



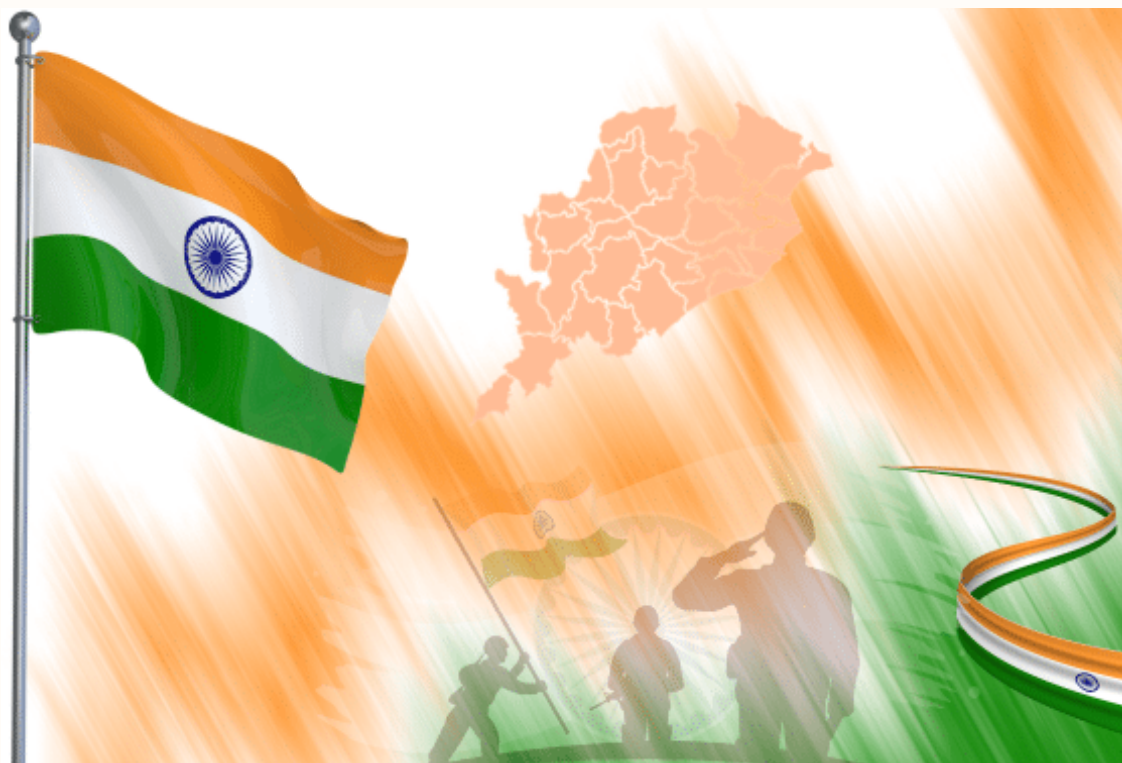
TRAUMA & EMERGENCY
TEAMS
ACADEMIC MEDICINE SENTINEL



Proclaiming & Promoting Academic Leadership

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Independence Day: A Tribute to Freedom and Nationhood

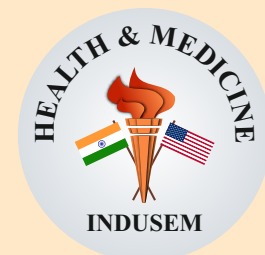


Every Independence Day, the tricolour rises not merely as a flag, but as a reminder of a dream won through extraordinary courage and sacrifice. 15 August marks the moment India awakened to freedom, but its significance reaches far beyond a date in history.

Independence is the privilege of having a voice, the dignity of making our own choices, and the responsibility of shaping the nation we inherit. From the valour of those who fought for freedom to the quiet dedication of citizens who build India each day, our progress is a collective legacy.

As India strides confidently into the future rooted in tradition yet alive with ambition, true patriotism lies not only in celebrating our freedom, but in being worthy of it. Let us honour the past with gratitude, embrace the present with pride, and build a future defined by courage, compassion and unity.

This Independence Day, let the tricolour remind us freedom was their gift to us; what we make of it is our gift to India.



Official Voice of
**Academic College of Emergency Experts
(ACEE)**
&
Emergency Medicine Association (EMA)
An INDUSEM Undertaking

Dr. A.P. Singh

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Club Drug Poisoning in India: Clinical Management

Dr. Linu

Introduction: Club drug poisoning is an important emergency toxicology problem, particularly in urban India, where recreational drug use may involve young adults, nightlife venues, and polysubstance exposure. “Club drugs” generally include MDMA/ecstasy, ketamine, gamma-hydroxybutyrate (GHB), and flunitrazepam, and they are often taken in combination with alcohol or other illicit substances. These cases are challenging because the exact substance is frequently unknown, routine drug screens may be negative, and clinical presentations can vary from agitation and hyperthermia to coma and respiratory depression.

Indian guidance emphasizes that there is no single standard treatment protocol for club drug overdose. As a result, management is symptom-based and focused on early recognition, stabilization, and prevention of complications.

Clinical Assessment: Initial evaluation should follow an emergency ABCDE approach with immediate attention to airway, breathing, circulation, disability, and exposure. Vital signs, oxygen saturation, cardiac rhythm, and temperature should be monitored closely, especially when stimulant toxicity, altered mental status, or mixed ingestion is suspected.

A detailed history should be obtained from the patient, bystanders, or emergency attendants whenever possible. Useful details include the likely drug taken, quantity, time of ingestion, route of use, co-ingestants, and the presence of similar previous episodes, seizures, self-harm, or trauma. Physical examination should focus on level of consciousness, pupil size, respiratory pattern, signs of agitation, diaphoresis, and evidence of aspiration or injury.

Emergency Management: The cornerstone of treatment is supportive care. Benzodiazepines are first-line agents for agitation, seizures, and sympathomimetic excess, and they help reduce central nervous system overactivity without directly worsening the toxidrome. Oxygen should be given when required, and airway protection is critical in patients with depressed consciousness or repeated vomiting.

Hyperthermia requires urgent active cooling, because it can rapidly lead to rhabdomyolysis, organ failure, and death. Tepid water bathing, fanning, ice packs, and escalation to intubation and deep sedation may be required in severe cases.

If opioid co-ingestion is suspected, naloxone should be administered promptly. Flumazenil should be used cautiously, if at all, because mixed overdoses are common and seizure risk may be increased.

Complications: MDMA and related stimulant drugs may cause serotonin syndrome, severe hyponatremia, arrhythmias, rhabdomyolysis, and acute kidney injury. Patients with hyponatremia may present with confusion, seizures, or reduced consciousness, while rhabdomyolysis should be suspected in prolonged agitation, hyperthermia, or collapse.

Basic investigations should include blood glucose, electrolytes, renal function, creatine kinase, and ECG. Urinalysis and a comprehensive chemistry panel are recommended where available to identify electrolyte

imbalance and renal toxicity. Patients with persistent symptoms, abnormal laboratory results, or mixed intoxication should be observed longer and admitted when needed.

Observation & Disposition: Observation for 24 to 48 hours may be appropriate in selected cases with residual effects, uncertain substance exposure, or risk of delayed complications. Psychiatric evaluation is recommended after stabilization, especially when the intoxication is linked to self-harm, dependence, or repeated high-risk use.

Discharge may be considered only when the patient is alert, hemodynamically stable, normothermic, able to take oral intake, and has no ongoing psychiatric or medical complication. Clear counseling about substance harms and return precautions should be provided before discharge.

Conclusion: Club drug poisoning in India is a significant clinical concern because presentations are often unpredictable, polysubstance use is common, and routine toxicology testing may not identify the agent. Emergency management should prioritize stabilization, benzodiazepine sedation, temperature control, complication surveillance, and careful observation. Since no universal antidote exists for most club drugs, early supportive care remains the most effective strategy for reducing morbidity and mortality.

References:

- ☑ Clinical Practice Guidelines for Assessment and Management of Patients with Substance Intoxication Presenting to the Emergency Department. Indian Journal of Psychiatry.
- ☑ Club drugs: review of the 'rave' with a note of concern for the Indian scenario.
- ☑ Club Drugs: Review of the 'Rave' with a Note of Concern for the Indian Scenario.
- ☑ CPG on Newer and Emerging Addictive Disorders in India.

The Innocent Frontline: Scaling Pediatric Trauma Resuscitation in an Age of Global Conflict

Dr. Neha Thakur Rai

Modern warfare is shifting. The battlefields of the twenty-first century are no longer confined to isolated fields or strategic outposts; they are increasingly fought in high-density urban centers. Consequently, the demographics of conflict casualties have catastrophically pivoted. The most vulnerable population—children—now bear the brunt of modern explosive weaponry, structural collapses, and prolonged siege warfare. While the volume of pediatric trauma victims surges globally, our medical infrastructure faces a silent, equally devastating crisis: a profound deficiency in pediatric-specific resuscitation training and resources worldwide.

The Grim Reality: Children in the Line of Fire: In contemporary geopolitical conflicts across Eastern Europe, the Middle East, and Sub-Saharan Africa, civilian infrastructure has frequently become the epicenter of hostility. The widespread deployment of modern artillery, improvised explosive devices (IEDs), drone strikes, and ballistic missiles means that children are sustained victims of high-energy blasts, severe shrapnel wounds, thermal injuries, and crush syndromes. According to humanitarian field registries, blast injuries account for a disproportionately large percentage of pediatric admissions in conflict zones. Unlike adult



combatants, a child's body is highly susceptible to the kinetic transfer of an explosive wave, resulting in multi-system trauma that presents unique, acute physiological challenges.

3x to 5x

KINETIC ENERGY ABSORPTION RELATIVE TO
BODY MASS IN PEDIATRIC BLAST TRAUMA

Children are not merely small adults. Their physiological response to trauma is starkly distinct. A pediatric patient's body can compensate for significant blood loss through intense vasoconstriction and tachycardia, maintaining a normal blood pressure until they are on the absolute brink of catastrophic cardiovascular collapse. When deterioration occurs, it is precipitous—a clinical cliff rather than a gradual decline. Furthermore, their large surface-area-to-mass ratio leaves them hyper-vulnerable to rapid hypothermia, which quickly fuels the lethal triad of trauma: hypothermia, metabolic acidosis, and coagulopathy.

The Training Gap: A Fatal Deficit in Emergency Care: Despite the predictable influx of young casualties in active conflict zones, frontline medical personnel are overwhelmingly under-trained in advanced pediatric resuscitation. The systemic roots of this problem lie in standard medical education curricula globally. Most emergency medicine residencies, general surgery programs, and paramedic training tracks focus predominantly on adult physiology. Pediatric trauma is treated as a rare, niche sub-specialty, leading to a profound lack of clinical exposure and procedural confidence among general practitioners.

In active war zones, local healthcare networks are quickly overwhelmed, forcing general practitioners, dental surgeons, and even nurses to act as primary trauma leaders. When faced with a severely injured child, these providers encounter massive cognitive overloads. Basic interventions become paralyzing hurdles. Calculating weight-based drug dosages under extreme duress frequently leads to catastrophic medication errors. Securing an airway in an infant—whose larynx is more anterior and superior, and whose tongue is disproportionately large—becomes an anatomical nightmare for a provider who only intubates adults.

The Danger of Cognitive Overload in Active Conflict Zones

Field studies indicate that over 60% of avoidable errors in frontline pediatric resuscitation stem from calculation stress regarding weight-adjusted medication volumes and fluid volumes, alongside acute equipment mismatch during emergency endotracheal intubation.

Furthermore, standard adult surgical tools and resuscitation equipment are completely incompatible with pediatric patients. Large chest tubes, standard adult laryngoscope blades, and adult fluid resuscitation volumes can cause severe iatrogenic injury to a small child. Without

specialised training in alternative access methods, such as intraosseous (IO) cannulation, providers spend precious, life-ending minutes attempting to place a peripheral intravenous line in a profoundly hypovolemic, vasoconstricted child.

The Mathematics of Resuscitation: Precision Under Fire: To grasp the complexity of pediatric resuscitation, one must look at the physiological calculations involved. Fluid resuscitation cannot be empirical; it must be tightly regulated to prevent volume overload or under-resuscitation. For a pediatric patient in hemorrhagic shock, the standard initial bolus is calculated as:

$$V_{\text{bolus}} = 20 \text{ mL} * W_{\text{kg}}$$

Where W_{kg} represents the child's weight in kilograms. If the child is in exsanguinating hemorrhagic shock due to penetrating trauma, modern protocols dictate transitioning early to a balanced blood product transfusion scheme rather than crystalloids, maintaining a ratio of:

$$PRBC : FFP : PLT = 1 : 1 : 1$$

Executing these precise calculations, alongside managing rapid heat loss and establishing surgical airways with tools scaled to sub-millimeter tolerances, highlights why general trauma education fails our children. Pediatric resuscitation requires an immediate, reflexive skill set that standard adult trauma paradigms simply do not provide.

A Global Call to Action: Democratizing Pediatric Trauma Education: Resolving this crisis demands a coordinated, aggressive international mobilisation to democratise pediatric trauma training. We cannot wait for conflicts to subside to build capacity; resuscitation expertise must be pre-positioned in vulnerable regions.

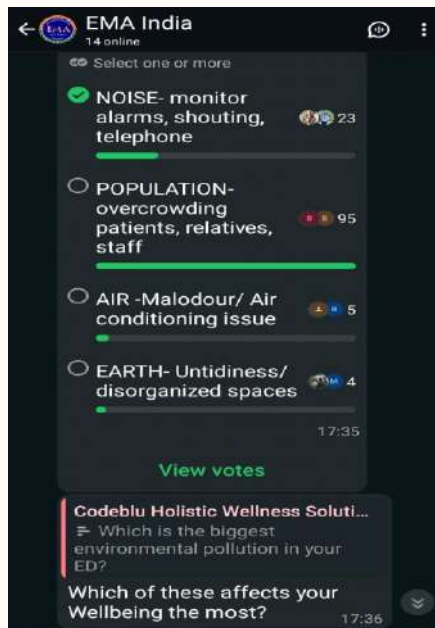
- ☑ **Universal Integration of Pediatric Trauma Resuscitation Module (PTRM):** International medical bodies must mandate comprehensive pediatric trauma protocols within all standard humanitarian and military pre-deployment training courses. Programs like PTRM must be adapted for low-resource, high-casualty wartime environments.
- ☑ **Widespread Distribution of Color-Coded Resuscitation Tools:** Systems like the Broselow Tape or digital weight-estimation apps must be universally deployed to eliminate mental math during high-stress resuscitations. These tools instantly map a child's length to pre-calculated drug dosages, fluid volumes, and properly sized equipment.
- ☑ **Deployment of High-Fidelity Simulation in Fragile States:** Establishing mobile simulation labs utilising low-cost, high-fidelity pediatric mannequins allows local frontline providers to build muscle memory for critical procedures such as intraosseous needle insertion, needle thoracostomy, and pediatric surgical airways.
- ☑ **Tele-Mentoring and Remote Specialist Support:** Leveraging satellite communication infrastructure to connect frontline clinicians in active war zones with pediatric trauma centers globally can offer real-time, intra-operative guidance during complex resuscitations.

Conclusion: A Moral Imperative: The measure of a society's humanity is reflected in how it protects its children during its darkest hours. As the geopolitical landscape fractures and warfare continues to encroach upon civilian sanctuaries, the number of pediatric trauma victims will inevitably climb. Leaving frontline clinicians untrained and ill-equipped to manage these fragile patients is an unacceptable failure of global healthcare solidarity.

By establishing global networks dedicated to spreading pediatric trauma resuscitation training, standardising pediatric emergency resources, and embedding specialised protocols within international humanitarian responses, we can tip the scales in favour of survival. The knowledge exists to save these young lives; our structural obligation now is to ensure it reaches the hands of those standing on the frontline, ready to receive it.

Which Pollution in ED affects your wellbeing the most – Wellness survey *Dr. Murtuza Ghiya*

A unique question was asked on the EM India Whatsapp group, managed by EMA – Emergency Medicine Association (India), the voice of board certified EM doctors in India. While we were aware this is not a validated tool for estimation of results, we thought this would serve as a good starting point to ask further research questions



Take home message :

- ☑ Clearly overcrowding affects most doctors wellbeing the most.
- ☑ Noise in ED is also the second most important factor affecting the wellbeing of Doctors.
- ☑ These issues create medical errors due to “human factors” while also affecting the morale of the team.

Way Forward :

- ☑ ACEE / WHO CCET- is publishing a whitepaper on overcrowding in ED.
- ☑ An international Faculty talk and then discussions around noise pollution in WACEM 2025.

Doctors Day – Wellness Activity

Dr. Murtuza Ghiya

An online event for organized to commemorate Doctors day on 6th July (as it was the first weekend after Doctors Day.

Unique features :

- ☑ Actual stretching done by all participants
- ☑ Real reflections on how all participants will be changing their routines to accommodate “me time”
- ☑ Laughter and stand up comedy



Participants were not limited to EM doctors only, and not limited to India as we had participants for UK and USA.



Event was well received as it was rehearsed and tailor made for engagement, rather than simple monologues / demonstrations.

Mast Masti and Medicine

Dr Murtuza Ghiya

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 Ss 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!



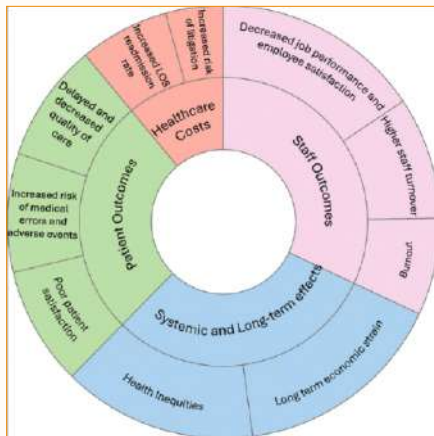
Watch out for our next big workshop along the river Ganga in Varanasi, EM India 2026 !!



Wellbeing – from a Buzzword to scientific legitimacy

Dr Murtuza Ghiya

Strategies to Combat Overcrowding at Emergency Department across India. A White Paper by the Academic College of Emergency Experts, India and the World Health Organization Collaboration Centre for Emergency and Trauma, South-EastAsia.



The meeting of ACEE and WHO CCET, South East Asia members meeting in 2025 which has lead to publishing of the white paper on Strategies to Combat overcrowding in Emergency departments across India has clearly laid focus on staff outcomes with literature backing the same.

The issues of burnout are multi-factoral and well researched; imploring policy makers to take a scientific and systematic approach to dealing with it. This is a major step forward to all advocates of staff wellbeing heralding a new outlook towards staff centered patient outcomes!

The Journey of India's B.Sc. EMT Graduates

Dr. Ajay A

The inaugural cohort of B.Sc. Emergency Medical Technology (EMT) graduates from AIIMS Nagpur has proven that this acute care degree program offers a versatile, high-impact career trajectory in India.

They have seamlessly integrated into diverse sectors of healthcare and technology. Three graduates joined an advanced Emergency Medical Services (EMS) network and are stationed at Indira Gandhi International Airport, New Delhi. One graduate transitioned into an M.Sc. program at an IIT, bridging ground-level clinical insights with biomedical device research and engineering. Another graduate is pursuing a certificate course in transplant coordination, where his knowledge of crisis physiology and logistical expertise serves as a major asset for organ retrieval. Furthermore, this group is working toward launching a startup under the IIM Nagpur Startup Incubator.

India's rapidly expanding trauma networks, highway emergency corridors, and private air evacuation services present a strong demand for degree-holding technologists. These graduates are well-positioned for roles in hospital administration, international paramedic registration, and indigenous medical device R&D.

Despite their versatility, challenges remain. Prehospital paramedics face demanding shift patterns and early-career compensation caps. Furthermore, standardizing state-level paramedic council registrations and establishing clear independent practice guidelines are necessary steps to unlock the full potential of these graduates within the national healthcare framework.

This inaugural batch proves that B.Sc. EMT is not a narrow skill trade, but a foundation for clinical execution, health systems leadership, and technological innovation.

Not Today. Not on My Watch.

Dr. Nisha Totuja

"Every pediatric intensivist has a few children they could not save. They become the silent teachers who shape every child they fight for thereafter."

There is something profoundly humbling about being entrusted with a child's life.

Among all the branches of medicine, pediatric emergency and critical care perhaps places one closest to the fragile boundary that separates life from death. Childhood is meant to be synonymous with innocence, laughter, scraped knees, school bags, and birthday cakes—not ventilators, vasoactive infusions, dialysis machines, and whispered discussions about prognosis. Yet, life has an uncanny ability to shatter that illusion in a heartbeat.

A child who was laughing in a swimming pool an hour ago is pulled out unconscious. A curious toddler mistakes a poison for candy. A road traffic accident steals away a family's future in seconds. A simple fever evolves over hours into fulminant septic shock, cytokine storm, and relentless multiorgan dysfunction syndrome. As pediatric intensivists, we are often introduced to children on the worst day of their lives.

Some survive.

Some do not.



Years later, I can still remember the faces of the children I could not save. Their names may fade from hospital records, but never from memory. They return unexpectedly—in quiet moments, during night shifts, in the silence after a code blue, or when another child presents with eerily similar signs. As I recount those little ones, I am filled with the same sense of helplessness that comes from fighting against a mountain of accumulated cytokines, refractory shock, and multiorgan dysfunction threatening to overwhelm a tiny body determined to live. Every pediatric intensivist carries these invisible scars.

The public sees the grieving family. Rightly so. The suffering of parents is beyond imagination. Their child is not merely another patient; that child is their entire universe.

What is less visible is the emotional burden carried by the team standing beside the bed.

Behind every critically ill child are physicians and nurses who have spent sleepless nights recalculating ventilator settings, titrating vasoactive infusions minute by minute, searching literature for one more therapeutic possibility, discussing options across specialties, and silently hoping that statistics will fail this once. We celebrate quietly when children recover, but we grieve privately when they do not.

Perhaps every PICU has one physician whom residents affectionately describe as "the one who never gives up."

One of my postgraduate residents once smiled and remarked, "Ma'am never lets a child go."

I laughed.

But it was true.

If another chest tube was needed, we inserted it.

If another inotrope could buy a few more hours, we started it.

If the child needed high-frequency oscillatory ventilation, prone positioning, nitric oxide, continuous renal replacement therapy, or another cycle of CPR—we did it.

Every resuscitation carried the same silent promise:

Not today. Not on my watch.

Is it stubbornness?

Perhaps.

Is it hope?

Certainly.

Maybe every pediatric intensivist is just a little irrational. We continue because somewhere in our minds lives that improbable one-percent chance. Medicine teaches us probabilities; parents teach us possibilities.

To us, it may be a one-percent survival.

To a mother and father, that one percent is one hundred percent of their world.

That realization changes everything.

Over the past decade, pediatric critical care has entered an extraordinary era. What once seemed impossible is steadily becoming routine. Extracorporeal therapies—once confined to a handful of centres—are increasingly rewriting outcomes.

Watching extracorporeal life support mature has felt, to my intensivist heart, like witnessing return of spontaneous circulation after prolonged arrest.

Every innovation follows the same journey.

First comes disbelief.

Then hesitation.

Then fear.

There are countless discussions, protocols, simulations, failed attempts, reinventions, and long learning curves. Gradually, unfamiliarity gives way to confidence. What was once considered experimental quietly becomes standard practice. One day, we wonder how we ever practised without it.

ECMO. Continuous renal replacement therapy (CRRT). Therapeutic plasma exchange. Molecular Adsorbent Recirculating System (MARS). Extracorporeal carbon dioxide removal (ECCO₂R). Advanced extracorporeal therapies are not miracles—but in carefully selected patients, instituted at the right time and monitored meticulously, they can appear astonishingly close.

They interrupt the spiral toward irreversible organ failure.

They buy time.

And in critical care, time is often the most powerful therapy we possess.

Among these advances, perhaps none captures the very spirit of pediatric critical care more than **Extracorporeal Cardiopulmonary Resuscitation (ECPR)**. There is something almost surreal about watching a child in refractory cardiac arrest—where conventional CPR is no longer enough—being cannulated onto ECMO while uninterrupted, high-quality chest compressions continue. It is the ultimate expression of refusing to surrender. ECPR is not about defeating death; it is about creating a precious window during which reversible pathology can be corrected while the brain and other vital organs continue to receive perfusion. It demands extraordinary teamwork, simulation, systems preparedness, and unwavering discipline. It is not meant for every patient, nor is it a substitute for excellent conventional resuscitation. But for the carefully selected child, ECPR transforms what was once the end of the story into the possibility of another beginning.

These technologies should never be viewed as desperate "Hail Mary" interventions reserved for the final moments. Their greatest strength lies in thoughtful patient selection, timely initiation, multidisciplinary teamwork, and vigilant monitoring. Whether it is ECMO for refractory cardiorespiratory failure, ECPR during refractory cardiac arrest, CRRT for severe acute kidney injury, or other extracorporeal organ support modalities, the future of pediatric critical care lies not merely in possessing these technologies but in mastering the science, judgment, and teamwork required to use them well.

Every intensivist has a few "rainbow children"—patients who survived against overwhelming odds and remind us why we continue this demanding profession. We also have children who continue to haunt us because we wonder whether another option, another technology, or another hour might have changed the ending.

Those questions are what drive our specialty forward.

Pediatric critical care has always stood at the interface between hope and despair, science and uncertainty, life and death.

In Indian mythology, **Yamdoot**, the messenger of death, arrives when a life has reached its destined end.



I often imagine our place as pediatric intensivists somewhere along that path.

Not to defy mortality forever—no physician can.

But to stand between Yamdoot and the child for as long as medicine, science, compassion, skill, innovation, and human perseverance allow.

Sometimes we succeed.

Sometimes we fail.

But every time we answer a code blue, prepare an ECMO circuit, initiate ECPR, or begin another exhausting night shift, we renew the same quiet promise to the child before us:

Not today.

Not on my watch.

Acknowledgment

The reflections on extracorporeal life support in this article were inspired by my recent clinical observership with Dr M Srivatsa Nagachandan, a Critical Care Consultant at Apollo Adlux Hospital. Witnessing the seamless integration of ECMO and ECPR into modern critical care reaffirmed my belief that timely extracorporeal support, in appropriately selected patients and delivered by a well-trained multidisciplinary team, has the power to transform outcomes and redefine the boundaries of hope.

Guidelines on Critical Care Hospital Blocks

Dr. Arin Choudhary

At a Glance:

- ☑ 602 districts across all States/UTs to be covered under PM-ABHIM.
- ☑ Critical Care Blocks (CCBs) of 100 / 75 / 50 beds, sized by existing District Hospital bed strength.
- ☑ 102 high-population districts (>20 lakh) | 274 districts (5–20 lakh) | 226 Medical College districts.
- ☑ Capital cost: Rs 23.75 Cr (50-bed) to Rs 44.50 Cr (100-bed). Recurring HR/O&M support only till FY 2025-26.

Why This Scheme - Background:

- ☑ Critical care (Emergency + Surgical + ICU) is presently concentrated at tertiary level with weak secondary-care & referral-transport linkages. Out-of-pocket expenditure is Rs 2,097/capita — 48.8% of Total Health Expenditure (NHA 2017-18).
- ☑ COVID-19 exposed critical gaps in health-system infrastructure and surge-response capacity.
- ☑ Top-5 causes of mortality — Coronary Artery Disease, COPD, Stroke, Diarrhoeal Diseases, Neonatal disorders — can be managed at the district hospital level itself, cutting both tertiary-care load and OOP.
- ☑ The Hon'ble PM therefore launched PM-ABHIM, mandating Critical Care Blocks in all districts with population > 5 lakh, in State medical colleges/District Hospitals, and in 12 Central Institutions

Purpose of the Guidelines: To guide States in undertaking civil construction of Critical Care Blocks — covering location, minimum covered area, patient/service flow, design principles, cost norms and statutory/legal clearances — so projects are

completed timely and efficiently.

Coverage & Bed-Strength Norms	
District Category	CCB Size
Existing DH bed strength < 200 (of 102 districts >20L pop.)	50 beds
Existing DH bed strength 200–300	75 beds
Existing DH bed strength > 300	100 beds
274 districts, population 5–20 lakh	50 beds
226 districts with Government Medical Colleges	50 beds

Area norm (IPHS: 85 sq.m/bed): 100-bed = 8,500 sq.m | 75-bed = 6,375 sq.m | 50-bed = 4,250 sq.m.

Suggestive Distribution of Beds (Table - 2)			
Component	100 - bed	75 - bed	50 - bed
ICU	20 (incl. 4 paed)	12 (incl. 2 paed)	10 (incl. 2 paed)
HDU	20 (incl. 4 paed)	12 (incl. 2 paed)	6 (incl. 2 paed)
Isolation Ward	30	30	24
Isolation Room	12	5	2
Dialysis	4	4	2
MCH	6	4	2
Emergency (Red+Yellow +Triage)	10 (4+4+2)	10 (4+4+2)	5 (2+2+1)
OT / LDR / Point-of-Care Lab	2 / 2 / 1	2 / 2 / 1	2 / 2 / 1

Location & Design Principles - Must - Do Checklist:

- ☑ **Integration:** CCB must be an integral part of the existing District Hospital/Medical College Hospital, but with separate **entry/exit** so it can be isolated as a dedicated facility during outbreaks (e.g., COVID-19).
- ☑ Core functional units: Emergency + ICU, Isolation Wards, OT, Labour-Delivery-Recovery (LDR) rooms with Newborn Care Corner; support services (Imaging, Dietary, CSSD/Laundry) linked to or created within the DH.
- ☑ Site selection: avoid flood-prone/low-lying land; ensure elderly & disabled-friendly access; minimise air/noise/water/land pollution; vector-breeding-proof construction.
- ☑ Prefer vertical construction (FAR-based expansion) over horizontal sprawl where land is constrained, subject to NBC and state by-laws; keep mandated open space on all sides.
- ☑ Ground floor placement (where possible) for Emergency and LDR complex; adequate road width for fire-engine/ambulance access; dedicated staff vs. visitor parking.
- ☑ Patient experience: clear signage/way-finding, waiting areas, gardens, washrooms, drinking water, tactile



- ☑ pathways for the visually impaired, fluorescent fire-exit plans.
- ☑ Structural safety: seismic-zone-compliant foundation with capacity for future vertical expansion; strict fire-safety compliance; anti-skid flooring in corridors, ramps, lifts and stairs.
- ☑ **Medical Gas Pipeline System (MGPS) is mandatory** for OT, ICU, Emergency and labour room, with a manifold area compliant with the Gas Cylinder Rules 1981, ISO 7396-1:2016 and Indian Explosives Act 1984.
- ☑ Infection control: negative-pressure isolation/HDU/ICU areas; air changes — 6/hr (Isolation), 12/hr (HDU/ICU), 20/hr (OT); HEPA-filtered Air Handling Units in all critical areas.
- ☑ Environment-friendly design: natural lighting, rainwater harvesting, solar energy where feasible; separate effluent line to an Effluent Treatment Plant; bio-medical waste handling per BMWM Rules.
- ☑ Full compliance with the Rights of Persons with Disabilities Act and the GoI barrier-free-access guidelines is mandatory, not optional.

Human Resource Norms (PHS-Based)	
Cadre	Norms
Specialists	Round-the-clock cover for OT, ICU, Emergency, Delivery Unit & other areas (per IPHS)
GDMO	1 per 10 beds in critical-care area; 1 per 20 beds in non-critical area
Nurses	1:1 (ICU) 1:2 (Step-Down Unit) 1:6 (Wards/other areas) 2 per OT per shift 1 round-the-clock for Delivery Unit
Support Staff	As per IPHS/GoI guidelines

Critical For States to Note:

- ☑ PM-ABHIM funds only contractual/outsourced HR — and only up to the scheme period (FY 2025-26). Recurring HR cost is NOT available beyond this.
- ☑ If States appoint permanent staff (on their own, or by Court order), the State bears that cost — Central liability is capped at the approved PM-ABHIM plan.
- ☑ States must commit to creating and filling regular posts so assets remain functional beyond the scheme period.
- ☑ State Health Society (not the Central Government) is responsible for all appointments, transfers, terminations and wage payments.

Cost Norms				
CCB Type	Construction	Equipment	Capiral Cost	Capiral Cost
50-bed	Rs. 16.63 Cr	Rs. 7.12 Cr	Rs. 23.75 Cr	Rs. 4.592 Cr
75-bed	Rs. 24.95 Cr	Rs. 11.40 Cr	Rs. 36.35 Cr	Rs. 5.844 Cr
100-bed	Rs. 30.55 Cr	Rs. 13.95 Cr	Rs. 44.50 Cr	Rs. 7.912 Cr
50-bed (Medical College)	-	-	Rs. 23.75 Cr	Borne by State Govt.

Recurring cost covers HR support, equipment maintenance, oxygen refilling, teleconsultation, drugs & consumables (reagents, diagnostic kits), infection-prevention supplies and bio-medical waste management.

- ☑ **Normative & capped:** Costs above are indicative ceilings. Actual cost is discovered via open, transparent tendering. Any amount beyond the normative ceiling must be funded by the State/UT from its own resources.
- ☑ Central share is released against fulfilment of conditions — Utilisation Certificates and expenditure reports — on the same terms as the National Health Mission.

Implementation Roadmap

- ☑ **Step 1:** MoU signed between State and MoHFW
- ☑ **Step 2:** Site selection as per prescribed criteria
- ☑ **Step 3:** Site survey
- ☑ **Step 4:** Preparation of DPR & layout plans
- ☑ **Step 5:** DPR finalisation with preliminary cost estimate (per State process)
- ☑ **Step 6:** Tendering
- ☑ **Step 7:** Initiation of construction work

Monitoring, Quality & Clearances

- ☑ **District level:** District Health Society tracks implementation of all sanctioned components against approvals, on a periodic basis.
- ☑ **State level:** Addl. Chief Secretary / Principal Secretary / Secretary (Health), as EC Chairperson of the State Health Society, monitors overall progress.
- ☑ **National level:** MoHFW monitors under the NHM framework; overall oversight rests with the Mission Steering Group (MSG).
- ☑ **Reporting:** Monthly progress must be updated in the NHM Progress Monitoring System (NHM-PMS) — this is essential for release of subsequent grant instalments.
- ☑ **Quality:** States may engage Third-Party Quality Assurance (TPQA) for construction quality control and structural design vetting.
- ☑ **Statutory clearances:** Building Plan approval, Fire NOC and Occupancy Certificate must be facilitated by the State Government and obtained by the implementing agency before commissioning — strict compliance is non-negotiable.

Action Points for District/ State Functionaries

- ☑ Confirm your district's population category and corresponding CCB bed size (50/75/100) before DPR preparation.
- ☑ Plan for future expansion and vertical construction; do not design to only the present footprint.
- ☑ Budget realistically for HR beyond FY 2025-26 — Central recurring support ends with the scheme period.
- ☑ Secure Fire NOC, Building Plan and Occupancy Certificate approvals early — these are frequent causes of delay.
- ☑ Update NHM-PMS monthly without fail to avoid disruption in release of grant instalments.



What's New in JETS? Helicopters, Bedside Ultrasound and Smarter Emergency Care

Dr. Vivek Chauhan

The April–June 2026 issue of the Journal of Emergencies, Trauma, and Shock (JETS) brings together thought-provoking research and practical lessons for emergency physicians. Covering trauma transport, critical care, emergency education, mental well-being, innovative diagnostic technologies and memorable clinical cases, this issue highlights how better outcomes are achieved not only through new technology but also through sound clinical judgement, skilled teams and efficient systems.

Helicopters: Faster Is Not Always Better

The lead editorial examines one of trauma care's most debated questions: does helicopter transport improve survival? Drawing on a systematic review involving more than three million trauma patients, the authors explain that although helicopter-transported patients appear to have higher mortality, they are also the most severely injured. The message is that helicopters should not be viewed simply as faster ambulances. Their value depends on expert crews, advanced prehospital interventions, careful patient selection and integration into an organised trauma network. For countries such as India, strengthening trauma systems and ground ambulance services may often deliver greater benefits than expanding helicopter fleets.

Predicting Weaning Success at the Bedside

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Investing in Emergency Professionals

An original research article explores parasternal intercostal muscle ultrasound as a simple bedside tool for predicting failure of ventilator weaning and identifying weaning-induced pulmonary oedema. If validated further, this non-invasive technique could help clinicians avoid failed extubations and improve intensive care outcomes.

Technology for Minor Head Injury

Two original studies focus on the people behind emergency care. One identifies important gaps in faculty educator development, emphasising the need for structured teaching programmes for emergency physicians. Another highlights the psychosocial stresses experienced by emergency medical services personnel, reminding us that resilient healthcare systems require resilient healthcare workers.

Ultrasound: The Modern Emergency Stethoscope

The pictorial education section demonstrates how point-of-care ultrasound can rapidly diagnose superficial thrombophlebitis in patients presenting with painful, red legs. The beautifully illustrated article reinforces ultrasound's growing role as an indispensable bedside investigation in emergency medicine.

Rare Cases, Enduring Lessons

The case reports feature a rare solid pseudopapillary pancreatic tumour presenting as abdominal pain and a three-patient series of spontaneous splenic rupture without trauma. The Letters to the Editor describe unusual but educational cases, including retropharyngeal haematoma causing airway obstruction, emphysematous pyelonephritis with portal venous gas, retained needles in intravenous drug users and innovative management of severe fever with thrombocytopenia syndrome.

Take-home Message

This issue of JETS reminds us that outstanding emergency care is built on evidence, teamwork and thoughtful decision-making. Whether choosing the most appropriate mode of trauma transport, using bedside ultrasound to answer difficult clinical questions or supporting the well-being of emergency professionals, the common goal remains unchanged: delivering the right care to the right patient at the right time. It is another excellent issue that blends scientific rigour with practical relevance for clinicians across emergency medicine, trauma, critical care and prehospital services.

REBOA and Whole Blood: Rewriting Damage Control Resuscitation

Dr. Shirshendu Dhar

Haemorrhage remains the leading cause of potentially preventable death after injury worldwide. Two techniques dominate current discussion on how emergency physicians can buy time and blood for the bleeding trauma patient: Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) for non-compressible torso haemorrhage, and low-titer group O whole blood (LTOWB) as a first-line resuscitation fluid. Both have moved from military and pilot-programme curiosities into mainstream civilian trauma protocols over the past two years — and both carry lessons for departments like ours.

REBOA: Powerful Adjunct, Not a Universal Answer

REBOA works by inflating a balloon catheter within the aorta to control bleeding below the level of occlusion, temporarily stabilising haemodynamics while the patient is moved toward definitive surgical or interventional-radiology control. Interest has expanded well beyond blunt/penetrating torso trauma into postpartum haemorrhage, placenta accreta spectrum disease, and even resuscitation adjunct roles in cardiac arrest.

The enthusiasm is tempered by hard data. The largest and only randomised controlled trial to date (UK-REBOA) found no mortality benefit in haemodynamically unstable trauma patients, with a signal toward harm compared with standard care alone.¹ Reported complications include ischaemia-reperfusion injury, acute kidney injury, arterial injury and embolism, and limb ischaemia up to amputation.² Current





synthesis across systematic reviews is consistent: REBOA is a lifesaving bridge in carefully selected patients when definitive control is imminent — not a routine resuscitation manoeuvre, and not a substitute for a functioning trauma pathway.

The India Context: Why REBOA Still Matters Here

The UK-REBOA findings were generated in systems where a trauma operating theatre and surgeon are typically minutes away. That assumption does not hold across much of India, including Northeast India's referral geography, where road trauma victims may face transport times of one to several hours between the point of injury, a first-contact facility, and a centre with an available trauma OR and blood bank capacity for damage control surgery. In this setting the relevant comparison is not "REBOA versus immediate laparotomy," but "REBOA versus exsanguination during transfer or during the wait for theatre availability.

In systems without round-the-clock trauma OR access, REBOA's role shifts from a routine resuscitation adjunct to a bridging tool that buys the minutes a transferring or waiting patient does not otherwise have.

This reframes REBOA for peripheral centres is less as a technique to adopt wholesale from Western civilian trauma centres, and more as a potential bridging strategy for a specific, narrow population: patients with non-compressible torso haemorrhage who cannot reach definitive haemorrhage control within a survivable window, whether due to interhospital transfer, operating theatre queuing, or interventional radiology unavailability. Reports from Japan and China describing REBOA use in non-trauma centres and during interhospital transfer, precisely to bridge patients to a facility capable of definitive care, are the closer analogue to the Indian district-to-tertiary referral pattern than the UK trial population.⁶ Any local adoption would still require honest accounting for the barriers that make REBOA harder to do safely here: device and consumable cost, ultrasound-guided femoral access proficiency, a credentialing and simulation-based training pathway, and a clear protocol defining who does not get the procedure. Adopting the tool without adopting the selection discipline is exactly the scenario the RCT data warns against.¹

Whole Blood: The Quieter Revolution

While REBOA's evidence base has cooled, low-titer group O whole blood has moved decisively into first-line status. The 2025 NAEMSP position statement now recommends LTOWB as the first-choice blood product for prehospital life-threatening traumatic bleeding, reflecting a broader civilian shift away from component therapy (separate red cells, plasma, and platelets) toward a single product that better approximates what the patient actually lost.³

Programme-level data continues to support the approach: a 2026 single-centre report on a low-titer O-positive whole blood protocol described favourable outcomes in patients receiving LTOWB in the emergency department,⁴ and pilot

prehospital programmes such as Los Angeles County's LA-DROP initiative are now modelling and operationalising field transfusion at scale, including safety questions specific to whole blood such as haemolytic disease of the fetus and newborn risk in transfused patients.

- ☑ One product, less logistical complexity than balanced component ratios
- ☑ Platelet and clotting factor content lost in fractionation is preserved
- ☑ Growing prehospital adoption suggests feasibility outside trauma centres⁵
- ☑ Cold-chain, donor screening, and titer-testing infrastructure remain real barriers in low-resource blood banks

For a department already engaged in walking blood bank and massive transfusion protocol development, whole blood resuscitation is arguably the more immediately actionable of the two innovations discussed here — it requires blood bank and donor-pool planning rather than a new invasive skill and device inventory.

Bottom Line

- ☑ REBOA: high-value only within a disciplined selection protocol and credentialed skill pathway; in India's referral geography its strongest justification is as a bridge to transfer or delayed OR access, not routine shock management.^{1,6}
- ☑ Whole blood: increasingly first-line evidence and NAEMSP-endorsed; the more tractable near-term investment for AGMC given existing blood bank engagement.³
- ☑ Both innovations reinforce the same principle — damage control resuscitation is a systems problem, and technology only helps within a protocol that defines who benefits and who is harmed.

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Why We Must Build First-Response Teams for Bikers, Trekkers and Anglers

Dr. Rajiv Singal

Emergency medicine does not begin at the hospital gate. It begins at the roadside, at the riverbank, on the mountain trail, near the canal, beside the crashed motorcycle, and in the first few confused minutes before professional help arrives.

For Indian bikers, trekkers and anglers, those first minutes are often decisive. A bleeding limb, an obstructed airway, a drowning casualty, a cold and shocked patient, or a fractured limb in a remote area does not wait for a perfect system. The person standing nearby becomes the first link in survival.

This is where emergency physicians must step forward.

We are trained to think in priorities. We understand that death in trauma is not usually prevented by a long lecture, but by a short sequence done correctly: scene safety, bleeding control, airway protection, spinal caution, warmth, rapid call for help, and a clean handover. The public does not need to become doctors. But they can be trained to become useful, calm and safe first responders until the ambulance arrives.

The Missing Link: Community Response

India has adventure bikers, highway riders, trekkers, riverbank anglers, canal-side fishing groups, dam visitors and weekend outdoor communities. These groups already travel together. They already carry bags, ropes, jackets, torches, phones and basic tools. What they often lack is a simple emergency sequence.

Emergency physicians can provide that sequence.

A biker group should know how to create a safe “steel shield” with parked bikes and hazard lights, how to stop catastrophic bleeding, when not to remove a helmet, how to suspect pelvic bleeding, and how to give a one-sentence handover to ambulance staff.

An angler group needs a different emphasis. Their risks are water, drowning, hooks, knives, slippery banks, cold exposure, snakebite, lightning and delayed rescue. Their mantra must be: **Do not drown the rescuer. Reach or throw before you go. Warm the wet patient. Do not pull a hook from the eye or face.**

This is practical emergency medicine translated into community language.

Why Anglers Need Special Attention

Drowning remains an urgent global public health problem. The World Health Organization estimates around 300,000 drowning deaths annually worldwide, with 92% occurring in low- and middle-income countries. WHO also highlights that drowning is preventable and needs organized public-health action, not just hospital care after the event.

Anglers often stand close to unstable banks, wet rocks, canals, deep water, boats, ghats and reservoirs. A slip may become a head injury. A fall may become drowning. A rescue attempt may create a second victim. A wet casualty may become hypothermic and shocked while waiting for help.

For drowning-related cardiac arrest, current American Heart Association guidance emphasizes CPR with rescue breaths and chest compressions after the person is removed from water; if a rescuer cannot provide breaths, compression-only CPR is still better than doing nothing.

This is exactly why emergency physicians must create short, hands-on modules for fishing communities, angling clubs, trekking groups and outdoor associations.

The Indian Context: Help Must Be Early, Safe and Legal

India has an integrated emergency helpline, 112, for police, fire and rescue, and health services through the Emergency Response Support System. But in remote locations, the caller must also know how to share a location pin, nearest landmark, number of victims, water involvement, bleeding status and what first aid has already been done.

Equally important is public confidence. In road traffic accidents, India's Good Samaritan protections state that a bystander who helps an injured person should not be harassed, is not compelled to disclose personal details, and is not liable for civil or criminal action for helping in good faith.

Emergency physicians should make this legal reassurance part of every community training session. Fear of police, paperwork or hospital detention prevents many people from helping. Education can change that.

What Should Emergency Physicians Do?

1. Build Simple, Local Training Modules

The training should not be overloaded. A 30-minute to 90-minute module is enough to start.

For bikers and trekkers:

- ☒ Scene safety and traffic control
- ☒ DR(c)ABCDE sequence
- ☒ Catastrophic bleeding and tourniquet use
- ☒ Helmet and cervical-spine precautions
- ☒ Splinting “as it lies”
- ☒ Pelvic wrap using a jacket or bedsheet
- ☒ Prevention of hypothermia
- ☒ Handover to 112/ambulance teams

For anglers:

- ☒ Safe water rescue: Reach, Throw, Row, Go only if trained
- ☒ Drowning response and CPR basics
- ☒ Slippery-bank falls and spinal caution
- ☒ Fish-hook, knife and fin injuries
- ☒ Bleeding control and embedded-object care
- ☒ Cold/wet casualty warming
- ☒ Snakebite, lightning and heat illness precautions
- ☒ Location-sharing and rescue communication

2. Teach Teams, Not Individuals

The real strength of bikers, trekkers and anglers is that they move in groups. Emergency physicians should train them as teams with assigned roles:





- ☑ Scene leader: controls crowd and danger
- ☑ Caller: contacts 112 and shares location
- ☑ Bleeding responder: applies pressure or tourniquet
- ☑ Airway watcher: monitors breathing and consciousness
- ☑ Warmth responder: covers, insulates and protects from wind
- ☑ Handover lead: speaks to ambulance staff clearly

This converts panic into organized action.

3. Replace Fear With Protocol

In an emergency, people freeze because they do not know what to do first. A protocol gives them permission to act.

A simple field sequence can save lives:

Danger → Response → Catastrophic bleeding → Airway → Breathing → Circulation → Disability → Exposure and warmth

For water incidents:

Do not enter unsafe water → Call early → Reach/Throw → Remove safely → Check breathing → CPR if needed → Warm and transport

These protocols should be printed on pocket cards, bike stickers, angler kit cards and WhatsApp posters.

4. Create Community Rescue Kits

Every riding or fishing group should carry a small emergency kit. It does not need to be expensive.

Suggested kit:

- ☑ Gloves
- ☑ Trauma dressing or clean cloth
- ☑ Crepe bandage
- ☑ Triangular bandage
- ☑ Tourniquet or wide improvised band
- ☑ Emergency blanket
- ☑ Torch/headlamp
- ☑ Whistle
- ☑ Rope or throw line
- ☑ Marker pen for tourniquet time
- ☑ Small splint material
- ☑ ORS sachets
- ☑ Phone power bank

For anglers, add:

- ☑ Pliers/wire cutter
- ☑ Waterproof pouch
- ☑ Floating rope
- ☑ Dry cloth or thermal layer

- ☑ Eye shield or cup for hook injuries near the eye

5. Audit and Improve

Emergency physicians should not stop after one workshop. We should create a cycle:

Train → Drill → Field feedback → Revise → Train again

Every real incident should become a learning case: What went right? What failed? Was 112 called early? Was the location shared correctly? Was bleeding controlled? Was the casualty kept warm? Was the handover clear?

This is how emergency medicine can move from hospital-based care to community resilience.

The Larger Vision

The future of emergency medicine in India should not be limited to resuscitation bays and monitors. It should include highways, schools, factories, religious gatherings, sports events, trekking groups, biker clubs and angler communities.

Emergency physicians are uniquely positioned to lead this work because we understand both chaos and order. We know that in the first few minutes, a simple action done correctly is more valuable than a complex action done late.

For bikers, the message is: **Ride prepared. Respond safely. Stop the bleed. Guard the neck. Keep them warm.**

For anglers, the message is: **Do not drown the rescuer. Reach or throw before you go. Restore breathing. Warm the wet patient.**

For emergency physicians, the message is even clearer:

We must not wait for the emergency to reach us. We must take emergency thinking to the people who will face it first.

That is the direction in which our specialty must grow.

Not only as doctors of the emergency department.

But as builders of emergency-ready teams.



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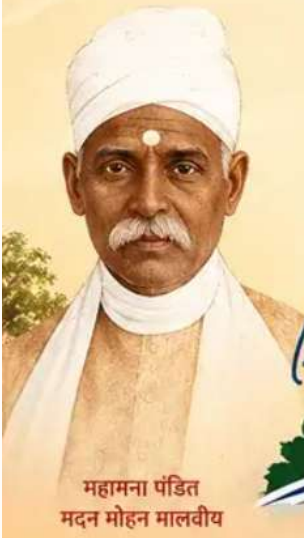
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Dr. Pooja Abbi

Raksha Bandhan is more than a cherished tradition, it is an exquisite celebration of a bond that effortlessly blends affection with annoyance, laughter with loyalty, and mischief with unwavering devotion. The rakhi tied around a wrist may appear delicate, yet it carries promises far stronger than its threads.

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