Celebrating 20 YEARS

TRAUMA & EMERGENCY
TEAMS
ACADEMIC MEDICINE SENTINEL

Proclaiming & Promoting Academic Leadership

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Happy New Year

Happy New Year heralds the arrival of a fresh beginning, enriched with hope, renewed ambitions, and endless possibilities. It is a moment to pause and reflect on the journey of the past year celebrating successes, acknowledging challenges, and carrying forward the lessons learned. As the calendar turns, hearts are filled with optimism and gratitude, and people come together to share warm wishes and strengthen relationships. The New Year symbolizes renewal and transformation, motivating us to embrace change with confidence, set meaningful goals, and move ahead with positivity, resilience, and a renewed spirit for a brighter, more fulfilling future.

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Official Voice of
Academic College of Emergency Experts (ACEE)
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Abusing the value of P-Value

Dr. Ankit

Following my previous newsletter article, "Beyond P-Values and P-Hacking: Putting Patients First in Research," this piece delves deeper into how p-values are actively abused in research, often with devastating consequences for clinical practice. While the prior article highlighted misconceptions and the need for effect sizes, here we expose deliberate manipulations and real EM trial pitfalls.

A p-value measures the probability of observing data as extreme (or more) assuming the null hypothesis is true—typically, no treatment effect. Conventionally, $p<0.05$ suggests "statistical significance," implying <5% chance of a false positive. However, p-values depend heavily on sample size, do not quantify effect magnitude, and offer no proof of causation.

P-values have critical limitations clinicians must grasp. P-value cannot distinguish between proof of "no benefit" (evidence of absence of benefit) and absence of proof of benefit/harm (absence of evidence of benefit). P-value can be same for a small effect in larger study or a large effect in a smaller study. P-value gives binary info (significant or not), while CI gives full information, direction and range of effect.

Misuse occurs through p-hacking (tweaking analyses until significance appears), multiplicity (testing multiple outcomes without correction), and selective subgroup reporting. In multi-endpoint EM trials like mortality plus ICU stay, random chance alone yields ~20-25% false positives across 5 tests. Dichotomous thinking—$p<0.05$ means "works," else "fails"—ignores clinical context.

Large EM trials show the harm. One such example is CRASH-2 (2010) which tested tranexamic acid (TXA) in 20,000 bleeding trauma patients. Overall, TXA cut deaths a bit ($p=0.0035$, fewer deaths by 9%). Good start. But they dug into data after. TXA in first 3 hours cut bleeding deaths a lot ($p<0.0001$). Sounds perfect for EDs. Problem: they did not plan this group ahead. They tried many time groups until one worked. This picks lucky winners by chance. It can push strict 3-hour rules that may not hold up. Still, this finding led to more studies like CRASH-3 that confirmed the real benefit of early TXA.

Handle wisely by prioritizing effect sizes (e.g., absolute risk reduction) and confidence intervals over p-values. Preregister trials on ClinicalTrials.gov and Clinical Trials Registry of India (CTRI) to prevent fishing. Report all pre-specified outcomes transparently, using Bayesian credible intervals for nuance. For borderline cases like $p=0.06$-0.09 with meaningful CIs, explore further—patients benefit from trends, not thresholds. Abusing p-values erodes evidence-based EM. We as emergency physicians, should commit to patient-centered stats: Judge by real impact, not magic numbers. Read full papers, question subgroups, and advocate transparency.

Well Dwell- 4.0

Dr. Murtuza Ghiya

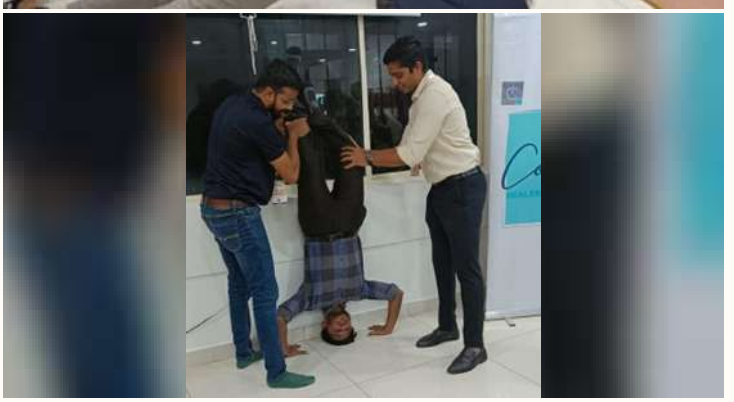
Mast Masti and Medicine

During the WACEM / EM INDIA 2025 in Mangalore, an exclusive soft skills and wellbeing workshop was organized, which saw great participation!

Why make a formal lecture on Fun and Fitness, when you have great participants who can actually demonstrate the 3 S s of Fitness—Strength, stamina and suppleness !

The workshops included Final health, night shift hygiene and Breaking bad news—all gamified with reflections for true and deep learning!

Watch out for our next big workshop along the river Ganga in Varanasi, EM India 2026 !!



Two States, One Stethoscope: A Paediatrician's Gut-Busting Guide to North-South Doctor Duels (Now with extra masala)

Dr. Nisha Toteja

Disclaimer: All views are 100% personal, sleep-deprived, caffeine-fueled nonsense. If you're offended, blame the 3 a.m. baby who decided breathing was optional. Not me!

We are two paediatricians:

- Me — a Punjabi girl from Delhi who believes rajma-chawal is soul food and volume control is optional.
- Him — a Thrissur Malayali boy who thinks whispering is a personality trait and Malabar biryani is a legitimate form of soul meditation.

Love? No filmi lightning—more like a slow IV drip of midnight ward rants, senior-bashing, and chai heists. Batchmates to soulmates: classic doctor love story, zero side effects except eternal night shifts.

Then we did the unthinkable. Plot twist: Marriage! The WhatsApp groups achieved enlightenment that day — through sheer panic. Families clash like Sadya vs. shaadi—2,000km cultural collision course.

Punjabi Girl in Kerala: Coconut Shock & Gold Avalanche

- Kerala families are like coconuts.
- Tough shell reveals gold-hearted fuzzballs.
- Takes forever to crack
- Once open → 90% pure sweetness + 10% passive judgments
- Elite education flex (subtle)
- Civic sense beats Singapore,
- Savings? They'd out-FD the Swiss.
- Degrees hanging like family portraits
- Gold reserves that could bail out a small European country

My first visit to a Kerala wedding was a spiritual experience. The bride was wearing so much gold she needed a separate ZIP code for her neck. I genuinely whispered, “Is she medically stable? Should I start CPR or call the RBI? He just gave the classic Malayali head-wobble: “That's tradition. Also, neck physiotherapy is included in the dowry package.”

A common Malayali friend sheepishly quipped -call it 'Nettipattam Neck-Toning'! I was amusingly amazed at her thick Gold Waist belt, the size of a WWE title.

Kerala weddings:

- Sunday brunch aesthetic
- Zero late-night drama
- Sadya feast so good even the banana leaf gains weight
- Guest list: 1,000–5,000 (considered “small family function”)

Malayali Boy in Delhi: Dhol Deafness & Oil Overload

Reverse: Punjabi households = perpetual mela on steroids. Dhols wake comatose patients and register on Richter scale. Aunties gossip at 140dB (louder than ER alarms). Food so rich cardiologists have it on their vision boards.

Gold? We keep it locked in banks like nuclear codes. Brides? Forced into lehengas weighing more than the average NICU baby + incubator combined. Requires a minimum of 6-friend rescue squad just to stand up.

Here's the level of bridal engineering we were dealing with:
(Imagine the heaviest, most blinged-out lehenga ever — preferably one that needs scaffolding)

Rituals include:

- Phoolon ki chadar (dramatic entry level: Oscar-worthy with brothers as pallbearers)
- Juta chori (where sisters turn into international ransom negotiators)
- Midnight pheras (because why sleep when you can orbit fire at 2 a.m.?)
- Vidai at dawn- ultimate survival test (everyone cries, including the caterer and random auto driver)

Our wedding? A United Nations peacekeeping mission with better catering. Only a handful of brave souls crossed 2,000+ km. The rest sent WhatsApp nukes ("Beta, you did not invite us?") forwards with varying emojis. Punjabis tried eating sadya like confused dinosaurs desperate for cutlery. Malayalis looked at butter chicken like a "Calorie apocalypse”. We spent the week-long gala event (two weddings and a reception), laughing, gossiping, and posing for 50 photographers who were convinced we were secretly royalty. The icing on the cake was post-wedding sightseeing tours of beaches, river cruises in the south and monument hopping in the north.

Decade Later: Post takeover (2 kids, 0 Regrets)

The differences are now mostly stand-up comedy material. I

order Fish curry meals like a pro; he craves mummy's paratha + Lajpat Nagar ke infamous chole bhature. Our kitchen is a glorious war zone of fusion crimes.

Kerala shaadis are now "Punj-ified": Haldi, mehndi, phoolon-chadar—glamour and spunk (because drama is universal)!

Punjabi weddings have toned down (courtesy 11 pm dhol ban).

Stereotypes? Phantom fevers—cured by the serum of culture, acceptance, tolerance and empathy.

When people ask, “Where are you from?” I just blink. Punjabi. Born in Orissa. Studied Delhi-Chandigarh. Worked in Rajasthan, UP, and Guwahati. Married Thrissur Malayali. Basically, I'm the human version of the Indian Railways route map.

Moral of the story (pediatric edition): Good marriages = good Peds ER. Requires:

- Infinite patience
- Sedation-level kindness
- Ability to laugh when everything is crashing
- And the wisdom to know that chole bhature + rasam is actually soulmate cuisine

We're all just trying to survive night duties, patient tantrums, and each other's families. One hilarious, hypertensive, multicultural combo plate at a time.

"Pro tip from Dr. Nisha Toteja: North-South doc combo? Best vaccine—against boredom!

Efficacy and Safety of Alternating Acetaminophen/Paracetamol and Ibuprofen for Pediatric Fever

Prof (Jr) Dr Neha Thakur Rai

Abstract : The management of pediatric fever remains a significant source of parental anxiety. While monotherapy with either acetaminophen or ibuprofen is the standard of care, the practice of alternating these agents has become prevalent. This article examines the pharmacological rationale, clinical efficacy, and safety profile of alternating therapy based on recent clinical trials and guidelines from the Indian Academy of Pediatric (IAP) American Academy of Pediatrics (AAP) and the National Institute for Health and Care Excellence (NICE).

- **Introduction -** Fever is a physiological response, not a disease. Current medical consensus emphasizes that the primary goal of antipyretic therapy is the improvement of the child's comfort rather than the achievement of normothermia (37C or 98.6F). Despite this, clinicians frequently encounter cases where monotherapy fails to alleviate distress, leading to the recommendation of alternating regimens.
- **Pharmacological Rationale** - Acetaminophen/ Paracetamol (PCM) and ibuprofen utilize distinct metabolic pathways and mechanisms of action:
  - ☑ Acetaminophen: Primarily acts on the central nervous system to inhibit prostaglandin synthesis; metabolized via the liver (glucuronidation/sulfation).
  - ☑ Ibuprofen: A non-steroidal anti-inflammatory drug (NSAID) that inhibits cyclooxygenase (COX-1 and COX-2) enzymes peripherally and centrally; metabolized via the kidneys.

Theoretically, alternating these drugs allows for "overlap" coverage—where one agent begins its peak effect as the other's plasma concentration declines—potentially providing more consistent symptom relief without exceeding the toxic threshold of either single metabolic pathway.

- **Efficacy Analysis -** Recent meta-analyses (including a 2024 network meta-analysis in Pediatrics) indicate that combined or alternating therapy is modestly more effective at lowering body temperature than monotherapy:
  - ☑ Temperature Reduction: Alternating therapy typically results in a greater reduction in temperature compared to acetaminophen alone.
  - ☑ Duration of Antipyresis: Children receiving alternating doses spend approximately 2.5 to 4.4 more hours "afebrile" (without fever) in a 24-hour period compared to those on monotherapy.
  - ☑ Clinical Significance: While statistically significant, researchers debate the clinical value of these marginal temperature drops if the child's comfort level (the primary outcome) remains unchanged.
- **Safety and Risk Profile -** The primary concern with alternating therapy is not the drugs themselves, but the complexity of the regimen.
  - ☑ Different intervals (4h vs 6h) increase the risk of accidental supratherapeutic dosing.
  - ☑ Excessive acetaminophen intake is a leading cause of acute liver failure.
  - ☑ Concomitant use, especially in dehydrated children, increases the risk of Acute Kidney Injury (AKI).
  - ☑ Aggressive alternating therapy reinforces the misconception that fever itself is dangerous.
- **Current Clinical Guidelines (2025-2026) -** The Indian Academy of Pediatrics (IAP) guidelines for 2024–2026 emphasize a "Comfort- First" approach. In the Indian context, specific attention is paid to the risks of tropical diseases like Dengue, which heavily influences their recommendation on using Ibuprofen (Brufen).

The IAP recommends Paracetamol as the safest and most effective first-line medicine for fever in It is the only antipyretic recommended when Dengue or Chikungunya is suspected, as it does not affect platelet count or increase bleeding risks.Ibuprofen (Brufen) – The Second ChoiceThe IAP advises more caution with Ibuprofen compared to Western guidelines. IAP strongly warns against Brufen if there is an outbreak of Dengue, as it can worsen Avoid if the child is vomiting or has diarrhea, as it can cause Acute Kidney Injury

IAP Stance on Alternating (Staggering) Therapy

The IAP discourages the routine alternating of Paracetamol and Ibuprofen by parents at home. Their reasoning includes:

- ☑ Complexity: High risk of "dosing confusion," leading to accidental toxicity.
- ☑ Fever Phobia: It reinforces the idea that fever is dangerous, whereas IAP considers fever a "friend" that helps fight infection.

- ☑ The "3-Hour Rule": If a pediatrician specifically recommends alternating due to severe distress, they typically advise giving PCM first, then waiting 3 hours before giving Brufen only if the child is still highly uncomfortable.
  - ☑ Sponging Can be combined with PCM but Not typically used with Brufen
  - ☑ AAP Stance: Monotherapy is strongly preferred. If alternating therapy is utilized, it should be done only under medical supervision with a strict written log.
  - ☑ NICE Guidelines: Advise against "routine" alternating but suggest considering it if the child remains distressed despite monotherapy.
  - ☑ Age Restriction: Ibuprofen should not be used in infants under 6 months of age due to immature renal clearance.

✦ **Conclusion -** Alternating acetaminophen and ibuprofen is more effective at lowering temperature than monotherapy, but it carries a higher risk of administration errors. It should be reserved for cases where monotherapy fails to improve the child's comfort. Education should focus on treating the child's behavior and hydration rather than the number on the thermometer.

Parental Instructions on Home Management: Alternating Fever Medication

Primary Goal: To make your child comfortable and hydrated, not to reach a specific number on the thermometer.

- ☑ **The Safety Checklist**
  - ⊙ Weight-Based Dosing: Always dose by weight, not age.
  - ⊙ Age Limit: Do not give Ibuprofen (Motrin/Advil) if the child is under 6 months old.
  - ⊙ Hydration: Ensure the child is drinking fluids. If they are dehydrated, Ibuprofen can be hard on the kidneys.
  - ⊙ The Log: Use the table below to track every dose. Never rely on memory.
- ☑ **The Alternating Schedule (The "3-Hour Gap" Method)**

  If your doctor approves alternating, the most common safe method is to give a dose of one medication every 6 hours, staggered by 3 hours.
  - ⊙ 0:00 (Start): Give Acetaminophen (Tylenol).
  - ⊙ 3:00 (3 hours later): If still distressed/high fever, give Ibuprofen (Motrin).
  - ⊙ 6:00 (6 hours after start): Give Acetaminophen.
  - ⊙ 9:00 (9 hours after start): Give Ibuprofen.
- ☑ **Dosing Reference**

  Acetaminophen 10-15 mg/kg, Every 4–6 hours (Max 5/day)

  Ibuprofen 5-10 mg/kg Every 6–8 hours (Max 4/day)

  When to Stop and Call the Doctor
  - ⊙ Infants <3 months: Any rectal temperature of 100.4°F (38°C) or higher is an emergency.
  - ⊙ Duration: The fever lasts more than 3 days.
  - ⊙ Dehydration: No wet diapers for 8+ hours, dry mouth, or no tears.
  - ⊙ Lethargy: The child is unusually drowsy or difficult to wake up.
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Snakes of India: Species and Treatment Strategies

Dr. Linu Sekhar

Overview: India hosts over 300 snake species across diverse habitats, making it one of the world's most snake-rich nations. Snakebite is a significant public health concern, causing approximately 58,000 deaths and 140,000 cases of disability annually, the highest rate globally. India's National Action Plan for Snakebite Prevention and Control addresses both prevention and clinical management through coordinated healthcare strategies.

Major Snake Species

India's medically significant snakes include the "Big Four" species responsible for most serious bites:

- ☑ Indian Cobra (Naja naja) - Neurotoxic venom, primarily found across the Indian subcontinent
- ☑ Common Krait (Bungarus caeruleus) - Highly neurotoxic, nocturnal species, common in agricultural regions
- ☑ Russell's Viper (Daboia russelii) - Hemotoxic and

- ☑ neurotoxic venom, widespread distribution
- ☑ Indian Saw-scaled Viper (Echis carinatus) - Highly hemotoxic, found in arid regions.

India also contains numerous non-venomous species, including Indian rock python, sand boas, and water snakes, along with endemic species found only in regions like the Western Ghats.

WHO Protocol and Treatment Approach

The World Health Organization South-East Asia Regional Office WHO/SEARO) guidelines emphasize a standardized management approach for snakebite envenoming. Key principles include: immediate immobilization of the bitten limb, rapid transport to medical facilities, reassurance to the patient, and avoidance of harmful practices such as application of ice, tourniquets, cutting, or suction.

Antivenom Administration

Anti-Snake Venom (ASV) is the primary and most effective treatment for snake envenomation. The polyvalent antivenom produced by Central Research Institute, Kasauli, and Haffkine Corporation Mumbai, targets the venom of the most common Indian species.

Supportive Care

Comprehensive management includes

- ☑ Cardiorespiratory support including mechanical ventilation for neurotoxic bites
- ☑ Administration of neostigmine and atropine for neurotoxic envenomation.
- ☑ Correction of coagulation disorders through monitoring and transfusion when needed.
- ☑ Pain management and tetanus prophylaxis

Emerging Treatment Molecules and Next-Generation Antivenoms

Recent research in India and internationally has focused on developing next-generation antivenoms and novel pharmacological agents to complement conventional polyvalent ASV. Key investigational approaches include:

- ☑ Varespladib: A small-molecule phospholipase A2 (PLA2) inhibitor being evaluated in multicentre clinical trials in India as a rapid, broad-spectrum antidote administered within hours of bite.
- ☑ Recombinant antibodies and fragment-based products: Engineered to be more potent, specific , and less immunogenic than conventional antivenoms.
- ☑ Repurposed agents: Including unithiol and heparin being explored in preclinical studies for synergistic effects with antivenom.

These investigational molecules are not yet part of standard clinical protocols in India but represent promising avenues for improving treatment efficeincy and reducing adverse effects.

Syndromic Approach to Treatment

Rather than relying on identification of the snake , Indian and WHO protocols emphasize syndromic management based on clinical presentation and bedside tests. This approach enables rapid decision-making at all levels of healthcare, particularly in rural settings.

Clinical Syndromes and Recognition

- ☑ Neurotoxic syndrome (cobras, kraits): ptosis, ophthalmoplegia, dysarthria, dysphagia, pooling of secretions, respiratory muscle weakness.
- ☑ Hemotoxic/viperine syndrome (vipers): local swelling, spontaneous bleeding, gum bleed, hematuria, shock, abnormal 20-minute whole blood clotting test (20WBCT).
- ☑ Local cytotoxic syndrome: severe local pain, rapidly progressive swelling, blistering, necrosis with minimal systemic signs.

No envenoming: fang marks only, minimal progression, normal vitals and 20WBCT.

Recommended ASV Dosing by Syndrome

Syndrome	Initial Dose	Re-dosing
Neurotoxic (neuroparalysis)	10 Vials	Reassess at 1-2 hrs; repeat up to max 20 vials
Hemotoxic (abnormal 20WBCT/ bleeding)	10 Vials	5-10 vials every 6 hrs until 20WBCT normalizes
Local-predominant (rapid swelling)	8-10 Vials if progressive	Based on clinical response and 20WBCT
No envenoming	None	Observe 24 hrs; discharge if stable

Table 1: ASV Dosing Protocol by Syndrome Type

National Action Plan and Healthcare Infrastructure

India's National Action Plan for Snakebite Prevention and Control (NAP-SE), launched in 2024, establishes a comprehensive framework with the vision to halve snakebite deaths by 2030 using a "One Health" approach. Key strategic components include:

- ☑ Ensuring adequate ASV stocks in all healthcare facilities, particularly rural and remote areas
- ☑ Strengthening emergency services and ambulance provision
- ☑ Training healthcare providers in snakebite management protocols
- ☑ Integration of snakebite treatment into medical curriculum

Establishment of Regional Venom Centres and inter-sectoral coordination

- ☑ Snakebite Helpline (15400) pilots in ve states for immediate public assistance and guidance
- ☑ Surveillance mechanisms to track incidence, morbidity, and mortality for evidence- based planning

Speaking Bones: Lessons That Outlive the Patient

Dr. Rajiv Singhal

In the ED, bones don't whisper. They scream.

A compound tibial-fibula rolls in—deformity, exposed cortex, blood pooling on the stretcher. It's impossible to look away. The team converges: splint, tetanus, cefazolin, ortho consult. Protocols fire seamlessly. We feel in control because the injury is right there, demanding fixation.

And that's the trap.

These loud fractures are consummate distractors.

Fractures are great fixers. They anchor our gaze while quieter threats brew. A gustilo III open ankle commands the resus bay, but the real killer might be the retroperitoneal bleed from a fractured pelvis we haven't fully interrogated yet. A mangled extremity draws serial exams and imaging, masking the evolving subdural or the subtle pneumothorax on initial CXR.

We've all seen it: the displaced femur that fixates the trauma survey, delaying the pan-scan that reveals splenic laceration. Or the grotesque forearm fracture in the polytrauma patient where C-spine clearance gets rushed, assumptions made.

Bones, however, are not just distractions. They are black boxes.

Every fracture records direction, magnitude, and intent. Bilateral calcanei mean height. A first-rib fracture whispers aortic injury. A spiral femur in a child demands that we think beyond accidents. Bones replay the crash if we bother to listen — not to the fracture itself, but to what it implies.

They also remember our decisions.

Months later, an incidental film shows growth arrest in a child whose fracture was "beautifully reduced." A malunited distal radius explains chronic neuropathy long after the chart says "lost to follow-up." In emergency medicine, we rarely see the aftermath. Bones keep the receipts.

But emergency medicine demands we override that pull. The obvious injury is rarely the lethal one. Trauma is multilayered; the body doesn't prioritize by decibel. Blood loss from an open fracture is real, but occult hypovolemia from abdominal sources compounds faster. Pain from a broken bone spikes catecholamines, but it can obscure compensatory mechanisms failing elsewhere.

Bones also falsely reassure.

A clean reduction on fluoro feels like victory. We've "fixed" something. In contrast, the occult injury—foraminal bleed, bowel perforation, early compartment in a closed limb—forces ongoing suspicion, serial exams, humility in the face of normal labs.

That's why bones are such unforgiving teachers. They force the discipline: address the loud without surrendering to it. Visualize every fracture as a marker of energy transfer — proximal, distal, axial. Ask what else absorbed the force.

Long-term, bones keep score in ways we rarely witness. Incidental old malunions on today's films remind us of past shifts: lives stabilized acutely, but functional outcomes shaped by what we prioritized in chaos. Missed associated injuries, inadequate clearance, tunnel vision—they ossify into permanent deformity.

In EM, we excel at the acute save. Bones test whether we're equally vigilant against the distractions that erode it.

Listening to bones is instinctive. Learning to hear past them—to the whispers of occult catastrophe—that's the skill that defines us.

And it's the one that lingers, case after case, long after the patient codes or walks out.

Comprehensive Multi-Pillar Model Exam Marks a Milestone for Final-Year MD Emergency Medicine

Dr Ajay Ambalakkatte

The final-year practical examination for the MD Emergency Medicine program continues to evolve, reflecting the dynamic and fast-paced nature of emergency care. Moving away from the traditional "long case" format—which is seldom encountered in real-world emergency departments—the assessment has now embraced a structured, multi-station model designed to evaluate the broad competencies required of an emergency physician.

This year's examination placed strong emphasis on managing the "undifferentiated" patient, testing candidates across a wide spectrum of specialties. Ten short clinical cases formed the core of the assessment, including two each from Internal Medicine and General Surgery, and one case each from Orthopedics, Trauma, Obstetrics & Gynecology, Ophthalmology, and ENT. These stations were evaluated using the Objective Structured Long Examination Record (OSLER), ensuring a standardized focus on history taking, clinical examination, and critical decision-making.

Clinical skills were further assessed through Objective Structured Clinical Examination (OSCE) stations in Dermatology and Psychiatry. Practical proficiency was tested using skill trainers for essential emergency procedures such as intubation and suturing. Point-of-care ultrasound competency was evaluated on a standardized patient, reflecting its growing importance in emergency diagnostics.

Teamwork, communication, and high-stakes procedural skills were assessed through ACLS mega code simulations and ATLS-based trauma scenarios, including CPR, cervical spine immobilization, and pelvic binder application. To test rapid data interpretation, ten spotter stations challenged candidates with ECGs, ABGs, X-rays, CT scans, CTG tracings, ventilator waveforms, clinical photographs, and emergency department instruments.

The examination concluded with a structured viva voce, where candidates demonstrated their ability to assess multiple patients simultaneously and addressed questions related to emergency drugs, instruments, medicolegal considerations, and their thesis work.

Conducted over a single day with adequate breaks, the multi-pillar model ensured a comprehensive, fair, and practice-oriented evaluation—preparing future emergency physicians for the realities of frontline medical care.

Masala Layered Lasagna

Dr. Arin Choudhury

Lasagna is a layered Italian pasta dish adapted in Indian recipes with vegetables and spices, often made without an oven. Popular vegetarian versions use simple ingredients like red sauce, white sauce, veggies, and cheese.

Follow these steps for an easy veg lasagna suitable for home cooking.

Ingredients:

- **Red sauce:** Tomatoes (pureed), onions, garlic, olive oil, chili flakes, oregano, salt, sugar.
- **White sauce:** Butter, flour, milk, cheese.
- **Veggies:** Bell peppers, zucchini, onions, carrots (sautéed).
- **Other:** Lasagna sheets (or roti for Indian twist), mozzarella cheese.

Method

- ☑ Prepare Red Sauce Heat olive oil, sauté chopped onions and garlic until translucent.
- ☑ Add tomato puree, chili flakes, oregano, salt, and sugar; cook covered on low flame for 10-12 minutes until thickened.
- ☑ Prepare White Sauce and Veggies For white sauce, melt butter, add flour, whisk in milk until thick, then mix in cheese.
- ☑ Sauté mixed veggies (bell peppers, zucchini, etc.) with salt, pepper, oregano, and chili flakes.
- ☑ Cook Lasagna Sheets Boil lasagna sheets in salted water until al dente (firm to bite), about 8-10 minutes.
- ☑ Drain and rinse with cold water to prevent sticking.
- ☑ Assemble and Bake in a greased baking dish, layer: thin red sauce, lasagna sheets, red sauce, veggies, white sauce, cheese.
- ☑ Repeat 4-5 layers.
- ☑ Bake at 180°C for 30-45 minutes (use makeshift oven if needed) until top is golden.

Basant Panchmi: A Festival of Wisdom and New Beginnings

Dr. Pooja Abbi

Basant Panchmi is a radiant celebration that welcomes the gentle arrival of spring and honors Goddess Saraswati, the divine source of wisdom, creativity, and learning. Observed on the fifth day of the bright fortnight of Magha, the festival transforms homes, schools, and temples into a golden spectacle of yellow symbolizing hope, prosperity, and the blooming mustard fields that sway with new life. The air feels lighter, filled with music, prayers, and the excitement of fresh beginnings. A cherished tradition of the day is the preparation of fragrant yellow rice, delicately sweet and infused with saffron or turmeric, which is offered to the goddess and shared as prasadam. This humble grain becomes a symbol of abundance, renewal, and gratitude, perfectly capturing the joyful spirit of Basant Panchmi.