QRS complex resulting from the simultaneous depolarization of the ventricles by both a supraventricular and a ventricular impulse. Again, highly suggestive of VT.
- **QRS Morphology in Lead V1/V2:** The shape of the QRS complex in the precordial leads, particularly V1 and V2, can be very informative.
  - ☑ **With Right Bundle Branch Block (RBBB) Morphology:** A monophasic R wave, a qR pattern,

☑ or an RS pattern in V1 strongly suggests VT, whereas an rSR' pattern is more typical of SVT with RBBB. Tall left rabbit ear (R > r') is suggestive of VT (Marriott sign)

- ☑ **With Left Bundle Branch Block (LBBB) Morphology:** A broad (≥0.04 sec) initial R wave in lead V1 or V2 favors VT.
- ☑ **Brugada sign:** In leads with RS complexes, time from onset of QRS to nadir of S wave > 100 ms is suggestive of VT.
- ☑ **Josephson sign:** Notching near the nadir of S wave, suggestive of VT.

✶ **QRS Concordance in Precordial Leads:**

- ☑ **Negative Concordance:** If all precordial leads (V1-V6) show predominantly negative QRS complexes (negative QRS concordance), it is highly suggestive of VT and incompatible with aberration.
- ☑ **Positive Concordance:** While less specific, positive concordance (all precordial leads showing predominantly positive QRS complexes) can also be seen in some cases of VT.

It is important to consider that:

✶ No single ECG finding or clinical clue is entirely sensitive or specific for differentiating VT from SVT with aberrancy. A combination of factors should be considered.

✶ Comparing the current ECG to previous ECGs, especially during sinus rhythm, is crucial.

✶ Certain medications and electrolyte abnormalities (e.g., hyperkalemia) can affect QRS duration and morphology in both VT and SVT with aberrancy, making the differentiation more challenging.

✶ In cases where the diagnosis remains uncertain, expert consultation with a cardiologist or electrophysiologist is recommended.

A combination of various ECG elements has been studied to differentiate VT from SVT. Some of the most studied algorithms are:

✶ Brugada algorithm
✶ Vereckei aVR lead algorithm
✶ R wave peak time
✶ Basel algorithm
✶ VT score algorithm
✶ Limb lead algorithm

It is important to recognize that most of these WCT algorithms are too complex to be easily recalled by the acute care provider. Also, their accuracy in the real-life setting ranges from 60 to 75%. These are good at ruling in VT than ruling it out.

Simple and practical approach in the emergency is required. Here is the perspective I adopt. 80% of regular WCT are VT. History of structural heart disease (ischemia, valvular, CHF) increases the probability to > 90%. Then, if there is AV dissociation or negative/positive concordance in precordial leads, it is almost certainly VT. If I see a monophasic R wave in aVR, it is VT. If a decision about the rhythm is not made still, I see the 'time-to-1st peak' (onset of QRS to 1st change in polarity: R or S) in II and aVR. If it is > 40ms, VT becomes more likely. Additionally, some morphologic indicators like Marriott sign, Josephson sign, north-west axis etc may increase your confidence in the diagnosis. If after all the deliberation, I am still unsure, I treat the rhythm as VT.

Common pitfalls:

✶ "Patient is too well for the tachycardia to be VT". Patients with VT can be clinically stable on presentation; instability is frequently the result of a missed diagnosis and inappropriate treatment.

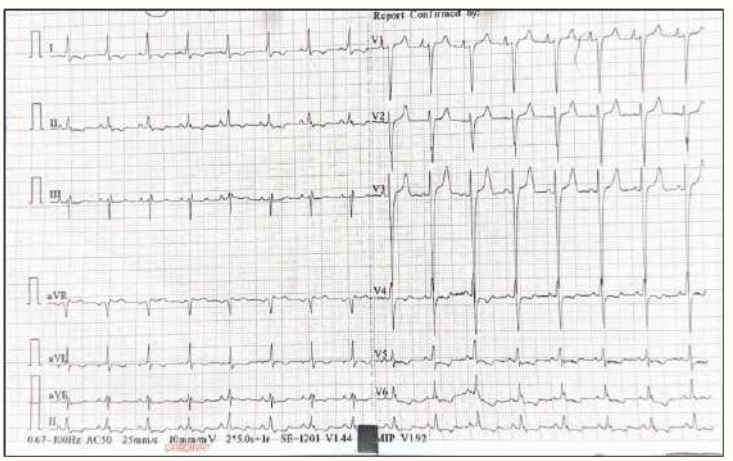
✶ "P-wave trap," focusing too much on a possible 1:1 P-QRS relationship. Sometimes one can not be sure that what appear to be P waves is not part of the ST-T segments.

✶ "QRS morphology trap" when the first responder prematurely focuses on the QRS morphology during WCT. Clinical scenario and the finding of AV dissociation should supersede the finding of a resemblance of the QRS complexes to bundle branch blocks or bifascicular blocks.

✶ The combination of a younger, healthier patient whose ECG suggests a 1:1 P-QRS relationship and typical bundle branch block morphology does increase the likelihood of SVT, but one still cannot be certain.

Case resolution:

The patient's ECG revealed regular wide complex rhythm with QRS width around 160 ms with RBBB type morphology. Patient's age of 76, with structural heart disease increases the probability of VT to > 90%. Additionally, the presence of Brugada sign and Josephson sign increased the probability of VT. Due to clinical instability synchronised DC cardioversion was done in ED. Patient became hemodynamically stable. Follow up ECG was obtained as shown below. Patient was admitted under cardiology for further care.



An Ode To B_{12}

Dr. Manuja

No more aches and no more pains, Eat anything and no weight gain, Sharp memory with sharper brain, B12 up and mood swings slain,

Skin will glow, Worries away u blow, Spring in my walk, No more slow Regain my favorite food taste, Smell no more like kitchen waste, I will be new, Like old wine brewed.

Orthopedic Emergencies Unraveled: A Blueprint for EM Physicians in India

Dr. Rajiv Singla

Picture this: an emergency medicine (EM) physician in a frenetic Indian ED faces a motorbike crash victim, his leg a twisted wreck—no orthopedic surgeon in sight. Polytrauma floods India's emergency rooms daily, thrusting EM physicians into the frontline spotlight. With time ticking and resources thin, they're the first hope for shattered limbs. So, how do they conquer orthopedic chaos amid the storm? Let's unravel a plan crafted for India's gritty realities.

India's roads and heights spell orthopedic trouble—road accidents alone account for 6% of the global toll (WHO data), swamping EDs with fractures, dislocations, and worse. Overcrowded wards, scarce X-ray machines, and delayed orthopedic consults haunt rural and semi-urban medical colleges. Here, EM physicians aren't just stabilizers; they're the lifeline until specialists arrive. In this high-stakes arena, orthopedic skills aren't optional—they're survival. Mastering them means tackling India's unique blend of volume, urgency, and constraint head-on.

Enter the "3S Framework"—Spot, Stabilize, Steer—a lifeline for EM physicians navigating orthopedic emergencies. First, Spot: Assess fast with the "Look, Feel, Move" drill to flag fractures or dislocations. For life-or-death calls like pelvic bleeds, a quick "squeeze test" exposes instability. Think cricket: spot the ball's spin in a split second—it's instinct sharpened by practice. Next, Stabilize: Improvise with what's available—plaster of Paris or even cardboard in a pinch secures a limb. Stem bleeding with pressure bandages, echoing India's resourceful first-aid traditions. Here's a tip: treat the limb like a fragile Diwali clay lamp—steady it gently but firmly. Finally, Steer: Decide smart—order an X-ray if feasible, refer if critical, or prioritize in polytrauma chaos. Adopt an Indian ED mantra: "Limb or Life?" It's triage distilled for settings where every minute and machine counts. This framework turns panic into precision, merging speed with skill for India's unpredictable EDs.

Now, imagine a game-changer: the "Trauma WhatsApp Protocol." Snap a photo of an injury or X-ray, ping it to a secure orthopedic group, and unlock instant expert input. India's tech-savvy docs can turn this into a night-shift savior, sidestepping delays. Train EM physicians to ace it—capture clear X-rays with proper angles and focus, then ask razor-sharp questions: "Stable enough to splint? Urgent referral needed?" This isn't just chat; it's a lifeline, fusing India's mobile edge with medical grit. With a bit of practice, it's a tool to bridge gaps and save time—and limbs.

Orthopedic crises don't wait for specialists—EM physicians are the quiet game-changers saving lives one fracture at a time. Test the 3S Framework in your next shift; kickstart that WhatsApp group with your ortho colleagues. In true jugaad style, let's innovate under pressure. India's EDs demand nothing less—step up, adapt, and redefine emergency care where it matters most.

Soft skills and Wellbeing at Bedford UK

Dr. Murtuza Ghiya

Organized by 2 WACEM speakers - Dr. Aditya Suresh and Dr. Firoze Sogiawala along with input from 2 early FACEE candidates Dr. Murtuza Ghiya and Dr. William Wilson this SAW event was a resounding success!

In the inaugural SAW (Soft Skills and Wellbeing) 1.0 , the team combined personal experience based talks and reflections from participants.

Blessings

With folded hands and deep humility, we express our heartfelt gratitude to Waheguru Ji for His divine blessings and protection during Operation Sindoor. In times of uncertainty and peril, it was His grace that gave us strength, clarity, and courage. As India and Pakistan stood at a critical juncture, our brave forces stood tall, guided by duty, devotion, and Dharma—and watched over by His infinite love. Today, we bow our heads in thanks—for safety, for peace, and for the unwavering spirit of those who serve our nations.

Sautéed Mushroom & Broccoli Fry Recipe

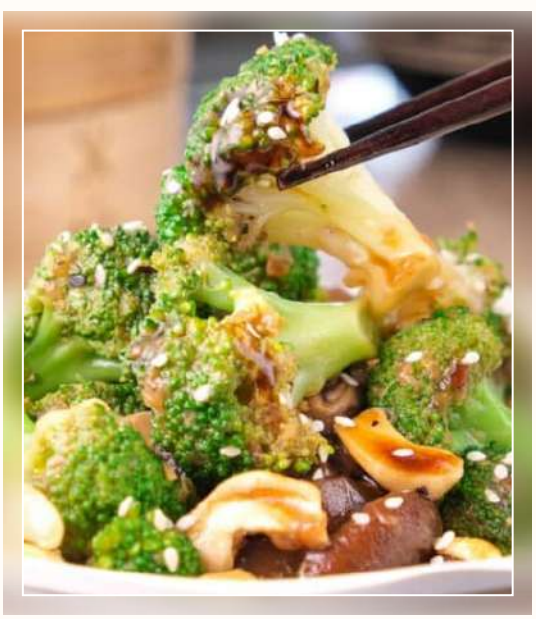
Ingredients:

- 1 cup broccoli florets
- 1 cup mushrooms, sliced (button or cremini work well)
- 1 tablespoon olive oil (or butter/ghee for richer flavour)
- 1 teaspoon garlic, finely chopped or minced
- 1/2 teaspoon black pepper
- Salt to taste
- Optional: chili flakes, soy sauce, lemon juice, sesame seeds

Instructions

Prep the veggie:

- ☑ Rinse the broccoli and mushrooms. Cut the broccoli into small florets and slice the mushrooms.
- ☑ Blanch the broccoli (optional but helps soften): Boil water, add broccoli, and cook for 2–3 minutes. Drain and keep aside.
- ☑ Heat oil in a pan or wok over medium heat.
- ☑ Add garlic, sauté until fragrant (about 30 seconds).
- ☑ Toss in the mushrooms and cook for 4–5 minutes until they release moisture and start to brown.
- ☑ Add the blanched broccoli and stir-fry for 3–4 minutes.
- ☑ Season with salt, pepper, and optional chili flakes or a splash of soy sauce for extra umami.
- ☑ Turn off the heat and optionally squeeze some lemon juice or sprinkle sesame seeds for a finishing touch.



Lassi With A Desi Twist

Ingredients

- 1 cup curd (yogurt) – fresh and chilled
- 1 tsp fennel seeds (saunf)
- 1 tbsp jaggery – grated or powdered (adjust to taste)
- 1/2 tsp fresh ginger, finely grated
- 1 tbsp fresh mint leaves, finely chopped• A pinch of salt (optional)
- A few crushed ice cubes (optional, for extra chill)

Instructions

- ☑ Roast the fennel seeds lightly in a dry pan for about 30 seconds – just until fragrant. Let them cool, then crush them slightly (you can also use them whole if you prefer a stronger flavor and crunch).
- ☑ In a mixing bowl, whisk the curd until smooth.
- ☑ Add jaggery, grated ginger, mint leaves, and the crushed fennel.
- ☑ Mix everything well and let it sit for 5–10 minutes to allow the flavors to infuse.
- ☑ Taste and adjust sweetness or salt if needed.
- ☑ Serve chilled. Garnish with a few extra mint leaves or a light dusting of fennel on top if you like.

Nectar Nights

1. Take a 1 litre water bottle devoid of water. Of course you take care of hydration and had emptied the bottle.
2. Pour 200 ml cold milk in the bottle.
3. Open the treasure. Take 2 coffee sachet, 9 to 10 milk powder sachet, 2 sugar sachet (haul from your last vacation stay)
4. Empty the contents of these sachet in bottle with milk.
5. Shake with all your might. Of course the bottle. Set the landmark with your biceps, triceps.
6. Take ice cubes in 2 glasses and Serve on the rocks.

The Pride Of Our Nation And The Guardians Of Our Dreams.

These past few days have been marked by tension and uncertainty, with the tragic events in Pahalgam and the recent escalation of India-Pakistan tensions weighing heavily on our hearts. Yet, never have I felt more proud to be an Indian. It fills me with immense pride to belong to such a resilient and great nation. It is because of our brave-hearted soldiers, standing resolutely at the borders, that we are able to sleep peacefully each night. Our heroes — our soldiers — have selflessly laid down their lives to keep us safe. We are deeply grateful for their tireless dedication and immense courage in confronting every threat. With utmost respect and reverence, we salute the indomitable spirit of the Indian Army. Their sacrifices are a silent promise that our sovereignty and unity will never falter. While we go about our daily lives, it is their vigilance, their discipline, and their love for the motherland that form the invisible shield protecting us all. Today, as we reflect on these turbulent times, let us not forget that every breath of freedom and every moment of peace we enjoy is written in the courage and sacrifices of our soldiers. Let us stand united as citizens and always remember to honour, support, and cherish our armed forces — not just in times of conflict, but every day. Their bravery inspires us to rise above fear and division, and to work towards a stronger, more united India. Our deepest gratitude, our unwavering respect, and our heartfelt salute to the Indian Army — the pride of our nation and the guardians of our dreams.

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