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Association of Physicians of India
(Malwa Branch)

MAPICON 2025

18th - 21st September 2025

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&
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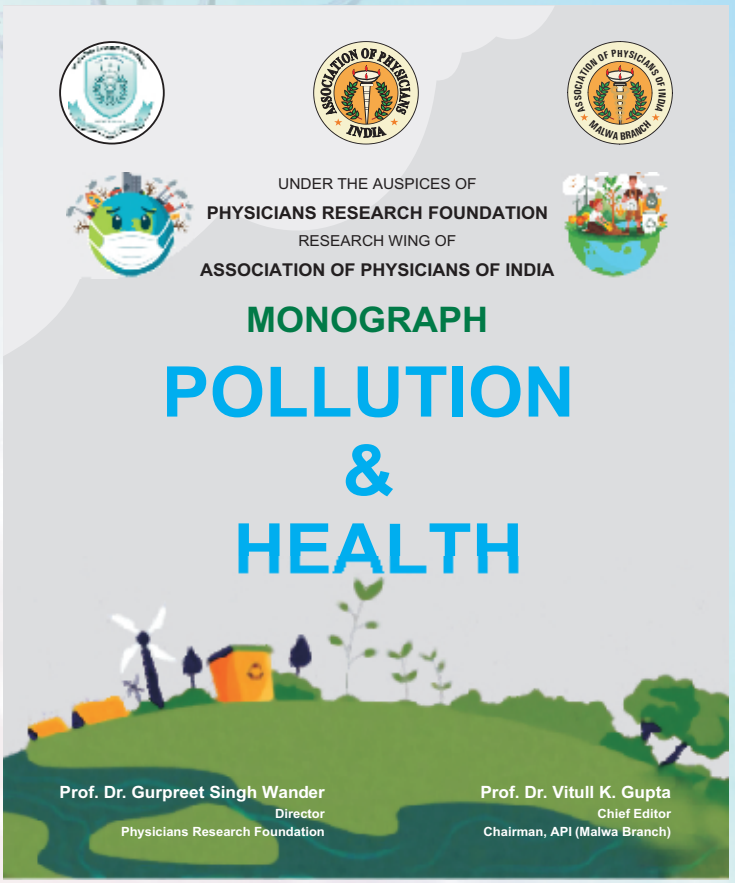

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This 34-chapter book provides detailed insights into the effects of air, water, soil, noise pollution and climate change on every system of the human body.

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Scientific Programme, 18-09-2025, Thursday (Day-1)

Breakfast: 9:00am to 10:00am, Lunch: 2:00pm to 3:00pm

Research Society for the Study of Diabetes in India (RSSDI) Session

Moderator: K. K. Nohria

10.00am to 10.20am	Neelesh Kapoor, Noida	AI in Cardio-Diabetes Care
10.20am to 10.40am	Puneet Saxena, Jaipur	Cardiovascular-Kidney-Metabolic Syndrome
10.40am to 11.00am	Arvind Gupta, Jaipur	Remission of Metabolic Disorders with Yoga and Lifestyle: Is It Possible?
11.00am to 11.20am	Pritam Singh, Chandigarh	Antibiotic Stewardship
11.20am to 11.40am	Seema Mahant, Bhopal	Rational Use of Blood and Blood Products
11.40am to 12.00pm	B K Agarwal, Ambala	Perioperative and Periprocedural Management of Antithrombotics

General Session

Moderator: Vitull K. Gupta

12.00pm to 12.20pm	G S Wander, Ludhiana	Indian Hypertension Guidelines: What is New?
12.20pm to 1.20pm	Inauguration	
1.20pm to 1.40pm	Atul Sachdeva, Mohali	Approach to Management of Dyspepsia
1.40pm to 2.00pm	Anil Goyal, Chandigarh	New Initiatives in Secondary Health Care in Punjab
2.00pm to 2.20pm	Shibba Chhabra, Ludhiana	Seeing the Unseen: Imaging for Women's CVD Prevention

Research Society for the Study of Diabetes in India (RSSDI) Session

Moderator: M. R. Gupta

2.20pm to 2.40pm	Ravinder Garg, Faridkot	Glycemic Variability: What, Why & How?
2.40pm to 3.00pm	Gursaran Kaur, Ludhiana	GLP 1A Manjaro: The New Kid on the Block
3.00pm to 3.20pm	Sandeep Suri, Haryana	Altered Chrono Biology & Diabetes

All India Institute of Medical Sciences (AIIMS) Session

Moderator: Ashok Goyal

3.20pm to 3.40pm	Rajiv Gupta, Bathinda	Recent Advances in CABG
3.40pm to 4.00pm	Gagandeep Kwatra, Bathinda	Environmental Impact of Drugs: Beyond the Patients
4.00pm to 4.20pm	Suresh Goyal, Bathinda	Serum PSA Levels: Myths and Facts

4.20pm to 4.40pm	Lajya Devi Goyal, Bathinda	Ovarian Cyst: Do All Need Treatment ?
4.40pm to 5.00pm	Rakesh Goyal, Hisar	Asthma COPD overlap syndrome: What is New ?
5.00pm onwards	**Scientific Paper Presentations**	

Scientific Programme, 19-09-2025, Friday (Day-2)

Breakfast: 9:00am to 10:00am, Lunch: 2:00pm to 3:00pm

Indian Medical Association (IMA) Session

Moderator: K. K. Nohria

10.00am to 10.20am	Arun Bansal, Bathinda	Behind the Smile: Unseen Struggles of the Students Mind
10.20am to 10.40am	Jagroop Singh, Bathinda	Fibromyalgia: A Challenge in Diagnosis and a Test of Empathy
10.40am to 11.00am	Poonam Poonia, Rohtak	Biologicals in Asthma
11.00am to 11.20am	Yasmeen Atwal, Bathinda	Pediatric Nuclear Medicine
11.20am to 11.40am	Vikas Chhabra, Bathinda	Management of Varicose Veins in 2025
11.40am to 12.00pm	Deepak Bansal, Bathinda	When to do TKR
12.00pm to 12.20pm	Abhishek Garg, Bathinda	Approach to Headache
12.20pm to 12.40pm	Swaranjit Bhullar, Bathinda	Approach to Patient of Interstitial Lung Disease (ILD)
12.40pm to 1.00pm	Nitika Dang, New Delhi	Rewriting Mind at Night: An Overview

Research Society for the Study of Diabetes in India, Punjab (RSSDI) Session

Moderator: M. R. Gupta

1.00pm to 1.20pm	Rajesh Jindal, Bathinda	Non-Statin Therapy for Dyslipidemia: An Update
1.20pm to 1.40pm	Rohit Aggarwal, Patiala	Type-5 diabetes / MRDM
1.40pm to 2.00pm	Arpit Garg, Patiala	Management of Thyroid Eye Disease
2.00pm to 2.20pm	Naveen Mittal, Ludhiana	Diabetes Ketoacidosis: Manangement
2.20pm to 2.40pm	Tanish Dhir, Ludhiana	Diabetic Kidney Disease: Prevention and Management
2.40pm to 3.00pm	Ginni Aggarwal, Jalandhar	Diabetic Retinopathy

General Session

Moderator: Ashok Goyal

3.00pm to 3.20pm	Navdeep Singh, Ludhiana	Tips And Tricks in Suspecting Malignancy

3.20pm to 3.40pm	Shifali Gupta, Chandigarh	Relevance of Genetic Testing in Medical Practice
3.40pm to 4.00pm	M M Bansal, Muktsar	Approach to Unknown Poisoning
4.00pm to 4.20pm	Manish Gupta, Amritsar	MDR infections in ICU
4.20pm to 4.40pm	Bharat Bhushan, Ferozpur	Hyperparathyroidism: What Physicians Should Know?
4.40pm to 5.00pm	Sahil Nohria, Jalandhar	MASLD: An Overview

Scientific Programme, 20-09-2025, Saturday (Day-3)

Breakfast: 9:00am to 10:00am, Lunch: 2:00pm to 3:00pm

Indian Dental Association (IDA) Session

Moderator: Parvinder Kaur

10.00am to 10.20am	Nidhi Verma, Bathinda	Gum Diseases and Health
10.20am to 10.40am	Inderpreet Kaur, Bathinda	Impact of Occlusion on TMJ
10.40am to 11.00am	Jatinder Singh, Bathinda	Periodontal Therapy and Glycemic Control in T2DM

General Session

Moderator: K. K. Nohria

11.00am to 11.20am	Usha Goyal, Bathinda	Millets Reinvented
11.20am to 11.40am	Mohanjeet Kaur, Ludhiana	New Vs. Old Management Guidelines for MDR TB
11.40am to 12.00pm	Meghna Gupta, Mathura	Preventing Suicides in Youth
12.00pm to 12.20pm	Achal Goindi, Jalandhar	Acute Ischemic Stroke: Imaging and Mechanical Thrombectomy
12.20pm to 12.40pm	Parth Bansal, Mohali	Osteoporotic Vertebral Fractures: The Silent Epidemic
12.40pm to 1.00pm	Sandeep Gupta, Mohali	Bone Health in 21st Century: Beyond Calcium
1.00pm to 1.20pm	Kheman Grover, Bathinda	Total Hip Replacement: An Overview
1.20pm to 1.40pm	Rajni Jindal, Bathinda	Polycystic Ovary and The Forgotten Uterus
1.40pm to 2.00pm	Vaibhav Saini, Bathinda	Vertigo: Diagnosis and Management

Innovative Physicians Forum (IPF) Session

Moderator: M. R. Gupta

2.00pm to 2.20pm	M M Mandhirata, Delhi	Clinical & Video Based Approach To Epilepsy
2.20pm to 2.40pm	J K Sharma, New Delhi	Type 1 Diabetes and Cardiovascular Risk

2.40pm to 3.00pm	A K Manchanda, New Delhi	Gut Microbiota in CVD
3.00pm to 3.20pm	Puneet Khanna, New Delhi	OSA: Newer Insights
3.20pm to 3.40pm	Meghna Aggarwal, Kota	Approach to Hematuria
3.40pm to 4.00pm	Joban Preet Singh Deol, Ludhiana	Approach to Connective Tissue Diseases

General Session

Moderator: K. K. Nohria

4.00pm to 5.00pm	T S Kler, New Delhi	ECG Quiz for doctors
5.00pm to 6.00pm	**Scientific Paper Presentations**	

Scientific Programme, 21-09-2025, Sunday (Day-4)

Breakfast: 9:00am to 10:00am, Lunch: 2:00pm to 3:00pm

Clinical Cardio Diabetic Society of India (CCDSI) Session

Moderator: K. K. Nohria

9.40am to 10.00am	Saibhal Guha, Patna	Steroid Induced Hyperglycemia
10.00am to 10.20am	Rajesh Aggarwal, Indore	Pre-Diabetes: Treat or Not to Treat
10.20am to 10.40am	Braj Kishore Singh, Bihar	ADA Standards of Care in Diabetes 2025 - What's New
10.40am to 11.00am	Anil Kumar Virmani, Jharkhand	Restoring the Warning signs of Cardiometabolic Disorders
11.00am to 11.20am	Mukesh Bhatia, Delhi	Hyponatermia
11.20am to 11.40am	T S Kler, New Delhi	Heart to Heart Talk
11.40am to 12.40pm	**Felicitation Ceremony and Award Distribution**	

General Session

Moderator: Vitull K. Gupta

12.40pm to 1.00pm	Baldev Aulakh, Ludhiana	Laser for prostate and stones
1.00pm to 1.20pm	Showkat Ahmad Parray, Bathinda	Universal Healthcare: Role of Private Sector
1.20pm to 1.40pm	Avnish Kumar, Mohali	Quality vs Quantity: Challenges in Medical Education

Lipid Association of India (LAI) Session

Moderator: K. K. Nohria

1.40pm to 2.00pm	Karamveer Goyal, Ludhiana	LAI Recommendations for Management of Dyslipidemia

2.00pm to 2.20pm	Manikant Singla, Ludhiana	LAI Recommendations for Management of Diabetic Dyslipidemia
2.20pm to 2.40pm	Ashish Saxena, Ludhiana	LAI Recommendations for Management of Dyslipidemia in ACS

All India Institute of Medical Sciences (AIIMS) Session

Moderator: Sonia Arora

2.40pm to 3.00pm	Manjit Kaur, Bathinda	Molecular Subtyping of CA Breast: Present & Future
3.00pm to 3.20pm	Ram Samujh, Bathinda	Common Paediatric Surgical Conditions in Office Practice
3.20pm to 3.40pm	Kawaljit S Kaura, Bathinda	Transplantation of Human Organs & Tissue Act 1994. Implications in Punjab
3.40pm to 4.00pm	Monica Kakkar, Bathinda	AI in Lab: A Revolutionary Inclusion
4.00pm to 4.20pm	Rakesh Kakkar, Bathinda	National Guidelines for Snakebite Management

4.20pm to 5.00pm: Delegate Certificate Distribution, Valedictory function and Vote of Thanks

ORAL & POSTER PAPER PRESENTATION SCHEDULES

18.9.2025 (Thursday) Oral Paper Presentation Schedule of MAPICON 2025			
S. NO	TIME	NAME	COLLEGE
OP 1	9.00am to 9.10am	Aditya Gupta	MMIMSR, Mullana
OP 2	9.10am to 9.20am	Akanksha Gupta	MMIMSR, Mullana
OP 3	9.20am to 9.30am	Aneesha Chhibber	MMIMSR, Mullana
OP 4	9.30am to 9.40am	Atrideb Misra	MMIMSR, Mullana
OP 5	9.40am to 9.50am	Charu Lakhi	MMIMSR, Mullana
20.9.2025 (Saturday) Oral Paper Presentation Schedule of MAPICON 2025			
OP 6	9.00am to 9.10am	Ankur Gupta	NC Med. College, Israna, Panipat.
OP 7	9.10am to 9.20am	Levis Abin Joy	MMIMSR, Mullana
OP 8	9.20am to 9.30am	Manjul Chopra	MMIMSR, Mullana
OP 9	9.30am to 9.40am	Manpreet S. Brar	KM Medical College, Mathura

18.9.2025 (Thursday) Poster Paper Presentation Schedule of MAPICON 2025			
S No	Poster	Name	College
PP 1	5.00pm to 5.10pm	Aditya Gupta	MMIMSR, Mullana
PP 2	5.10pm to 5.20pm	Aneesha Chhibber	MMIMSR, Mullana
PP 3	5.20pm to 5.30pm	Arpit Kumar	MMIMSR, Mullana
PP 4	5.30pm to 5.40pm	Harsh Gupta	MMIMSR, Mullana
PP 5	5.40pm to 5.50pm	Yogesh Garg	MMIMSR, Mullana
PP 19	5.50pm to 6.00pm	Meneka	GGSMCH Faridkot
PP 20	6.00pm to 6.10pm	Bahadur Varun Kumar	GGSMCH Faridkot
19.9.2025 (Friday) Poster Paper Presentation Schedule of MAPICON 2025			
PP 6	9.00am to 9.10am	Ankit Gulia	DMC & H, Ludhiana
PP 7	9.10am to 9.20am	Gurleen Kaur	DMC & H, Ludhiana
PP 8	9.20am to 9.30am	Harsheel Gupta	DMC & H, Ludhiana
PP 9	9.30am to 9.40am	Parul	DMC & H, Ludhiana
PP 10	9.40am to 9.50am	Sakul Kapahi	DMC & H, Ludhiana
PP 11	9.50am to 10.00am	Diksha Singla	GMC, Amritsar
20.9.2025 (Saturday) Poster Paper Presentation Schedule of MAPICON 2025			
PP 12	4.00pm to 4.10pm	Ankur Gupta	NC Medical College, Panipat
PP 13	4.10pm to 4.20pm	Himani Pandey	GGSMCH Faridkot
PP 14	4.20pm to 4.30pm	Nariender pal	GGSMCH Faridkot
PP 15	4.30pm to 4.40pm	Pooran Yadav	GGSMCH Faridkot
PP 16	4.40pm to 4.50pm	Praveen Kumar Nyaria	Civil Hospital Faridkot
PP 17	4.50pm to 5.00pm	Ranjit Rupchand Shahare	Civil Hospital Faridkot
PP 18	5.00pm to 5.10pm	Mekha Jude George	GGSMCH Faridkot
PP 21	5.10pm to 5.20pm	Nayan Kumar Amrutiya	MMIMSR, Mullana

ABSTRACTS
ORAL PRESENTATIONS

OP 1 To Estimate the Prevalence of Sarcopenia in COPD Patients and to Correlate with Disease Severity

Aditya Gupta, Maharishi Markandeshwar Institute of Medical Sciences and Research, Mullana, Ambala, Haryana

Chronic obstructive pulmonary disease (COPD) is a progressive respiratory disorder often complicated by systemic manifestations. Sarcopenia, defined as loss of skeletal muscle mass, strength, and function, adversely affects exercise capacity, quality of life, and overall prognosis in COPD.

Objectives: To determine the prevalence of sarcopenia in COPD patients using EWGSOP2 (2019) criteria and evaluate its correlation with disease severity.

Methods: A cross-sectional study was conducted at MMIMSR, Mullana, including 100 COPD patients (67 males, 33 females). Sarcopenia was diagnosed using EWGSOP2 criteria: muscle mass (ASM/HT^2 measured by bioelectrical impedance), muscle strength (handgrip dynamometry), and physical performance (gait speed- 6-minute walk test). COPD severity was graded according to GOLD classification. Data were analyzed using Chi-square test.

Results: Sarcopenia was present in 31% of COPD patients, with a significantly higher prevalence in males (27%) than females (4%). The majority of cases occurred in the 50–69 year age group. Low muscle mass was found in 31 patients, reduced grip strength in 34, and impaired gait speed in 41. Prevalence increased with disease severity: 0% in mild, 35.7% in moderate and 31.3% in severe/very severe COPD (χ^2=4.73, p=0.0295).

Conclusion: Sarcopenia is common in COPD, particularly in older males and those with advanced disease. Routine screening using EWGSOP2 criteria may enable early nutritional and rehabilitative interventions, improving clinical outcomes in COPD care.

OP 2 Clinical Profile and Outcome in Severe Dengue Patients in Tertiary Care Centre

Akanksha Gupta (JR), Sunita Gupta , Dept. of General Medicine, Maharishi Markandeshwar Institute of Medical Sciences and Research, Mullana, Ambala, Haryana

Introduction: Dengue fever is a major cause of morbidity in India. Clinical manifestations range from mild febrile illness to severe dengue,

characterized by plasma leakage, bleeding, and multiorgan dysfunction.

Aims and Objectives: (a) To examine the clinicobiochemical profile of patients with severe dengue fever (b) To identify key predictors of clinical outcomes.

Material and Methods: This descriptive cross-sectional study was conducted at MMIMSR, Mullana, after ethical approval. Patients meeting WHO criteria for severe dengue admitted to emergency/ICU were included after informed consent. Clinical evaluation and investigations were performed. SOFA and APACHE II scores were calculated within 24 hours. Requirements for ventilatory support, vasopressors, blood products, and albumin were recorded. Outcomes were noted as discharge or mortality.

Results: Fifty-six patients were included (mean age 46.4 years; 59% males). Respiratory distress (60.7%) and cardiac/other organ involvement (50%) were most common, followed by severe bleeding (41.1%) and shock (35.7%). Vasopressors were required in 37.5% and ventilatory support in 30.4%. Mortality was 17.9 %. Conclusion: Understanding the clinical profile and outcomes of severe dengue assists in early risk stratification and resource allocation. Such data are crucial for planning targeted interventions to reduce dengue-related mortality.

OP 3 Study of Correlation Between Glycated Hemoglobin Level and Lipid Profile In Type 2 Diabetes Mellitus

Aneesha Chhibber, JR, Shivani Saini, Associate Professor. Dept of General Medicine, Maharishi Markandeshwar Institute of Medical Sciences and Research, Mullana, Ambala, Haryana

Background: Atherosclerosis leading to coronary artery disease (CAD) remains the major cause of death and premature disability in developed countries and its prevalence is rising constantly in developing countries. Dyslipidaemia due to insulin resistance, the major cause of coronary atherosclerosis and ischemic heart disease is the frequently associated with T2DM. T2DM is an emerging pandemic.

Objective: To study the correlation between glycated haemoglobin level and lipid profile in T2DM.

Methods: In this study lipid abnormalities associated with T2DM were studied and association between HbA1c level and extent of dyslipidaemia detected. In this cross-sectional study 100 known cases of T2DM were investigated for HbA1c and lipid profile. The data obtained was analyzed by appropriate statistical methods.

Results: In this present study, dyslipidaemia was found to be present in 89% patients with T2DM. Of these 21% had single abnormal lipid parameter while 68% had combined dyslipidaemia. Thus, prevalence of dyslipidaemia was alarmingly high in T2DM patients. There was highly significant direct

correlation between HbA1c & total cholesterol (r=0.636; p<0.001), HbA1c & LDL cholesterol (r=0,617; p <0.001), HbA1c & triglycerides (r= 0.523; p <0.001), HbA1c & Tc/HDL ratio (r=0.721; p<0.001) and HbA1c and non HDL cholesterol (r=0.690; p<0.001). We also found highly significant inverse correlation between HbA1c and HDL cholesterol (r= -0.561; p<0.001).

Conclusion: Prevalence of dyslipidaemia was alarmingly high in T2DM patients. Thus HbA1c can be considered as a marker of dyslipidemia in T2DM.

OP 4 To determine prognostic factors in patients with altered sensorium

Atrideb Misra, 3rd Year Resident, Dept of General Medicine, Maharishi Markendeswar Institute of Medical Sciences and Research, Mullana, Ambala, Haryana

Introduction: Altered sensorium is a common but non-specific presentation resulting from diverse systemic and neurological disorders, often associated with high morbidity and mortality. Early identification of prognostic indicators can guide timely intervention. This study aimed to assess the etiological spectrum, clinico-biochemical profile, and prognostic factors in patients with altered sensorium.

Materials and Methods: A prospective observational study was conducted in the Department of General Medicine, MMIMSR, Mullana, from April 2024 to June 2025. A total of 250 adult patients (GCS < 15 or disoriented) were included, excluding trauma, post-operative cases, and known neurological or psychiatric illnesses. Clinical, biochemical, and radiological evaluations were performed. APACHE II and SOFA scores were calculated, and patients were followed until discharge or death.

Results: Mean patient age was 54.45 ± 17.86 years; males comprised 52%. Major etiologies were sepsis (36.4%), metabolic derangements (25.6%), CNS disorders (23.2%), poisoning (8%), and respiratory failure (6.8%). Overall mortality was 38.8%, highest in sepsis (69.2%). Mortality correlated with lower GCS, hypotension, hypoxemia, need for inotropes or ventilation, elevated TLC, AST, ALT, urea, creatinine, lactate, and low albumin, protein, pH, and bicarbonate (all $p < 0.05$). Positive blood cultures predicted poor outcomes. APACHE II and SOFA scores were significantly higher in non-survivors ($p = 0.001$). Hospital stay was longest in CNS disorders (12.4 days) and shortest in poisoning (6.7 days).

Conclusion: Sepsis, metabolic derangements, and CNS disorders were leading causes of altered sensorium, with sepsis showing highest mortality. APACHE II and SOFA scores provided superior prognostic accuracy, and integrating them with bedside indicators enables early risk stratification and improved outcomes.

OP 5 Relationship between Anthropometric Measurements and Lipid Profile in Hypertensive Adults

Charu Lakhi, Junior Residenharishi Markandeshwar
Institute of Medical Sciences and Researct 3, Mah, Mullana, Ambala, Haryana

Background: Hypertension and dyslipidemia remain major contributors to cardiovascular morbidity. Their link with central obesity highlights the importance of anthropometric indices in predicting early cardiometabolic risk.

Objective: To study the relationship between anthropometric parameters and lipid profile in adults with essential hypertension.

Methods: We conducted a case–control study on 200 participants (100 hypertensives, 100 normotensives) at MMIMSR, Ambala. Anthropometric indices recorded were BMI, waist and hip circumference, waist-to-hip ratio, and skin fold thickness (biceps, triceps, subscapular, suprailiac). Fasting lipid profile including total cholesterol, LDL-C, HDL-C, and triglycerides was measured by enzymatic methods. Statistical analysis was done using SPSS v25.0, with significance set at $p < 0.05$.

Results: Hypertensive subjects had significantly higher BMI, waist and hip circumference, waist-to-hip ratio, and skin fold thickness at triceps, subscapular, and suprailiac sites ($p < 0.05$). Biceps thickness showed no significant difference. Lipid abnormalities were prominent in hypertensives: higher total cholesterol, LDL-C, and triglycerides, with lower HDL-C ($p < 0.0001$). BMI correlated positively with total cholesterol ($r = 0.45$), LDL-C ($r = 0.42$), and triglycerides ($r = 0.39$), and negatively with HDL-C ($r = –0.40$), all $p < 0.001$.

Conclusion: Central adiposity strongly correlates with adverse lipid parameters in hypertension. Regular screening of anthropometric and lipid indices is crucial for early identification and management of cardiometabolic risk.

OP 6 Spectrum of Macrocytic Anemia in Adult Population: A Study from Tertiary Care Centre, Haryana

Ankur Gupta, NC Medical College & Hospital, Israna , Panipat

Background: Macrocytic anaemia is a common hematological condition with varied etiologies, including nutritional deficiencies, systemic illnesses, and bone marrow disorders. Understanding its spectrum is essential for timely diagnosis and effective management.

Objectives: To evaluate the clinical profile, etiological distribution, and hematological features of macrocytic anaemia in adults presenting to a tertiary care center in Haryana.

Methods: This cross-sectional study was carried out among adult patients (>18 years) with anaemia and mean corpuscular volume (MCV) >100 fL. All patients underwent detailed history-taking, clinical examination, complete blood counts, peripheral smear evaluation, and relevant biochemical investigations including vitamin B12 and folate levels. Additional tests such as thyroid profile, liver function, and bone marrow examination were performed when indicated.

Results: The majority of patients presented with nonspecific symptoms like fatigue, weakness, and pallor. The leading cause of macrocytosis was megaloblastic anaemia, primarily due to vitamin B12 deficiency. Other contributing factors included folate deficiency, chronic alcoholism, liver disease, hypothyroidism, and less commonly, bone marrow disorders. Peripheral smear typically revealed macro-ovalocytes and hypersegmented neutrophils, while bone marrow studies in selected cases demonstrated megaloblastic changes.

Conclusion: Vitamin B12 deficiency remains the predominant cause of macrocytic anaemia in the adult population of this region, with nutritional and lifestyle factors playing a significant role.

OP 7 Left Ventricular Function in Type 2 Diabetes Mellitus Patients with Microvascular Complications

Levis Abin Joy, Junior Resident 3, Dept of General Medicine, Maharishi Markandeshwar Institute of Medical Sciences and Research, Mullana, Ambala, Haryana

Background: Diabetes mellitus, a prevalent metabolic disorder, contributes significantly to microvascular and macrovascular complications, including retinopathy, nephropathy, neuropathy, and cardiovascular disease. The present study aimed to assess left ventricular function in type 2 diabetes mellitus (T2DM) patients with microvascular complications.

Methods: A cross-sectional observational study was conducted on 114 T2DM patients aged >30 years, excluding those with hypertension, valvular disease, arrhythmias, or comorbidities. Data collected included demographics, laboratory investigations, and screening for retinopathy, nephropathy, and neuropathy. Echocardiographic evaluation assessed ventricular dimensions, ejection fraction, and diastolic function.

Results: The mean patient age was 62.5 years, with most (54%) having diabetes <10 years. Cardiac dysfunction was observed in 66% of participants: 21% had HFrEF, 11% HFmrEF, and 34% HFpEF. Diabetic retinopathy was present in 68% of cases, nephropathy in 53%, and neuropathy in 55%. A strong correlation existed between microvascular complications and cardiac dysfunction, particularly in patients with neuropathy (80% had dysfunction).

Conclusion: Microvascular complications strongly correlate with impaired left ventricular function in T2DM patients. Early detection and management of these complications may aid in preventing progression to overt heart failure, reducing morbidity and mortality.

OP 8 Correlation of Serum Vitamin D Levels with Left Ventricular Mass Index in Patients with Essential Hypertension

Manjul Chopra, Junior Resident -3, Dept of General Medicine, Maharishi Markandeshwar Institute of Medical Sciences and Research, Mullana, Ambala, Haryana

Background: Left ventricular hypertrophy (LVH) is a major complication of essential hypertension, contributing to cardiovascular morbidity and mortality. Vitamin D deficiency may influence cardiac remodeling via the renin–angiotensin–aldosterone system, fibrosis, and vascular health.

Objective: To determine the prevalence of LVH using Left Ventricular Mass Index (LVMI) in essential hypertension, evaluate vitamin D status, and assess associations between vitamin D levels and echocardiographic indicators of LVH.

Methods: This cross-sectional study included 100 patients with essential hypertension (Jan 2023–Mar 2025) at MMIMSR, Mullana. Echocardiography was performed for LVMI, interventricular septal thickness (IVST), posterior wall thickness (PWD), and end-diastolic diameter (EDD). Serum 25(OH) D levels were categorized as deficient (<20 ng/mL), insufficient (20–30 ng/mL), or sufficient (>30 ng/mL). Associations were analyzed using Chi-square, ANOVA, and Pearson correlation.

Results: Of 100 patients (mean age 59.8 ± 12.7 years, 55% female), 62% were vitamin D deficient, 20% insufficient, and 18% sufficient. LVMI was abnormal in 66%, IVST in 90%, PWD in 92%, and EDD in 53%. A significant association was found between PWD and vitamin D status ($p = 0.031$), while associations with LVMI, IVST, and EDD were non-significant. Subgroup analysis indicated vitamin D deficiency correlated with higher LVMI, greater PWD, and increased IVST, though not all findings reached significance.

Conclusion: Vitamin D deficiency is highly prevalent in hypertension and associated with trends of adverse cardiac remodeling, particularly posterior wall thickening. Routine screening and correction of vitamin D may help attenuate structural cardiac changes.

OP 9 Insomnia in Patients with Tinnitus

Manpreet Singh Brar, PG Resident, Department of ENT, KM Medical College, Mathura

Tinnitus, the perception of sound without an external source, affects 15% of adults globally and 6.7% in India. Sleep disturbance is a frequent

comorbidity. This cross-sectional study analysed 203 patients with tinnitus lasting more than one month using the Tinnitus Handicap Inventory (THI) and Insomnia Severity Index (ISI). Overall, 55.3% of participants reported insomnia. Severity of insomnia increased significantly with higher THI grades, with all patients in the catastrophic group experiencing severe insomnia, while most without insomnia fell into the mild handicap group. Prevalence of tinnitus was highest in individuals over 65 years. The findings demonstrate a clear association between tinnitus severity and insomnia burden. Screening for insomnia should be routinely incorporated in tinnitus management. Study limitations include the cross-sectional design, self-report bias, and lack of objective measures.

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ABSTRACTS
POSTER PRESENTATIONS

PP 1 A Rare Case of Acute Spinal Infarct Presented with Hemiparesis and Progressed to Quadriparesis

Aditya Gupta, Maharishi Markandeshwar Institute of Medical Sciences and Research, Mullana, Ambala, Haryana

Spinal cord infarction is an uncommon neurological emergency that may initially mimic acute cerebral stroke, leading to diagnostic challenges and potential delays in management. A 77-year-old male with uncontrolled type 2 diabetes mellitus presented with sudden-onset right-sided hemiparesis of 4 hours duration. Examination revealed motor power of 4/5 on the left and 2/5 on the right, with extensor plantar reflex on the right, flexor plantar on the left. Non-contrast CT brain was normal, and he was initially managed as ischemic stroke. Within 24 hours, the patient deteriorated to quadriparesis, with intact sensory modalities, absent deep tendon reflexes, and bilateral extensor plantar responses. MRI brain was unremarkable, but MRI spine demonstrated spinal cord infarction from C3 to D2, with associated diffuse disc bulge compressing bilateral traversing nerve roots. Over the course, left-sided motor function improved (4/5), but right-sided recovery was limited (upper limb 2/5, lower limb 4/5). This case underscores the diagnostic challenge of spinal cord infarction when presenting with stroke-like features. The rapid progression from hemiparesis to quadriparesis highlights the need for high clinical suspicion and early spinal imaging when initial brain workup is inconclusive. Although rare, spinal cord infarction should be considered in elderly patients with vascular risk factors presenting with acute motor deficits. Timely MRI of the spine is essential for accurate diagnosis and management.

PP 2 An Unusual Case of TB Meningitis With Brain Tuberculoma During Pregnancy

Aneesha Chhibber, Nitin Gupta. Dept. of General Medicine, Maharishi Markendeswar Institute of Medical Sciences and Research, Mullana, Ambala, Haryana

This poster presents a rare case of tuberculous meningitis with brain tuberculoma in a 23-year-old pregnant woman at 16 weeks of gestation. The patient exhibited low-grade fever, right lower limb weakness, and a prior seizure episode. Diagnosis was challenging due to symptom overlap with pregnancy-related conditions. Cerebrospinal fluid analysis, blood investigations, and MRI confirmed CNS tuberculosis with multiple brain and spinal tuberculomas. Management included antitubercular therapy (HRZE), adjunctive steroids, and supportive care. The patient recovered and delivered a healthy preterm baby; both mother and infant showed good outcomes. This case highlights that CNS-TB during pregnancy can mimic common obstetric conditions, underscoring the importance of thorough evaluation of atypical neurological symptoms in pregnant women for timely diagnosis and management.

PP 3 Hypokalemic Paralysis Involving Respiratory Muscles as A Result of Distal RTA Secondary to Primary Sjogren's Syndrome Complicated by Pregnancy

Arpit Kumar, Nitin Gupta. Dept. of General Medicine, Maharishi Markandeshwar Institute of Medical Sciences and Research, Mullana, Ambala, Haryana

Background: Hypokalemic paralysis is an uncommon but potentially fatal manifestation of severe hypokalemia, arising from diverse etiologies including renal tubular acidosis (RTA) and thyrotoxicosis. Distal RTA is frequently associated with autoimmune disorders such as Sjögren's syndrome, and pregnancy may exacerbate the electrolyte disturbances.

Case Presentation: We describe a 29-year-old female (P1L1) in early pregnancy who presented with progressive flaccid quadriplegia, respiratory distress, and vaginal bleeding. Initial evaluation revealed profound hypokalemia, normal anion gap metabolic acidosis, and electrocardiographic features consistent with hypokalemia. Imaging demonstrated retained products of conception with bilateral nephrolithiasis. Despite aggressive replacement therapy, the patient developed respiratory acidosis requiring mechanical ventilation. Serological testing showed strongly positive anti-SSA/SSB antibodies, and urine studies confirmed distal RTA secondary to primary Sjögren's syndrome. Following potassium and bicarbonate supplementation and surgical evacuation, the patient gradually improved, was successfully extubated, and discharged with counseling regarding future pregnancies.

Conclusion: This case emphasizes the rare but critical presentation of

hypokalemic paralysis with respiratory muscle involvement in pregnancy due to distal RTA from primary Sjögren's syndrome. Clinicians should maintain a high index of suspicion for hypokalemia in cases of acute flaccid paralysis, particularly in pregnancy where physiological changes may unmask underlying disorders. Timely recognition and appropriate correction of electrolyte imbalance are essential to prevent life-threatening complications, optimize maternal outcomes, and guide anticipatory care in subsequent pregnancies.

PP 4 Paradoxical Worsening in Tubercular Meningitis: A Case Report

Harsh Gupta, Maharishi Markandeshwar Institute of
Medical Sciences and Research, Mullana, Ambala, Haryana

Background: Tubercular meningitis (TBM) represents the most severe form of extrapulmonary tuberculosis, associated with high morbidity and mortality. Despite appropriate anti-tubercular therapy (ATT), paradoxical reactions—characterized by new or worsening clinical and radiological findings after initial improvement—occur in up to 30% of patients with central nervous system involvement. Early recognition is essential to avoid misdiagnosis as treatment failure or drug resistance.

Case Presentation: A 22-year-old male presented with headache, vomiting, and altered sensorium. Baseline magnetic resonance imaging (MRI) of the brain was normal, and empirical ATT was initiated. After two months of therapy, he developed worsening headache, irritability, gait disturbance, and new focal neurological signs. Repeat MRI demonstrated development of basal exudates and multiple tuberculomas, consistent with paradoxical worsening.

Management and Outcome: The patient's first-line ATT regimen was continued, and adjunctive corticosteroid therapy was optimized to attenuate meningeal inflammation. Supportive measures including hydration, nutritional supplementation, and physiotherapy were instituted. The patient subsequently demonstrated progressive clinical improvement, with resolution of headache and restoration of ambulatory function, and was discharged in a stable condition with advice for strict follow-up,

Conclusion: Paradoxical reactions in TBM reflect an exaggerated host immune response rather than therapeutic failure. Awareness of this entity is critical to prevent unnecessary modification of ATT regimens. Serial neuroimaging and vigilant clinical monitoring are pivotal for accurate diagnosis and appropriate management, ensuring favorable long-term outcomes.

PP 5 Immune-Mediated Necrotizing Myopathy (IMNM): A Case Report

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Immune-mediated necrotizing myopathy (IMNM) is an uncommon entity within the spectrum of idiopathic inflammatory myopathies, distinguished by rapidly progressive symmetrical proximal muscle weakness, markedly elevated serum creatine kinase (CK), and histopathological evidence of myofiber necrosis with minimal inflammatory infiltrates. Unlike polymyositis and dermatomyositis, IMNM generally lacks cutaneous manifestations and may present in the absence of myositis-specific autoantibodies, posing a diagnostic challenge.

We report the case of a 37-year-old female who developed progressive limb weakness following a gastrointestinal illness. Clinical examination demonstrated symmetric proximal weakness with preserved reflexes and intact cranial nerve and sensory functions. Laboratory evaluation revealed a significantly elevated CK level (7844 U/L), with subsequent normalization following therapy. Serological workup, including anti-HMGCR and extended myositis antibody panel, was negative. Magnetic resonance imaging of the thighs showed diffuse muscle edema, and muscle biopsy confirmed necrotizing myopathy.

The patient was managed with high-dose intravenous corticosteroids, transitioned to tapering oral steroids, adjunctive methotrexate, physiotherapy, and nutritional optimization. Substantial clinical and biochemical improvement was observed within one month.

This case underscores the importance of considering IMNM in patients presenting with unexplained progressive proximal weakness and elevated CK, even in the absence of serological markers. Muscle biopsy remains the diagnostic gold standard in such scenarios. Early initiation of aggressive immunosuppressive therapy is critical to mitigate muscle damage and restore functional capacity.

PP 6 To Study Risk Factors, Clinical and Angiographic Profile of Women with Acute Coronary Syndrome

Ankit Gulia, DM Cardio Resident, Dayanand Medical College & Hospital, Ludhiana

Background: Acute Coronary Syndrome (ACS) remains a leading cause of morbidity and mortality among women. Unlike men, women often present with atypical symptoms and face treatment disparities. Menopause, reproductive factors, and pregnancy-related complications further modify cardiovascular risk in women.

Objectives: This study aimed to evaluate risk factors, clinical characteristics, and angiographic profiles of women with ACS, comparing findings with age-matched male controls, and to assess differences between pre- and

postmenopausal women.

Methods: A prospective case-control study was conducted at Dayanand Medical College & Hospital, Ludhiana, from June 2023 to May 2024, including 125 consecutive female ACS patients and 125 age-matched male controls. Detailed clinical history, menstrual and obstetric data, ECG, biomarkers, echocardiography, and coronary angiography were assessed. Data were analyzed using standard statistical tests, with $p<0.05$ considered significant.

Results: Women with ACS exhibited significantly more RWMA (93.6% vs. 81.6%, p=0.006), mitral regurgitation (p=0.011), complications (19.2% vs. 8.8%, p=0.028), and higher IABP use (12.8% vs. 4.0%, p=0.021). In contrast, men had higher rates of NSTEMI (33.6% vs. 21.6%, p=0.047). Premenopausal women demonstrated greater metabolic risk, including overweight, gestational diabetes, hypertension, and contraceptive use, whereas postmenopausal women experienced more preterm deliveries, stillbirths, and acute decompensated heart failure.

Conclusion: Women with ACS face greater myocardial dysfunction and in-hospital complications, strongly influenced by menopausal and reproductive history. Integrating obstetric factors into cardiovascular risk assessment may improve early diagnosis, prevention, and outcomes.

PP 7 The Energy Crisis Within: Clinical Clues to Metabolic Myopathy

Gurleen Kaur, Resident, Dept. of General Medicine
Dayanand Medical College and Hospital, Ludhiana.

Introduction: Metabolic myopathies are a heterogeneous group of metabolic disorders characterized by defects of enzymatic pathways involved in myocyte metabolism. The diagnosis in absence of family history is challenging. Case report: A 14-year-old male presented with bilateral lower limb weakness with pain in thighs for 15 days following exercise, with some improvement in symptoms with continued exercise. Next day, he experienced difficulty in standing from sitting position and climbing stairs. He recalled similar episode of thigh pain with lower limb weakness after running in school four years ago. No history of upper limb and cranial nerve involvement. No family history with normal nutrition history. His general physical examination was normal with no skeletal abnormalities. Higher mental functions and cranial nerves were normal. Motor system examination showed normal tone, proximal lower limb muscle weakness (MRC 2/5), preserved distal muscle power, normal deep tendon reflexes and sensory examination. NCV-EMG showed myopathic pattern with no spontaneous activity. In view of possibility of metabolic myopathy, 1-minute forearm exercise test was performed which revealed pre-exercise lactate 1.12 mmol/L and ammonia 23 µmol/L, with post-exercise lactate 1.34 mmol/L and ammonia 14 µmol/L, indicating no significant rise. CPK levels

(29 U/L) and uric acid levels (4.9 mg/dL) were normal. Genetic testing confirmed PYGM mutation consistent with McArdle disease.

Discussion: Young boy with two episodes of painful weakness with partial improvement with no family history suggested glycogen storage disorder myopathy. The learning point is to keep metabolic myopathy in differential diagnosis, especially in young person with episodic muscle weakness.

PP 8 To Compare the Safety, Tolerability and Efficacy of Denosumab and Alendronate in CKD3-5D Patients with Osteoporosis

Harsheel Gupta, Dayanand Medical College and Hospital, Ludhiana

Background: Osteoporosis is common yet under diagnosed in chronic kidney disease (CKD), especially stages 3–5D. CKD-related mineral and bone disorder reduces bone strength, predisposing to fragility fractures. This study compared the efficacy and safety of alendronate and denosumab in this high-risk group.

Objective: To compare denosumab and alendronate regarding bone mineral density (BMD) and biochemical markers and safety

Methods: A prospective observational study enrolled 40 patients (>18 years) with CKD 3–5D over 18 months. Participants received either oral alendronate or subcutaneous denosumab. Baseline and 6-month follow-up included DEXA scans (lumbar spine, femoral neck, total hip) and biochemical markers (calcium, phosphorus, PTH, ALP, vitamin D). Exclusion criteria were prior antiresorptive therapy, adynamic bone disease, malignancy, or liver disease.

Results: Osteoporosis prevalence was high. Both agents significantly improved lumbar spine and femoral neck BMD. Denosumab showed a greater lumbar spine T-score gain (+0.48, p=0.001) than alendronate (+0.42, p=0.01). Femoral neck BMD improved in both, while total hip BMD increased significantly with alendronate (p=0.02) but not denosumab (p=0.91). Denosumab caused transient hypocalcemia and suppressed PTH more effectively at 3 months (p=0.03) but was associated with higher adverse events (hypocalcemia 40%, musculoskeletal pain 15%, GI symptoms 25%). Alendronate was better tolerated.

Conclusion: Both drugs improved BMD in CKD 3–5D. Denosumab offered modestly superior efficacy but greater hypocalcemia risk, while alendronate combined efficacy with better tolerability. Therapy should be individualized.

PP 9 Cologastric Fistula- A Rare Presentation of Colonic Cancer

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Cologastric fistula is an abnormal pathological communication between the

epithelialized mucosal layer of colon and stomach. The etiology is usually malignant (gastric cancer in east and colonic cancer in west), however penetrating gastric ulcers, Crohn's disease and complicated diverticulitis may also result in development of such fistulae. Cologastric fistula due to colon adenocarcinoma is extremely rare. We report the case of a 66-year-old gentleman presented with post prandial diarrhea with passage of undigested food particles in stool for 6 weeks. His appetite had reduced and he had lost 10kg since the onset of symptoms. On examination, he was pale and emaciated with a BMI of 19kg/m2. Colonoscopy revealed an ulceroproliferative growth involving the splenic flexure which was negotiated with mild difficulty and the scope passed into the upper GI tract and we could identify gastric rugae, pylorus and duodenal mucosal folds with bile in the lumen. The diagnosis of cologastric fistula was confirmed by CECT enterography. Patient was managed surgically with a radical left hemicolectomy with gastric wedge resection, diaphragm repair, and loop ileostomy. Histolopathology revealed mucinous adenocarcinoma of the colon with gastric resected end and both colonic resected ends free of tumor, staged as pT4N0M0, Stage 2 (pTNM and AJCC/UICC criteria). Post operatively the patient showed gradual improvement with resolution of diarrhoea and weight gain of 3 kg in 2 months. This case highlights the importance of considering cologastric fistula in the differential diagnosis of colon cancer.

PP 10 Rare Case of Primary Sclerosing Cholangitis with IgG4 Positive and Hypereosinophilic Syndrome

Sakul Kapahi, Dayanand Medical College and Hospital, Ludhiana

Introduction: Primary sclerosing cholangitis is a chronic cholestatic syndrome that is characterised by diffuse inflammation and fibrosis involving the entire biliary tree, resulting in chronic cholestatis. Methods: A 36 yr-old male known case of IGG4+ related PSC presented with anorexia, jaundice, abdominal pain, andelevated liver function tests (LFTs). Upon presentation to clinic, his AST was 41, ALT 64, and alkalinephosphatase 334, with elevated serum bilirubin B (I) 7.6 and B (D) 7.1.ESR-120.Serum IGG4+ levels-28.5. Autoimmune work-up as well as serologies for Hepatitis A, B, and C were negative. Ultrasound abdomen showed irregularly dilated intra hepatic biliary radicals with organised sludge throughout extent of common bile duct. MRCP revealed intrahepatic bile duct dilation, and common bile duct calculi, loss of lobulations of pancreas showing hyperintense signal. ERCP was done which showed CBD stricture and CBD double pigtail stent was placed. CBD brushings showed no risk of malignancy.

Discussion: IgG4-associated cholangitis, akin to primary sclerosing cholangitis, is steroid- responsive and more prevalent in males. Presentation often includes obstructive jaundice, with elevated IgG4 levels aiding diagnosis. Differential diagnosis is crucial, distinguishing it from conditions

like cholangiocarcinoma. Diagnosis requires a multidisciplinary approach, incorporating serological, histological, and imaging techniques. Treatment involves high-dose corticosteroids or immunosuppressants, both effective in inducing remission.

PP 11 Surgical Resection of Mucinous Ovarian Carcinoma Presenting as Post Menopausal Bleeding per Vaginum

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Introduction: Ovarian carcinoma is the second most common gynaecological malignancy, with Epithelial ovarian carcinoma (EOC) being the most common histological subtype. Mucinous ovarian carcinoma (MOC) is a molecular and clinical- pathological classification subtype of EOC. MOC can be primary or metastatic. Primary MOC is a rare entity with an incidence of ≤3%.

Case Report: A 68 yr old female presented to Gynae OPD with on and off bleeding per vaginum for 2 months, 20 yrs post menopause. There was a history of loss of appetite and weight loss for 2 weeks. MRI pelvis revealed well defined cystic lesion with internal septations in left adnexa, ascitis with internal septations and omental thickening and nodularity. CT whole abdomen with contrast showed the same changes with suspicion of mitotic origin. S. CA- 125 levels were raised to 202.5 and S.CEA levels were raised to 1074 pre op. She was sent to surgical oncology department for her management. A diagnosis of stage-3 mitotic ovarian carcinoma was made. She under-went exploratory laprotomy under GA and on opening peritoneum large amounts of mucinous jelly like material was seen. TAH + BSO+ omentectomy + appendectomy was done. HPE of the specimens sent revealed well differentiated MOC with peritoneal and omental implants. Patient post- operatively was planned for adjuvant chemotherapy.

Conclusion: Primary MOC is rare ovarian cancer with ≤3% incidence. We hereby report surgical management of a stage- 3 mitotic ovarian tumor with peritoneal and omental spread which revealed large mucinous jelly like material intra-operatively and was diagnosed to be MOC on HPE later.

PP 12 Critical Illness Polyneuropathy with Severe Diabetic Ketoacidosis

Ankur Gupta, NC Medical College & Hospital, Israna, Panipat

Introduction: Critical Illness Polyneuropathy is the acute or subacute onset of extensive symmetric weakness in critically ill patients, usually with sepsis, respiratory failure, multiorgan failure, or septic inflammatory response syndrome (SIRS). It is basically, ICU acquired weakness.

Background: A 27 year old female, was admitted with history of fever with chills since 3days, breathlessness on exertion since 2 days, vomiting

episodes ≥ 3 since 2 days and altered sensorium since 1 day. No history of diabetes mellitus, hypertension, thyroid disease, and or other systemic illness.

Clinical Course: On day 2, she started developing acute onset flaccid paralysis in all four limbs. After 4-5 hours, she developed paradoxical breathing, not maintaining saturation in room air. Patient was intubated immediately and kept her on mechanical ventilation. Later she went into cardiac arrest and was revived. Her RBS- 550 mg/dl and urine ketones were positive. Antibiotics, parenteral nutrition support, antioxidant therapy and physiotherapy was given.

Diagnosis: Type I Diabetes Mellitus with severe Diabetic Ketoacidosis, sepsis with Critical Illness Polyneuropathy.

Conclusion: Critical Illness Polyneuropathy is a neuron weakness in patient admitted in ICU. Once diagnosis of CIPN has been established.

PP 13 Acute Myocardial Infarction in Situs Inversus with Dextrocardia treated with Percutaneous Coronary Intervention (PCI).

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Dextrocardia is a rare congenital anomaly (~1–2/10,000). Heart is positioned in the right hemithorax. In such patients, standard ECG interpretation can be misleading. Especially important in anterior wall MI.70-year-old male, non-diabetic, non-hypertensive. Symptoms: Right-sided chest pain × 2 days, no breathlessness. Vitals: BP 110/70 mmHg, PR 83 bpm. CVS exam: Cardiac impulse in right 5th ICS; louder heart sounds on right chest.ECG: q waves in V1, RAD, negative P in I &aVL.Right-sided leads showed q waves & T inversion in V1–V4.Troponin I ↑ (4.3). Chest X-ray → dextrocardia with situs inversus. 2D Echo → RWMA (IVS, apex), moderate LV dysfunction, LVEF 36%. CAG → CAD-SVD, proximal LAD plaque with 95–99% stenosis. Intervention: PTCA to LAD done successfully. Outcome: Uneventful recovery, discharged after 2 days. Diagnosis: Situs inversus with dextrocardia Evolved anterior wall MI, Post-MI angina Moderate LV dysfunction (LVEF 36%) CAD-SVD Incidence of CAD in dextrocardia ≈ normal population. Clinical presentation is similar to ACS in general population. Challenge: ECG interpretation – P waves, QRS axis, poor R wave progression. Correct right-sided ECG leads are crucial for diagnosis. Coronary angiography and PCI are feasible but technically

PP 14 Acute Pancreatitis with Splenic Vein Thrombosis: A Rare Complication of Organophosphorus Poisoning

Nariender Pal, Guru Gobind Singh Government Medical College, Faridkot, Punjab

Background: Organophosphorus compound (OPC) poisoning is a common medical emergency in developing countries, usually presenting with

cholinergic features due to acetylcholinesterase inhibition. Pancreatic involvement is rare but potentially serious, with acute pancreatitis reported as a complication.

Case Presentation: We report a case of a 20-year-old male who presented with a history of intentional OPC ingestion. The patient initially exhibited muscarinic and nicotinic symptoms of OPC poisoning and was managed with standard atropine and pralidoxime therapy. During the hospital stay, he developed abdominal pain, distension, and vomiting. Laboratory investigations revealed elevated serum amylase and lipase, suggestive of acute pancreatitis.

Imaging Findings: Contrast-enhanced CT of the abdomen showed a relatively well-defined hypodense collection measuring 6.6 × 3.5 × 5.9 cm in the peripancreatic region related to the tail and distal body of the pancreas, extending into the left anterior pararenal space (maximum AP diameter 3.3 cm). Ill-defined hypodensities involving the distal body and tail suggested necrotic changes. Peripancreatic fat stranding was present. Additionally, a focal non-enhancing hypodensity involving the splenic vein was noted, consistent with splenic vein thrombosis.

Discussion: Acute pancreatitis following OPC poisoning is uncommon and may be overlooked due to overlapping systemic manifestations. The pathophysiology is thought to involve hyperstimulation of pancreatic acinar cells by excess acetylcholine. Severe forms may be complicated by peripancreatic collections, necrosis, and vascular involvement, as seen in this case. Conclusion: This case highlights acute pancreatitis as a rare but serious complication of OPC poisoning, underscoring the need for early recognition and timely management to reduce morbidity.

PP 15 Triple Immune Mediated Neuromuscular Syndrome: Coexistence of Polymyositis, Polyneuropathy, and Myasthenia

Gravis Pooran Yadav, Ravinder Garg, Sulena, Sumit Chawla. Dept. of Medicine, GGS Medical College Faridkot

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PP 16 Study of Serum Magnesium Levels, Glycemic Indices, Lipid Profile & Correlation With Microvascular Complications In T2DM

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PP 17 The Future of Healthcare Is Intelligent: Integrating Artificial Intelligence into Clinical Practice

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Methodology: A structured literature review was conducted using PubMed,

Scopus, and EMBASE, focusing on English-language studies related to AI in healthcare, including machine learning, natural language processing, and large language models.

Result: AI tools showed improved diagnostic accuracy—90% in breast cancer detection and 96% sensitivity in pneumonia diagnosis. In laboratories, AI accelerated workflow efficiency. Personalized medicine applications enhanced treatment precision and minimized side effects. Predictive models aided in chronic disease prevention and reduced hospital readmissions. AI chatbots improved patient education and engagement, while digital therapies supported mental health.

Discussion: AI offers transformative benefits in diagnosis, treatment planning, and system efficiency. Yet, challenges remain, including data privacy, algorithmic bias, and the need for transparent, explainable models. Collaboration between clinicians and AI systems, along with strong ethical and regulatory oversight, is essential for safe and effective implementation.

PP 18 TTP with colitis: Hidden GPA, Unfriendly UC or Simple Infection, When Rare Overlap Creates a Therapeutic Challenge

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Background: Thrombotic thrombocytopenic purpura (TTP) is a rare, life-threatening microangiopathy caused by ADAMTS13 deficiency. Colitis in TTP may result from infection, vasculitis (C-ANCA/GPA), or ulcerative colitis. Differentiating these is challenging but crucial, as management varies. Rare co-occurrence of TTP with vasculitis or IBD poses a significant diagnostic dilemma.

Clinical presentation: A 22-year-old male with a known history of thrombotic thrombocytopenic purpura (TTP), maintained on steroids, azathioprine and rivaroxaban, presented with a relapse over six months, characterized by progressively worsening renal function and thrombocytopenia. He developed per-rectal bleeding for one month, decreased urine output, and generalized anasarca. Previously, at an outside hospital, he received hemodialysis and blood product transfusions, and colonoscopy revealed ulcers at the hepatic flexure, which were temporarily managed with hemoclips. Biopsy suggested possible infective colitis, and laboratory evaluation showed elevated total leukocyte counts and raised procalcitonin. Steroids were withheld, and he was discharged on broad-spectrum antibiotics.

He presented to our center with recurrent rectal bleeding, severe anemia, and acute-on-chronic kidney injury. Imaging demonstrated bilateral normal-sized kidneys with increased echogenicity. Serology revealed C-ANCA positivity, raising suspicion for vasculitic involvement (GPA), while ANA titres

were elevated but profile was inconclusive. The patient was considered for ischemic colitis secondary to vasculitis or inflammatory bowel disease. Management included steroids, mesalazine, and broad-spectrum antibiotics including rifaximin, which controlled the bleeding within 12 hours. He was planned for fecal calprotectin, renal biopsy, IV rituximab, and referred for hematology consultation for plasmapheresis.

Conclusion: Colitis in TTP is rare and diagnostically challenging. Differentials include infection, vasculitis (GPA), or ulcerative colitis. Early recognition and multidisciplinary management are essential for optimal outcomes and organ preservation.

PP 19 **Rosai Dorfman Disease**

Meneka (JR), Ravinder Garg, Jasmeen Chahal. Guru Gobind Singh Medical College and Hospital, Faridkot

I am presenting the case of patient who came with complaints of fever, cough, lymphadenopathy, abdominal distension and generalized body ache for last 6 months. On general physical examination there was massive splenomegaly and hepatomegaly and a provisional diagnosis of generalized lymphadenopathy with lymph proliferative disorder was kept and patient was investigated further. In routine investigations like CBC pancytopenia was there. ESR was also raised. Chest x-ray shows bilateral clear lung fields. Ultrasound whole abdomen revealed hepatomegaly and splenomegaly. FNAC of cervical lymph node done which showed scattered histiocytes with lymphoid cells with focal emperipolesis suggestive of Rosai Dorfman disease. Patient was put on steroids followed which size of lymph nodes started decreasing and patient got improved. Rosai Dorfman disease needs to be differentiated from diseases like lymphoma, disseminated TB, LCH and malignant histiocytosis. In this disease, any age group can be involved but 80 percent cases manifest within first 2 decades of life. Classically it presents with bilateral pain less massive lymph nodes. Extra nodal involvement can be there involving skin, subcutaneous tissue, orbit, breast, bone marrow and abdomen. It must be considered as differential diagnosis in patients who presents with bilateral or generalized lymphadenopathy with multisystem complaints as this disease can present with various characteristics and a mimicker of lymphoproliferative diseases. But once it is diagnosed it can be treated with steroids. Surgery can also be done for local resectable lesions. Radiation therapy can be used for un- resectable and refractory localized disease.

PP 20 **Bilateral Renal Artery Stenting in a Young Patient with Bilateral Renal Artery Stenosis**

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Case Report: I am presenting a case report of 22 years old female presented

with chief complaints of Breathlessness from past 1 month associated with orthopenia and PND. On examination, patient is conscious, oriented to time, place and person. BP 180/100 mmHg, PR was 104/min, SpO2 was 94% on RA, temp was 97.6 degree F. Pallor and pedal edema was present. No icterus, clubbing or cyanosis seen. JVP was raised. On CVS examination systolic murmer heard, radiating to axilla. On RS examination bilateral basal fine crepitations heard. PA & CNS – within normal limit. Past history suggestive of hypertension from last 2 years poorly controlled by taking 2-3 anti hypertensive medicines. Investigation suggestive of 2D Echo stating global hypokinesia of left ventricle severe LV dysfunction with EF 25%. CBC – Hb 9.4g/dl, TLC-6.1 x 103, platelets – 222 x 103. RFT – Serum Creatinine – 2.2 mg/dl, blood urea – 63 mg/dl. Serum Electrolytes – Serum Sodium/ Potassium/ Chloride – 126/3.6/89 meq/L. Viral Markers – HIV, HbsAg, HCV-Non reactive. Renal angiography suggestive of 100% occlusion of renal artery in right kidney.90% occlusion in left kidney.

Discussion: A young hypertensive male should always be screen for bilateral renal artery stenosis otherwise ACE or ARB will worsen the creatinine level.

Conclusion: After bilateral stenting TIMI 3 flow was achieved in bilateral renal artery procedure went uneventful. Immediate clinical improvement and control of hypertension was sustained.

PP 21 Case of Millard-Gubuler Syndrome: One of the Presentation of Posterior Circulation Stroke

Nayan Kumar Amrutiya. Dept. of General Medicine, Maharishi Markandeshwar Institute of Medical Sciences and Research, Mullana, Ambala, Haryana

A 79 year old male presented to emergency with complaints of sudden onset left sided upper limb and lower limb weakness and right sided deviation of angle of mouth since 5 days. Patient was a known case of hypertension and hepatitis-c reactive (CLD). On clinical examination left sided power was 0/5, left sided reflexes- brisk and left plantar mute along with right lmn facial nerve palsy, also right 6th nerve palsy. MRI brain s/o acute to subacute infarct in brain stem involving right paramedian pontine region and medullary pyramid patient was managed conservatively.