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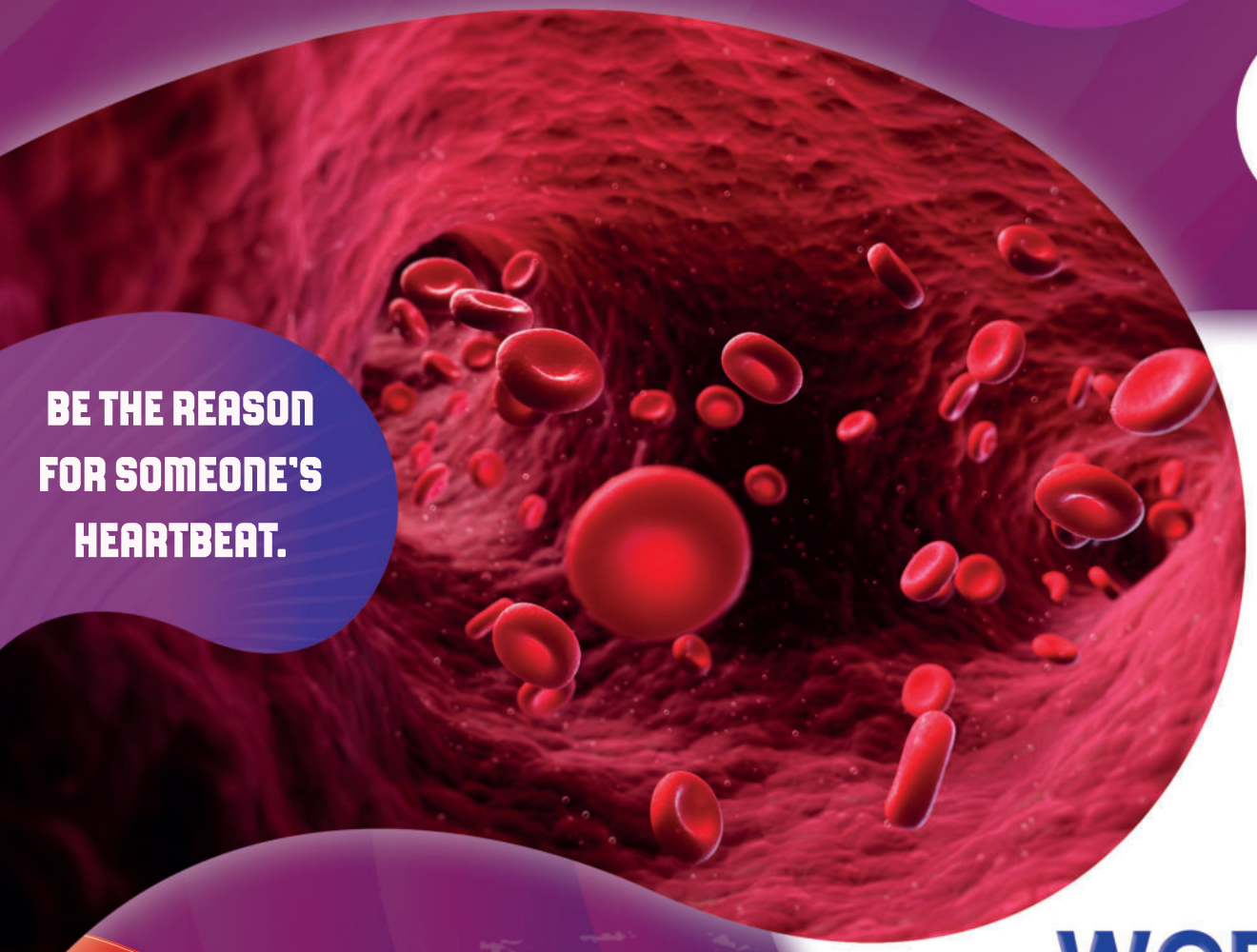
pulse

Sri Ramakrishna
Hospital (Multi-Speciality)

49 YEARS OF EXCELLENCE



BE THE REASON FOR SOMEONE'S HEARTBEAT.

WORLD BLOOD DONOR DAY

JUNE 14TH, 2025

Shri.R.Sundar
Managing Trustee

It is with great honor and joy that I write to you in this landmark month as we celebrate our **Hospital's 50th Anniversary on June 12th**. This occasion not only marks half a century of dedicated service but also stands as a powerful testament to the unwavering commitment and clinical excellence of our entire healthcare team.

This golden jubilee is a tribute to the vision of our founders, the commitment of our medical professionals, and the trust of our community. Over the past five decades, our institution has grown into a beacon of healing and hope – adapting, innovating, and always putting patients first.

To commemorate this achievement, our team has organized a series of impactful events throughout June – from honoring long-serving staff and showcasing our future plans. These activities reflect our unwavering commitment to public health and community engagement.

June also brings our attention to **World Blood Donor Day on the 14th**, reminding us of the life-saving power of a simple, selfless act. Let us continue to foster a culture of voluntary donation and gratitude.

Dr.S.Rajagopal
Medical Director

As we welcome the month of June, I feel immense pride and gratitude as we prepare to celebrate a momentous milestone – our Hospital Day on June 12th, marking 50 years of excellence in healthcare.

June also brings important health observances – World Blood Donor Day on June 14th. These provide us opportunities to engage the public through awareness, screenings, and outreach activities, reaffirming our role as advocates of preventive health.

As we step into our sixth decade, we reaffirm our commitment to advancing patient care, clinical research, education, and community outreach. Plans are underway to expand our super-specialty services, upgrade our infrastructure, and adopt next-generation digital health tools to improve accessibility and precision in diagnosis and treatment.

Editorial Team

Dr.N.Loganathan Pulmonologist	**Dr.S.Prahadeeshwaran** Head - Public Relations	**Mr.Santhosh Vijayakumar** Head - Corporate Relations & International Affairs

International Nurses Day 2025 Celebration

Sri Ramakrishna Hospital proudly celebrated International Nurses Day 2025 at the Velumaniammal Mandapam, honoring the dedication and compassion of our nursing staff. The event began with a traditional lamp lighting ceremony, symbolizing the light nurses bring into the lives of patients each day.

The ceremony was graced by Managing Trustee Mr. Sundar, who lit the ceremonial lamp and inaugurated the event. He was joined by Joint Managing Trustee Mr. Narendran, Chief Administrative Officer Mr. Mahesh, Chief Nursing Officer Mrs. Girija, and Deputy CNO Mrs. Jayasri. Their presence underscored the value the institution places on its nursing team.

The theme of this year's celebration, centered around "Our Nurses. Our Future. The Economic Power of Care", was reflected throughout the event, emphasizing not only the clinical excellence of nurses but also their pivotal role in shaping resilient healthcare systems. The venue was tastefully decorated, with a vibrant floral rangoli encircling the traditional kuthuvilakku, embodying the cultural richness and reverence accorded to this noble profession.

In his keynote message, Mr. Sundar, Managing Trustee, spoke about the institution's deep-rooted respect and admiration for nurses, calling them the "backbone of our hospital care." He acknowledged their constant sacrifices, professional integrity, and selfless care, especially during challenging times like the pandemic. Mr. Narendran, Joint Managing Trustee, highlighted the evolution of nursing as a profession and expressed the Trust's commitment to empowering nurses through continuous training, recognition, and leadership opportunities.

The celebration also included cultural performances by nursing staff, which added a joyful and vibrant touch to the day. Nurses were honored for their exemplary service with tokens of appreciation and certificates, recognizing their tireless dedication to patient care.

This occasion was not just a celebration but a reaffirmation of Sri Ramakrishna Hospital's deep commitment to fostering a supportive and empowering environment for its nursing team. As we look to the future, we salute our nurses – the heartbeat of healthcare – for their strength, compassion, and healing hands.

SRH - Nurses Day - Rally at Race Course

Sri Ramakrishna Hospital Celebrates "International Nurses Day" to Empower the Healthcare Heros.

Our Hospital marked International Nurses Day 2025 with a vibrant Walkathon themed "Our Nurses Our Future - Caring for Nurses Strengthens Economy" and a series of awareness programs, honoring the dedication and compassion of nurses who form the backbone of healthcare. The event, held on May 9, 2025, at Thomas Park, Race Course, Coimbatore, witnessed enthusiastic participation from nurses, healthcare professionals, and the general public.

The Walkathon was flagged off by Mr. K Pavan Kumar G Giriyappanavar, IAS, District Collector of Coimbatore, and Shri R. Sundar, Managing Trustee of SNR Sons Charitable Trust. The theme, " " highlighted the pivotal role nurses play in promoting health, delivering quality care, and supporting communities around the world.

Nurses stand at the forefront of healthcare, recognized for their commitment to innovation and promoting health equity. Even as healthcare continues to evolve, their unwavering expertise remains a constant force, serving as the backbone of improved patient outcomes and significantly enhancing the quality of life for countless individuals.

Our Hospital has always recognized the dedication and selfless service of its nursing team. The International Nurses Day celebration is a testament to the hospital's commitment to

Colonoscopic closer of colovaginal fistula by apollo x tracking system.

Case Summary:

A 69-year-old female, known case of Diabetes Mellitus, Hypertension, and Rheumatoid Arthritis on regular medications, presented with complaints of passage of feces and air through the vagina, more prominently during urination. She reported a weight loss of approximately 6 kg over the past 6 months. There was no history of abdominal pain, distension, fever, or gastrointestinal

On Examination:

The patient was conscious, oriented, and clinically stable. She had mild pallor but no icterus or pedal edema.

- Vital Signs: Temperature – Normal; Pulse Rate – 90 bpm; Respiratory Rate – 20/min; Blood Pressure – 140/80 mmHg.
- Per Abdominal Examination: Abdomen was soft, with no tenderness, guarding, rigidity, or palpable mass.

Investigations:

- Routine blood tests (CBC, LFT, urea, creatinine) were within normal limits.
- CT Abdomen revealed multiple sigmoid diverticula with a thickened segment (~8 cm) of sigmoid colon, but no features suggestive of malignancy.
- CT Cystogram showed no evidence of contrast leakage from the urinary bladder
- Gynecological evaluation showed no evidence of a mass lesion.

Procedures Performed:

Colonoscopy revealed multiple diverticula in the sigmoid colon with inflamed and edematous mucosa. A suspicious fistulous opening was noted. Cystoscopy and vaginoscopy were performed, and the fistulous tract was identified with difficulty. A guide wire was inserted from the vaginal side through the fistula and confirmed inside the sigmoid colon on colonoscopy. The internal opening of the fistula was visualized, and the mucosal edges were marked using diathermy. Closure was achieved using the Apollo X-Tack Helix Tracking System (160 cm).

Colonoscopy guided X tracking system deployment

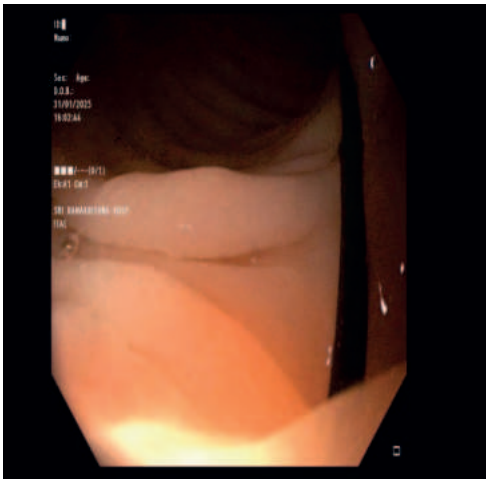
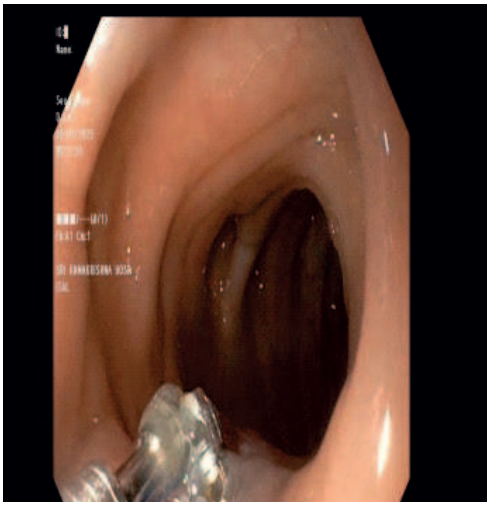


Image 1- Visualisation of Guidewire



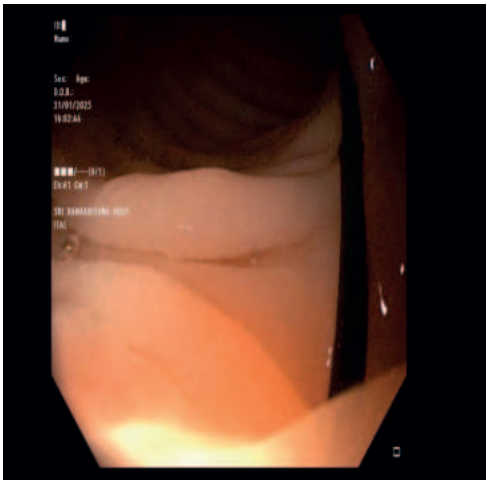


Image 2 & 3- X tracking system initial and final deployment

Post-procedure Care:

The patient was kept nil by mouth (NPO) for two days and had continuous bladder catheterization. She was treated with intravenous antibiotics, fluids, and supportive care. The fecal discharge through the vagina gradually subsided, and the patient became asymptomatic. She was discharged in stable condition.

Discussion:

Colovaginal fistulas are abnormal epithelial-lined tracts between the colon and vagina. Though rare, they are most commonly secondary to diverticular disease. Patients typically present with passage of gas or feces through the vagina. Potential complications include intra-abdominal abscesses, sepsis, and significant morbidity.

Surgical repair remains the gold standard, typically through single or multi-stage procedures. In select cases, conservative management with antibiotics and bowel rest may be attempted. Recently, minimally invasive endoscopic techniques such as over-the-scope clips (OTSC), covered stents, endoscopic suturing, and cardiac septal occluders have been explored.

Endoscopic closure with the Apollo X-Tack system is a novel, minimally invasive approach that enables mucosal and submucosal tissue approximation with reduced risk and faster recovery compared to surgery.

This case is notable for the presence of multiple sigmoid diverticula and the difficulty in localizing the fistula. Multidisciplinary collaboration, including urology and gynecology teams, enabled successful guidewire placement and fistula localization. To the best of our knowledge, this is the first reported case of colovaginal fistula closure using the Apollo X-Tack system in a patient with multiple diverticula.

Dr. M. MURUGESH
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Palliative care in advanced carcinoma of head of pancreas with biliary obstruction

Clinical Case Summary: A 42-year-old female presented with loss of appetite and weight loss of 3 kg over one month, along with jaundice for 15 days. She had no known comorbidities. On general examination, she was icteric with no pedal edema. Abdominal examination revealed a soft, non-tender abdomen with a distended and palpable gallbladder. There was no palpable organomegaly or free fluid.Vital signs were stable. BP: 130/80 mmHg, PR: 88/min & RR: 20/min. Laboratory Investigations:Total bilirubin: 12.3 mg/dL, Direct bilirubin: 10.1 mg/dL, Alkaline phosphatase: 1079 U/L & CA 19-9: 534 U/mL.

Radiological Findings (CVT Abdomen - Plain and Contrast) – Figure 1: An irregular, heterogeneously enhancing mass measuring 4.9 x 3 x 2.7 cm was noted in the head and uncinate process of the pancreas. Few calcific foci were seen within the mass. The common bile duct (CBD) was dilated (1.2 cm) as was the main pancreatic duct (1.1 cm), with abrupt cut-off at the margin of the mass. Posteriorly, the mass encased the superior mesenteric artery (SMA) and infiltrated the superior mesenteric vein (SMV). Anterolaterally, it showed loss of fat planes with the first part of the duodenum, suggestive of a locally advanced pancreatic malignancy. Few small peripancreatic lymph nodes were noted, the largest measuring 8 x 5 mm. Bilobar intrahepatic biliary radicle dilatation was seen. The portal vein was normal. The gallbladder was

As the tumour was deemed inoperable, palliative care was planned. Endoscopic Ultrasound (EUS)– Figure 2: EUS was performed under general anaesthesia using a linear echoendoscope. At the duodenal bulb (D1 junction), the portal vein was visualized. The CBD was dilated, with narrowing at its lower end. A hypoechoic mass measuring 3 x 3 cm was noted in the head of the pancreas. Fine needle biopsy (FNB) was performed using a 22-gauge Acquire needle (Boston Scientific), with four passes made using the fanning technique. Core tissue and smears were sent for histopathological examination (HPE).

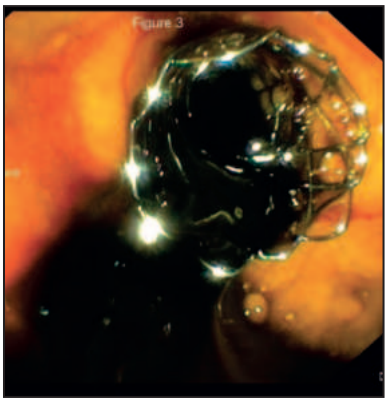
Endoscopic Retrograde Cholangiopancreatography (ERCP) – Figure 3: Selective CBD cannulation using a bow sphincterotome was unsuccessful. A precut sphincterotomy was done using a needle knife sphincterotome. Deep CBD cannulation was then achieved. A 0.035" guidewire was placed into the right hepatic duct, with position confirmed fluoroscopically and by bile aspiration. Cholangiogram showed abrupt cut-off at the distal CBD with upstream dilatation. An uncovered self-expanding metallic biliary stent (WallFlex, Boston Scientific, 10 mm x 60 mm) was placed in the CBD. Free flow of dark bile was noted.

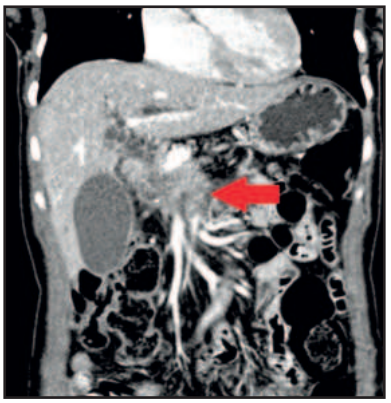
Post-Procedure Course: The patient was treated with IV fluids, antibiotics, analgesics, and supportive measures. She was kept nil per oral for 12 hours. The postoperative period was uneventful. Oral liquids were started the next day, followed by a soft diet, which she tolerated well. She was discharged in good condition.

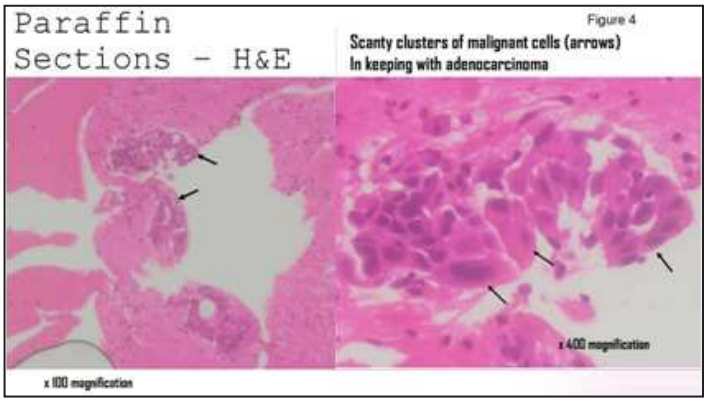
Follow-Up: Liver function tests showed significant improvement: Total bilirubin: 1.8 mg/dL, Direct bilirubin: 1.3 mg/dL, Alkaline phosphatase: 290 U/L. EUS guided FNB report was suggestive of adenocarcinoma – Figure 4. She was subsequently started on chemotherapy with Gemcitabine and Carboplatin.

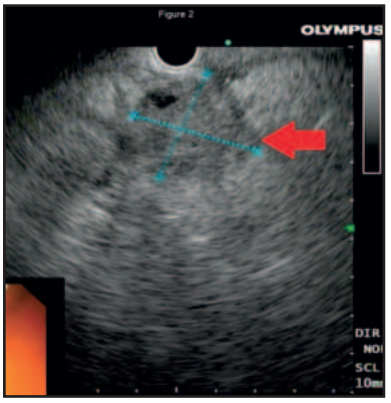
EUS-Guided Biopsy in Pancreatic Cancer: EUS-guided fine needle biopsy (EUS-FNB) is a highly effective method for diagnosing pancreatic cancer, particularly when high tissue cellularity and core histological samples are required. It has the advantage of providing well-preserved tissue for histological grading and subsequent molecular analysis. Studies have shown that EUS-FNB offers high diagnostic accuracy for pancreatic malignancy, with a pooled sensitivity of 84% and a pooled specificity of 99%. EUS-FNB is often preferred over fine needle aspiration (FNA) due to its ability to obtain more tissue and preserve structural integrity, which facilitates molecular profiling and histological evaluation. EUS-guided tissue acquisition has become the standard practice for diagnosing solid pancreatic masses due to its technical ease, cost-effectiveness, and lower morbidity.

ERCP-Guided Biliary Drainage in Pancreatic Cancer:
ERCP-guided biliary drainage or decompression with transpapillary stenting is the mainstay of management for patients with biliary obstruction and its related complications. In patients with advanced pancreatic malignancy, both endoscopic and surgical biliary drainage have shown similar success rates and long-term symptomatic relief. However, endoscopic biliary decompression is minimally invasive, more convenient, and relatively safer than surgical bypass, particularly in patients with unresectable pancreatic cancer. Endoscopic decompression is associated with fewer complications, shorter hospital stays, lower costs, and better









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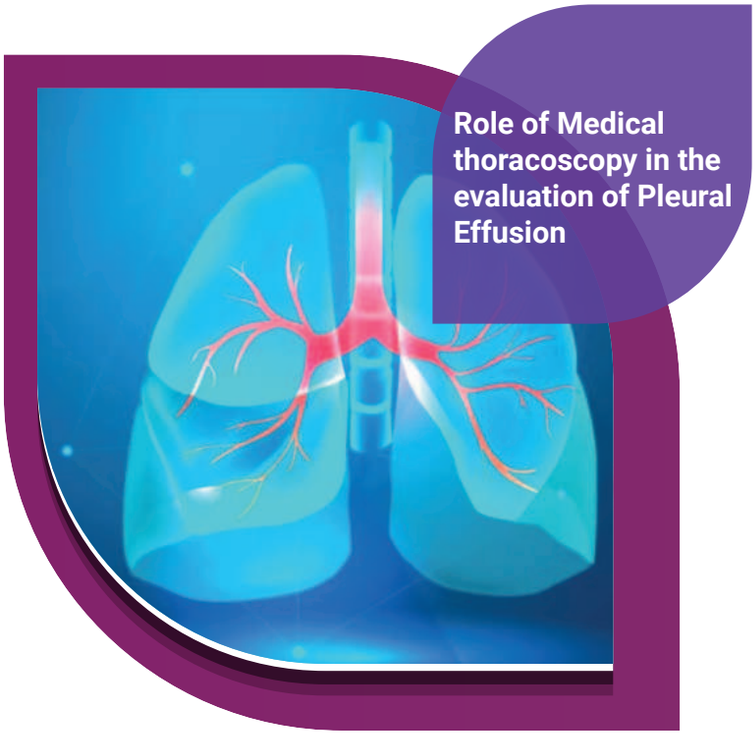


Role of Medical thoracoscopy in the evaluation of Pleural Effusion

The pleural space is bounded by two membranes, the visceral pleura covering the lung and the parietal pleura covering the chest wall and diaphragm. Normally, liquid and protein enter from the systemic circulation and are removed by the parietal pleural lymphatics. Pleural pressure is subatmospheric and thus ensures inflation of the lungs. The mesothelial cells covering the pleura are leaky and thus excess pleural fluid can move across into this lower-pressure, high-capacitance space and collect as a pleural effusion. Pleural effusion results from abnormal collection of fluid due to excessive production or decreased pleural fluid absorption. Thus, pleural effusions are common and of highly diverse etiologies. Excess pleural fluid can accumulate in the pleural space when there is excessive pleural capillary permeability and there is pleural inflammation. The etiologies for the pleural effusion can have pulmonary, pleural and extra pulmonary causes. The fluid can be transudative or exudative depending on the pleural fluid composition [Light's criteria].

The development of a pleural effusion is a common manifestation of pulmonary disease. In about half of all cases of pleural effusion, the diagnosis is apparent after a thorough history and physical examination and a work-up, including diagnostic thoracentesis and with other selected diagnostic tests. Unfortunately, as many as 15% to 20% of all pleural effusions remain undiagnosed despite intensive efforts for the diagnosis after diagnostic thoracentesis and/or closed pleural biopsy. An undiagnosed pleural effusion is often a difficult problem that needs histological study for a definitive aetiological diagnosis. Medical thoracoscopy/pleuroscopy is a minimally invasive procedure that allows access to the pleural space using a combination of viewing and working instruments. It also allows for basic diagnostic (undiagnosed pleural fluid or pleural thickening) and therapeutic procedures (pleurodesis) to be performed safely in addition to pleural biopsy for etiological diagnosis of pleural effusion.

A thorough history may provide clues to aetiology. Pleural effusions are classified as transudates or exudates according to the light's criteria. The erect PA chest radiograph is usually abnormal once >200 ml of fluid is present, whereas a lateral film will show blunting of the posterior costophrenic angle with as little as 50 ml. Ultrasound can be used to identify even small effusions. Ultrasound is clearly more sensitive for detecting pleural effusions than a lateral decubitus chest radiograph, and is also better able to predict the nature of the fluid. . CT chest allows small amounts of pleural fluid to be detected. CT is helpful in the assessment and management of loculated pleural effusions in addition to obtaining other informations regarding the etiologies of pleural effusion. Why is it important to differentiate transudates from exudates? If a patient has a transudative pleural effusion, then it is only necessary to treat the cause of the effusion, such as heart failure or cirrhosis. However, if it is an exudative effusion, more investigation is indicated to identify the local problem that is causing the pleural effusion

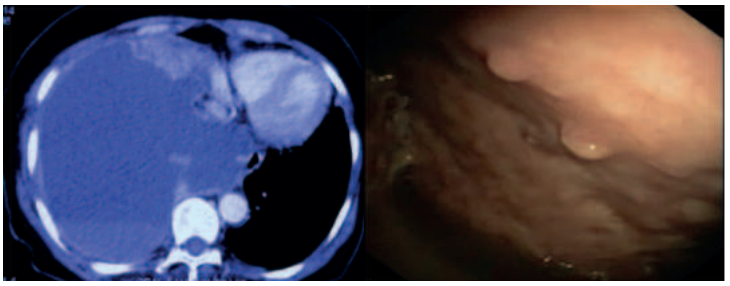
Medical thoracoscopy, or pleuroscopy, refers to thoracoscopy typically conducted by a nonsurgeon pulmonologist with the patient under local anesthesia and conscious sedation. Pleuroscopy is an endoscopic procedure that examines the pleural cavity, facilitates drainage of pleural fluid, and guides parietal pleural biopsy, talc pleurodesis, and chest tube placement without endotracheal intubation and general anesthesia. Some practitioners in Europe perform pleuroscopic sympathectomy for essential hyperhidrosis, and lung biopsy for diffuse lung disease. Medical thoracoscopy is a safe, reliable, and minimally invasive procedure with a high diagnostic yield in pleural effusions of unclear etiology. Contraindications are uncommon and rarely absolute. The main limitation is the size of free pleural space. Thoracoscopic procedures can be Semi-rigid thoracoscopy and rigid thoracoscopy procedures. Traditionally, medical thoracoscopy had been performed using rigid instruments and the same continued to be the case till the introduction of the semi-rigid thoracoscope.

Medical thoracoscopy is an extremely useful diagnostic modality that can often contribute crucially to accurate clinical decision-making in patients with undiagnosed pleural effusion. n patients where a successful pleural biopsy can be obtained, the yield of medical thoracoscopy performed by either rigid or semi-rigid thoracoscopy instruments has been reported to be similar in a randomized comparison between

the two techniques. In a prospective randomized study comparing the size, quality and diagnostic adequacy of biopsy specimens obtained by semi-rigid and rigid thoracoscope, it was demonstrated that there were no differences in the quality and interpretability of the specimens obtained by both the procedures. Although the specimens obtained by semi-rigid thoracoscope were smaller, they were still of adequate quality and the diagnostic accuracy was comparable with that of rigid thoracoscopy in the evaluation of pleural effusion of undiagnosed etiology. In cases, where an aggressive adhesiolysis is not the aim, semi-rigid thoracoscope offers particular advantages in terms of the procedure being less painful, lesser requirements of analgesic drugs and a smaller scar size. The greatest advantage, however, is the ease of adoption of the semi-rigid thoracoscope by bronchoscopist as the handling of the instrument essentially resembles that of a flexible bronchoscope.

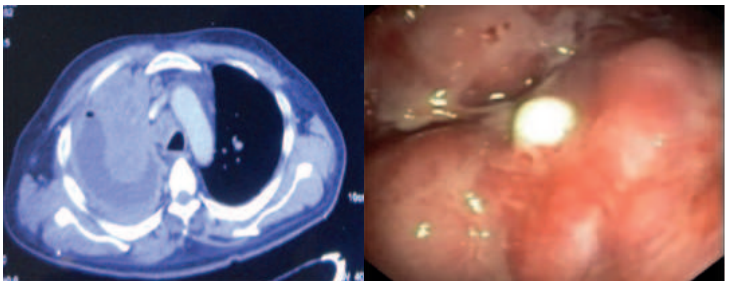
Radiological (CT), thoracoscopy pleural appearance in malignant pleural efusion

Adenocarcinoma Lung



CT chest: Large right pleural effusion with right pleural thickening Thoracoscopy: Shows variable sized nodules over the parietal pleura with parietal pleural infiltration

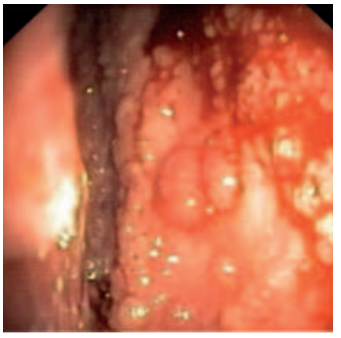
Squamous cell carcinoma lung



CT chest: Large right pleural effusion associated with right pleural thickening with right pleural nodularity

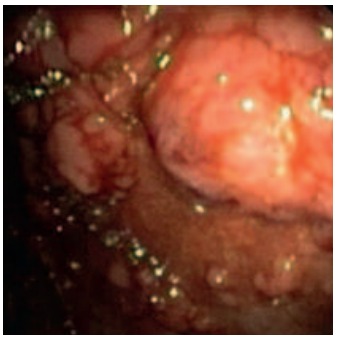
Thoracoscopy: Shows large pleural nodules over the parietal pleura with parietal pleural infiltration

Thoracoscopic image: Metastatic pleural effusion



Thoracoscopic image: Tuberculosis

Thoracoscopic image: Metastatic pleural effusion



Thoracoscopic image: Multiple Pleural adhesions

Thoracoscopic image: Visceral pleural infiltration by tumour

Thoracoscopic image: Multiple parietal pleural nodules

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The Pleural Frontier: Medical Thoracoscopy as a Diagnostic Compass

In the field of respiratory medicine, few situations are as exasperating - for both physician and patient - as the persistent, unexplained pleural effusion. While initial workup with fluid cytology, ADA, and imaging often leads us closer to a diagnosis, a significant subset of patients is left in a grey zone - where the cause of the effusion remains elusive, even after multiple tests.

This is where medical thoracoscopy proves its worth. It allows for direct, magnified visualization of the pleural surfaces and enables targeted pleural biopsies under conscious sedation. It is safe, well-tolerated, and offers a diagnostic yield of over 90 - 95% in most pleural diseases.

At Sri Ramakrishna Hospital, our Interventional Pulmonology unit routinely uses thoracoscopy to evaluate pleural pathology - especially in cases where conventional diagnostics fail. But more than that, we see it as a first-line tool in the right context, not just a fallback after all else has failed.

A Crucial Reminder Before Thoracoscopy: Tap Smart
Before we delve into actual cases, a brief but vital reminder one we always emphasize:

Avoid performing therapeutic pleural taps - especially in patients with suspected malignancy or TB - prior to thoracoscopy referral.
Even a single symptomatic drainage done outside can reduce pleural fluid volume to the point where thoracoscopy becomes technically difficult or even unsafe. The result? The lung may re-expand, the pleura may appose, and we lose the space we need to work within. In some cases, we've had to postpone or abandon thoracoscopy simply because too much fluid had already been drained.

Always aim for a diagnostic tap only, draining minimal fluid - just enough to send for cytology, ADA, GeneXpert, microbiology, and biochemistry. If the suspicion for TB or malignancy is high, and the effusion is moderate-to-large, consider direct thoracoscopy referral.

Case 1: Massive Effusion with Diagnostic Ambiguity – IHC to the Rescue

A 62-year-old man with no prior comorbidities presented with massive right-sided pleural effusion. Fluid biochemical and cytological analysis were inconclusive, and imaging showed pleural effusion only without mass lesions. Medical thoracoscopy was performed for definitive diagnosis. This case was performed using the latest Olympus LTF-H290 semirigid pleuroscope - a state-of-the-art instrument offering improved optics and flexibility.

Thoracoscopy revealed diffuse parietal pleural thickening with focal nodularity, raising suspicion for either mesothelioma or metastatic adenocarcinoma. Multiple biopsies were taken. Histopathology showed malignant cells, but immunohistochemistry (IHC) clinched the diagnosis - positive for TTF-1 and Napsin A, consistent with primary pulmonary adenocarcinoma.

The patient was referred for targeted systemic therapy.

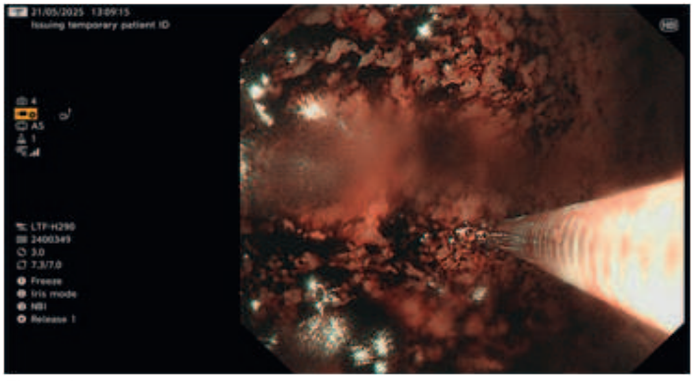

Figure 1

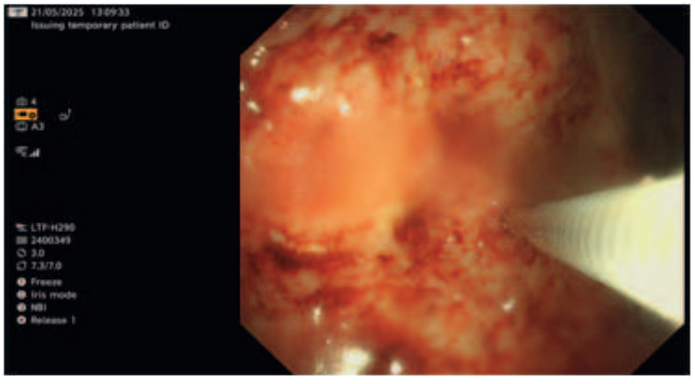

Figure 2

Figures 1 and 2: Endoscopic images- Diffuse smooth pleural thickening with scattered nodularity- representative of malignant pleural effusion

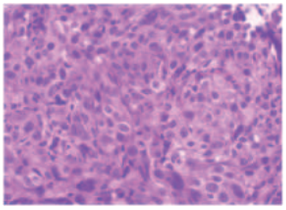

Figure 3:Pleural biopsy showing dense sheets of atypical epitheloid cells with high nuclear- cytoplasmic ratio and prominent nucleoli. (Pic courtesy: Dr T. Sethumadhavan, Consultant Oncopathologist, SRH)

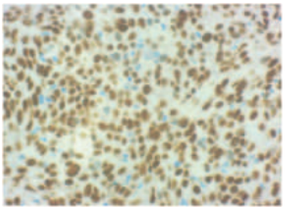

Figure4: IHC showing strong positivity for TTF1, confirming adenocarcinoma. (Pic courtesy: Dr T. Sethumadhavan, Consultant Oncopathologist, SRH)

Case 2: Delayed Recurrence – RCC After 15 Years

A 68-year-old man, previously treated for renal cell carcinoma (RCC) 15 years earlier, presented with recurrent right pleural effusion. PET-CT showed pleural uptake without systemic disease. Cytology was non-diagnostic.

Thoracoscopy revealed discrete, highly vascular pleural nodules, especially over the posterior chest wall. Biopsies confirmed metastatic RCC. In the same procedure, talc pleurodesis was performed.

The patient experienced symptomatic relief and was re-initiated on oncology follow-up.

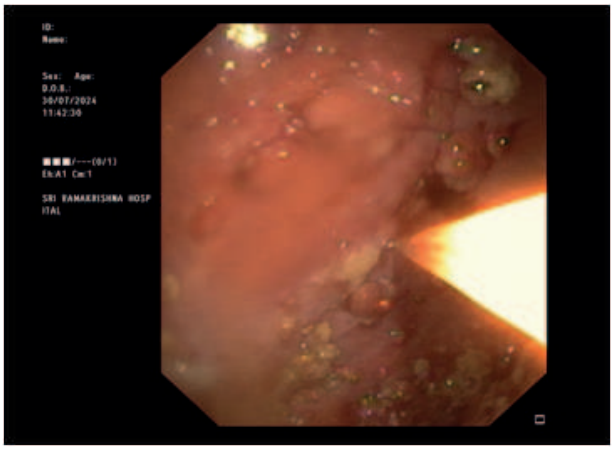

Figure 5: Multiple discrete pleural nodules over the parietal pleura. Biopsy confirmed metastatic RCC

Case 3: Low ADA TB – Atypical Biochemistry, Typical Visuals

A 76-year-old woman with a right-sided lymphocytic exudative pleural effusion with low ADA (28 IU/L) underwent thoracoscopy after negative cytology and non-revealing imaging. The pleura showed whitish, miliary nodules scattered across inflamed areas - strongly suggestive of TB.

Biopsies confirmed necrotizing granulomas, Gene Xpert MTB/RIF ultra of the tissue revealed MTB with no rifampicin resistance; she was initiated on anti-TB therapy with good response.

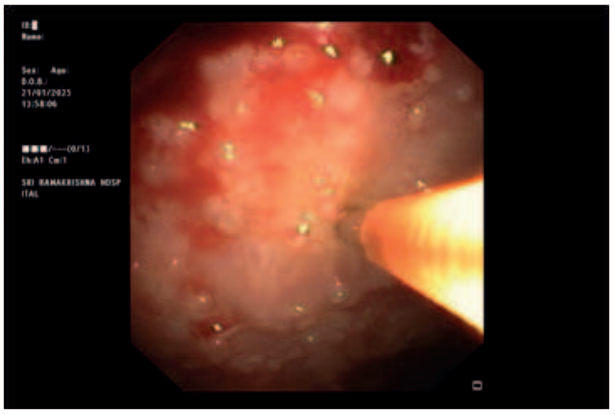

Figure 6:Multiple small, raised white plaques over parietal pleura- classical appearance of pleural TB

Case 4: Empyema with Septations - Dissecting the Problem Early

A 40-year-old diabetic man presented with a loculated effusion and low-grade fever for two weeks. CT thorax suggested early empyema. Given the multiloculated nature of the effusion and the patient's stable condition, medical thoracoscopy was preferred to allow direct visualization, targeted drainage, and biopsy in the same sitting. Upon entering the pleural space, thick septations and early organization were seen.

Mechanical disruption of septae was performed with suction and forceps, and targeted lavage helped break down early loculations. This patient avoided surgery and improved with antibiotics post-procedure.

"Thoracoscopy allows direct intervention in complex pleural infections - early enough to avoid decortication."

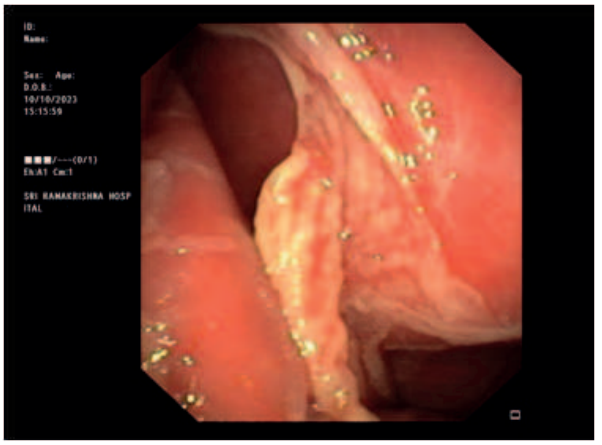

Figure 7: Multiple fibrous septations within the pleural cavity, consistent with multiloculated effusion. Direct visualisation allowed precise adhesiolysis & targeted drainage.

Conclusion:

If the effusion stays unexplained despite fluid work-up, or if CT hints at pleural thickening or nodularity, it's worth thinking early about thoracoscopy.

We've seen particular value in cases with suspected malignancies, TB with non-confirmatory fluid ADA, and even in recurrent malignant effusions - where pleurodesis can be done in the same sitting. In complex empyema too, a timely referral can be the difference between a clean plane and a trapped lung. Often, waiting means losing both fluid and time - along with diagnostic clarity.

The earlier the referral, the greater the diagnostic yield and the better the patient outcome. Waiting until the effusion shrinks or the lung gets trapped is a lost opportunity - one we see far too often.

As pulmonologists with a focus on interventional care, it is suggested to:

Refer early. Avoid unnecessary taps. Think thoracoscopy.
Let's work together to turn pleural uncertainty into diagnostic clarity - one scope at a time.

Dr.ARUN GANGADHAR
Consultant Interventional Pulmonologist
MBBS, DNB (Respiratory Medicine), MNAMS, IDCCM (Critical care),
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WORLD NO TOBACCO DAY - 2025

Sri Ramakrishna Hospital observes **World No Tobacco Day 2025**

District Collector launches **30 Cancer Awareness Instagram Reels** on interesting topics Sri Ramakrishna Institute of Oncology & Research (SRIOR), a unit of Sri Ramakrishna Hospital, Coimbatore observed World No Tobacco Day 2025 on 31.5.2025.

Coimbatore District Collector Pavankumar.G. Giriyappanavar took part as the Chief Guest. Shri. R.Sundar, Managing Trustee, SNR Sons Charitable Trust - the parent body of Sri Ramakrishna Educational Institutions and Sri Ramakrishna Hospital presided over the event. Dr.P.Guhan, Director, SRIOR delivered the welcome address.

At the event, **District Collector Pavankumar G.Giriyappanavar** launched **SRIOR's 30 Cancer Awareness Instagram Reels** on different interesting topics in the presence of various guests.

Shri R.Sundar, Managing Trustee of SNR Sons Charitable Trust thanked the collector for taking part in this event amidst his busy schedule.

In his presidential address, he said "We at Sri Ramakrishna Hospital have tried to create awareness among people in the form of Instagram reels, explaining the ill effects of tobacco and how it can lead to health issues like cancer, COPD, stroke, cardiac related issues etc., in that limited few minutes they have. The reason why we do this year after year is to make the message reach more People,"

The Chief Guest, **District Collector Pavankumar** said that while awareness about the side effects and long term effects of tobacco usage is much needed today, a few articles mention that the attention span among people is getting low. This idea to spread awareness about harms of tobacco usage in the form of Instagram reels has the possibility to alert the public, especially those who have short attention span.

Speaking at the event, **Dr.P.Guhan** said that for 22 years, SRIOR has created awareness about cancers and ill-effects of tobacco through various novel means in the form of animated videos, interactive flipbooks, websites etc. This time, SRIOR has created 25 cancer awareness Instagram Reels aimed at reaching the public especially the youth through one of the most popular social media sites.

Dr.K.Karthikesh, Surgical Oncologist, SRIOR, proposed the vote of thanks. SNR Sons Charitable Trust's Chief Executive Officer C.V. Ramkumar, Chief AdministrativeOfficer Mr. Mahesh Kumar, Sri Ramakrishna Hospital's Medical Director Dr. S. Rajagopal, Medical Superintendent Dr. S Alagappan and other doctors and students were present during the event.

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