



# Dr. KM CHERIAN INSTITUTE OF MEDICAL SCIENCES

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5<sup>th</sup> November 2024

THIRD ISSUE

A Healthcare Newsletter

# HOPE

A NEW HOPE IN HEALTHCARE

UPDATES FROM THE  
DEPARTMENT OF  
ONCOLOGY

DR. SARAH J. EASAW

THE JUNGIAN  
"WOUNDED HEALER"  
REVISITED

DR. RUBEN JOHN

HIGH FREQUENCY  
OSCILLATORY  
VENTILATION

DR. DEENA THOMAS

DEBUNKING THE MYTH:  
WHY DYSPEPSIA ISN'T  
ALWAYS FUNCTIONAL

DR. NIKHIL KENNY THOMAS

A CRITICAL ANALYSIS OF  
THE PARIS 2 TRIAL: THE  
IMPACT OF EARLY HIGH-  
FLOW NASAL OXYGEN ON  
HOSPITALIZED CHILDREN  
WITH ACUTE HYPOXEMIC  
RESPIRATORY FAILURE

DR. VYSAKH. K

CENTRE FOR ADVANCED  
NEUROVASCULAR &  
INTERVENTIONAL RADIOLOGY

DR. ASWIN PADMANABHAN



# MESSAGE FROM THE CHAIRMAN



**Shri. P. M. Sebastian**  
Chairman,  
Dr. KM Cherian Institute of Medical Sciences

## Greetings!

I extend my warm greetings to all.

Dr. KM Cherian Institute of Medical Sciences has always been at the cutting edge of care. We understand the importance of your well-being and are fully committed to providing you with the highest quality of medical care, cutting-edge technology and compassionate services. At KMC Hospital we give importance for unparalleled and unprecedented measures to bridge gaps and make high quality medical care accessible to all. It gives me immense happiness to be a part of this organization and privilege to be the part of the team that constantly strives to provide the best health care services. We work with a vision to provide affordable world-class healthcare services. We believe constant change is important to bring the best out of anything. Similarly, technology is the change that act as a foundation to provide best medical services. I am so delightful in knowing the periodically publishment of newsletter-HOPE. Together, let us forge a path towards better health and a brighter future.

Regards,

**P. M. Sebastian**

# MESSAGE FROM THE MANAGING DIRECTOR



**Rev. Fr. Dr. Alexander Koodarathil**  
Managing Director  
Dr. KM Cherian Institute of Medical Sciences

## Greetings!

Dr. KM Cherian Institute of Medical Sciences has always been a forerunner in conducting diverse academic programs alongside its clinical achievements. I express my heartfelt appreciation for the incredible work undertaken by our team every day and night. Your dedication, compassion, and unwavering commitment to patient care are truly admirable. I am privileged for witnessing the first hand impact of your hard work and professionalism. Your skills and expertise are the backbone of our healthcare team, and we are grateful for your unwavering dedication, especially during these challenging times. We appreciate your tireless efforts, your unwavering dedication and your commitment to excellence. We continuously explore opportunities for improvement, engaging in ongoing research and adopting innovative practices to enhance our services. As we move forward, we remain committed to our core values of integrity, compassion and excellence.

**Regards,**

**Fr. Dr. Alexander Koodarathil**

# Updates from the Department of Oncology



## Dr. Sarah J. Easaw

MBBS, MD, FACP

Medical Director & Consultant Oncologist  
Oncology Centre

Dr. KM Cherian Institute of Medical Sciences

K.M.C. Hospital's Oncology Department was inaugurated on February 4, 2024 by Dr. C.S. Pramesh, Director of Tata Memorial Hospital and Convenor of the National Cancer Grid. Our department is now well equipped with a multidisciplinary team of doctors and nurses.

We provide chemotherapy, immunotherapy, and biologic therapy as well as the latest surgical oncology procedures. Our infusion suite offers a calm and peaceful atmosphere during chemotherapy infusions.

Here are a few of the latest highlights from our department:

## 1. Membership in the National Cancer Grid (NCG)

National Cancer Grid is a coalition of cancer centres across India, led by Tata Memorial Hospital, Mumbai. NCG aims to provide uniform and high standards of cancer care, follow uniform evidence-based guidelines for management of patient care, and conduct collaborative clinical research of a high standard.

We are very happy and proud to announce that our hospital has been accepted to the National Cancer Grid. As of September 2024, we are listed as one of the members of the NCG along with other reputed cancer centres across the country. Membership in NCG is determined by the credentials of the department and standards of patient care. It is a true honor to be accepted as a member of this esteemed organization.

As an NCG member, we will be able to interact with

the faculty at Tata Memorial and seek expert opinions for complex cases. We will also be able to participate in virtual tumor boards weekly. We hope to utilize this partnership to provide the latest treatment options for our patients.

## 2. Cancer Registry

We participated in a cancer registry training conducted by Tata Memorial Hospital. Sneha Sebastian, Oncology coordinator and Minnu Benny, Statistician attended the course and are certified to run the cancer registry. We are in the process of registering our cancer registry to the International Association of Cancer Registries (IACR). All the cancer cases that are diagnosed and/or treated at K.M.C. Hospital will be entered into the cancer registry. In addition to being a part of the global cancer database, this will provide us an opportunity to perform clinical research.

## 3. Pink Promise: a 6-month long campaign to promote breast cancer awareness

October is celebrated as breast cancer awareness month worldwide. As part of the month's special focus on breast cancer, we are launching a 6-month long campaign called Pink Promise.

Breast cancer is the leading cause of cancer among women worldwide. The incidence of breast cancer in women, especially younger women, is rising in India. More women die from breast cancer in our country compared to the western world. This is due to the general trend of women in India being diagnosed at later stages and having delays in appropriate care.

Pink Promise is aimed at spreading awareness about breast cancer among Malayalee women of various walks of life.

Here are a few of our goals:

1. Educate women about the signs and symptoms of breast cancer
2. Encourage screening
3. Equip survivors with support programs
4. Emphasize risk reduction and lifestyle modifications
5. Envision outreach programs in the community

Pink Promise will be launched with an inaugural ceremony on October 26, 2024. Her Highness Pooyam Thirunal Gouri Parvathi Bhai, cine-artist Poornima Indrajith and Christina Cherian (Assistant Editor 24 News) are our guests of honor. We plan to have an interactive discussion about the various aspects of breast cancer diagnosis, treatment, and prevention.

Our expert team of doctors will be answering questions from the audience about these various topics. Christina Cherian is the moderator for this discussion.

The audience for the inaugural function holds leadership positions in different organizations. They will be our ambassadors in their respective organizations. As part of the Pink Promise campaign, K.M.C. Hospital will work together with our ambassadors to conduct breast cancer awareness programs.

During the next six months, we are planning to reach out to the various communities in the neighboring four districts and conduct awareness programs and early detection camps, provide informative talks, and encourage women to have annual mammograms done for early detection.

## Together, we can fight breast cancer.



# The Jungian “Wounded Healer” revisited



**Dr. Ruben John**

MBBS, DPM, DNB

Consultant Psychiatrist

One of the more fundamental psychoanalytic archetypes that was described by Carl Gustav Jung was the wounded healer archetype. Jung drew material from his own life experiences to explain the phenomenological content that he was trying to dissect. This eventually led him to the use of the term wounded healer (1951).

A reason to bring up such an uncommon psychoanalytical construct for discussion is the fact that it is, surprisingly, very much alive even today and lies at the core of 2 main debates that are going on around the world.

## The Jungian wound:

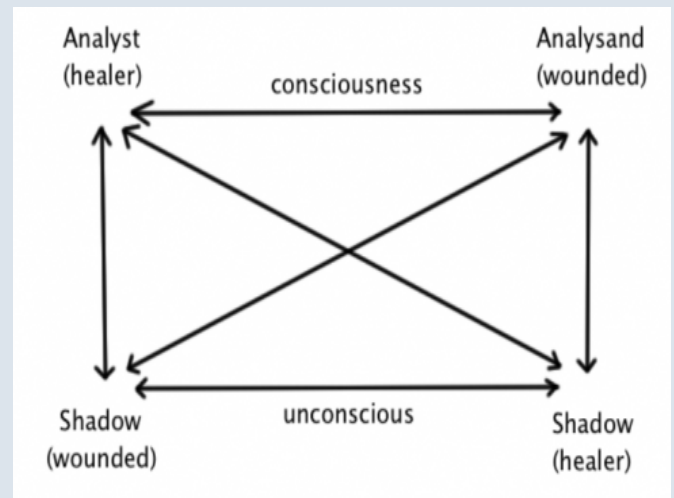
Did Jung really mean that only persons who suffered from a syndromal psychiatric diagnosis and successfully treated themselves could become good therapists? I strongly doubt it. I doubt it because Jung was a pure-bred psychoanalyst and the above reasoning is just far too superficial.

Jung was referring to the wounding experience that will result when one's Jungian limited Ego meets the all-encompassing Jungian Self, that is, when the conscious dares to bare the unconscious. In a single word: Introspection. Jungian wounds are from self-exploration of our own psychological schemas, ego-defences, cognitive distortions, IP relationships etc., irrespective of the cause for which we do so.

## Wounded Healer Archetype Paradigm:

Jung spoke of the wounded archetype as an unconscious therapeutic relationship that would occur between the therapist's inner wounds and the patient's inner healer. The patient's wounds activate those of the therapist, which reacts, identifies the conflict, and then consciously or unconsciously passes this awareness back to the patient.

The multiple arrowheads show that there is a bidirectional therapeutic flow which implies that the therapist also continues to further grow with each session.



## What was he talking about?

The basic tenet of psycho-dynamic development is how the ego defends the conscious. There are no hard and fast rules to its development and hence it is a functional system which has the licence to do what is needed to get the job done. The result is an ego system that, while preventing psychological conflicts successfully, may still fall short of those psychological ideals, mature coping strategies, perception vs reality cognitions etc., that we try to develop in our patients.

The next logical step would be to correct any existing immature defences. But attempts to understand our ego defences, break it down and build it up with an organized structure can be an inexplicably painful experience. Yet, it is at the end of that painful road where we find the Jungian wounded healer.

Our own experience is what helps face the suffering client in simple relatedness. Jung is suggesting that the therapist's “mental health” is not presumed “superior”, but instead to constantly revisit the way the wounds were dealt with while willing to accept that we may have dealt with it wrongly. The training to hold the patient's wound comes from

the therapist's willingness to confront their own unconscious material.

### Relevance in Contemporary psychiatry:

This Jungian concept has been the core in 2 main areas:

1. A discussion to make it mandatory that psychotherapist trainees to undergo psychoanalytic therapy, aka Personal therapy as part of their training.
2. Reports of higher psychiatric morbidity and suicide rates in physicians when compared to other occupational groups has fostered interest in the possible role of this concept in reducing the psychological burden within the medical community.

# High frequency oscillatory ventilation

Mechanical ventilation is the cornerstone of management of neonates with respiratory failure. However, one should be cautious of various modes of ventilator induced lung injury like barotrauma, volutrauma, atelectotrauma and biotrauma. Rapid changes in lung volume tends to cause more lung injury than changes in airway pressure. Since high frequency ventilation allows ventilation with very small lung volumes, considerable interest has been generated in the same in recent years.

### Mechanism of action

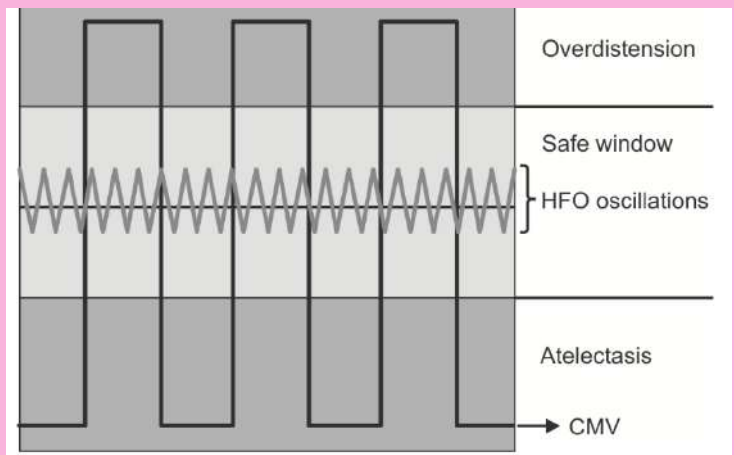
High frequency oscillatory ventilation is the most used modality of high frequency ventilation wherein both inspiration and expiration are active. In HFOV, lung recruitment is maintained by the application of relatively high mean airway pressure, while ventilation is achieved by superimposed pressure oscillations that are delivered by a motor-driven piston or diaphragm at a frequency of 3–15 Hz (180–900 cycles). Oscillation is generated by a piston oscillator. A bias flow system supplies fresh gas. The pressure oscillates around a constant distending pressure delivered by this continuous flow which passes through a variable restriction valve on the expiratory limb.

### Box 1. Mechanism of gas exchange in high frequency ventilation

- Bulk convection for proximal alveolar units
- Asymmetric velocity profiles of gases



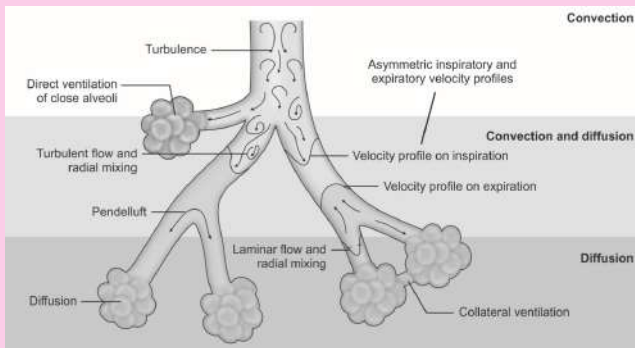
**Dr. Deena Thomas**  
MBBS, MD, DM  
Consultant Neonatologist



**Fig 1. Smaller tidal volumes keep ventilation in the safe zone.**

along the periphery and central portions of airway

- Pendelluft flow
- Turbulence
- Cardiogenic mixing
- Taylor dispersion (principle mechanism)



**Fig 2. Mechanism of gas exchange**

Control variables in HFOV: Determinants of oxygenation and ventilation

HFOV allows effective decoupling of oxygenation and ventilation where oxygenation is determined by  $F_{iO_2}$ , Mean Airway Pressure and I:E ratio. Higher the  $F_{iO_2}$  and MAP, higher will be oxygenation. I:E ratio at 1:2 gives lower pressures at the alveolar end compared to proximal airway than an I:E ratio of 1:1, hence preventing barotrauma. Ventilation is determined by the frequency, amplitude and inspiratory time. Minute ventilation = frequency \* (tidal volume)<sup>2</sup>. Carbon dioxide removal increases with increase in amplitude, decrease in frequency (longer cycle time), and increase in inspiratory time.

### Clinical application of HFOV in Neonatology

1. Persistent Pulmonary Hypertension of the Newborn
2. Meconium Aspiration Syndrome
3. Air leak syndromes: pneumothorax, pulmonary interstitial emphysema
4. Severe Respiratory Distress Syndrome
5. Pulmonary hypoplasia
6. Failure of conventional ventilation (plateau pressures  $\geq 25-30$  cm H<sub>2</sub>O with tidal volumes of 5-7 ml/kg and severe respiratory acidosis, pH < 7.1)
7. Failure of oxygenation (e.g. ARDS)
  - SpO<sub>2</sub> < 90%, or
  - PaO<sub>2</sub>/F<sub>iO<sub>2</sub></sub> < 150, despite F<sub>iO<sub>2</sub></sub> > 60% and optimal PEEP, or
  - Oxygenation index (OI) > 15 (where OI = [MAP x F<sub>iO<sub>2</sub></sub>(%)] / PaO<sub>2</sub>)

### Implementation of high frequency oscillatory ventilation

Initial setting:

1. Mean Airway Pressure (MAP)- 2-3cm above the current conventional ventilation Mean Airway Pressure (MAP)
2. Amplitude (AP)- Should be sufficient to see the wiggle upto umbilicus (typically approx. double the value of MAP)



**Fig 3. SLE 6000 ventilator with High frequency oscillation**

3. Frequency (Hertz) - Usually set at 10 Hz
4. I:E ratio - Set as 1:2. higher I time may lead to air trapping

### Disease specific strategies

1. Patients with air leak/ Pulmonary interstitial emphysema. Patients with air-leak syndromes (e.g., pneumothorax and bronchopleural fistula) are placed on HFOV using a low- volume strategy, where a use of a higher F<sub>iO<sub>2</sub></sub> (between 80 and 100%) is permitted, especially in the first 12-24 hours to minimize MAP to prevent extension of the air-leak syndrome and to promote its resolution. Keep initial MAP 1 cm below the conventional ventilator setting.
2. Patient with Respiratory distress syndrome. Use high volume strategy wherein MAP is kept 2 cm above conventional ventilator setting and thereby increased in steps of 1- 2 cm to attain a decrease in F<sub>iO<sub>2</sub></sub>.

### Monitoring

1. Blood gas after 30 min of initiation and then 6-8 hourly. Monitor for hypocarbia and oxygenation
2. Chest Xray: Ideally expanded lungs show 8-10 posterior intercostal space of Xray. Thereafter Xrays are required every 1-2 days.

## Sedation

Analgesia using morphine or fentanyl is desirable, as it prevents excessive agitation of the neonate and helps to achieve better oxygenation and ventilation.

## ET suctioning

Suction of the tracheal tube must be restricted as much as possible, especially in the first 24 hours unless secretions are evident in the tube or decrease in chest wiggles. In-line suctioning is the preferred method of suctioning.

## Weaning

### Oxygenation

1. Decrease FiO<sub>2</sub> in steps of 0.05 until  $\leq 0.60$  unless hyperinflated.
2. If hyperinflation is present or when FiO<sub>2</sub> < 0.6 start decreasing MAP every 4-8 hours Ventilation

If frequency is below the standard frequency for patient's age and weight, increase the frequency to baseline before decreasing P by 2-3 cm H<sub>2</sub>O till a P of 15-20 cm H<sub>2</sub>O.

When MAP ~10-14 cm H<sub>2</sub>O with FiO<sub>2</sub>  $\leq 0.5$  consider shifting to conventional ventilation. One can also consider extubation to CPAP/ non-invasive ventilation if MAP is 8-10cm H<sub>2</sub>O with FiO<sub>2</sub> < 0.4.

## Troubleshooting

↓ PaO <sub>2</sub> (<50 mm Hg) / Poor oxygenation	↑ PaO <sub>2</sub> (>70 mm Hg)/ Over oxygenation	↑ PaCO <sub>2</sub> (>60 mm Hg)/ Poor Ventilation	↓ PaCO <sub>2</sub> (<45 mm Hg)/ Over ventilation
Increase FiO <sub>2</sub>	Decrease FiO <sub>2</sub>	Increase Amplitude	Decrease amplitude
Increase MAP (1-2 cm H <sub>2</sub> O)	Decrease MAP (1-2 cm H <sub>2</sub> O)	Decrease frequency (1-2 Hz) if amplitude maximal	Increase frequency (1-2 Hz) if amplitude minimal



# Debunking the Myth: Why Dyspepsia Isn't Always Functional



**Dr. Nikhil Kenny Thomas**

MBBS, MD, DM, DrNB

Consultant Gastroenterologist

Dyspepsia is the commonest presenting gastrointestinal symptom. Dyspepsia of recent onset, sometimes accompanied by weight loss, rings alarm bells over the possibility of malignancy and dictates the need for endoscopy, but most patients do not fit this paradigm. It is important that we identify the chameleons early.

A 34-year-old lady visited my outpatient department 2 weeks ago with symptoms of dyspepsia going on for the last six months. She had visited many doctors and was treated with antacids and PPIs with no symptom relief. She even had finished a course of anti H Pylori therapy. She was labelled as "functional" and was started on anxiolytic medications. She was worried for the persistent symptoms, however denied any significant stressors. There was no weight loss, melena, family history of cancers. On examination she had stable vitals with no pallor or nutritional deficiencies. Per abdominal examination revealed epigastric fullness which was not tender.

Her hemogram and routine laboratory was normal. Ultrasound revealed a suspicious pancreatic mass which was confirmed with CT abdomen that revealed a cystic pancreatic lesion.



We did an Endoscopic Ultrasound-Guided Fine Needle Aspiration (EUS- FNA) which revealed the diagnosis of pancreatic neoplasm with low grade dysplasia. Patient is planned for a definitive surgery.

EUS-FNA has proven to be of crucial value in the diagnostic evaluation of benign and malignant disorders, as well as in staging of malignant tumors of the GI tract and surrounding organs. Given the high prevalence and mortality associated with pancreatic cancer, this is an ideal approach to diagnosing pancreatic mass lesions that is safe, highly sensitive, and reproducible across various practice settings.

## Take Home Message:

1. A detailed medical history and comprehensive physical examination are essential for evaluating patients with chronic symptoms.
2. Utilizing appropriate investigations early can aid in prompt diagnosis and effective management.
3. Always rule out organic causes before considering symptoms as functional in nature.

# A critical analysis of the PARIS 2 Trial: The impact of early high-flow nasal oxygen on hospitalized children with acute hypoxemic respiratory failure



**Dr. Vysakh K**

MBBS, MD (Paediatric Medicine),  
IDPCCM

Pediatric Intensivist

Acute hypoxemic respiratory failure is a common cause of hospital admissions in children under five years old, with mortality rates remaining high in under resourced settings. A new trend is using nasal high-flow oxygen therapy as an alternative to noninvasive ventilation, as it can be used early in the disease process and requires little child cooperation. A study- Paediatric Acute Respiratory Intervention Study (PARIS 1 trial) conducted between 2013 and 2016 found that among infants with bronchiolitis who were treated outside of an ICU, those who received high-flow oxygen therapy had significantly lower rates of escalation of care due to treatment failure than those in the group that received standard therapy high-flow oxygen therapy, but there was no significant difference in ICU admissions or length of hospital stay.

The Paediatric Acute Respiratory Intervention Study 2 (PARIS 2), a multicenter, randomized clinical trial aimed to test the hypothesis that high-flow oxygen therapy in children with acute hypoxemic respiratory failure would reduce hospital stay compared to standard oxygen therapy. The trial involved 3030 children, with 1567 children (51% of eligible patients) enrolled (4 inclusion criteria: Increased work of breathing due to acute respiratory disease. Oxygen requirement to keep sats at or above 92% at most hospitals, but 90% in one hospital. Respiratory rate over 34. Admission to hospital. Exclusions: Craniofacial abnormalities, upper airway obstruction, cyanotic heart disease, and those who required immediate higher-level care in the ICU, or required noninvasive or invasive mechanical ventilation.) There were 9 secondary outcomes, including length of oxygen therapy and admission to the intensive care unit. Of the 9 prespecified secondary outcomes, 4 showed no significant difference. The median length of total hospital stay since presentation to the emergency department was 1.93 days in the high-flow oxygen group compared to 1.72 days in the standard oxygen group. The median length of oxygen therapy after randomization was 1.07 days in the high-flow oxygen

group compared to 0.75 days in the standard oxygen group.

Tolerance of therapy did not show any significant between-group difference. The per-protocol population included 834 children, showing similar results to the primary analysis with a longer length of hospital stay, longer length of oxygen therapy, and a greater proportion of ICU admissions in the high-flow oxygen group compared to the standard oxygen group.

The trial did not explain why the length of oxygen therapy and hospital stay were prolonged in children allocated to high-flow oxygen therapy. There was a greater number of patients in the high-flow oxygen group who crossed over to standard oxygen therapy, which may have prolonged time receiving oxygen therapy and thus a longer stay in the hospital. However, it seems unlikely that this factor accounts for these findings because the significant between-group differences in length of oxygen therapy and hospital stay were still apparent in the per-protocol analysis, which excluded all participants who switched oxygen therapies.

Slow weaning of oxygen therapy in pediatric patients, prolonging the length of the hospital stay, is well documented. The weaning protocol of oxygen therapy targeting an Spo<sub>2</sub> of 92% to 98% was the same for both intervention groups. It is possible that greater familiarity with the weaning of standard oxygen resulted in the differences demonstrated. Alternatively, children randomized to high-flow oxygen therapy may have been unconsciously perceived by clinicians to be sicker by virtue of receiving a perceived higher level of respiratory support. Regardless of the reason, the trial failed to find any benefit of starting high-flow oxygen therapy early during hospital management.

The study concludes that, nasal high-flow oxygen used as the initial primary therapy in children aged 1 to 4 years with acute hypoxemic respiratory failure with mild hypoxemia did not significantly reduce

the length of hospital stay compared with standard oxygen therapy. The research is significant but has several issues that increase the risk of bias. The trial is unblind, with a primary outcome heavily reliant on clinical assessment, making it easily influenced by the lack of blinding. This could lead to children being weaned slower and discharged later, possibly due to the HFNC which makes the child just sicker, and so were weaned slower, and therefore discharged later. Selection bias is also a potential issue, with only 51% of eligible patients included without explanation for most missed patients. With a baseline oxygen saturation of 88% and a median hospital length of stay under 2 days, it seems likely that many of these children would have been fine without any intervention. If this trial is replicated, the addition of a no oxygen arm would be informative. However, we need to be careful not to extrapolate these results to a different group of patients, as HFNC provides no value in a group that

may not have required any oxygen at all. In a group of patients with very mild hypoxia, there is no benefit of early high flow humidified nasal oxygen. This trial should caution us about the massive indication creep we have seen with these devices over recent years.

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## Relevance of Cancer Registry

Dr. K M Cherian Institute of Medical Sciences will launch a hospital-based cancer registry, a pivotal step in enhancing the quality of cancer care we provide. This initiative will allow us to gather and analyse crucial patient information, leading to improved treatment strategies and contributions to cancer research. Cancer registries in hospitals are critical tools that provide numerous benefits directly to patients, improving the overall quality of care and outcomes.

Firstly, the registry allows for personalized treatment. By collecting detailed information about each patient's diagnosis, treatments, and outcomes, healthcare providers can tailor therapies to the individual's unique cancer type and condition. This leads to more effective treatment and better patient outcomes, as doctors can make data-driven decisions based on similar cases and long-term trends.

Secondly, cancer registries ensure continuous care and follow-up. Patients often require long-term monitoring to track their progress, and registries help doctors easily access the patient's medical history, which is vital for evaluating treatment success and adjusting over time. This consistent follow-up reduces the chances of cancer recurrence going unnoticed and ensures that patients receive the necessary care even after initial treatment is completed.



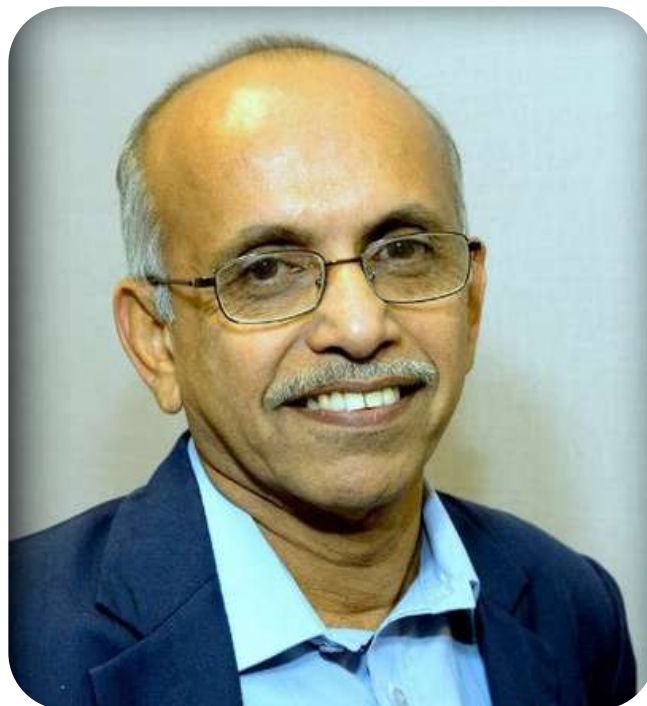
Cancer registries also support multidisciplinary care by enabling various specialists, oncologists, surgeons, radiologists, and others—to access and share a patient's data. This collaborative approach ensures that all aspects of the patient's care are aligned and optimized, leading to more comprehensive treatment plans.

Lastly, cancer registries contribute to better overall survival rates by tracking treatment outcomes over time. Hospitals use this data to refine and improve care protocols, ensuring that patients receive the best possible treatment based on the latest evidence.

# Intergrating Palliative Care-when, where?

## About the Author

**Dr. M. R. Rajagopal** is an Indian palliative care physician (anesthesiologist) and professor referred to as the 'father of palliative care in India in honor of his significant contribution to the palliative care scene in India. Dr. M.R. Rajagopal founded Pallium India in 2003, with a mission to catalyze and facilitate integration of palliative care with healthcare in India. Dr Rajagopal is also the director of Trivandrum Institute of Palliative Sciences, the flagship of Pallium India. Rajagopal was the prime mover in the creation of the National Program for Palliative Care (NPPC) by the Ministry of Health of Government of India. His advocacy has contributed to amendment of Narcotic Drugs and Psychotropic Substances (NDPS) Act of India in 2014 and in its implementation—a critical step in reducing needless suffering and allowing millions to access pain relief. Human Rights Watch honored him with Alison Des Forges award in 2014. In 2017, Moonshine Agency, Australia, released a documentary titled "Hippocratic: 18 experiments in gently shaking the world" based on Dr. Rajagopal's work. He was honored with Padma Shri, the third highest civilian award of India (2018). He was nominated in 2018 and 2023 for the Nobel Peace Prize. Dr Rajagopal's memoir titled 'Walk with the Weary: Life-changing Lessons in Healthcare' was published in 2022. Dr Rajagopal believes in a balance between compassion and competence in medicine.



**Dr. M. R. Rajagopal, M.D.**  
Chairman – Pallium India &  
Director – Trivandrum Institute of  
Palliative Sciences

### **Someday, it will be my turn to be ill. And some day, a serious illness will end my life.**

I have some concerns about how I will be treated then. I worry that my treating team will see me as a body that holds a disease for them to address. Of course, the disease needs to be tackled. My concern is, in the process of treating the disease how much will I suffer? Will I be destroyed by intolerable pain, breathlessness, or other symptoms while my doctor keeps focusing on a tumour or a microorganism? And will the nurse be totally concerned with my temperature, pulse, blood pressure and integrity of my skin to the exclusion of my feelings or suffering? If they do, I will admit it will not be their fault. That is the way I myself was trained as a doctor as one who understands the body and knows how to treat diseases. Just as a nurse is trained to focus on a body's integrity.

But though a patient in that bed, I am not just a body. Eric Cassel said, "It is persons that suffer; not bodies." I want my pain treated. My treating team needs to understand that the suffering from pain can be beyond their power of imagination. It is fearful to feel unable to take in air; the breathing that we all ordinarily take for granted. And if my body has a visible, ugly, foul-smelling ulcer and I see your face flinching, how would that make me feel?

I know it would be difficult for my treating team to decide whether I am just sad because of my circumstances and suffering or whether I now have a depressive illness. Would that team know that 8–24% of all people living with cancer have depressive illness? Or that the prevalence of depression could be as high as 42.7% in paraplegia and 67.2.2% in tetraplegia? If yes, would they be using screening tools to identify them and treat it appropriately?

That treating team may not recognize that I may have issues with my relationships. I may be totally obsessed with thoughts like, “Will I get to see my son before I die?” “Why is my wife looking out of the window? Is she finding my body so totally disgusting that she doesn’t even want to look at me anymore?”

Many of these elements of suffering may lead me to the thought, “Has God deserted me? Why? Why am I alone in this world? Why is it that in this vast crowded world nobody cares for me for what I am and nobody bothers about my sufferings? Why am I in this hospital any way when it is only making me feel miserable? I wish I could be in my own home at home where I could look out of the window and have at least the trees and plants to offer me some company.”

Have I painted a dismal picture? Dismal, yes; but very much the reality.

### **The good news: what we can do about it**

The solutions to many elements of my suffering at that time could be simple and inexpensive; that is the good news. It doesn’t take any rocket science or expensive gadgetry to make me feel better. But it is necessary for my treating doctor to know the principles of palliative care whether he/she be a cardiothoracic surgeon, a neuro-ophthalmologist, or an oncologist or a doctor of any stream of medicine. He/she would need to learn the fundamental principles of palliative care which would empower them to see me as a person and address my sufferings, thus improving my quality of life. And all the staff should understand those principles too, even if they do not have to study the therapeutics of palliative care.

If they have such an orientation in palliative care, as I enter the hospital the uniformed person at the gate would not have a fearsome look on her/his face. That person would smile at me, a gentle smile. And I will meet that smile again at the reception desk. As they proceed with documentation of my name, address and so on, that person would hopefully talk with compassion to my wife who may be feeling bewildered in the unfamiliar environment. Perhaps, a trained volunteer could take me to the waiting room where she/he will put my wife and me at ease.

My nurse and my doctor will not be afraid, I hope, to lay a hand on my hand and to acknowledge my suffering with words like, “You seem to be a lot of pain” or “Are

you feeling a bit anxious?”. I want them to tell me about my illness without using medical jargon as they proceed with my diagnostic process. If I have a fear of needles, I hope I will not be laughed at; but instead that technician would have compassion in her/his eyes and will reassure me that she/he would do it with as little pain as possible. If I look scared as I enter an imaging room, I hope I will not laugh at again, but instead enough sedation will be offered to me if necessary. I hope along with my disease-specific treatment offered to me, my pain and breathlessness would be treated scientifically, with compassion. I hope a medical social worker would go into the details about my concern regarding seeing my son again and may even offer to call my son to convey a message. I may feel totally disconnected from my familiar world and so it will be an enormous relief to feel that there are some people who care enough about me.

While you attend to my agony, I hope someone will notice my wife who could be suffering more than myself. She may be worried about how serious my illness is and may even be trying to ward off thoughts about my death, which she may fear will make her lonely in this world. She may be battling health issues like diabetes or hypertension which may go out of hand at this stressful time. Who knows, as they left home in a hurry to come to hospital, she might have forgotten to bring her medicines with her. Nobody including herself may bother about it. I hope the healthcare system will consider her also as a suffering person and take a minute to hear how she is and to give her essential support.

The process that I described above would form the integration that the World Health Assembly exhorted all nations to do in 2014 - ‘Integrate principles of palliative care into healthcare at all levels’ (primary, secondary, tertiary) ‘across the continuum of the disease’ (from the beginning of the suffering to the end)iii. Do you think I am asking for too much? If yes, please reflect; this is not about ‘them’, this is about ‘us’ - about a journey that each one of us will be forced to take some day.

### **Palliative care Units**

I have been talking about integration of palliative care into healthcare - how every

healthcare provider must incorporate principles of palliative care into her/his work. If that is done, would a specialized palliative care unit be still relevant? The answer is yes. While the bulk of the suffering can be alleviated with the palliative approach of every clinician, there will always be difficult issues to take care of. For example, though roughly 75% of all pain in cancer can easily be treated by any clinician, there would be that other 25% who may need specialized treatment. That 25% of people may have to be seen by a palliative care team.

This holds true not only for difficult symptoms, but also for emotional, social, or spiritual suffering. The palliative care team may also find issues that are not usually talked about – issues like sexuality (a man no longer feeling that he is a complete man or a woman no longer feeling that she is a complete woman). The palliative care unit would have a multi-disciplinary team addressing difficult issues like this.

### Care at home

In most hospitals, the process of care giving ends when the patient gets discharged. The family or a paid caregiver (who usually has very little training) thereafter is forced to play the role of a doctor, nurse and counselor all rolled into one with no support from the healthcare system. This must change. Every patient discharged from the hospital should be able to access continued care by home visits or at least Telehealth programs.

This is not as difficult as it seems; it is happening all around us. Every home-bound patient in every one of the 960-odd panchayat in Kerala has a trained palliative care nurse visiting the home at least once in a every month. This is happening in the government sector and in the NGO sector. It doesn't happen much in the corporate sector where 65% of all healthcare happens in our state. True; there are exceptions. Some institutions have now started offering home visits for those who can afford to pay; but seldom with personnel trained in palliative care.

### 10 years of World Health Assembly resolution 2014: Where are we now?

World Palliative Care Day 2024 falls on October 12. The theme for this year is “Ten years of the resolution – where are we?” India has taken many steps in integrating palliative

care into healthcare. It created a National Program for Palliative Care (NPPC) in 2012. In 2014, Indian Parliament amended the NDPS Act which was preventing access to controlled medicines like morphine for people who need pain relief. In 2017, India included palliative care in the National Health Policy of 2017. Most importantly and more recently the National Medical Commission included palliative care in undergraduate medical curriculum. In 2022, Indian Nursing Council followed suit by including it in undergraduate nursing curriculum too.

## These giant steps make us optimistic for the future.

We are proud to announce the initiation of the **PALLIATIVE CARE DEPARTMENT**  
Comfort & Compassion in Care



OUTPATIENT CLINIC

INPATIENT SERVICES

HOME CARE

**Our expert and compassionate team of doctors and other professionals are committed to provide quality care to patients and their families.**

# Update from Academics Research & Analysis (R & D) Department



Academics Research & Analysis Department started in January 2024 in Dr. KM Cherian Institute of Medical Sciences with an aim of playing critical role in advancing medical science, improving patient care, and fostering innovation and responds with the changing landscape of healthcare. The department initially deals with clinical research with the studies. The department is collaborated with Tata Memorial Hospital, Mumbai for setting up Cancer Registry, signed Memorandum of Understanding (MoU) between Believers Church Medical College Hospital and Dr. K M Cherian Institute of Medical Sciences for Ethical Committee, started paramedical courses in affiliation with UGC approved Lingaya University, Coordination with concerned departments for the internal, regional, and international CME programs, awaiting approval for Diplomate of National Board courses. Also Analysis team will manage and interpret data to optimise hospital operations, enhance patient care and guides strategic decision-making through data-driven analysis. R & D Department is relevant in an hospital for the Global Health, Innovation, Patient Outcomes, Public Health, and Economic Impact. The department will be dynamic and vital department that continually adapts to scientific advancements and societal needs, driving progress in medicine and improving health outcomes globally.

# Ex-Servicemen Contributory Health Scheme (ECHS)



Ex-Servicemen Contributory Health Scheme (ECHS) was launched with effect from 1st April 2003. The Scheme aims to provide allopathic and AYUSH Medicare to Ex-servicemen pensioner and their dependents through a network of ECHS Polyclinics, Service medical facilities, Government hospitals, empanelled private hospitals/specified Govt. AYUSH hospitals spread across the country. The Scheme has been structured on the lines of CGHS to ensure cashless transactions, for the patients and is financed by the Government of India. Matters relating to Ex-Servicemen Contributory Health Scheme have been allocated to Department of Ex-Servicemen Welfare after its creation in September 2004. Later vide Notification dated 29th January 2009 ECHS has been designated as an attached office of Department of Ex-servicemen Welfare. The Central Organisation of ECHS is headed by a Managing Director, a serving Major General.

The Scheme is managed through the existing infrastructure of the Armed Forces to minimize the administrative expenditure. The existing infrastructure includes command and control structure, spare capacity of Service Medical facilities (Hospitals and Medical Inspection Rooms), procurement organization for medical and non-medical equipment, Defence land and buildings etc. Station Commanders assisted by Senior Executive Medical Officers (SEMO) exercise direct control over the ECHS Polyclinics.

## **ECHS membership is available to the following categories:**

1. Ex-servicemen receiving pension or disability pension
2. Widows receiving family pension
3. Spouse of pensioner
4. Unemployed sons under 25 years of age
5. Unemployed and/or unmarried daughters
6. Dependent parents with an income less than Rs. 3,500 per month
7. Mentally or physically challenged children for life
8. Newborn baby up to 3 months based on birth certificate

## **List of Departments Empanelled in ECHS in our Hospital:**

1. Anaesthesiology OPD and IP
2. Cardiology (Interventional) OPD and IP
3. Cardiothoracic Surgery OPD and IP
4. Dermatology and Venereology OPD and IP
5. General Surgery Including Laparoscopic Surgery OPD and IP
6. Medical Gastroenterology OPD and IP
7. Nephrology (Including Dialysis) OPD and IP

8. Neurology OPD and IP
9. Neurosurgery OPD and IP
10. Obstetrics and Gynaecology (Including High -Risk Pregnancy) OPD and IP
11. Ophthalmology OPD and IP
12. Orthopaedic Surgery OPD and IP
13. Otorhinolaryngology/ Head & Neck OPD and IP
14. Paediatrics (Including Neonatology ) OPD and IP
15. Endocrinology OPD and IP
16. Psychiatry OPD only
17. Respiratory Medicine OPD and IP
18. Urology OPD and IP

## **Dr. KM Cherian Institute of Medical Sciences: Advancing Healthcare with a Multi-Organ Transplantation Programme**

Dr. KM Cherian Institute of Medical Sciences, a premier super-specialty hospital, is set to start its Multi-Organ Transplantation Programme. With the recent acquisition of licenses for heart and kidney transplants, the hospital is poised to become a leading center for organ transplantation in the region. Inspection for obtaining transplant licenses for other solid organs like the liver, pancreas, and small intestine has been conducted by the government authority and expecting the issuance of the license from the government soon.

### **Commitment to Excellence**

The institute, named after the renowned cardiac surgeon Dr. KM Cherian, is committed to delivering world-class medical care. Our state-of-the-art facilities and highly skilled medical professionals ensure that patients receive the best possible treatment and care. The addition of the Multi-Organ Transplantation Programme marks a significant milestone in our journey to enhance healthcare services.

### **Heart Transplant Programme**

Our heart transplant programme is designed to provide a new lease on life for patients suffering from end-stage heart disease. With a dedicated team of cardiac surgeons, transplant specialists and support staff, we are equipped to handle the complexities of heart transplantation. Our comprehensive approach includes pre-transplant evaluation, surgical intervention, and post-transplant care, ensuring optimal outcomes for our patients.

### **Kidney Transplant Programme**

The kidney transplant programme aims to address the needs of patients with chronic kidney disease and kidney failure. Our nephrologists and transplant surgeons work collaboratively to offer seamless and efficient transplant services. The programme encompasses thorough pre-transplant assessments, advanced surgical techniques, and continuous post-transplant monitoring to ensure the long-term health and well-being of our patients.

### **Multi-Disciplinary Approach**

A key feature of our Multi-Organ Transplantation Programme is the multi-disciplinary approach we adopt. Our team comprises experts from various specialties, including cardiology, nephrology, urology, gastroenterology, anaesthesiology, and interventional radiology, who work together to provide holistic care. This collaborative effort enhances the precision and success of each transplant procedure.

### **Cutting-Edge Technology and Infrastructure**

Dr. KM Cherian Institute of Medical Sciences is equipped with cutting-edge technology and infrastructure to support complex transplant surgeries. Our operation theatres are designed to meet international standards, and our intensive care units (Transplant ICU) are equipped with advanced monitoring and life-support systems to ensure the best possible care for transplant patients.

## Patient-Centred Care

Patient-centred care is at the core of our transplantation programme. We understand the emotional and physical challenges that patients and their families face during the transplant journey. Our dedicated transplant coordinator, counsellors, transplant nurses and support teams provide personalized care, education, and counselling to help patients navigate the process with confidence and ease.

## Community Engagement and Awareness

As part of our commitment to advancing healthcare, Dr. KM Cherian Institute of Medical Sciences actively engages in community outreach and awareness programmes. We aim to educate the public about

the importance of organ donation and the life-saving impact of transplantation. Through various initiatives, we strive to increase awareness and encourage more individuals to become organ donors.

## Looking Ahead

The launch of the Multi-Organ Transplantation Programme is a testament to our unwavering dedication to improving healthcare outcomes. As we embark on this new chapter, we remain focused on delivering exceptional medical care and pioneering advancements in the field of organ transplantation. Our vision is to become a center of excellence in transplantation, offering hope and a better quality of life to patients in need.

**Together, we are transforming lives and building a healthier future**

# Oman Health Exhibition 2024



Dr. Sreenath P. R. (Consultant Neurosurgeon) with Shri. Amit Narang (Hon'ble Ambassador of India to the Sultanate of Oman) Standing nearby Mr. Nebu Sam John (Marketing Manager)

Dr. KM Cherian Institute of Medical Sciences proudly participated in the Oman Health Exhibition 2024, showcasing its dedication to transforming healthcare through cutting-edge innovation and expertise. This prestigious event held at the Oman Convention & Exhibition Centre from 23rd - 25th September provided an ideal platform for the hospital to highlight its advanced medical services and world-class healthcare solutions to a diverse global audience.

Renowned for its excellence in healthcare, KMC Hospital showcased its dedication to enhancing lives through advanced and innovative treatments. The exhibition also enabled meaningful interactions with Shri. Amit Narang (Hon'ble Ambassador of India to the Sultanate of Oman), Industry leaders, Policymakers, and Healthcare professionals, fostering collaborations for research,

training, and technological advancements.

Participation in the event further reinforced the hospital's mission to stay at the forefront of medical science and address global healthcare challenges. By engaging in knowledge exchange and presenting its pioneering programs, Dr. KM Cherian Institute of Medical Sciences underscored its role as a leader in healthcare innovation and excellence.

Dr. Sreenath. P. R (Consultant Neurosurgeon) and Mr. Nebu Sam John (Marketing Manager) represented Dr. KM Cherian Institute of Medical Sciences at the event.



## Editorial Team

**Dr. Sarah J. Easaw**  
MBBS, MD, FACP  
Medical Director,  
Oncology Centre at  
KMC Hospital

**Dr. Devarajan K. A**  
MBBS, MD, DM  
Consultant Cardiologist

**Dr. Arun Thomas**  
MBBS, MD, Fellowship in Neonatology  
(IAP & RCPCH)  
Consultant Neonatologist

**Seby Paulose**  
Chief Operating Officer

**Nebu Sam John**  
Marketing Manager

**Meera Mariyam Skariah**  
Coordinator, Research and Development

## EVENTS



4<sup>th</sup> July 2024

Dr. KM Cherian Institute of Medical Sciences organized the Cardio-Oncology CME by the Department of Oncology & Cardiology - "Landscape of Cardio-Oncology: Past, Present and Future" on 4<sup>th</sup> July 2024. The chief guest and main speaker was Dr. Amit Arbune (Director, Cardio - Oncology Program, Department of Medicine Quality and Patient Safety Officer, University of Kentucky, USA).



12<sup>th</sup> July 2024

Blessing ceremony of the advanced Bone Density Scan Unit (DEXA scan) at Dr. KM Cherian Institute of Medical Sciences by the Managing Director, Rev. Fr. Dr. Alexander Koodarathil. L-R : Dr. Alex Paul (Consultant Radiologist), Dr. Gopika N (Consultant Radiologist), Dr. Geovarghese K. Mathew (Medical Superintendent & Consultant Cardiothoracic & Vascular Surgeon), Dr. Sarah J. Easaw (Medical Director & Consultant Oncologist, Oncology Centre at KMC Hospital), Dr. Naveen J. Tom (Consultant Radiologist), Dr. Aswin Padmanabhan (Consultant Neurovascular & Interventional Radiologist), Shri. Seby Paulose(COO, KMC Hospital)



12<sup>th</sup> July 2024

Blessing ceremony of the advanced Mammography Machine at Dr. KM Cherian Institute of Medical Sciences by the Managing Director, Rev. Fr. Dr. Alexander Koodarathil. L-R: Dr. Gopika N (Consultant Radiologist), Dr. Sarah J. Easaw (Medical Director & Consultant Oncologist Oncology Centre at KMC Hospital), Shri. Seby Paulose(COO, KMC Hospital), Dr. Aswin Padmanabhan (Consultant Neurovascular & Interventional Radiologist), Dr. Naveen J. Tom (Consultant Radiologist), Dr. Alex Paul (Consultant Radiologist), Dr. Geovarghese K. Mathew (Medical Superintendent & Consultant Cardiothoracic & Vascular Surgeon).



16<sup>th</sup> July 2024

Blessing ceremony of the advanced Endoscopic Ultrasound (EUS) Machine at Dr. KM Cherian Institute of Medical Sciences by the Managing Director, Rev. Fr. Dr. Alexander Koodarathil. L-R : Fr. Bibin Baby (Psychiatric and Spiritual Counsellor), Dr. Nikhil Kenny Thomas (Consultant Gastroenterologist), Dr. Anup S Nair (Consultant Gastroenterologist), Dr. Sarah J. Easaw (Medical Director & Consultant Oncologist, Oncology Centre, KMC Hospital), Dr. Murali Appukkuttan (Consultant HPB, Gastro-Onco and Transplant Surgeon), Shri. Seby Paulose(COO KMC Hospital), Sr. Pheba (Nursing Superintendent)



17<sup>th</sup> July 2024

Social Media Influencers from Oman, Mr. Muhammed Balushi & Mr. Ali Alhoom, made a friendly visit to meet the Managing Director, Rev. Fr. Dr. Alexander Koodarathil. Standing nearby Shri. Seby Paulose (Chief Operating Officer, KMC hospital, Chengannur)

# EVENTS



28<sup>th</sup> July 2024

Workshop on Comprehensive Newborn Care for Paediatricians was held at Dr. KM Cherian Institute of Medical Sciences on 28th July 2024. This event was organized by IAP Kerala, with invaluable support from NNF and IAP Pathanamthitta. The conference saw a packed session with delegates from various regions, making it a highly successful and engaging event.



1<sup>st</sup> August 2024

Inauguration of the Organ Donation Campaign at Dr. KM Cherian Institute of Medical Sciences, by Dr. Noble Gracious S. S, Executive Director, Kerala State Organ and Tissue Transplant Organization (K-SOTTO) on 1st August 2024. L-R Dr. Appu Jose (Consultant Nephrologist), Noble Gracious S. S, Executive Director, (Kerala State Organ and Tissue Transplant Organization (K-SOTTO)), Rev. Fr. Dr. Alexander Koodarathil (Managing Director, KMC Hospital), Dr. Sunil Agarwal (Consultant Cardiothoracic & Vascular Surgeon), Dr. John Peter (Consultant Urologist), Dr. Geevarghese K. Mathew (Medical Superintendent & Consultant Cardiothoracic & Vascular Surgeon).



2<sup>nd</sup> August 2024

Dr. KM Cherian Institute of Medical Sciences organized the Endocrinology Seminar – 'Approach to Hypoglycemia' in association with Central Travancore Physicians Club on 2nd Aug 2024. The scientific Session was led by Dr. Amal Dev, D (Consultant Endocrinologist, KMC Hospital, Chengannur) and chaired by Dr. G Vijayakumar (Diabetologist, Medical Trust Hospital).



7<sup>th</sup> August 2024

During World Breastfeeding Week, the Department of Neonatology & Paediatrics at Dr. KM Cherian Institute of Medical Sciences organised a poster competition and awarded prizes to the winners. L-R Shri Seby Paulose (Chief Operating Officer, KMC Hospital), Dr. Rony Joseph (Consultant Neonatologist & Paediatrician), Dr. Arun Thomas (Consultant Neonatologist), Dr. Sojeed Hashim (Consultant Neonatologist & Paediatrician), Dr. Deena Thomas (Consultant Neonatologist), Dr. Vysakh K. (Paediatric intensivist).



10<sup>th</sup> August 2024

Employees of Dr. KM Cherian Institute of Medical Sciences has contributed ₹10 lakh to the CM's disaster fund for Wayanad. The cheque was handed over by Shri Seby Paulose (Chief Operating Officer, KMC Hospital) to Shri Alex Varghese IAS (District Collector of Alappuzha).



15<sup>th</sup> August 2024

Flag Hoisting Ceremony at Dr. KM Cherian Institute of Medical Sciences on the 78th Independence Day.

# EVENTS



17<sup>th</sup> August 2024

Dr. KM Cherian Institute of Medical Sciences organized the Seminar on – 'Introduction to Palliative Care' by Dr. Sunitha Daniel (Lead Consultant in Palliative Medicine, York and Scarborough teaching NHS Hospital Foundation Trust, York, UK).



17<sup>th</sup> August 2024

Inauguration of Advanced Trauma Care Centre at Dr. KM Cherian Institute of Medical Sciences I-R : Shri Seby Poullose (Chief Operating Officer, KMC Hospital), Dr. Aju Joy (Intensivist), Dr. Arunraj S. L. (Consultant Emergency Medicine), Dr. Goevarghese K. Mathew (Medical Superintendent & Consultant Cardiothoracic & Vascular Surgeon), Rev. Fr. Dr. Alexander Koodarathil (Managing Director, KMC Hospital), Dr. Krishnakumar Mahadevan (Consultant Orthopaedic Surgeon), Dr. Rajeev R. (Consultant Neurosurgeon), Dr. Farish Shamsudeen (Consultant Minimally Invasive & Laparoscopic Surgeon), Dr. Sroenath P.R. (Consultant Neurosurgeon)



22<sup>nd</sup> August 2024

Prof. Dr. Vinod Menon (Consultant Bariatric & Upper Gastro-intestinal Surgeon [Robotic & Laparoscopic], University Hospitals Coventry & Warwickshire NHS Trust, UK; Immediate Past President & Chair of Trustees – British Obesity & Metabolic Surgery Society [BOMSS]; Honorary Clinical Professor, University of Warwick) visited Dr. KM Cherian Institute of Medical Sciences, Chengannur on 22nd Aug 2024 for the discussion on Comprehensive Specialist Weight and Diabetes Management Service.



3<sup>rd</sup> September 2024

Department of Cardiothoracic and Vascular Surgery at Dr. KM Cherian Institute of Medical Sciences organised – "Lung Cancer Symposium" on 3rd September 2024.

The scientific sessions were led by Dr. Luie Fernandus (Consultant Thoracic Surgeon, University Hospital Coventry & Warwickshire, UK), Dr. Mathew Patteril (Consultant Anaesthesiologist, University Hospitals of Coventry and Warwickshire, UK).



13<sup>th</sup> September 2024

Shri. Jiji Thomson, former Chief Secretary of Kerala, graced the Onam celebration as the esteemed Chief Guest.



23<sup>rd</sup> September 2024

The first patient under ECHS (Ex-servicemen Contributory Health Scheme) was gladly received by the Senior Consultant Cardiologist, Dr. Madhu Paulose Chandy, at Dr. KM Cherian Institute of Medical Sciences, Chengannur.

# EVENTS



20<sup>th</sup> September 2024

Inauguration of Hospital Day Celebration and Chairman's Birthday – Fiesta 2024 at Dr. KM Cherian Institute of Medical Sciences, by Shri Alex Varghese, IAS (District Collector, Alappuzha), on 20th September 2024.  
L-R : Dr. Geevarghese K. Mathew (Medical Superintendent & Consultant Cardiothoracic & Vascular Surgeon), Rev. Fr. Dr. Alexander Koodarathil (Managing Director, KMC Hospital), Very Rev. Nathaniel Remban (Superior, Mar Kuriakose Ashram, Mylapra), Shri Seby Poulso (Chief Operating Officer).



28<sup>th</sup> September 2024

On World Heart Day, Dr. KM Cherian Institute of Medical Sciences organized an Awareness Session. Dr. Jibi Zacharia (Cardiology) has led the session. The event was graced by the presence of Dr. Geevarghese K. Mathew (Medical Superintendent & Consultant Cardiothoracic and Vascular Surgeon) along with doctors from various departments and staff at KMC Hospital.



4<sup>th</sup> October 2024

Dr. KM Cherian Institute of Medical Sciences, Chengannur, organized ATTP (Accident Treatment Programme with Public Support) training for the Kerala Police at the District Police Training Centre, Kollam. The function was inaugurated by Smt. Chaitra Teresa John IPS (District Police Chief, Kollam) and was graced by the presence of Shri Jeeji N (Addl. Dy. Commissioner, Kollam) and Shri A. Prateep Kumar (ACP, Special Branch, Kollam).



4<sup>th</sup> October 2024

ATTP Training (Accident Treatment Programme with Public Support) for Pathanamthitta Police Department (2<sup>nd</sup> Batch) at Dr. KM Cherian Institute of Medical Sciences, Chengannur on 17th October 2024.



18<sup>th</sup> October 2024

On World Infection Prevention Week, Dr. KM Cherian Institute of Medical Sciences, organized the Quiz competition and Poster competition on 18th October 2024.



26<sup>th</sup> October 2024

PINK PROMISE – The Breast Cancer Awareness Campaign by Dr. KM Cherian Institute of Medical Sciences, Chengannur, inaugurated by Her Highness Pooyam Thirunal Gowri Parvathi Bai.  
L-R : Dr. Geevarghese K. Mathew (Medical Superintendent & Consultant Cardiothoracic & Vascular Surgeon), Christina Cheria (Asst. Editor, 24 News), Rev. Fr. Dr. Alexander Koodarathil (Managing Director, KMC Hospital), Her Highness Pooyam Thirunal Gowri Parvathi Bai, Smt. Poornima Indrajith, Dr. Sarah J. Easaw (Medical Director & Consultant Oncologist, Oncology Centre at KMC Hospital), Shri Seby Poulso (Chief Operating Officer).

# Hearty Welcome



**Dr. T. B Sebastian**  
MBBS, DTCD  
Consultant Fastrack Medicine



**Dr. Arunkumar A**  
MBBS, MS, DNB, MCh  
Consultant Gastrosurgeon



**Dr. Aravind R**  
MBBS, DA, DNB  
(Anaesthesia)  
Intensivist



**Dr. Athul Mohan**  
MBBS, MS  
Consultant Ophthalmologist  
& Medical Retina Specialist







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