Child India

Monthly e-Newsletter of Indian Academy of Pediatrics

April 2023

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CONTENT

Editor's Note

Dear friends,

Greetings from April issue of Child India!

World Health Day was celebrated on April 7th with the theme 'Health for All'. The day commemorates the 75th anniversary of the day UN conceived its specialised agency for health – the World Health Organisation (WHO) – its 75th birthday. The WHO was conceived in 1948 and became operational in 1950. WHO's 75th year is an opportunity to celebrate the successes that have resulted in improved quality of life of people on this universe and motivate action to act on health challenges of today and the years ahead.

April 17th – World Hemophelia Day was celebrated with the theme 'Access for All: Prevention of bleeds as the global standard of care' to motivate community together with government to improve access to care with emphasis on better control and prevention of bleeds for all with bleeding disorders.

April 25th- World Malaria Day – Theme – Time to deliver zero malaria; invest, innovate, implement'. Within this theme WHO will focus on the third I'- implement - specially to reach the marginalised population with todays tools and strategies to combat malaria.

April 24th to 30th – World Immunisation Week – action on theme 'The Big Catch Up' wherein WHO is working on accelerating rapid progress of immunisation to ensure that more people, especially children, are protected from vaccine preventable disease.

This issue's academic content focuses on management of Healthcare-associated infections (HAIs) which all of us need to be able to recognize and manage.

Happy reading

Yours in IAP,

Dr Jeeson C Unni
Editor-in-Chief

President's Address

Dear All,

Greetings from CIAP!

As pediatricians we ensure that the child seeking medical help in hospital/nursing home receives best medical care from all the team members. Ideally, no one should catch another infection, yet it is not uncommon to find that patients sadly get infections during their hospital stay for an altogether different medical condition. These infections can spread rapidly and are a common occurrence which affects hundreds of millions of people each year.

The World Health Organization (WHO) has reported that the risk of HAIs in the developing countries can be up to 20 times greater than in the developed ones and the proportion of infected patients regularly exceeds 25%. This high rate of nosocomial infections leads to more antibiotic usage and higher emergence of antibiotic-resistant microorganisms. If the child is immunocompromised then HAIs can spread rapidly via person-to-person contact through unclean hands, medical instruments, respiratory machines, and other hospital tools. HAI cases also increase when there has been excessive and improper use of antibiotics, which can lead to emergence of MDR bacteria.We must also understand that there are definite flaws in hygiene and bacterial prevention in many hospitals. Our infection prevention methods need to be more robust, to reduce the risk of MRSA and Clostri. difficile on floors especially near the sinks and surfaces alike.

It is the growth of such multi-resistant microorganisms, within a biofilm, that has posed the greatest challenge in treating HAIs. The most common types of HAIs seen in children are bloodstream infections, pneumonia, urinary tract infections, skin, and surgical site infections etc. And it is extremely challenging to treat HAis considering the resistance of this microorganisms to the most commonly used antibiotics.

I'm sure the articles presented in this issue of Child India on HAIs will help pediatricians in preventing and managing HAIs in their practice.

Thanking you,

Dr Upendra Kinjawadekar
National President 2023
Indian Academy of Pediatrics

Secretary's Message

Dear Colleagues,

"Many ideas grow better when transplanted into another mind than the one where they sprang up."

I am delighted to share with you the remarkable achievements we have accomplished in our various projects and initiatives in the month of April. We have successfully conducted several workshops, campaigns, and events to promote child health and development across the country. We have also strengthened our collaboration with other organizations and stakeholders to advance our common goals and vision.

On 2nd April 2023, various branches commemorated the Autism Awareness Day as per the theme decided by the CIAP. I would like to express my sincere appreciation and congratulations to all Office bearers, Executive Board members, and Office bearers of branches for their active participation in organizing the days/activities in their respective branches.

We have successfully conducted Administrative Meeting in the month of April ie. IAP Office Bearers Meeting on 4th April 2023 IAP Executive Board Meeting in 3 sessions on 13th , 14th and 16th April 2023. Subsequently, regular follow-up meetings of State Branch Office Bearers Central Zone, North Zone, East Zone and West zone have been conducted smoothly. The various issues and challenges faced by the branches have been discussed in the said meetings and suggested ways to overcome them. The meeting also reviewed the progress of various programs and activities undertaken by the branches and appreciated their efforts.

Regarding the ECD, a total of 143 workshops of ECD have been completed to date and 14 workshops of ECD in April 2023. This month total of 44 Basic NRP and 11 Advanced NRP provider courses have been successfully conducted. The ECD program focuses on enhancing the early childhood development of children from birth to six years through screening, assessment, intervention, and referral.

The Special General Body Meeting (SGM) scheduled on 7th May, 2023 from 9.30 AM to 5.00 PM. The purpose of this meeting is to review and discuss the feedback from our valued members on the CRC Committee's recommendations. The Special General Body Meeting will be held at Hotel Vivanta, D/40-1, Turbhe MIDC Road, MIDC Industrial Area, Sanpada, Navi Mumbai, Maharashtra 400705.

On behalf of IAP, I urge you to organize various activities in the best interest of the health and welfare of the country's children.

Thank you for your continued dedication and hard work.

Long Live IAP, Jai IAP

Yours sincerely,

Dr Vineet Saxena
Hon. Secretary General 2022 & 23

President's Engagements

27-4-23 Sankalp Sampoorna Swasthya launched in Shillong Meghalaya for Both Junior as well as Senior classes. VP EZ Dr Bishwajit Mishra and EB Assam Dr Devajit Sarma addressed the children in a very interactive manner. Special mention about Dr Hunsi Giri our EB member for taking special efforts in involving government officials who asked their doctors to attend the program and get trained. Senior committed IAPan Dr Santanu Deb, Dr Himesh Barman State President Meghalaya IAP, Secretary Dr Jenica Swett,Jt Sec Dr Enboclang and the team deserve special mention for conducting the program in a very short time

President's Engagements

A humble efforts to reach out to Dr Zoya Rizvi, Addl Commissioner MOHFW, Govt of India was made by Dr Upendra along with Dr Vineet, Dr Alok B and Dr Rajeev Seth. While appreciating IAP SSS program, Dr Rizvi guided us to meet the Director of CBSE (who controls more than 28k private schools nationals). The same day met with Dr Ram Director CBSE

President's Engagements

The Sankalp Sampoorna Swasthya Goa TOT was held today on 30-4-2023 in Margao Goa. Dr Deepak Pande and Dr Sandeep Kelkar explained the intricacies of key messages in a most interactive manner.

Apart from the President of Goa IAP Dr Harshad Kamat, Secretary Dr Priyanka Amonkar, Treasurer Dr Siya Caro, Jt Sec Dr Mukul, all the team IAP Goa were extremely enthusiastic in taking the program all over the state once the schools reopen after the summer vacation. Our dynamic EB member Dr Arvind Almeida was leading from the front suggesting unique ways of going about conducting the program. The Past EBMs Dr Virendra Gaokar, Dr Deo also actively participated in the program. The highlight of the day was the presence of Mr Shailesh Zingde, Director of Education Government of Goa who waited for almost an hour and gave valuable inputs for conducting the program across the state.

President's Engagements

SSS TOT Goa on 30-4-23

Guru Dron Oration in Midterm CME at Gurgaon

President's Engagements

IAP East Delhi installation

Jagannath Hospital CME Bhubaneswar

President's Engagements

Infectious Disease Chapter CME at Nagpur on 8-4-23

SSS at Vidya bhavan school Navi Mumbai

President's Engagements

SSS at Hindupur Andhra Pradesh

National consultative meeting of IYCF chapter

President's Engagements

AIMC MEETING of FBS at Hyderabad on 23rd April

SSS at Sarla Birla school Guwahati

President's Engagements

SSS Sarla Birla School Guwahati

Thalassemia training program at Noida

Healthcare-associated infections (HAIs)

Infections associated with intravascular access devices

Central Line Associated Blood Stream Infections (CLABSI)

A central line-associated bloodstream infection (CLABSI) is a culture proven bloodstream infection not related to an infection at another site that develops within 48 hours of central line placement. Most cases are preventable with proper aseptic techniques, surveillance, and management strategies.

Gram positive cocci predominate; more than half are caused by coagulase negative staphylococci. Gram negative enteric bacteria are isolated in approximately 20 30% of episodes, and fungi account for 5 10%.

Tunneled hemodialysis catheters are prone to catheter-related bloodstream infections (CRBSIs) - 40%–80% by gram-positive organisms - coagulase-negative staphylococci, staphylococcus aureus, and enterococcus.

Staphylococci, Pseudomonas, and Candida produce extracellular polysaccharide (biofilm)], which favors increased virulence, adherence to catheter surface, and resistance to antimicrobial therapy.

Non-tunneled catheters, temporary central venous catheters inserted percutaneously are more proneto develop CLABSIs. Bacteria on the skin surface - through the exit site - along the external surface of the catheter to the blood within 7-10days of placement. The cuff of the tunneled generate a fibrotic reaction around the catheter that prevents bacterial migration.

Contamination of the hub (intraluminal) from a health care provider's contaminated hands is the usual cause of CLABSI that occur beyond ten days of placement.

If either localized or systemic catheter related infection is diagnosed in a short-term peripheral catheter or central venous catheter (CVC), the device should be removed.

Antibiotics should be administered in cases of systemic infection, with the exception of uncomplicated coagulase negative staphylococcal bacteremia in normal hosts, for which catheter removal will suffice.

For infections associated with long term vascular access devices antibiotic treatment is successful for most systemic bacterial infections without removal of the device.

Antibiotic therapy should be directed to the isolated pathogen and given for a total of 10 14 days. Empirical therapy with a third-generation cephalosporin or aminoglycoside plus vancomycin is indicated.

Antibiotic lock or dwell therapy, with administration of solutions of high concentrations of antibiotics that remain in the catheter for up to 24 hr, may improve outcome.

Antifungal therapy must be considered in femoral catheterization, TPN, prolonged administration of broad-spectrum antibiotics, hematologic malignancy, or solid organ or bone marrow transplant recipients. Intravenous fluconazole would suffice. If azole resistance is suspected echinocandins (micafungin, caspofungin, anidulafungin) are preferred. In case of candidial infections - Remove catheter and administer amphotericin B (1 mg/kg/24 hr,

total dose of 20 mg/kg) for 2 to 3 weeks. May add flucytosine or fluconazole, especially in central nervous system infections and parenchymal kidney infections

If blood cultures remain positive after 72 hours of appropriate therapy, as confirmed by susceptibility testing, or if a patient deteriorates clinically, the device should be removed.

Exit site infections usually respond to local care or systemic antibiotics, but tunnel tract infections require removal of the catheter in approximately two thirds of patients.

Duration of therapy:

For patients with uncomplicated CRBSI (e.g., no endocarditis, or metastatic infection), in the absence of risk factors for hematogenous spread (e.g., immunosuppression) and negative blood cultures

1. S. aureus - 14 days in the absence of endocarditis
2. Coagulase-negative staphylococci - 7 days
3. Enterococci and gram-negative bacilli - 10 to 14 days
4. Candida - 14 days in the absence of retinitis

Prevention of infection:

Meticulous surgical aseptic technique, routine use of antibacterial ointment, avoidance of occlusive or semi permeable dressings, avoidance of bathing or swimming, and careful catheter care.

The use of CVCs impregnated with antibiotics may be a future means to prevent catheter related infection.

Catheter-associated Urinary Tract Infections (CAUTI)

Among UTIs acquired in the hospital, approximately 75% are associated with a urinary catheter. Many sick children receive urinary catheters during their hospital stay. The most important risk factor for developing a catheter-associated UTI (CAUTI) is prolonged use of the urinary catheter. Therefore, catheters should only be used for appropriate indications and should be removed as soon as they are no longer needed.

Appropriate Management Strategies for Patients with CAUTI

A urine specimen for culture should be obtained prior to initiating antimicrobial therapy for presumed CAUTI because of the wide spectrum of potential infecting organisms and the increased likelihood of antimicrobial resistance.

If an indwelling catheter has been in place for >2 weeks at the onset of CAUTI and is still indicated, the catheter should be replaced to hasten resolution of symptoms and to reduce the risk of subsequent catheter-associated-bacteriuria and CAUTI.

The urine culture should be obtained from the freshly placed catheter prior to the initiation of antimicrobial therapy to help guide treatment.

If use of the catheter can be discontinued, a culture of a voided midstream urine specimen should be obtained prior to the initiation of antimicrobial therapy to help guide treatment.

It is important to know the bacterial spectrum and the susceptibility patterns to various classes of antibiotic agents (hospital antibiogram) to improve empiric antibiotic therapy of children with CAUTI. If not available:

A 5-day regimen of either cefixime, co-amoxiclav or levofloxacin may be considered in patients with CAUTI who are not severely ill, till culture and sensitivity reports become available.

Empiric regimens in sick symptomatic child with CAUTI include Piperacillin-tazobactam, given is coverage of Pseudomonas and Enterococcus; ceftazidime or aztreonam are other options till culture and sensitivity report is available.

Duration of Treatment

Seven days is the recommended duration of antimicrobial treatment for patients with CAUTI

who have prompt resolution of symptoms, and 10–14 days of treatment is recommended for those with a delayed response, regardless of whether the patient remains catheterized or not.

Infections associated with CSF shunts

Organisms implicated

Coagulase negative staphylococci 50%, staphylococcus aureus 20% and gram-negative bacilli in 15%.

With distal infection of VP shunts with peritonitis gram negative isolates predominate and mixed infection is common. The usual meningeal pathogens, S pneumoniae, N meningitidis, and H influenzae type b, can also cause bacterial meningitis in patients with shunts in place.

Management

Shunt colonization and distal infection with peritonitis - antibiotics against the specific organisms isolated and, in most situations, removal of the shunt is warranted. Additionally, intra shunt antibiotics needs to be administered as penetration of most antibiotics across uninflamed meninges is poor. Parenteral anti staphylococcal penicillin with intra shunt vancomycin is the treatment of choice especially if organism is penicillin resistant.

Gram negative organisms causing shunt infection may be treated with a combination of third generation cephalosporin and intra shunt aminoglycoside.

When using intra shunt antibiotics, monitor CSF levels to avoid toxicity.

The best treatment success occurs with initial systemic and intra shunt antibiotics in combination with exteriorization of the distal end of the shunt.

After CSF from the reservoir has remained sterile for 48 hours, shunt replacement on the opposite side is recommended.

Occasionally, partial shunt revision with antibiotic therapy or antibiotic therapy alone suffices but the relapse rates are higher.

With wound infection, shunt almost always needs removal. A temporary catheter is often placed, with replacement on opposite side after infection has healed.

Systemic antibiotics alone will suffice for treatment of bacterial meningitis in patients with a shunt in place; the shunt does not need to be removed.

Prevention of infection

Meticulous cutaneous preparation and surgical technique.

Systemic and intra ventricular antibiotics and soaking the shunt tubing in antibiotics have been used with varying success.

Peri operative use of an antimicrobial agent in CSF shunt placement may reduce the risk for infection.

Ventilator-associated pneumonia (VAP)

Endotracheal intubation breaches airway defenses, impairs cough and mucociliary clearance, and facilitates micro-aspiration of bacteria-laden secretions that pool above the inflated endotracheal tube cuff. In addition, bacteria form a biofilm on and within the endotracheal tube that protects them from antibiotics and host defenses. The highest risk of VAP occurs during the first 10 days after intubation. Ventilator-associated pneumonia occurs in 9 to 27% of mechanically ventilated patients.

Pathogens and antibiotic resistance patterns vary significantly among institutions and can vary within institutions over short periods (eg, month to month). Hence regular updation of local institutional antibiograms are essential in deciding appropriate empiric antibiotic therapy.

Common causes for VAP include Pseudomonas aeruginosa, MSSA and MRSA. Other important pathogens include enteric gram-negative bacteria including Enterobacter species,

Klebsiella pneumoniae, Escherichia coli, Serratia marcescens, Proteus species, and Acinetobacter species.

VAP developing within 4-7days of ventilation is often caused by MSSA, Streptococcus pneumoniae, and Hemophilus influenzae and that occurring after increasing days of intubation and hospital stay is caused by P. aeruginosa, MRSA, and enteric gram-negative organisms.

There is a greater risk of VAP by antibiotic-resistant organisms, particularly MRSA and Pseudomonas in children who have received parenteral antibiotic within the previous 90 days. Other risk factors for VAP due to antibiotic-resistant organisms include septic shock at time of VAP and prior acute respiratory distress syndrome (ARDS), hospitalization for ≥ 5 days and/or acute renal replacement therapy.

VAP. Infection with a resistant organism markedly increases mortality and morbidity.

High-dose corticosteroids increase the risk of Legionella and Pseudomonas infections.

Chronic suppurative lung diseases such as cystic fibrosis and bronchiectasis increase the risk of gram-negative pathogens, including antibiotic-resistant strains.

Treatment of VAP

If VAP is suspected, treatment is with antibiotics that are chosen empirically based on

Institutional antibiogram

Patient risk factors for antibiotic-resistant pathogens

The 2007 guidelines of the Infectious Diseases Society of America and the American Thoracic Society suggested a antibiotic schedule that favoured a regimen for antibiotic-resistant organisms and so a majority received broad-spectrum antibiotics that covered MRSA and resistant Pseudomonas.

Presently the emphasize is on the use of a narrower spectrum of empiric antibiotics wherever possible.

Empiric therapy for VAP without risk factors for antibiotic-resistant organisms and high mortality like mechanical ventilation for pneumonia or septic shock, hospital MRSA incidence is < 10% to 20% of S. aureus isolates and <10% resistance to empiric antipseudomonal antibiotics, could include either piperacillin/tazobactam, cefepime, levofloxacin, imipenem or meropenem at a dose appropriate for the given child's renal function.

If institutional MRSA rates are > 10%-20%, vancomycin or linezolid should be added.

In patients at high risk for mortality and/or high risk for infection with antibiotic-resistant organisms; and/or in the absence of reliable local antibiograms, a triple therapy using 2 drugs with activity against Pseudomonas (a cephalosporin - cefepime or ceftazidime; or a carbapenem -imipenem, meropenem; or a beta-lactam/beta-lactamase inhibitor - piperacillin/tazobactam; or a fluoroquinolone - ciprofloxacin or levofloxacin or an aminoglycoside - amikacin, gentamicin, tobramycin) and 1 drug with activity against MRSA (linezolid or vancomycin); is preferred.

Since judicious use of antibiotics significantly decreases development of antimicrobial resistance in the community, treatment may be initiated with high end antibiotics, but needs to be changed to the narrowest regimen possible based on clinical response and the results of culture and sensitivity report.

Infections associated with peritoneal dialysis catheters

Bacterial entry comes from luminal or peri luminal contamination of the catheter or by translocation across the intestinal wall. Hematogenous infection is rare. Infections may be localized to the exit site, present as peritonitis or both.

Spectrum of infection include Coagulase negative staphylococci (30 40%), S. aureus (10 20%), streptococci (10 15%), Escherichia coli (5 10%), Pseudomonas (5 10%), other gram-negative bacteria (5 15%), Enterococcus (3 6%),

and fungi (2 10%). S. aureus is more common in localized exit or tunnel tract infections (42%). Most infectious episodes are due to a patient's own flora, and carriers of S. aureus have been shown to have increased rates of infection as compared with non-carriers.

Management

If child presents with cloudy fluid and clinical symptoms give empirical therapy, preferably guided by results of a Gram stain.

If no organisms are visualized, vancomycin and either an aminoglycoside or third generation cephalosporin with anti-pseudomonal activity should be given via the intra peritoneal route.

Patients without cloudy fluid and with minimal symptoms may have therapy withheld pending culture results.

Once the cause is identified by culture, changes in the therapeutic regimen may be needed.

Oral rifampin may be added for S. aureus infections.

For fungal peritonitis, a combination of oral flucytosine and intra peritoneal or oral fluconazole may be used.

Duration of therapy

The duration of therapy must be for a minimum of 14 days; with longer treatment of 21-28 days for episodes of S. aureus and Pseudomonas; and 28-42 days for fungi.

Repeat episodes of peritonitis within 4 weeks of previous therapy apparently represent relapsing peritonitis. If the patient responds to reinstitution of antimicrobial therapy, a course of up to 6 weeks should be instituted.

In all cases, if the infection fails to clear on appropriate therapy or if a patient's condition deteriorates, the catheter should be removed.

Exit site and tunnel infections may occur independently of peritonitis, or may precede it. Appropriate antibiotics should be administered on the basis of gram stain and culture findings.

Some experts recommend that the peritoneal catheter be removed if pseudomonas or fungal organisms are isolated

Tracheostomy associated infections

Gram-negative organisms are responsible for 50% of deep infections in patients with tracheostomies. Streptococcus pneumoniae, Hemophilus influenzae, Staphylococci and beta Hemolytic Streptococcus Group A are also common causes of bacterial infection. Viral infections (respiratory syncytial virus, parainfluenza) are also implicated.

The incidence of tracheostomy stoma infection varies from institution to institution. Stoma infections can occur following the tracheotomy procedure, but may be reduced following percutaneous dilatational tracheotomy procedures (PDT). Following surgical tracheotomy, rates vary between 0-63%, while PDT rates have been between 0-10%.

The site should be inspected daily for signs of infection. Signs of tracheostomy stoma infection include erythematous change, swelling around wound, purulent discharge from wound and discharge and is confirmed by culture from the site with bacterial growth. The patient may also complain of pain at the tracheotomy site.

It is important to keep the stoma site dry and free of secretions as moisture can predispose the patient to infection and skin breakdown.

A tracheostomy tube is a risk factor for aspiration with the potential to lead to the development of aspiration pneumonia. Food, liquid, and secretions could pass around the tracheostomy tube cuff and into the lower airways. Patients with an inflated cuff are at high risk of aspiration.

Treatment

Identifying the optimal empiric antibiotics remains challenging, including the benefit of covering with anti-pseudomonal antibiotics given the frequent airway colonization with P. aeruginosa in children with tracheostomy.

Limiting therapy based on previously obtained cultures and regularly updated institutional antibiograms is also largely effective, as empiric antibiotics based on prior respiratory cultures provide adequate antimicrobial coverage.

The first-line treatments suggested include amoxicillin-clavulanic acid, ceftriaxone plus nafcillin or vancomycin, clindamycin plus a third-generation cephalosporin, or ampicillin-sulbactam.

Infections associated with orthopedic prostheses

Infection most often follows introduction of microorganisms at surgery or via hematogenous spread.

Isolation of the infecting organism and antimicrobial treatment may allow salvage of the implant.

Late chronic infections occur more than 1 month after surgery and are often caused by organisms of low virulence that contaminated the implant at the time of surgery. These infections respond poorly to antibiotic treatment and usually require removal of the implant.

Hematogenous infections are most often observed 2 or more years after surgery.

As with other long term implanted devices, the most common organisms are about equally divided between coagulase negative staphylococci and S. aureus.

Prevention of infection

The use of systemic antibiotic prophylaxis, antibiotic containing bone cement, and operating rooms fitted with laminar airflow all have been proposed as beneficial in reducing infection. To date, results from clinical studies are conflicting.

Infection associated with percutaneous endoscopic gastrostomy (PEG)

The most common complication of PEG tube placement is infection at the PEG tube site. Peristomal irritation at the site occurs commonly, but few infections require antimicrobial therapy or surgical man-agement. The standard pull technique for PEG insertion is associated with infections in 5% to 30% of cases. A rare but potentially life threatening complication is the development of necrotizing fasciitis.

Signs of infection include: redness, foul smelling discharge, green thick or white discharge, swelling around the feeding tube, abscess formation, pinpoint rash, pain and fever.

Patients with diabetes, obesity, poor nutritional status, immunosuppressed and those on chronic corticosteroid therapy are at increased risk for infection. Excessive pressure between the PEG's external and internal bolsters is associated with a higher infection rate.

Treatment

If diagnosed early, oral broad-spectrum antibiotics (co-amoxiclav) for 5–7 days may be all that is re-quired for a PEG site infection. If there are more systemic signs as in necrotizing fasciitis, intravenous broad-spectrum antibiotics coupled with local wound care are necessary. Should the patient with local site infection develop signs of peritonitis, surgical intervention may be required

Prevention

Administration of prophylactic antibiotics prior to PEG placement reduces the risk of infection - a single dose of a first or third generation cephalosporin 30 minutes prior to the procedure.

Setting and maintaining the proper tension can decrease the likelihood of infection.

PEDICON 2024 – ANNOUNCEMENT

RATES PEDICON 2024 KOCHI

Category	Early Bird upto 31Mar 23	Up to 30 Jun 23	Upto 30 Sep 23	upto 31 Dec 23	From 01 Jan 24
IAP member	11000	18700	27500	37400	45000
Accompanying	11000	18700	27500	37400	45000
Non IAP	16000	37400	44000	55000	66000
Accompanying	16000	37400	44000	55000	66000
PG student	6000	9000	10000	12000	16000
Accompanying	11000	18700	27500	37400	45000
SR citizen	-			11000	11000
Accompanying	11000	18700	27500	37400	45100
SAARC	$250	$250	$300	$550	$750
Non SAARC	$450	$450	$550	$750	$950
Corporates	25000	38500	44000	49000	60000
Accompanying	25000	38500	44000	49000	60000

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Organising Chairman

DR M. NARAYANAN
Organising Secretary

DR M. I. JUNAID RAHMAN
Organising Treasurer

FOR ASSISTANCE
Contact Conference Secretariat @ 7012025938

IAP Yavatmal

Dr Swati Patil [Secretary] **Dr Girish Dawale [President]**

World Autism Day. Paediatric neurologist Dr Amarjeet Wagh
Awareness talk for people on 05April2023

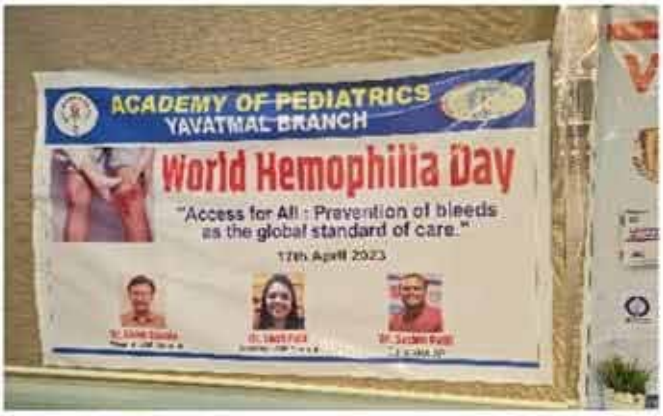
IAP Yavatmal

BASIC NRP WORKSHOP on 15 April 2023. 42 DELEGATES benefited.
FACULTY: Dr Sachin Patil, Dr Swati Patil,Dr Sripad Jahagirdar,Dr Sonali Shirbhate,Dr Sanjeev Joshi
Dr Satish Agrawal

IAP Yavatmal

HLA SCREENING CAMP FOR THALASEMIA PATIENTS on 23 April 2023
DR RAVINDRA CHAVAN, DR SANJEEV JOSHI, DR GIRISH DAWALE, DR SAWTI SHENDE
With Association of Rotary Club Yavatmal

IAP Yavatmal



World Haemophilia day celebration
Dr Subodh Tikhe talked over approach to bleeding disorders on 18 April 2023

IAP Navi Mumbai

IAP Navi Mumbai

ACHEIVEMENTS & AWARDS –

1. **Dr, Prashant Patil, Pediatric Endocrinologist is nominated by Lokmat for emerging doctor** category. https://lmoty.lokmat.com
2. **Royal College of Pediatrics and Child Health (RCPCH) has selected Dept Of Peds, MGM Medical College Navi Mumbai as a India Centre for MRCPCH Exams this year onwards.**
3. President CIAP, **Dr Upendra Kinjawdekar** was bestowed upon the prestigious **Guru Dron Oration at Gurgaon.**
4. **CIAP President, Dr Upendra Kinjawdekar** had an important meetings at
   a. **Delhi NITI AAYOG** with Dr Vinod Paul who appreciated IAP s efforts in ECD, B4E & school health project, suggested ways to reach 28 crore families across India.
   b. **UNICEF Headquarters** with Chief of Nutrition Dr Ajan De Waqt, Dr Sameer Pawar, Dr Richa Pandey planning to work with IAP for B4E, feeding of Low birth weight babies & early detection of growth failure.
   c. **CBSE headquarters** with Dr Ram Shankar who welcomed the idea to work with IAP in promoting SSS in their 29000 schools across India.

IAP Navi Mumbai

ambassadors.

Monday 3rd April Had many important meetings in Delhi--@Niti Aayog with Dr Vinod Paul who appreciated IAPs efforts in ECD,B4E and the school health project and suggested ways to reach 28 crore families across the country

@ Unicef HQ with chief nutrition- Dr Arjan de waqt, Dr Sameer Pawar & Dr Richa Pandey. Planning to work with IAP for B4E, feeding of LBW babies and early detection of growth failure

@ CBSE HQ with Director Dr Ram Shankar welcomed the idea to work with IAP in promoting SSS in their 29000 schools

@MOHFW with Dr Zoya Rizvi, in charge of adolescent health-suggested ways to about implementing SSS in Govt schools with the help of students as health and wellness ambassadors

IAP Navi Mumbai

IAP Jalandhar

World Autism Awareness Day, April 02, 2023

"Empowering Parents for better outcomes: The vital role of Pediatricians"

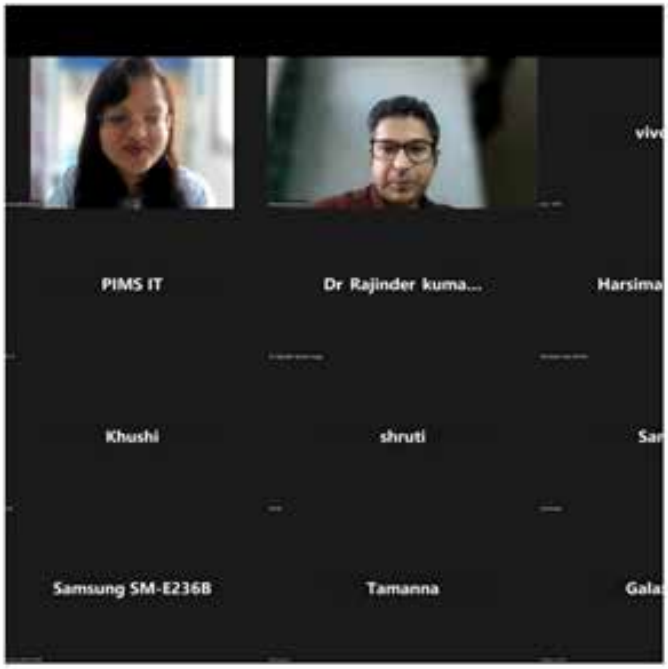
1. On April 2, 2023, PMG Hospital Jalandhar organised an AUTISM AWARENESS CAMP for parents. Dr Atul Madaan, clinical psychologist from "Care for Autism Foundation" and Dr Surjeet Madaan, Consultant Pediatrician from Jalandhar discussed with parents regarding need for developmental screening for early diagnosis of autism. Dr Ravi Paul Patron JAP also attended the camp.

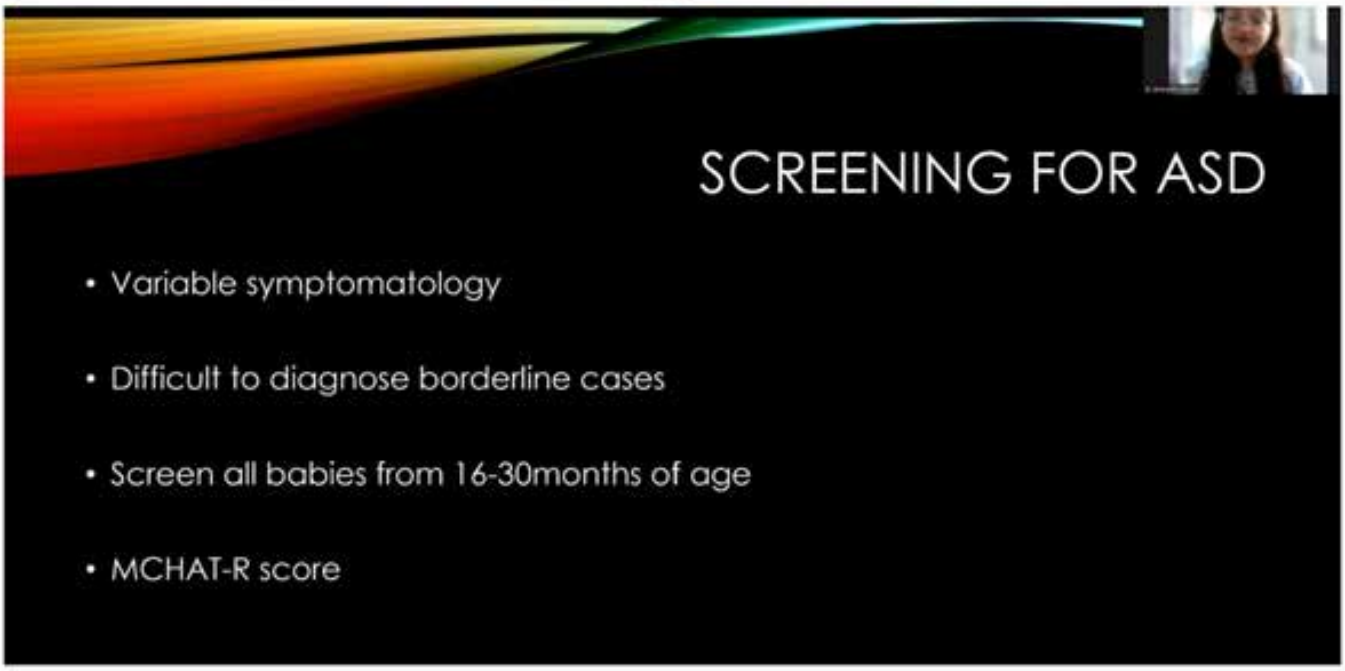
IAP Jalandhar

2. On April 3, 2023, Jalandhar Academy of Pediatrics in association with Soch Autism Society organised an inclusive Art show and fundraiser for Autistic children. Proceeds of the exhibition were deposited in accounts of autistic artists to help in their rehabilitation. Event was attended by around 300 art lovers from in and around Jalandhar

IAP Jalandhar

3. On April 02, 2023, Dr Anuradha Bansal, Secretary Jalandhar Academy of Pediatrics and Associate Professor, department of Pediatrics PIMS Jalandhar organised a webinar on "Introduction to Autism & ASD" for first and second year MBBS students of PIMS. The webinar was attended by 200 students. It was followed by a short quiz on autism. Top 3 responders were awarded by the Director Principal PIMS, Dr Rajiv Arora.



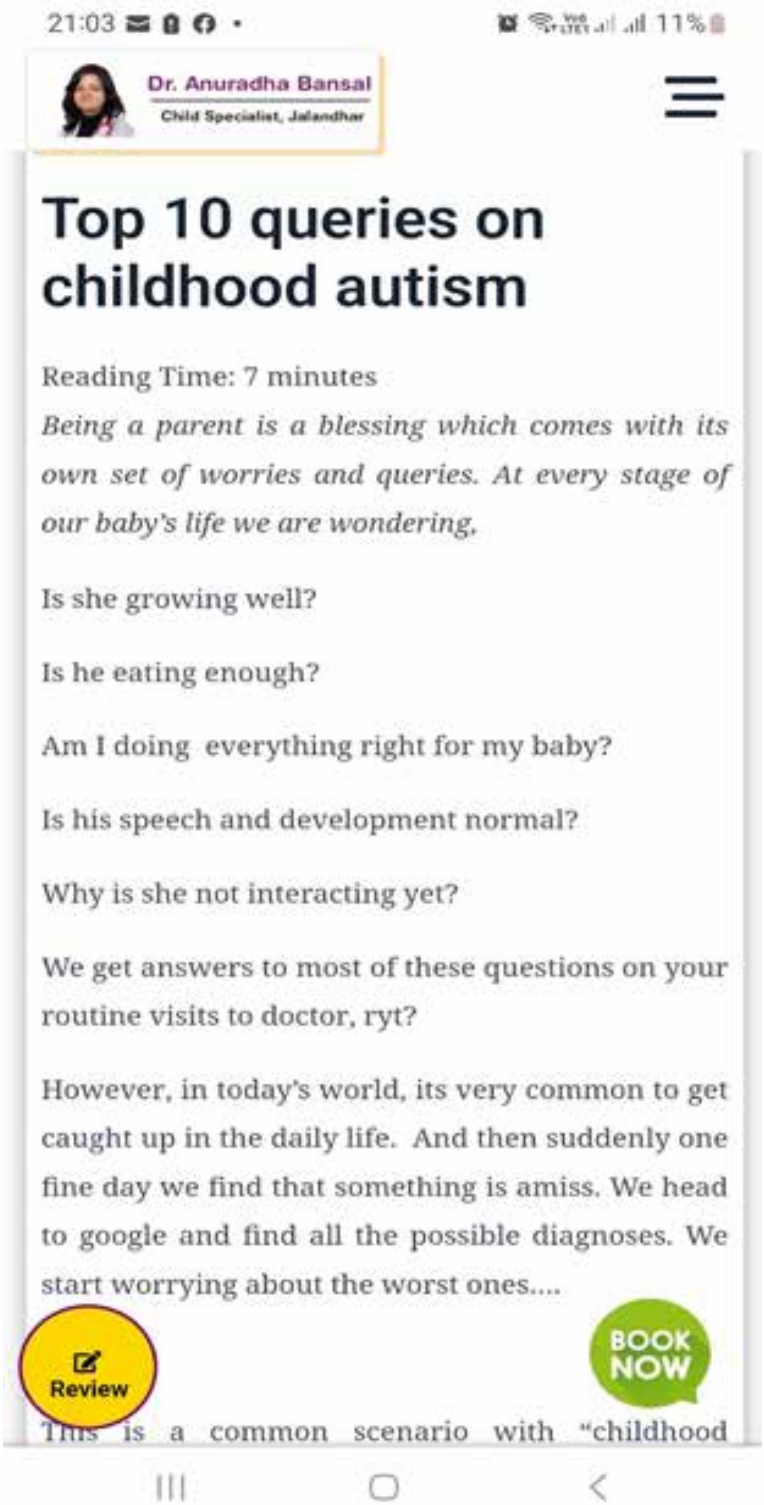


IAP Jalandhar

4. On April 11, 2023, Jalandhar Academy of Pediatrics organised a talk on " Case based discussion on Childhood Autism" by renowned developmental pediatrician Dr Chhaya Prasad. Meeting was attended by more than 50 pediatricians from Jalandhar. Chairman NCDPA Dr Anil Sud , President SAP (IAP Punjab) Dr TS Randhawa, Secretary SAP Dr Nidhi Malhotra and CENTAL IAP EB from Chandigarh Dr Arun Prasad attended the meeting among others.

IAP Jalandhar

5. Dr Anuradha Bansal, Secretary JAP published a blog on " Childhood Autism" to raise awareness about this issue.



IAP Jalandhar

6. Dr Jatinder Singh, Professor Pediatrics PIMS Jalandhar conducted an interactive webinar for students of Apeejay School on “Say No to JUNCS”

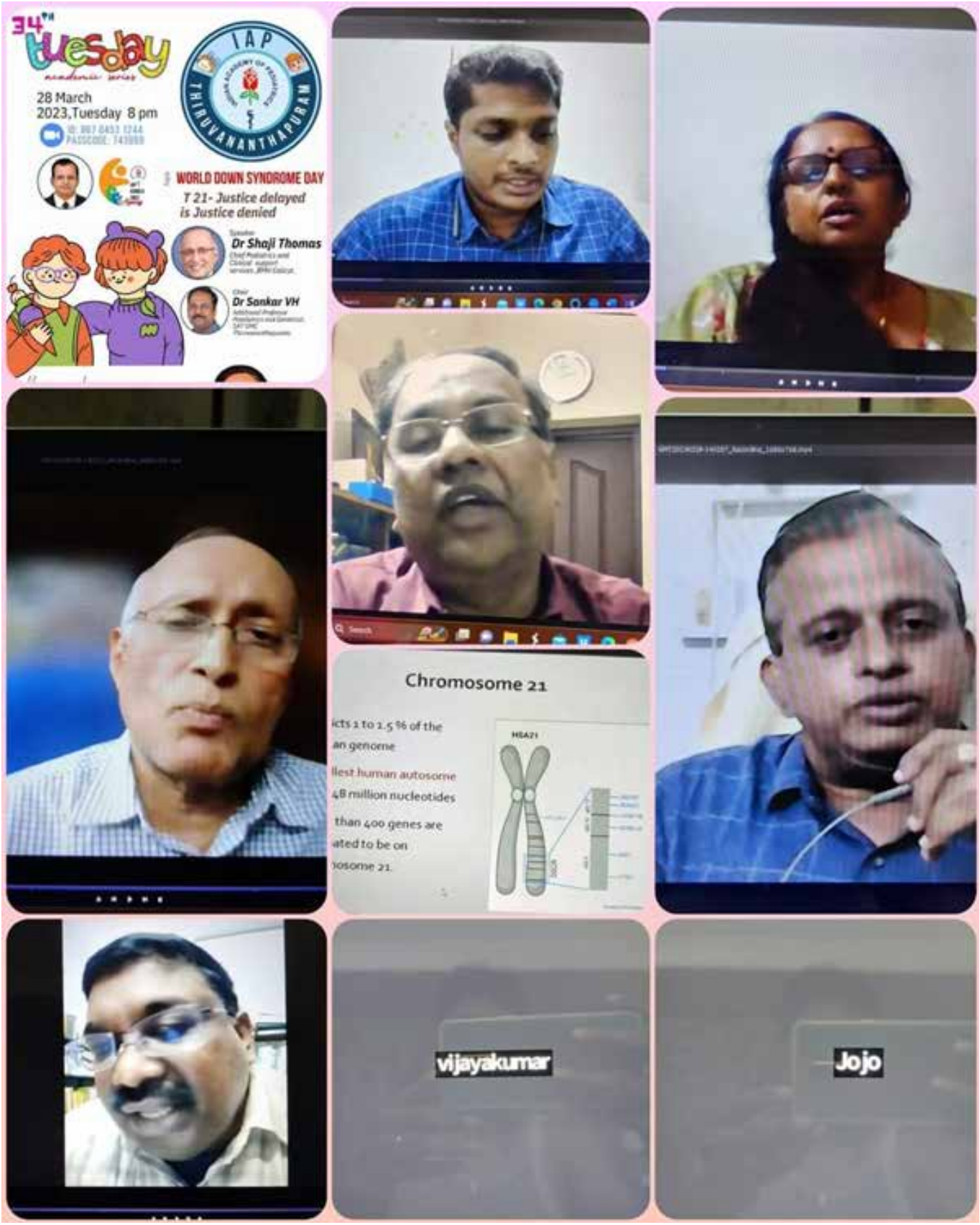
IAP Jalandhar

7. Dr Noopur Sud, EB member JAP conducted a session on healthy lifestyle for the students and parents in Dayanand Model Senior Secondary School

IAP Kerala


IAP WAYANAD
association with World TB Day 2023
tes you to a CME on
Latent TB Infection
Chief Guest:
Dr Sindhu K V,
ct TB Officer, Wayanad
Speaker: Dr Balachand
Senior Consultant Pediat
General Hospital Pathana
On 25/3/2023 ,8.30pm
Google Meet Link https://meet.google.com/dkr-gmd
YES!
WE CAN END TB
WORLD TB DAY 2023
(Latent) TB Infection - What's new ?
Dr D BALACHANDAR D
Senior Consultant, General Hospital, Pathanamthitta
Case 3:
2 year old baby girl presented with recurrent lower respiratory symptoms (3 e/s in 2 months),
weight loss (1.5 kg in 2 months), no known contact with TB.
No palpable lymph nodes or swelling. ESR 95.
Mantoux positive 30mm(with 1 TU).
IGRA positive, in January 2023.
In February, ESR 35. Gastric aspirate Truenat negative.
USG abdomen normal. CXR attached.
How to proceed?? Will go for ATT or TPT or f/u ?
YES, TPT

IAP Kerala


34th
Tuesday
academic series
28 March
2023,Tuesday 8 pm
IAP
THIRUVANANTHAPURAM
WORLD DOWN SYNDROME DAY
T 21- Justice delayed
is Justice denied
Dr Shaji Thomas
Dr Sankar VH
Chromosome 21
HSA21
vijayakumar
Jojo

IAP Kerala









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LIGHT IT UP BLUE
LIGHT IT UP BLUE
LIGHT IT UP BLUE
LIGHT IT UP BLUE

IAP Kerala


HARITHAM
INDRANEELAM
TMCAA
CADEMIC COMPLEX
MEDICAL COLLEGE ALUMNI ASSOCIATION
Cystic Fibrosis Workshop & CME
INDIAN ACADEMY OF PAEDIATRICS
THRISSUR
INDIAN ACADEMY OF PAEDIATRICS
THRISSUR

IAP Kerala


Welcome Address : Dr Suresh Kumar E K
Senior Consultant & HOD Paediatrics
Chair : Dr Ajith Kumar V T
Senior Consultant-Paediatrics
President, IAP Calicut
Inauguration : Dr Shaji Thomas John
Senior Consultant-Paediatrics
Past State President-IAP
Felicitation : Dr Krishna Mohan
Senior Consultant-Paediatrics
State Secretary-IAP
Dr Sudha Krishnanunni
Senior Consultant-Paediatrics
Vote of thanks : Dr Vishnu Mohan P T
Senior Consultant-Neonatology


PIC•COLLAGE

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FRIDAY
CLINICAL CLUB
Organized by
IAP Kozhikode
Presenters
Dr. Amrutha
Dr. Ajnas V V
Dr. Karthika


RARE
OBINOPATHIES


PIC•COLLAGE

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BREAK THE STIGMA - AN AWARENESS ABOUT
DOWN SYNDROME
FLASH MOB & THEME SHOW
19/03/23
5PM
KOZHIKODE BEACH


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IAP THALASSERY

HOPE THALASSERY

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INDIAN ACADEMY OF PEDIATRICS
VATAKARA


INDIAN ACADEMY OF PEDIATRICS
VATAKARA


INDIAN ACADEMY OF PEDIATRICS
VATAKARA


INDIAN ACADEMY OF PEDIATRICS
VATAKARA (EST:2009) (KKD/CA/77/2813)

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Aster


UPDATE - PICU


PEDIATRIC
INTENSIVE CARE
Aster
MIMS HOSPITAL


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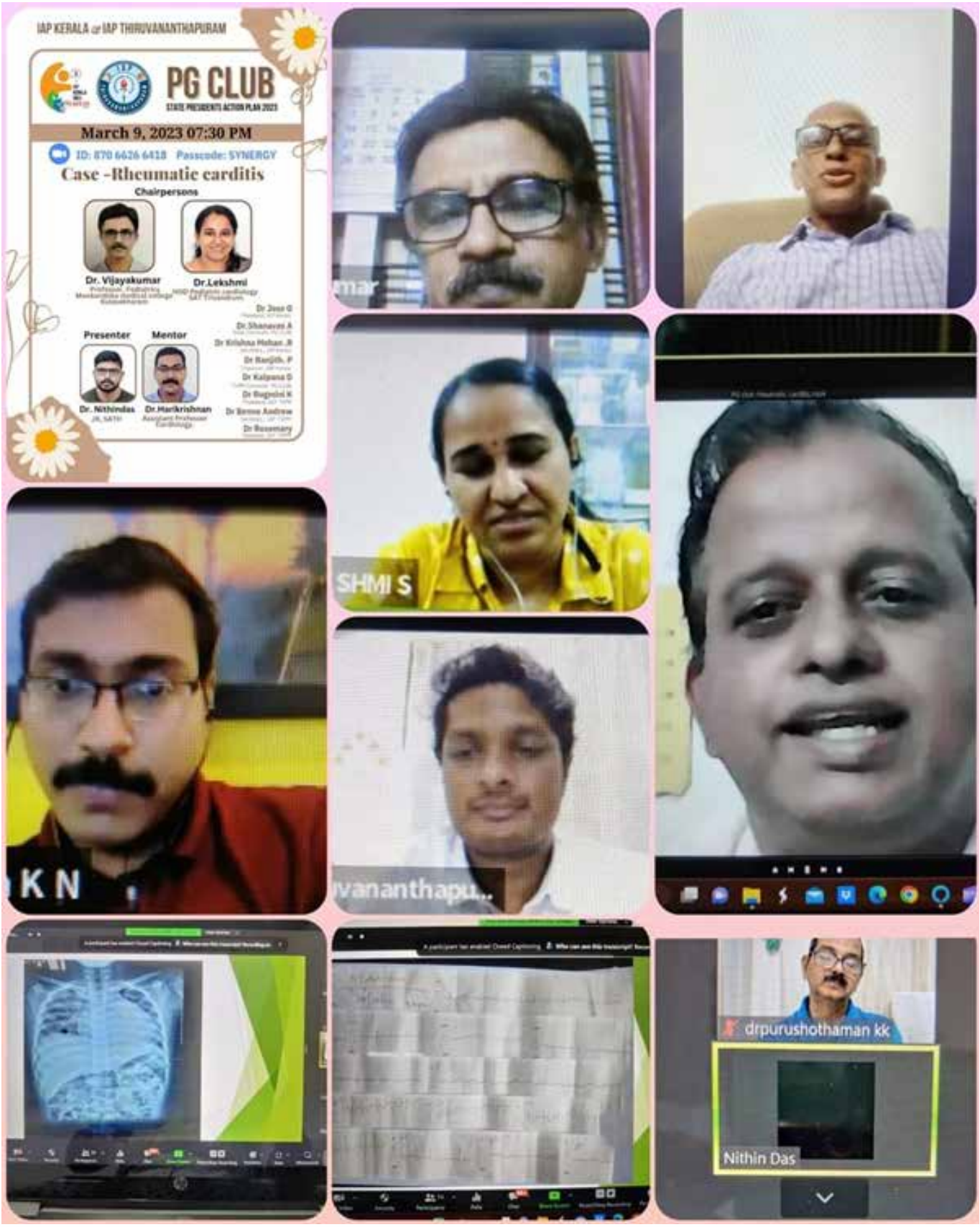
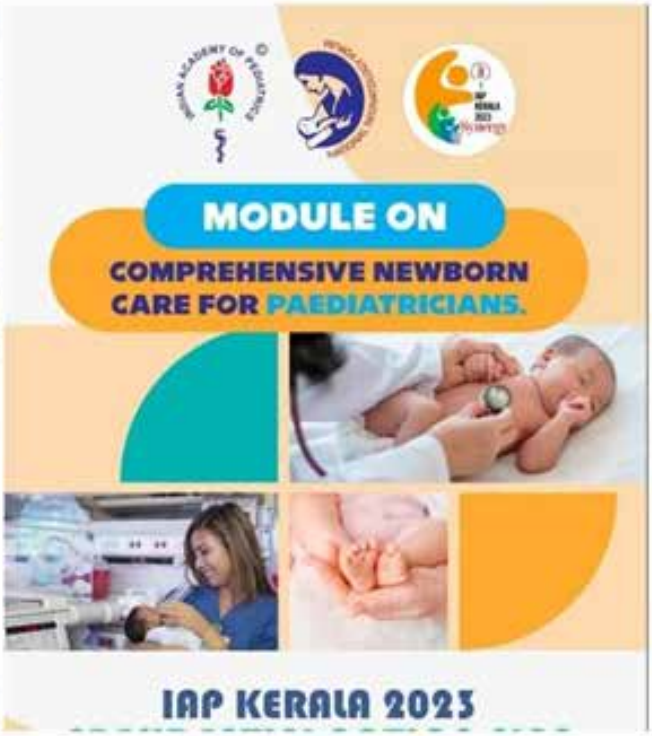

IAP KERALA & IAP THIRUVANANTHAPURAM
PG CLUB
March 9, 2023 07:30 PM
ID: 870 6626 6418 Passcode: SYNERGY
Case -Rheumatic carditis
Chairpersons
Dr. Vijayakumar
Dr.Lekshmi
Presenter
Mentor
Dr. Nithindas
Dr Harikrishnan
SHMI S
KN
drpurushothaman kk
Nithin Das

IAP Kerala


MODULE ON
COMPREHENSIVE NEWBORN
CARE FOR PAEDIATRICIANS.
IAP KERALA 2023