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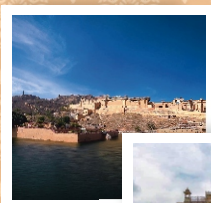
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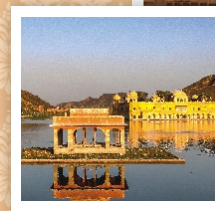
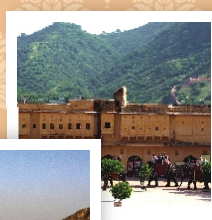
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Editors : Dr. Raja Dhar, Dr. Shivani Swami, Ms. Aaindrilla Dutta



From the President's Desk

Dr. J. K. Samaria

Dear Esteemed Members of the Indian Chest Society,

It is with immense pride and heartfelt emotion that I address you through the pages of *Respire*. This message holds special significance for me, as it is my **last communication to all of you as the President of the Indian Chest Society (ICS)**.

As we all know, the Society has been **passing through unprecedented challenges over the last three years**. Despite our collective efforts and resilience. Nevertheless, the unity, patience, and commitment demonstrated by our members during these trying times have been truly commendable.

I feel sorry that we could not conduct the ERS HERMES Diploma Examination this year, an event that has always been a matter of pride for our fraternity. I am confident, however, that with continued determination and support, the Society will soon overcome these obstacles and restore all its academic and professional activities to their full strength.

Over the past years, the Indian Chest Society has continued to uphold its ideals of promoting respiratory health, education, and research despite adversity. I have been deeply inspired by the **dedication, collective spirit, and perseverance** of our members who remain the backbone of this organization.

The past year has been particularly momentous. **NAPCON 2024 in Pune** was a resounding success, witnessing the participation of more than 3500 delegates from across the nation. The scientific deliberations, interactive sessions, and exchange of ideas reflected the immense depth of talent and passion within our fraternity.

Equally noteworthy was the ERS India Summit 2025, a landmark collaboration between the Indian Chest Society and the European Respiratory Society (ERS). Under the able leadership of **Dr. Raja Dhar**, Secretary, ICS, and **Dr. Sundeep Salvi**, Past President, ICS, the summit was held across three major cities Mumbai, Delhi, and Kochi. We were honoured by the gracious presence of **Prof. Silke Ryan**, President, ERS, along with other members of the ERS leadership. With a remarkable attendance of nearly 12001300 delegates, the summit served as a powerful platform for international academic exchange and collaboration in respiratory medicine.

Our **ICS Webinars** on key topics such as ILD, Asthma, COPD, and Lung Cancer have continued to foster knowledge sharing and discussion among experts and practitioners nationwide. These initiatives have strengthened our educational outreach and reinforced our commitment to continuous professional development.

We have also taken pride in supporting **young talent** through the ICS International Travel Grants, enabling our members to present their work and participate in renowned global conferences including ERS, ATS, ACCP, and the Lung Health Workshop. These opportunities have helped young researchers gain invaluable exposure and contribute meaningfully to global respiratory science.

Our official journal, **Lung India**, with an impressive Impact Factor of 1.3, continues to be the cornerstone of academic dissemination within the Society. As a bi-monthly, peer-reviewed publication, it plays a pivotal role in highlighting cutting-edge research and clinical advancements in respiratory medicine. I urge all members to actively contribute and support its continued growth.

Looking ahead, we eagerly anticipate **NAPCON 2025**, to be held in the historic city of Jaipur under the dynamic leadership of **Dr. N. K. Jain, Dr. Nitin Jain, Dr. S. K. Luhadia**, and **Dr. Virendra Singh**, and their dedicated team. I am pleased to share that the **Scientific Programme for NAPCON 2025 has already been meticulously prepared under the chairmanship of Dr. S. K. Luhadia, Chairman, Scientific Committee, NAPCON 2025, Jaipur**. The team has put in exemplary effort to ensure that the academic content will be rich, diverse, and globally relevant. I am confident that this event will once again set new benchmarks in scientific excellence and camaraderie.

As I complete my tenure, I extend my deepest gratitude to every member for your **unwavering support, trust, and cooperation** during these challenging times. The Indian Chest Society has always been a symbol of strength, unity, and academic excellence. I am confident that, with collective determination, ICS will soon overcome its current hurdles and reach even greater heights.

With warm regards and best wishes,

Dr. J. K. Samaria

President

Indian Chest Society



From the Secretary's Desk

Dr. Raja Dhar

Dear Friends,

As another year draws to a close and we move towards **NAPCON 2025**, I find myself reflecting on the journey that has transpired. The past year has been filled with achievements that have strengthened our Society, brought immense satisfaction to the Governing Body, and inspired positivity within our fraternity. Of course, there have been a few challenges along the way, but each has taught us valuable lessons and guided our path forward.

Let me take this opportunity to revisit some of the key highlights from **2024-2025**, which have added great momentum and pride to the Indian Chest Society.

Our year began on a difficult note, as Kolkata faced an unfortunate tragedy with the demise of a young colleague and huge protests which caused havoc in the city. Consequently, **NAPCON had to be relocated from Kolkata to Pune**. What could have been a setback turned into a story of remarkable teamwork. Despite the challenges and short notice, the **Pune team rose to the occasion** with exemplary efficiency and teamwork, delivering a memorable conference that upheld the academic standards of ICS. The academic quality, participation, and overall execution made it one of the most memorable NAPCONs in recent years. The success of NAPCON Pune, both in terms of scientific quality and participation from across India, stands as a testament to our collective resilience and unity.

Soon after, we experienced another moment of pride - the **ERS-ICS Joint Summit**, a collaborative meeting between the **Indian Chest Society** and the **European Respiratory Society**. Held across three cities, this academic exchange brought together esteemed faculties from India and Europe. The initiative received widespread appreciation and has laid the foundation for stronger future collaborations, with plans already underway for a similar event in 2026.

Moreover, the **ICS-sponsored ERS membership for our members** further strengthens our global engagement - a partnership both societies deeply value and intend to build upon. ICS took the initiative to sponsor ERS memberships for the members of the Indian Chest Society, ensuring that our members stay globally connected. This gesture has strengthened the relationship between the two societies and created avenues for meaningful academic exchange.

The **Training and Education Initiative**, led by **Dr. Amita Nene**, continued to make remarkable progress with a structured series of **modular webinars** that offered high-quality, certificate-based learning. These sessions have been well-received by members nationwide, showcasing the continued success of our digital education efforts even in the post-pandemic era.

Our growing reputation has also been reflected in the number of **requests for ICS endorsement** received from various International Conferences, Institutions, and pharmaceutical companies. The Society has been proud to extend its support to prestigious events such as the *World Bronchiectasis Congress*, *International Lung Health Workshop*, and several others. Each endorsement was granted only after careful review of the academic content to ensure they were scientific, non-promotional, and credible. These collaborations underscore the increasing global recognition of Indian Respiratory Medicine through the platform of ICS.

We also continue to support young researchers through International Travel Grants. This year, ICS proudly facilitated participation in major meetings such as *CHEST*, *World Bronchiectasis Congress*, *International Lung Health Workshop*, and most importantly the *European Respiratory Society Meeting*. The growing number of applicants each year is a reflection of our thriving research community.

Among our academic collaborations, the **MECOR Programme**, spearheaded by **Dr. D. J. Christopher** in association with the **American Thoracic Society (ATS)**, deserves special mention. This intensive, week-long research training initiative has been gaining momentum, inspiring young investigators across India to enhance their research capabilities under expert mentorship.

Our official journal, **Lung India**, continues to grow in stature and international recognition, with an ever-increasing number of global submissions, citations, and readership. It has truly evolved into one of Asia's most respected journals in Respiratory Medicine, and we aspire to see it reach even greater heights in the coming years.

This year also marked the successful launch of the **ICS National Talent Search**, held across four zones of India, culminating in the grand finale at NAPCON Jaipur 2025. Under the coordination of **Dr. Vishnu Sharma**, this initiative has been instrumental in identifying and encouraging young talents in Respiratory Medicine - a step toward the future of our discipline.

As we look ahead, I sincerely hope that our **research initiatives expand further**, promoting **multi-centre collaborations** across government, private, and smaller institutions. The goal is to make research inclusive, data-driven, and globally impactful - showcasing the true academic strength of Indian Respiratory Medicine.

While we celebrate these successes, we must also acknowledge areas where we need progress. A sense of **division within the Society** still lingers, despite continuous efforts

from our side to bring all members together under **ONE ICS** and hold a **single NAPCON**, complete harmony remains a work in progress. Unity has always been our greatest strength, and I remain hopeful that with time, fresh perspectives and renewed enthusiasm will restore the spirit of togetherness that defines our fraternity.

As I move on after completing more than a decade's service to this esteemed Society, I look back with immense pride and gratitude. I have seen ICS evolve, adapt, and grow into a respected national and international academic organisation. I am confident that under the capable leadership of the future Governing Body, ICS will continue to thrive and elevate the standards of Respiratory Medicine in India. Our shared dream of mentorship, inclusivity, and excellence will continue to drive us forward.

I extend my warm wishes to all our members for a productive and fulfilling year ahead. May the coming year bring us more opportunities for collaboration, learning, and camaraderie as we continue to strengthen Respiratory Medicine in India and beyond.

Dr. Raja Dhar

FCCP (USA), CCT (UK), M.Sc. (UK), FRCP (London)

MD (Respiratory Medicine), MBBS (Cal.)

National Secretary, Indian Chest Society



MEET THE NEW ICS GOVERNING BODY



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Editor, Lung India



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Chair, Research
Committee



DR. A. G. GHOSHAL
Chair, Awards
Committee

Conference HIGHLIGHTS



ICS ORATIONS AND AWARD

ICS – Dr. O.A. Sharma
Oration Award 2017

ICS – Dr. K.J.R. Murthy
Oration Award 2013

ICS – Dr. C.V. Ramkrishnan
Oration Award 2016

ICS – Dr. S.N. Tripathy
Oration Award 2016

J C KOTHARI-YOUNG SCIENTIST AWARD FOR BEST PAPER.

**All the selected Abstracts will
be published in Lung India.**

NAPCON-2025, JAIPUR

AWARDS

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Call to action : Addressing asthma diagnosis and treatment gaps in India

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ABSTRACT

In comparison to the worldwide burden of asthma, although India contributes to 13% of the total asthma prevalence, it has a threefold higher mortality rate and more than twofold higher DALYs, indicating a substantial gap in asthma diagnosis and treatment. Asthma causes significant suffering, affecting people's quality of life and draining the country's resources; therefore, we must devise ways and means to fill these gaps. The most successful and cost-efficient strategy to battle asthma is to form strong partnerships between patients, the general public, the government, the pharmaceutical industry and non-governmental organisations. This necessitates a comprehensive approach that involves raising awareness, developing universally applicable recommendations, increasing access to high-quality asthma care, and other measures. The purpose of this article was to review the existing scenario of asthma management in India and the factors that contribute to it and devise unique and all-encompassing strategies to fill these gaps.

KEY WORDS : Asthma, corticosteroids, inhalation therapy, salbutamol

INTRODUCTION

The global rise in asthma rates can be attributed to the pervasive effects of urbanisation and industrialisation, marking a significant health concern on a worldwide scale.^[1] Asthma therapy is generally suboptimal, especially in impoverished nations, despite effective drugs.^[2] Poor asthma management causes morbidity, death and socioeconomic concerns.^[3,4] Despite 65% of India's population residing in rural areas, only 33% of doctors and nurses serve in these regions, revealing a notable urban-rural healthcare disparity, according to the World Bank's 2021 report. Additionally, most of the health workforce is employed in the private sector, with about 60% of inpatient care and 70% of outpatient care in India provided by private facilities.^[5]

The rural economy holds a substantial share, constituting 46% of the national income, and despite the ongoing trend of urbanisation, projections suggest that over half of India's population will remain rural by 2050.^[6] In the context of healthcare, the Union Budget 2022-23 reveals that India's healthcare spending is a mere 3.2% of the GDP.^[7] This financial allocation has significant repercussions on health outcomes, particularly in rural areas where healthcare services and resources are already limited. The need for increased investment in rural healthcare is evident, given the persistent rural population and the existing challenges in delivering adequate healthcare services to these regions. Given this background, we sought to identify asthma management gaps and related factors in India and provide solutions.

Prevalence

As per the 2019 Global Burden of Disease report, India's total asthma burden is 34.3 million, which accounts for 13.09% of the global burden.^[8] However, India reports three times higher mortality and more than two times higher disability-adjusted life years (DALYs) than the global proportion of asthma burden.^[8,9] This is alarming and could be attributed to late reporting, underdiagnoses, delayed treatment, undertreatment or no treatment.^[8]

Asthma exhibits a higher prevalence in rural areas, emerging as a significant cause of morbidity and mortality in rural India.^[10] This underscores the crucial necessity for targeted healthcare interventions in rural settings. Interestingly, the study by Rashmi *et al.*^[11] presented a contrasting perspective, revealing higher rates of asthma prevalence in urban areas as opposed to rural areas. This observation aligns with existing evidence, emphasising the role of urbanisation and increased exposure to biomass fuel smoke as environmental risk factors for asthma. These findings highlight the complex interplay of environmental factors in shaping asthma prevalence across different geographical settings.

Triggers for asthma

The pathological process of asthma starts after exposure to a triggering factor, leading to bronchial hypersensitivity, inflammation of the airways and excessive mucus production.^[12,13] Allergens, pollution and occupational irritants are common triggers, but they vary by country.

In India, the AP-AIM study found that dust and air pollution caused asthma in nearly half of the asthmatic patients, while seasonal weather changes, gases, odours, chemicals, cigarette smoke, and iced drinks caused asthma in 25%. Asthmatics reported few breathing problems from animals (9%) and pollen grains (5%). This differed from what has been published about asthma triggers in Western countries.^[14] Asthma triggers are known to vary by region, with allergens, emotional factors (in Australia), and a combination of allergens, rhinitis, weather/climate, occupational irritants, air pollutants, tobacco smoke, and respiratory symptoms (in Europe, UK, North America, and South America) being identified as common triggers.^[15]

Burning incense in Indian homes and temples can lead to airway dysfunction and worsen respiratory symptoms,^[16] while exposure to tobacco and biomass smoke air pollutants increases the risk of asthma, particularly in adult Indian women.^[17,18]

Diagnosis of asthma and the gaps

Diagnosis of asthma is frequently challenging and prone to misdiagnosis. It primarily relies on the presence of typical features, followed by the assessment of lung function.

Laboratory and imaging tests play a minimal role in the diagnosis of asthma.

Diverse nomenclature

The terminology used by physicians and patients to describe asthma is intriguing. In a recent study, only 71% of clinicians referred to the condition as ‘asthma,’ while 29% used alternative terms. From the patients’ perspective, only 23% referred to their condition as asthma, with the remainder using terms like ‘shwas’, ‘dama’, or cold and cough.^[8]

Lack of disease terminology knowledge and lost prescriptions during follow-up visits waste consultation time and lead to unnecessary investigations which in turn leads to delays in disease diagnosis.^[19]

Under-reporting and underdiagnosis

Asthma’s impact extends beyond respiratory limitations, affecting individuals’ self-perception and social interactions. The stigma associated with asthma can lead to lower self-esteem, prompting individuals to conceal symptoms and delay reporting.^[8] The stigma not only concerns those diagnosed but also causes worry for patients and parents, complicating disclosure.^[20] Underdiagnosis of asthma can lead to ineffective treatment and adverse outcomes, as patients may appear healthy and are less likely to be referred to specialists for confirmation of the diagnosis compared to less common disorders.^[21]

Significant portions (20% to 30%) of people living with asthma in India, particularly from low-income households, rely on government hospitals for affordable care. Unfortunately, these clinics lack essential asthma diagnosis and treatment equipment.^[22] Many healthcare providers, both in private and government sectors, lack the necessary knowledge and skills to diagnose and treat asthma, often resorting to prescribing only oral drugs. In a recent study, about 82% of patients with early symptoms and 70% with severe asthma

were clinically underdiagnosed in India, which may be attributed to the similarity of symptoms to other conditions, leading to frequent misdiagnosis.^[8]

Under usage of spirometers and peak flow meters

Despite being the gold-standard diagnostic method for asthma, spirometry is under-used throughout our country, especially in primary care.^[23,24] The expense of the spirometer, the patient's inability to afford the test, and the doctor's busy schedule are the leading causes of the underuse of spirometry in India.^[24] Salvi *et al.*^[25] found that spirometry is underutilised in India due to limited access (41.6%) and patient affordability issues (36.2%). The misconception that spirometry is a challenging test to conduct and understand is another reason clinics do not have a spirometer.

The studies by Kotwani *et al.*,^[24] Shahid *et al.*^[26] and Bhattacharyya *et al.*^[27] revealed a low utilisation rate (ranging from 9.0% to 18%) of spirometers or peak flow meters for asthma diagnosis and management.

Management of asthma and its gaps

Countries address asthma differently based on cultural and educational factors.^[28] In India, frequent asthma exacerbations result in functional and emotional challenges, indicating inadequate care and awareness of uncontrolled asthma.^[29] This lack of awareness is sometimes owing to their treating doctors' belief that asthma symptoms are lifelong ('dama dam ke saath hi jaata hai' - asthma lasts until your last breath). Most asthmatics overestimate their control.

Many Indian asthma patients, concerned about steroids, prefer oral bronchodilators. Sodhi *et al.*^[30] found that tablets, capsules and syrups constituted the favoured mode of drug administration for 59.28% of patients, with the inhalational route being the second choice for 36.42% of patients. A study on oral medication users revealed that 50% had emergency doctor visits, and 32% faced hospitalisation, indicating poor control and a substantial healthcare burden. Despite available inhalers, only 36% of Indian patients use them, highlighting deficiencies in asthma management, underdiagnosis and reliance on oral medication, leading to high illness and mortality rates in India.^[31] Furthermore, the use of corticosteroids is associated with adverse effects such as weight gain, osteoporosis, immune system suppression and adrenal gland dysfunction.^[32]

Proper asthma education reduces reliance on oral medications, improving long-term control. Individualised therapy, with regular check-ups, enhances patient well-being.

The objective of asthma therapy is to manage the condition effectively, enabling individuals to resume their daily activities without hindrance. It is crucial to prevent exacerbations and minimise the side effects associated with therapeutic pills. However, the multitude of available asthma combination inhalers and treatment options in India may pose a challenge for non-specialists in determining the most appropriate prescription. As per the 2023 Global Initiative for Asthma (GINA) guidelines, Track 1 asthma management recommends a single inhaler for maintenance and relief treatment (MART), typically containing low-dose formoterol and inhaled corticosteroids like budesonide. The MART approach, in contrast to short-acting beta-agonist (SABA) relievers, minimises severe exacerbation risks, offering a unified prescription for symptom relief and maintenance therapy to help control the inflammation. This simplifies treatment and allows flexibility for necessary therapy adjustments without changing medication or inhaler devices; MART with inhaled corticosteroids (ICS)-formoterol is indicated for stages 3-5 and in children aged 6-11 in steps 3-4.^[33,34]

The GINA Track 1 strategy tailors phases based on asthma severity. In stages 1-2, low-dose ICS-formoterol is recommended as anti-inflammatory reliever for symptom relief without ongoing maintenance. This approach, in contrast to SABA alone or daily ICS with as-needed SABA, markedly reduces severe exacerbations and emergency visits/hospitalisations.^[33]

Overuse of SABAs in India is due to their over the counter (OTC) availability, as β_2 -agonists are the most commonly prescribed asthmatic drug (100%),^[35,36] with high usage rates in urban and rural settings, including paediatric patients. Overuse increases aggravation and death.^[37,38] Salvi *et al.*,^[22] showed that India sells less than 10% of the ICS needed for its estimated 34.2 million asthma patients, creating a treatment gap that may contribute to high asthma death rates. WHO considers ICS necessary. Unfortunately, many Indian tertiary care teaching institutions do not include these in their formularies, underscoring the urgent need to address this issue.^[39,40]

When Track 1 is not feasible, or a patient has been stable, adherent and without exacerbations, GINA Track 2 suggests using a SABA and low-dose ICS together in Step 1. A SABA or ICS-SABA reliever is recommended in steps 2-5. Before opting for a SABA reliever, assess the patient's adherence to ICS-containing medications, as poor adherence increases the risk of exacerbations.^[33]

Combining ICS / formoterol in a single inhaler for on-demand usage has been shown to effectively reduce SABA overuse.^[41] Clinicians are advised to instruct patients on the importance of avoiding self-medication and transitioning to an as-needed approach to minimise potential hazards. Furthermore, initiating newly diagnosed patients on Track 1 is recommended.^[42]

To treat severe asthma (that is refractory to the standard therapeutic toolset), it is necessary to explore advanced approaches such as biologics. Omalizumab, benralizumab and mepolizumab are the biologics available within India's public healthcare system through initiatives like the Central Government Health Scheme, Railways and Army Medical Services. While these medications are also available in limited private healthcare markets, it is essential to note that they may be associated with high costs and may not be affordable to most patients.^[43]

Increasing insurance coverage for biologic medicines can make it easier for more people to get them without paying full price, negotiating lower drug prices with pharmaceutical companies, encouraging biosimilar development and funding research into more affordable options.

Managing asthma in India also presents a significant challenge due to notably lower lung function values among Indians. Indians have the lowest "normal" lung function globally, with levels approximately 30% lower than Caucasians.^[44] This is likely attributed to poor air quality, inadequate childhood nutrition, unhealthy lifestyles, urbanisation, industrialisation and lower socioeconomic status. A study indicates higher daily smoking rates in asthmatic teenagers compared to non-asthmatic peers, highlighting a link between adolescent smoking and an increased risk of new-onset asthma.^[45,46] These findings emphasise the interconnected nature of respiratory health, lifestyle choices and environmental factors and the importance of addressing these issues within the Indian population.

Stigma, taboos, myths and underuse of inhalers

Successful asthma treatment relies on inhalation therapy, which aims to deliver a greater drug concentration to the airways more efficiently and minimise systemic side effects.^[47] Despite proven efficacy, misconceptions persist in India, associating "steroids" and "inhalers" with negative outcomes, leading to concerns about addiction and limited use for severe cases.^[48] Cultural barriers, especially for women, hinder inhaler acceptance, contributing to varied asthma control levels among men and women.^[49] Dispelling stigma and myths associated with inhalers is crucial, which is achievable through comprehensive education initiatives debunking myths around 'steroids' and 'inhaler'. Addressing gender biases and societal norms is essential to reduce discrepancies in asthma control. To overcome these barriers and ensure optimal care for individuals with asthma, it is essential to promote accurate information, encourage open communication and create a supportive and understanding environment. Through these measures, we can foster a shift in societal attitudes, ultimately improving the overall management of asthma in the community.

Errors in using the inhalational device

Incorrect inhaler use by asthmatics has been linked to poor outcomes. Dalal *et al.*^[50] found that 64.6% of asthma patients had faulty inhaler techniques, and 40.7% of those with poor clinical control had partly or uncontrolled asthma.

Mullerpattan *et al.*^[51] assessed inhaler techniques in Indian patients, doctors and nurses, revealing mean scores of 4.65 for patients, 6.35 for doctors, and 4.70 for nurses. Although doctors scored higher, patients and nurses may benefit from additional training. Kshatriya *et al.*^[52] found that interns had difficulties identifying and using various inhalers. Improving healthcare provider education would help enhance inhaler technique, compliance and asthma management, leading to better symptom control and cost savings.

Non-adherence

Non-adherence to asthma medication, including poor inhaler usage and technique, is a significant problem affecting asthma management.^[53]

In India, adherence to inhalers is an issue, with studies reporting non-adherence as high as 75.3%.^[54] This may be attributed to various factors, including the use of controller medications, viz. ICS only during symptoms rescue medication stemming from inappropriate prescribing practices, complex and time-consuming regimens, insufficient training in inhalation techniques, and the stigma or taboo associated with using inhalers.^[54]

Lack of knowledge and healthcare delivery issues

In India, with an estimated 34 million asthma patients, it is crucial to ensure that general practitioners have sufficient training to diagnose and treat this respiratory condition. Unlike high-income countries where primary care settings manage a significant proportion of asthma cases, the substantial burden in India emphasises the need for well-equipped primary care physicians. A physician's understanding of disease management and clinical practices significantly influences their ability to provide high-quality treatment, leading to effective asthma control and improved patient quality of life.^[55,56]

Most medical students in India need more instruction in diagnosing and treating asthma. This may be due to little emphasis on teaching this skill in the undergraduate curriculum.^[22]

The practice of alternative and native therapies for asthma

"Fish medicine" and natural remedies have been commonly used for asthma management in India for over 159 years.^[57] Alternative medicine practitioners often warn against steroids and inhalers, quoting addiction and adverse effects.^[22] However, collaboration, modern therapy and education can enhance asthma control and raise awareness among Indian patients and healthcare providers.

ASTHMA MEDICATIONS IN INDIA : AVAILABILITY, AFFORDABILITY AND THE PARADOX

Clinical guidelines advocate treating asthma with inhaled respiratory medicines.^[58] India has more medicine combinations than many other countries, allowing doctors to tailor asthma treatment to different age groups and severity levels. While the country offers biologics for severe asthma, there is a shortage of newer options. Importantly, these disparities may not significantly impact the treatment outcomes for the majority of asthma patients.

The World Health Organization created the list of essential medications to assist nations in selecting drugs that enhance health and are less expensive.^[40] Despite the endorsement of a limited range of respiratory medications in national essential medicines lists, their actual availability in low-and middle-income countries is often significantly limited, with only 30.1% and 43.1% accessibility in commercial and public sector medications for asthma management, respectively.^[59]

In five Indian states, Dr. Kotwani found that important asthma inhalation drugs were unavailable or expensive in the public sector, which serves low-income people.^[60] Another study found that Delhi government hospitals lacked asthma inhalers.^[61]

While some patients in India may struggle to buy asthma medicine, it is important to note that asthma treatments are affordable. Pressurised metered dose inhaler (PMDIs), unit-dose dry powder inhalers (DPIs), multi-dose DPIs and breath-actuated inhalers are available in the country. Despite their availability, few patients are prescribed these inhalers.

Beclometasone-formoterol, a typical asthma drug, costs 692 rupees (8.3_\$) for 120 tablets at the normal dosage of two puffs twice a day, which is comparable to a cup of tea. Essential asthma medications are on the National List of Essential Medicines, and the government limits their prices.

The major asthma paradox in India is that asthma drugs are economical and widely available yet not commonly prescribed. Understanding the causes of this phenomenon is essential for improving asthma management and patient access to suitable medicines nationwide. This inequality and asthma care in India requires more research and interventions.

ASTHMA COMORBIDITIES

Comorbidities typically accompany asthma and have been linked to poor disease control, increased healthcare usage, poor treatment adherence, poor quality of life and higher mortality rates, especially in geriatrics.^[62-64] A meta-analysis of 11 studies of asthmatic patients from different countries found that cardiovascular/cerebrovascular diseases, obesity, hypertension, diabetes, psychiatric and neurological comorbidities, gut and urinary conditions, cancer and respiratory problems are commonly associated.^[62]

In an Indian study of 90 asthmatics, sinusitis was the most common comorbidity, followed by obesity, GERD, psychiatric problems, vocal cord dysfunction, OSA, bronchiectasis and atopic and recurring respiratory infections.^[66] In a study of 95 children, allergic rhinitis was most common, followed by psychological disturbance, snoring, GERD, atopic dermatitis and sinusitis.^[66]

Identifying comorbidities and important knowledge gaps can affect asthma control, symptom persistence, and the natural history of the illness.

Renewed government focus on asthma and other chronic respiratory diseases

The Union Ministry of Health released the first Medical Officers Manual for Prevention and Management of Chronic Obstructive Pulmonary Disease and Asthma under the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) on World COPD Day 2021.^[67]

The Union Ministry's flagship programme is the National Programme for Prevention and Control of Non-Communicable Diseases, established on May 3, 2023. Previous names were NPCDCS, the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke. Due to the addition of new ailments, disease groups or initiatives, such as one for COPD and asthma, the programme name has been modified to NP - Non communicable diseases (NCD) and is a flagship programme of the Indian government across Ministries.^[68]

States have been instructed to ensure all districts deliver COPD and asthma care by December 2025 and enable the same on May 17. The National Programme for Prevention and Control of Non-Communicable Diseases (2023-30) updated operating instructions. COPD and asthma are included for the first time in this operational guideline. This would teach 40000 Primary Health Care Medical Officers on Standard Treatment Workflow for NCDs including asthma to bring healthcare closer to the community through the Shashakt Portal.^[69] The government is committed to addressing NCDs through resource allocation, capacity building, mobilisation and multi-sectoral collaboration.

Table 1 : Asthma in India : Challenges and Solutions

Category	Challenges	Solutions
Physician Level	Inadequate knowledge of the terms, phenotypes, aetiology and comorbidities related to asthma. ^[8,62]	Programmes to increase awareness of and educate about asthma, including those that highlight the advantages of peak flow meters, spirometry and lung function testing. ^[70]
	Excessive use of reliever inhalers and the need for more efficient prescription practices. ^[35,36]	Approaches for promoting proper prescribing based on standard guidelines patterns and preventing excessive use of reliever inhalers. ^[71]
	Lack of training on obstructive airway diseases in primary healthcare centres. ^[51,52]	Including obstructive airway disease education in updates to primary healthcare facilities and providing clinicians with information on early diagnosis, prevention and management. ^[72]
	Outdated methods of managing asthma using oral/ inhaled bronchodilators. ^[35,36]	Adopting innovative ways of managing asthma, including MART single-inhaler therapies and adding them to the government formulary. ^[73]
	Limited accessibility to diagnostic equipment and lack of training. ^[25]	Enhancing the accessibility of diagnostic tools and offering thorough skill training. ^[74]
Patient Level	Inadequate health education regarding management of asthma, using inhalers and adhering to treatment regimens for disadvantaged individuals. ^[24]	Enhancing the health education programmes for promotion of effective inhaler use, medication adherence and efficient asthma management knowledge. ^[75]
Population Level	Disparities in socioeconomic status between those who use health services associated with asthma. ^[11]	Broad-based service improvement to alleviate socioeconomic disparities in access to healthcare services For people with asthma. ^[76]
	Inadequate access to and affordability of diagnostic testing and treatments for asthma. ^[24]	Local production of cost-effective, top-notch generic drugs, enhanced supply chains and equitable subsidies for healthcare budgets. ^[77]
	Access to diagnostic resources and a need for more emphasis on chronic respiratory disorders in medical education. ^[8,24,25]	Increasing access to diagnostic technologies and funding for doctor training in respiratory medicine to help in the early diagnosis and treatment of respiratory disorders. ^[78]
Policy Makers Level	The requirement for healthcare policies with an emphasis on treating asthma. ^[79]	The development of healthcare policies by individual governments to give modern asthma medications more Attention and to prioritise treating asthma. ^[80]
	Insufficient access to inhalers at public hospitals. ^[60,61]	Increasing the supply of inhalers in all public hospitals nationwide ensures that asthma patients receive prompt and effective care. ^[81]
	Lack of access to affordable diagnostic equipment and lack of training. ^[60,61]	Enhancing the accessibility of inexpensive diagnostic tools and offering thorough skill training. ^[82]
	Limited funding and resources to carry out asthma education and awareness programmes. ^[70]	Seeking grants, partnerships, and donations to support the organisation's initiatives and activities. ^[83]
	Coordination and collaboration challenges with other stakeholders in the healthcare system. ^[84]	Establishing strong partnerships with healthcare providers, government agencies and other NGOs to streamline efforts and share resources. ^[85]
NGOs and Professional Associations Level	Reaching remote or marginalised communities with limited access to healthcare services. ^[84]	Developing innovative outreach programmes and mobile clinics to bring asthma education and treatment closer to underserved areas. ^[86]
	Measuring the impact and effectiveness of asthma management programmes. ^[87]	Implementing data collection and evaluation systems to assess the outcomes of their interventions and identify areas for improvement. ^[88]

Table 1 Summary - Asthma management challenges and solutions in India for medical practitioners and policymakers.

CONCLUSIONS

To improve asthma management in India, it is necessary to increase awareness, enhance access to lung function evaluation, address socioeconomic disparities, promote appropriate prescription practices, provide adequate health education, improve the availability and affordability of medications and diagnostic tests, learn from successful programmes, develop targeted healthcare policies, invest in respiratory medicine training and prioritise asthma in primary healthcare education and public hospitals.

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Conflicts of interest

There are no conflicts of interest.

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DR. G. C. KHILNANI

Serving as the Chief Guest at the Nepalese Respiratory Society Conference in Kathmandu, delivering the Keynote Address, and being conferred with an Honorary Life Membership by the Nepalese Respiratory Society. The Indian Chest Society expresses its deepest gratitude for your invaluable contributions as a Governing Body Member and takes immense pride in your continued accomplishments. You are indeed a true leader and inspiration to the entire ICS fraternity.

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AN EDUCATIONAL INITIATIVE FOR POSTGRADUATES IN RESPIRATORY MEDICINE

Last Date Of Application 10 Oct Friday	Selected Candidates Will Be Informed By 15 Oct Wednesday	Date Of Contest 25 Oct Saturday
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JUDGES

Dr. Rakesh K. Chawla	Dr. Vishnu Sharma	Dr. Manoj Goel	Dr. Arun Madan
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Organizing Chairman
Dr. Rakesh K. Chawla

Organizing Secretary
Dr. Aditya K. Chawla
(98100 72880)

Joint Secretary
Dr. Ishan Thakkar
(93133 39243)

Categories of Competition

- Clinical Case Discussions
- Thoracic Images/Video Presentations (Bronchoscopy, Thoracoscopy, CXR, CT and USG image/video)

* NORTH ZONE *

INDIAN CHEST SOCIETY ORGANIZED BY
INDIAN CHEST SOCIETY, EAST ZONE

ICS NATIONAL TALENT SEARCH EAST ZONE 2025

AN EDUCATIONAL INITIATIVE FOR POSTGRADUATES IN RESPIRATORY MEDICINE

DATE
29-10-2025

VENUE
CMRI Hospital Auditorium

LAST DATE FOR RECEIVING PRESENTATIONS
15-10-2025

SELECTED CANDIDATES WILL BE INTIMATED BY
18-10-2025

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2025 ERS Travel Grant Winners & their Abstracts

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DR. ABIRAMI D.

05.02 - Monitoring airway disease

54119

Performance of DECAF and BAP 65 scores in assessment of acute exacerbation of chronic obstructive pulmonary disease

COPD - exacerbations, Education, Measurement properties

A. Dharmalingam¹, R. Gopal¹, M. Sivakumar¹, B. Jasmine Jawahar¹

¹Sri ramachandra institute of higher education and research - Chennai (India)

Introduction

Chronic obstructive pulmonary disease (COPD) is one of the leading causes of death worldwide, including in India. Various scoring systems have been proposed to assess the risk of clinical deterioration and mortality in patients with acute exacerbations of COPD (AECOPD).

Objective

This study aimed to compare the Dyspnea, Eosinopenia, Consolidation, Acidemia, and Atrial Fibrillation (DECAF) score and the Blood Urea Nitrogen, Age, and PaO₂ (BAP-65) score in predicting in-hospital mortality among patients with AECOPD.

Methods

A retrospective analysis was conducted on the medical records of consecutive patients with AECOPD admitted to the Pulmonology Department at Sri Ramachandra Medical College and Hospital, Porur, between January 2023 and January 2024.

Results

A total of 153 patients were included, with a mean age of 64 years. The majority were male (82%). The overall in-hospital mortality rate was 5.8% (n = 9). There was a statistically significant difference in DECAF and BAP-65 scores between survivors and non-survivors (p = 0.001). Both scores were significantly associated with the need for mechanical ventilation and ICU admission.

- The DECAF score demonstrated high sensitivity (100%) but low specificity (63%) for predicting mortality when using a cutoff of 2.

- The BAP-65 score showed a sensitivity of 89% and low specificity (30%) for mortality at a cutoff of 1.

Conclusion

Both DECAF and BAP-65 scores are useful predictors of in-hospital mortality and the need for mechanical ventilation in AECOPD patients. However, the DECAF score exhibited higher sensitivity, while the BAP-65 score had relatively lower specificity.

14/07/2025

1/2

DR. ANCHAL JAIN

10.02 - Tuberculosis and non-tuberculous mycobacterial diseases

52153

Cross-cultural reliability of Van Rie TB perceived stigma scale among TB survivors in North India

Psychosocial problems, Mental health, Primary care

A. Jain¹, A. Saha²

¹Positron Hospital - Rohtak (India), ²Andaman & Nicobar Islands Institute of Medical Sciences - Sri Vijaya Puram (India)

Background: Stigmatization of TB has an important influence on compliance with treatment and on health-seeking behavior. Stigma assessment, therefore, becomes mandatory considering the elimination of TB in India under NTEP. This study investigates the cross-cultural reliability of the Community Perspectives Van Rie TB Stigma Scale among TB survivors in North India.

Aims and Objectives: To establish the reliability of the Community Perspectives Van Rie TB Stigma Scale among TB patients in post-treatment scenarios. It was hypothesized to have a good degree of internal consistency for the Indian context.

Methods: A cross-sectional study of 400 TB patients within the Rohtak district of Haryana was done using random sampling from the NIKSHAY database. Participants' data was collected using the Van Rie TB Stigma Scale with 11 items, graded 0-3. Reliability was established using Cronbach's Alpha and McDonald's Omega.

Results: The sample had an overall male representation of 64.3% among the mean age of 38.6 years. The Cronbach's Alpha (0.826) and McDonald's Omega (0.832) indices indicate good reliability of the instrument. High stigma because of social exclusion items was 'Item 11: 58.3%, Item 10: 53.3%'. The item-wise variation was within the limit-based reliability.

Conclusion: The Community Perspectives Van Rie TB Stigma Scale is reliable for use as a stigma screening tool and for programmatic assessment in TB elimination strategies of India.

10/06/2025

1/1

DR. ANKITA MOHANTY

05.03 - Allergy and immunology

50049

Observational Study on Dietary Intake Differences in Asthma Patients vs. Healthy Controls

Allergy, Asthma - management

A. Mohanty¹, N. Gupta¹, M. Madan¹, R. Kumar¹, P. Ish¹

¹Vmmc and Safdarjung hospital - Delhi (India)

Introduction: Asthma is influenced by environmental and lifestyle factors, including diet. While epidemiological studies have suggested links between dietary habits and asthma risk, there is limited research on how dietary patterns impact asthma management.

Methods: This observational study aimed to evaluate dietary patterns and their association with asthma in adults attending the outpatient department at VMMC and Safdarjung Hospital, New Delhi. The study excluded pediatric participants. A structured questionnaire was used to collect dietary data. The controls were characterized by normal lung function and the absence of respiratory symptoms. Chi-square and independent t-tests were employed for statistical comparisons. **Results:** The case control study consecutively enrolled 346 asthma patients and 276 healthy controls. The asthma groups were significantly older than the control group ($p < 0.001$). Analysis revealed that individuals with asthma consumed fewer varieties of foods, such as salads, fruits, bread, rice, dairy, ghee, sweets, nuts, and certain meats ($p < 0.05$). In contrast, there were no significant differences in the intake of vegetables, pulses, refined oil, salted snacks, or eggs. Asthma patients showed a higher consumption of other oils and vitamin supplements ($p < 0.05$). Gender analysis indicated that females constituted 55.5% of the asthma group compared to 31.9% of the controls ($p < 0.001$). The study also identified that consumption of dairy, bread, rice, and sweets was associated with symptom exacerbation in asthma patients.

Conclusion: These findings highlight the need for dietary modifications as part of comprehensive asthma management strategies.

18/06/2025

1/1

DR. JOHN MUCHAHARY

14.01 - Interventional pulmonology

55527

Radial endobronchial ultrasound for the diagnosis of peripheral pulmonary lesions: First study from North East India

Bronchoscopy, Diagnosis, Lung cancer - diagnosis

J. Muchahary¹, V. N. Nongpiur¹, P. Kalita¹, N. Gogoi¹

¹North Eastern Indira Gandhi Regional Institute of health and Medical Sciences - Shillong (India)

Background

Tissue diagnosis of an invisible peripheral lung lesions is quite challenging. With the advent of radial probe endobronchial ultrasound (R-EBUS) it offers a safer approach in evaluation and sampling of periphery pulmonary lesions.

Objective

To analyse the yield of radial probe endobronchial ultrasound (R-EBUS) in the diagnosis of peripheral pulmonary lesions.

Methods

This was a retrospective analysis over a period of one year between February 2023 to February 2024 where bronchoscopically invisible peripheral pulmonary lesions were included. R-EBUS was used to localize and sample the lesion and the yields were analysed.

Results

Of 50 patients, 70% were male and 30% were female. The mean age was 58.18 years. The most common histological diagnosis was malignancy (44%) followed by chronic inflammatory cells (12%) and granuloma (10%). Right upper lobe lesions were most common (n=18, 36%) followed by left upper lobe (n=10, 20%). 58% lesions in the study were >3cm in size while true Solitary Pulmonary nodules (SPNs) defined as ≤3cm were 42%. The diagnostic yield was 72%.

Conclusion

Radial probe EBUS guided transbronchial lung biopsy can safely be used in producing a satisfactory diagnostic yield of peripheral pulmonary lesions.

15/07/2025

1/2

DR. PRANAY SAI CHANDRAGIRI

14.01 - Interventional pulmonology

55484

Augmenting diagnostic yield of EBUS with combination of transbronchial mediastinal cryobiopsy (TMC) and transbronchial needle aspiration (TBNA)

Experimental approaches

C. Pranay sai¹, K. Madan¹, A. Mohan¹, V. Hadda¹, S. Mittal¹, P. Tiwari¹, A. Nambirajan¹, A. Bhalla¹

¹All India Institute of medical sciences - Delhi (India)

This prospective observational study demonstrates the incremental diagnostic yield of a combined EBUS TBNA and TMC in patients with mediastinal lymphadenopathy.

Patients aged ≥ 18 years undergoing EBUS TBNA were included. The primary objective was to find the incremental diagnostic yield of a combined EBUS TBNA and TMC. A 1.1mm cryoprobe was used to obtain a cryobiopsy through the tract of EBUS TBNA needle of 22G (11.5%), 21G (84.6%), 19G (0.03%) or an electrocautery needle knife incision (28.8%) if needed.

Cryobiopsy could be obtained with a freeze time of 4-6 seconds in 37 patients and was unsuccessful in obtaining any tissue in 15 patients. A combined procedure had a higher diagnostic yield (83.7%) compared with EBUS TBNA alone or EBUS TMC alone (70.2% and 75.6% respectively). Other biopsy procedures performed [transbronchial lung biopsy (TBLB) and/or endobronchial biopsy (EBBx)] in addition to the EBUS procedure have also increased the diagnostic yield (86.4%). In those 15 patients where cryobiopsy was unsuccessful, EBUS TBNA was diagnostic in 7 (47%) patients. The incremental diagnostic yield was 13.5% though not statistically significant ($p=0.134$). Minor bleeding was the only complication encountered.

EBUS TMC can increase the diagnostic yield of EBUS TBNA when combined. EBUS TBNA remains a strong diagnostic tool in our arsenal and is here to stay. More research is warranted to use EBUS TMC as a stand-alone procedure.

27/02/2025 1/1

DR. RISHAB RAMPRADEEP

14.03 - Ultrasound

49763

Development and validation of a novel sonographic scoring system to differentiate exudative and transudative pleural effusions-The TELL score

Pleura, Diagnosis

R. Rampradeep[†], G. Vadivelu[†]

[†]Saveetha Institute of Medical and Technical Sciences - Chennai (India)

Introduction

Classifying pleural effusions is crucial for treatment. This study explores a novel ultrasound-based scoring system as a simple, non-invasive means to enhance diagnosis of pleural effusions.

Methods

In this prospective study of 74 patients, pleural effusions were categorized by clinical diagnosis. Thoracic ultrasound assessed pleural thickening (≥ 3 mm), fluid echogenicity (anechoic or echogenic), laterality and loculations-TELL. Each positive finding contributed one point to a 4-point sonographic score (TELL score). Diagnostic performance was compared to Light's criteria in terms of sensitivity and specificity.

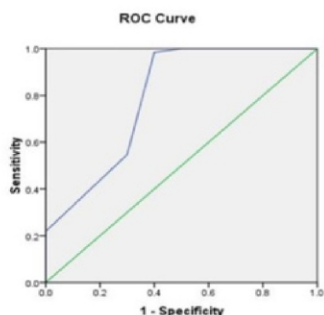
Results

The sonographic TELL scoring system correlated significantly with exudative effusions, achieving a sensitivity of 98.4% and a specificity of 40%, positive predictive value of 62% and negative predictive value of 94%.

Conclusions

With a sensitivity of 98.4%, the TELL score offers strong diagnostic value but shows overlap between effusion types, as reflected by its specificity of 40%. High scores suggest exudative effusions, though specific etiologies require additional biochemical data. Ultrasound features like loculations and pleural thickening strongly correlate with exudative effusions, making the system especially useful in resource-limited settings.

Area under Curve	Cut off Value	Sensitivity%	Specificity%	Significance
0.791	1.5	98.4	40	0.003



DR. SHARVARY RATHOD

05.01 - Airway pharmacology and treatment

54832

Exploring the Challenges of Managing Difficult-to-Treat Asthma: A Questionnaire-Based Approach

Asthma - mechanism, Diagnosis, Allergy

S. Rathod¹, P. Ghadage¹, T. Kulkarni¹, A. Dalal¹

¹Jupiter Hospital - Thane (India)

Introduction: Difficult-to-treat asthma (DTA) presents a major clinical challenge, with persistent symptoms despite optimal therapy. This study aims to identify key factors contributing to DTA to enhance management strategies and patient outcomes through a semi-structured interview-based approach.

Methods: A one-year ongoing observational study is being conducted in a tertiary care Pulmonary Medicine Department. 78 patients with poorly controlled asthma were recruited and assessed through a semi-structured questionnaire based interview and detailed Asthma Counseling Program. Data from routine outpatient and inpatient visits were analyzed, with a focus on patients with poor asthma control despite guideline-directed management.

Results: The study identified key factors impacting asthma control, including comorbidities (37%), with allergic rhinitis (55%) and GERD (15%) being the most common. Multiple triggers, such as stress and indoor pollution, affected 87% of patients. Poor adherence (43%) and incorrect inhaler technique (57%) further contributed to inadequate control. Spirometry was not performed in 61% of cases, limiting objective assessment. GINA classification placed 46% in step 3 (moderate asthma) and 32% in steps 4 and 5, requiring high-dose therapy.

Conclusion: Environmental triggers & incorrect inhaler techniques were major contributors to poor asthma control. Patient education on environmental measures and proper inhaler use significantly improved symptom control and quality of life. A comprehensive, patient-centered approach, including early diagnosis, targeted interventions, and regular follow-ups, is essential for optimizing asthma management and preventing disease progression.

DR. SHUBHAM AGARWAL

01.02 - Rehabilitation and chronic care

49613

Effect of a hybrid pulmonary rehabilitation programme on performance status in patients eligible for lung transplant

Physiotherapy care, Chronic diseases, Quality of life

S. Agarwal¹, A. Mohan¹, V. Rathi¹, K. Madan¹, V. Hadda¹, S. Mittal¹, P. Tiwari¹, T. Suri¹, R. Guleria¹, M. Hote¹, M. Sahu¹, S. Seth¹, A. Vij¹, S. Yadav¹, M. Khan¹

¹AIIMS - New Delhi (New Delhi) (India)

Introduction: Pulmonary rehabilitation (PR) in chronic respiratory diseases improves symptoms, quality of life, and exercise capacity and has an integral role in lung transplantation (LT). Virtual PR has recently emerged to cater to patients who otherwise may not have regular access to PR. However, little is known about effect of virtual PR strategies on candidates for LT.

Aims and objectives: Primary objective was to study effect of a protocolised hybrid PR programme on performance status using Karnofsky Performance Status (KPS) score. Secondary objectives were ECOG status, quality of life, symptom severity, sarcopenia, spirometry (PFT and DLCO), six-minute walk distance, and eligibility for LT waitlisting.

Methods: Prospective, single arm, interventional study on patients with end-stage lung disease, meeting referral criteria for LT. A protocolised 12-week hybrid hospital and home-based virtual PR intervention was conducted, and all outcomes were assessed at baseline, and within 1 month of completion of the intervention.

Results: 75 patients were enrolled, and intervention completed by 51 patients (68%). 35 patients met LT listing criteria, 27 being "unfit" for LT at baseline, 18 of whom completed the intervention. Significant improvement seen in KPS, ECOG, SGRQ score, visual analogue scale (VAS) score for cough and dyspnoea, and sarcopenia for all 51 patients. Of the 18 patients unfit for waitlisting, 12 became fit, and 7 were waitlisted for LT.

Conclusion: Patients eligible for LT benefit from a hybrid PR programme, with improvement in KPS, quality of life and sarcopenia, and eligibility for LT waitlisting.

30/06/2025

1/1

DR. SOUMYA KANTI GHATAK

05.02 - Monitoring airway disease

54136

Mortality in patients with COPD post-hospitalization for AECOPD: a tertiary care experience from Mumbai, India

COPD - exacerbations, Exacerbation, Airway management

S. K. Ghatak¹, Z. F. Udwadia¹, R. Banka¹, J. Mullerpattan¹, L. M. Pinto¹

¹P.D Hinduja Hospital, Mumbai, India - mumbai (India)

Aims: Chronic obstructive pulmonary Disease (COPD) is the 2nd leading cause of death in India. Acute exacerbations of COPD (AECOPD) are associated with lung function decline, morbidity and death.

Methods: P.D.Hinduja hospital is a tertiary care centre in Mumbai,India.Patients hospitalized from July '19-July '23 with a diagnostic ICD-10 code of J44.9 (AECOPD) were included.Telephonic interviews were conducted with consenting patients/caregivers.Mortality was calculated, and predictors were analyzed.

Results: 265 participants were included. 155(58.5%) were male.227(85.6%) were older than 60 years. 133 (50.18%) had expired at the time of the interview.Mortality post-hospitalization for AECOPD was 20.7 deaths/100 person-years (Fig.1).Demographic predictors of mortality included smoking (p=0.026),age >65 years (p=0.0001) and presence of pulmonary hypertension(p=0.0415). Severity of AECOPD was a strong predictor of mortality; usage of NIV during hospital stay or after discharge(p=0.0001), type 2 respiratory failure(p=0.045), admission to the ICU(p=0.0001), and Decaf score (p=0.0001) were strong predictors of mortality.

Conclusion:Hospitalization for AECOPD is a strong predictor for mortality in the next 3-5 years, especially when the AECOPD is severe.Patients at a high risk of death need close follow-up and monitoring, and early palliative care intervention when appropriate.

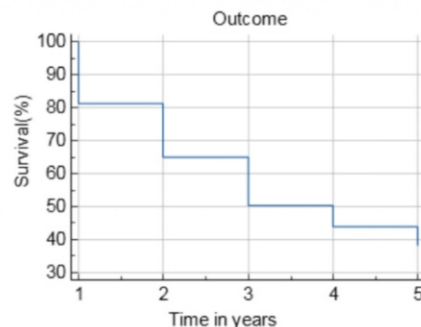


Fig.1 Cumulative Survival post-hospitalization for AECOPD

DR. YASH KEDIA

05.02 - Monitoring airway disease

52483

Diaphragm Excursion Evaluated on Ultrasound Can Predict Risk of Exacerbations in Chronic Obstructive Pulmonary Disease Patients

COPD - exacerbations, Monitoring, Measurement properties

Y. Kedia¹, N. K. Gupta¹, R. Kumar¹, N. Gupta², P. Ish¹, R. Kaushik¹, T. Talukdar¹, N. Chandra¹

¹VMMC & Safdarjung Hospital - New Delhi (India), ²VMaVMMC & Safdarjung HospitalMC & Safdarung Hospital - New Delhi (India)

Background: Ultrasonography (USG) diaphragmatic excursion (DE) and diaphragmatic thickness fraction (DTF) have been identified as useful indicators of diaphragmatic dysfunction in COPD. Patients with COPD have a lower DE than healthy individuals and it further reduces during exacerbation.

Aim: The study aimed to evaluate the correlation of DE and DTF with number and severity of exacerbations over a 6-month period follow up period.

Methods: 64 COPD patients were enrolled. Baseline DE and DTF were recorded. Patients were followed for 6 months to document the number and severity of exacerbations.

Results: 59 patients completed the 6-month follow-up (76% males; mean CAT score: 16.89 ± 5.70 ; mean FEV1%: $49.97 \pm 9.64\%$; mean 6MWD: 333.18 ± 56.80 m; GOLD Group A: 9 patients, Group B: 25 patients, Group E: 25 patients). The mean DE was 4.17 ± 0.63 cm, and the mean DTF was $35.18 \pm 4.40\%$. 72 exacerbations were recorded during follow-up. DE had a significant negative correlation with the number of exacerbations ($r = -0.43$, $p = 0.001$), whereas DTF did not show significant co-relation ($r = -0.19$, $p = 0.14$). DE also correlated significantly with CAT score ($r = -0.36$, $p = 0.004$) and post-bronchodilator FEV1% ($r = 0.45$, $p = 0.0003$). ROC analysis indicated that a DE <4.45 cm was associated with a higher risk of moderate to severe exacerbations (AUC: 0.66, Sensitivity: 93.1%, Specificity: 46.7%).

Conclusion: DE can predict the risk of future exacerbations in COPD patients. DE showed a significant correlation with both exacerbation risk and disease severity, highlighting its potential role as a predictive tool in COPD management.

13/06/2025

1/1

Reinstatement of Respiratory Medicine Department in MBBS

“A specialty that saves lives cannot be erased by silence.”



Dr. Rajesh Swarnakar

Treasurer
Indian Chest Society

The recent marginalisation of Respiratory Medicine from the undergraduate framework is not a curricular adjustment - it is a direct blow to the visibility, dignity and essentiality of one of India's most clinically crucial medical specialties. Respiratory Medicine carries the burden of the country's most widespread diseases - TB, COPD, pneumonia, asthma, occupational lung disease, post-COVID sequelae, sleep disordered breathing - yet it is the very specialty pushed into the background in the name of “integration.” What has happened is not integration - it is erasure disguised as reform.

Respiratory Medicine is not a theoretical domain; it is frontline medicine. It is the specialty that holds the patient when oxygen saturation is dropping, when ARDS is worsening, when a wheezing child is gasping, when a post-TB lung is failing, when ventilatory support becomes the line between survival and collapse. Without structured exposure to Respiratory Medicine, no MBBS graduate can claim clinical readiness in a country where lung disease is the most common cause of admissions after fever.

PMR and Emergency Medicine, too, have been sidelined in the same sweep - but Respiratory Medicine carries an even heavier public health responsibility. When a specialty that anchors the nation's TB elimination programme and critical respiratory care is pushed into invisibility, it is not a curriculum change - it is an undermining of national health priorities. If Respiratory Medicine is weakened at the foundational level of MBBS training, the system weakens from its roots.

The manner of exclusion is as concerning as the exclusion itself.

No consultation with subject experts.

No dialogue with teaching faculty.

No justification based on disease burden.

No educational rationale linked to competencies.

No public health reasoning.

It was done quietly, without transparency, and without the participation of the very specialists who shoulder the responsibility of respiratory care in India.

When a specialty is removed without consultation, recognition is not the only thing lost - accountability, mentorship, structured skill-building, and academic identity are also lost. Without explicit departmental presence, competencies are assumed rather than nurtured. Assessment becomes superficial. Expertise becomes invisible. The next generation enters practice with dilution, not depth.

This is not an academic inconvenience - this is an **institutional displacement** of a specialty that is central to clinical outcomes. It weakens the pipeline of future specialists and reduces respiratory care to a footnote instead of a foundation.

And yet - this issue is not only about injustice. It is about what must follow next.

This is the moment where silence becomes complicity. If we remain passive, the erasure becomes precedent. If we stand up collectively, restoration becomes inevitable.

The strength of Respiratory Medicine has never been in paperwork - it has always been in patient bedsides, oxygen bays, bronchoscopy suites, HDUs, NIV units, community TB clinics, and critical procedures that change prognosis in minutes. The heartbeat of this specialty is clinical reality, not administrative classification.

But clinical necessity must now translate into **collective voice**.

We must stand together - not as isolated colleges, or as individual faculty members but as a united fraternity. The message must be clear: Respiratory Medicine is indispensable to medical training and cannot be relegated to anonymity by administrative drafting.

The Fight Ahead :

The Indian Chest Society, led by Dr. Sundeep Salvi and Dr. Raja Dhar, filed a case in the High Court, which I represented as Dr. Rajesh Swarnakar, and we recently provided our final response. We are very hopeful that the concerned jury will hear us well and find a solution to this predicament. I am grateful to Prof. Radha Munje, Prof. Dr. Gyan Mishra, Assistant Prof. Dr. P. Rajaraman, Dr. Neel Thakkar, Dr. Amita Nene, and many others for their contributions to the cause.

Our unity must express itself on multiple fronts :

- Academic solidarity between departments across states and institutions
- Collective professional positioning that Respiratory Medicine must be visible at the MBBS level
- National-level presence through conferences, scientific fora, and academic bodies
- Faculty-driven consensus building
- Unified messaging that this is not opposition - this is reclamation

We are not fighting for privilege.

We are not demanding favour.

We are defending rightful academic identity.

When three frontline specialties - Respiratory Medicine, PMR and Emergency Medicine - are simultaneously marginalised from undergraduate training, it signals a worrying pattern : that what is most clinically relevant can be made institutionally invisible.

That is why this moment demands unity more than grievance. The response must be strategic, organised, and unshakeable. We are not asking to be heard - we are **ensuring** that we cannot be sidelined again.

The reinstatement of Respiratory Medicine is not a request for inclusion.

It is a restoration of rightful presence.

It is a correction of course.

It is a reaffirmation that training must follow disease burden, not paperwork convenience.

India needs doctors who can ventilate, oxygenate, intubate, decompress, stabilise, and rescue lungs from the brink. Such competence cannot come from silence.

We stand together - as a fraternity with purpose, dignity and resolve.

We are not here to protest.

We are here to **reclaim**.

This is not the end of a specialty.

This is the beginning of its collective awakening.



Respire 2025



INDIAN CHEST SOCIETY

ICS ENDORSED EVENTS

SRI LANKA COLLEGE OF PULMONOLOGISTS

Respire 2025 - The 15th Annual Academic Sessions of the Sri Lanka College of Pulmonologists, as endorsed by the ICS, was held from 9th - 11th February 2025. The Conference was a resounding success. The participation for the main congress, pre and post congress workshops were excellent. The program was rich, varied and covered the key topics in respiratory medicine that was of key importance to this region.

The Faculty who flew in from different countries such as India, UK, Bangladesh, Singapore, Hong Kong and USA all praised the content structure and flow of the program. There was excellent feedback from the participants.

ICS SPIROMETRY WORKSHOP - KOLKATA



After a lengthy hiatus, the much loved ICS certified Spirometry Technician Training Course and workshop was conducted under the aegis of National Allergy Asthma Bronchitis Institute Kolkata at Lung Care Clinic Mogra , West Bengal on 29th and 30th March 2025.

30 technicians were educated on basic lung anatomy and physiology, and spirometry. The two day workshop encompassed all major topics including methods and manoeuvres of spirometry and indications, contraindications and interpretation.

The certified course allows respiratory technicians to be proficient and qualified in performing office and lab spirometry. This is a valuable skill in 2025, as air pollution and number of new cases of chronic respiratory illnesses are at an all time high. The course was well received by the participants. Esteemed local and outside faculty were generous with their time and expertise, and the participants gained a wealth of knowledge and skills!

CPET WORKSHOP CHENNAI



ICS endorsed the Cardio-Pulmonary Exercise Testing (CPET) Workshop held on 09th August 2025 at Medway Institute of Pulmonology, Chennai. The program saw the participation of 25 delegates from diverse disciplines—Pulmonology, Respiratory Therapy, Cardio-Pulmonary Physiotherapy, Physician Assistants, and Biomedical Engineering students from IIT Madras.

The day was enriched by:

- Engaging lectures that simplified complex physiology for clinical and research application.
- Hands-on sessions demonstrating CPET protocols, clinical interpretation, and patient-oriented decision-making.
- A unique cross-disciplinary exchange—biomedical students explored sensor technology and device functionality, while medical and paramedical participants had the understanding of clinical applications and interpretation.

ILD CaseQuest

The Indian Chest Society, in collaboration with Insignia Learning, brings you ILD CaseQuest – Supported by Glenmark.

ILD CaseQuest is a unique, digital learning initiative crafted exclusively for chest physicians. Every month, you will engage with two real-world ILD cases, apply your diagnostic instincts, and test your current skills, further unlocking the expert-led video insights that distil key clinical pearls. With 12 thought-provoking cases spread across the program, ILD CaseQuest is designed to sharpen your decision-making and help you see ILD management through the lens of top specialists. With integrated perspectives from pulmonology, radiology, and rheumatology, ILD CaseQuest empowers you to differentiate ILD subtypes, adopt multidisciplinary strategies, and approach patient care with confidence.



The poster features the ILD CaseQuest logo at the top left, with a stylized lung icon. To the right is a glowing blue lung graphic. The text 'Endorsed by ICS' is in the top right corner. The main body of the poster has a dark background with white and blue text. It asks 'Ready to put your diagnostic instincts to the test?' and 'Join in for an immersive, case-based challenge in ILD'. Below this are three circular icons: 'Solve real patient scenarios' (with a brain icon), 'Sharpen your clinical judgement' (with a target icon), and 'Watch the experts crack the case' (with a group of people icon). A large 'REGISTER TODAY' button is in the center, with 'Visit- www.ildcasequest.com' below it. At the bottom, it says 'Improve your ILD approach – One case at a time!' and includes logos for Glenmark and ICS. Fine print at the very bottom mentions copyright and disclaimer.

We warmly invite you to be part of this initiative and join a community of physicians committed to redefining ILD management.

The cases are live—log in, explore, and experience the difference today!

Visit:

<https://ildcasequest.com/>

Glenmark Training & Certification Course

Glenmark's Shwas 2 Division collaborated with the Indian Chest Society (ICS) to enhance the skills of their sales team through a series of virtual training sessions conducted by Dr. Raja Dhar, a renowned pulmonologist of India.

The program focused on practical aspects of respiratory care, including:

- Correct use of the Peak Flow Meter
- Application of the CAT Questionnaire in patient assessment
- Demonstration and differentiation of MDI, DPI, and Nebulizer techniques

The sessions were highly insightful, equipping their team with hands-on knowledge and confidence to engage meaningfully with healthcare professionals.

The initiative concluded with a certification from ICS, marking a significant step in our journey to strengthen scientific excellence and customer engagement.

ILD SYMPOSIUM PUNE



The ILD Symposium was attended by 43 doctors from Pune. The event featured highly engaging and insightful discussion on ILD and PAH management. The highlight of the meeting was an enriching exchange of real world experiences and practical perspectives shared by the speakers, focusing on the evolving landscape of ILD and PAH treatment.

The Symposium was moderated by Dr. Nitin Abhyankar and the Speakers were Dr. Lakshmikant Yenge, Dr. Vrushali Khadke, Dr. Prashant Mishra and Dr. Nachiket Kulkarni.

Key topics covered were:

- * Antifibrotics in Pulmonary Fibrosis
- * CHP & Immunosuppressants
- * PAH Management
- * CTD-ILD Insights

This session significantly strengthened the impact of ILD and PH enhancing scientific engagement and therapeutic positioning.

INDIAN SOCIETY FOR HEART & LUNG TRANSPLANTATION (INSHLT) 2025 CONFERENCE



- The conference was inaugurated by the Hon'ble Speaker of the Indian Parliament, Shri Om Birla Ji.
- The joint symposium in between Indian and international society of heart and lung transplantation (ISHLT-INSHLT) was a major highlight, received overwhelming appreciation from all the delegates and faculties.
- Two parallel scientific halls run throughout the three days — one dedicated to Heart Transplantation and the other to Lung Transplantation.
- A third hall hosted focused sessions on ECMO, Transplant Infectious Diseases, along with dedicated discussions on Pulmonary Arterial Hypertension, Transplant Immunology, and a live demonstration of LVAD implantation.
- The event witnessed participation from over 500 delegates representing diverse specialties from India and abroad, both physically and virtually.

Beyond the Travel Grant: Our Scholars' Experience

DR MUNIZA BAI

TITLE OF YOUR WORK/RESEARCH PRESENTED –

HIGH FLOW NASAL OXYGEN THERAPY VERSUS NON-INVASIVE VENTILATION FOR PREVENTION OF RE INTUBATION IN PATIENTS WITH HYPEROPIA AT EXTUBATION - A RANDOMISED CONTROLLED TRIAL (HYPERHOT NIV TRIAL), RESULTS FROM AN INTERIM ANALYSIS

INTERNATIONAL CONGRESS ATTENDED – AMERICAN THORACIC SOCIETY SAN FRANCISCO

YEAR OF RECEIVING THE GRANT – 2025

WAS THIS YOUR FIRST TIME PRESENTING AT AN INTERNATIONAL CONGRESS? –
NO

TO WHAT EXTENT DID THE GRANT SUPPORT YOU IN ATTENDING THE CONGRESS? – COVERED MY ACCOMMODATION EXPENSE

HOW WAS THE EXPERIENCE PRESENTING YOUR WORK INTERNATIONALLY? MEMORABLE EXPERIENCE. I GOT TO DISCUSS MY IDEAS AND WORK WITH PEOPLE ON A GLOBAL STAGE

DID YOU FACE ANY CHALLENGES IN THE APPLICATION OR REIMBURSEMENT PROCESS? NOT MUCH

WHAT ADDITIONAL ACTIVITIES (MENTORSHIP, PRESENTATION SKILLS, WORKSHOPS, ETC.) WOULD YOU LIKE ICS TO CONDUCT? AI EDUCATION

DO YOU THINK THE ICS TRAVEL GRANTS ENCOURAGES YOUNG CHEST PHYSICIANS? YES



INDIAN CHEST SOCIETY

DR AKHIL PAUL

TITLE OF YOUR WORK/RESEARCH PRESENTED –

SETTING UP A MORE AFFORDABLE INDWELLING PLEURAL CATHETER INSERTION SET AND ITS PROCEDURAL APPLICATION IN RESOURCE LIMITED SETTINGS. PARTS, ASSEMBLING AND COST EFFECTIVENESS OF PAUL'S IPC SET.

INTERNATIONAL CONGRESS ATTENDED –
EUROPEAN RESPIRATORY CONGRESS

YEAR OF RECEIVING THE GRANT – 2024

WAS THIS YOUR FIRST TIME PRESENTING AT AN INTERNATIONAL CONGRESS? – NO

TO WHAT EXTENT DID THE GRANT SUPPORT YOU IN ATTENDING THE CONGRESS? –
VERY MUCH. THE GRANT COVERED ABOUT 1/3RD OF MY TOTAL EXPENSE. BUT MORE
THAN THAT, THE FEELING THAT OUR NATIONAL SOCIETY WAS SUPPORTING ME, WAS
ENCOURAGING.

HOW WAS THE EXPERIENCE PRESENTING YOUR WORK INTERNATIONALLY?
IT WAS AN EXPERIENCE WHICH BOOSTED THE CONFIDENCE.

DID YOU FACE ANY CHALLENGES IN THE APPLICATION OR REIMBURSEMENT PROCESS?
NO

WHAT ADDITIONAL ACTIVITIES (MENTORSHIP, PRESENTATION SKILLS, WORKSHOPS,
ETC.) WOULD YOU LIKE ICS TO CONDUCT? MENTORSHIP

DO YOU THINK THE ICS TRAVEL GRANTS ENCOURAGES YOUNG CHEST PHYSICIANS?
DEFINITELY



DR JONNALAGADDA V S ASWITH CHOWDARY

TITLE OF YOUR WORK/RESEARCH PRESENTED –

A VALIDATION STUDY EVALUATING COMMONLY USED MATHEMATICAL MODELS FOR ASSESSING THE RISK OF MALIGNANCY IN PULMONARY NODULES IN INDIA.

INTERNATIONAL CONGRESS ATTENDED –

IWLH 2025, LISBON PORTUGAL

YEAR OF RECEIVING THE GRANT – 2025

WAS THIS YOUR FIRST TIME PRESENTING AT AN INTERNATIONAL CONGRESS? – NO

TO WHAT EXTENT DID THE GRANT SUPPORT YOU IN ATTENDING THE CONGRESS? – IT COULD PARTIALLY SUPPORT TRAVEL ALONE.

HOW WAS THE EXPERIENCE PRESENTING YOUR WORK INTERNATIONALLY?
VERY GOOD.

DID YOU FACE ANY CHALLENGES IN THE APPLICATION OR REIMBURSEMENT PROCESS?
SLOW RESPONSE, AND I GOT ACCEPTANCE ON THE DAY OF TRAVEL. QUICKER RESPONSE TIME WOULD BE BETTER. OVERALL ICS TEAM WAS VERY SUPPORTIVE.

WHAT ADDITIONAL ACTIVITIES (MENTORSHIP, PRESENTATION SKILLS, WORKSHOPS, ETC.) WOULD YOU LIKE ICS TO CONDUCT?
WORKSHOPS AND MENTORSHIP.

DO YOU THINK THE ICS TRAVEL GRANTS ENCOURAGES YOUNG CHEST PHYSICIANS?
YES, BUT TOTAL VALUE NEEDS REVISION DUE TO RISING COSTS



DR KARMAY SHAH

TITLE OF YOUR WORK/RESEARCH PRESENTED –

THE TUBERCULOSIS-CANCER CONUNDRUM – EXPERIENCE OF 1000 PATIENTS AT A TERTIARY CANCER CENTRE.

INTERNATIONAL CONGRESS ATTENDED –

ERS CONGRESS 2024

YEAR OF RECEIVING THE GRANT – 2024

WAS THIS YOUR FIRST TIME PRESENTING AT AN INTERNATIONAL CONGRESS? – YES

TO WHAT EXTENT DID THE GRANT SUPPORT YOU IN ATTENDING THE CONGRESS? – HELPED PAY FOR MY REGISTRATION AND TRAVEL.

HOW WAS THE EXPERIENCE PRESENTING YOUR WORK INTERNATIONALLY?

OPENED UP NEW PERSPECTIVES IN LEVEL OF PULMONARY MEDICINE BEING PRACTICED WORLDWIDE. MADE ME CONFIDENT TO PRESENT INDIAN DATA ON A GLOBAL PLATFORM.

DID YOU FACE ANY CHALLENGES IN THE APPLICATION OR REIMBURSEMENT PROCESS?

NO

WHAT ADDITIONAL ACTIVITIES (MENTORSHIP, PRESENTATION SKILLS, WORKSHOPS, ETC.) WOULD YOU LIKE ICS TO CONDUCT?

CONTINUE CURRENT ACTIVITIES.

DO YOU THINK THE ICS TRAVEL GRANTS ENCOURAGES YOUNG CHEST PHYSICIANS?

YES



ICS Webinars

Sr. No.	Webinar Topic	Date	YouTube Links
1	Novel Strategies to improve ARDS Survival	6th December 2023	
2	Targetting the unknown Enemy, Newer Antibiotics & Multiplex PCRR	13th December 2023	https://youtu.be/R4bZzj_7RxA
3	Hypersensitivity Pneumonitis	27th December 2023	https://youtu.be/lrLMW50FfCI
4	Mechanical Ventilation - Tips and Tricks	10th January 2024	https://youtu.be/7fydYzxW9Mw
5	ABPA - State of the Art	17th January 2024	https://youtu.be/N3Ma5IIYPtE
6	MTS-ICS Asthma	20th January 2024	
7	Mechanical Ventilation - Ventilatory Graphs and Troubleshooting	24th January 2024	https://youtu.be/maFM9ZJJzkQ
8	Sarcoidosis - The Great Mimic	31st January 2024	https://youtu.be/_tlxbok-9M
9	Pulmonary Embolism - The Silent Killer	7th February 2024	https://youtu.be/_pF6dfeEJiw
10	Masterclass on Lung Oscillometry	14th February 2024	https://youtu.be/1jYissi3Vxl
11	Idiopathic Pulmonary Fibrosis	21st February 2024	https://youtu.be/ql-StO5_RFM
12	Ventilator Weaning	28th February 2024	https://youtu.be/7UNjOyKLX90
13	TOPD - the Unknown Enemy	13th March 2024	https://youtu.be/UxckTDB5g1k
14	Expanding Diagnostic horizons in TB and viral infections	20th March 2024	https://youtu.be/g76aDFqPmwQ
15	TB Diagnostics - State of the Art	22nd March 2024	https://youtu.be/78naE6p00_4
16	Tracheostomy - Improving the Outcomes	27th March 2024	https://youtu.be/EWUWtA6oIOk
17	Imaging in Airways - All that you need to know	29th March 2024	https://youtu.be/fnnfeSVwy8E
18	NSIP & OP - The Best Approach	03rd April 2024	https://youtu.be/MOMNrtPhNIg
19	Non-invasive Ventilation - Tips & Tricks	10th April 2024	https://youtu.be/i-Fz0vngS9k
20	Bronchiectasis - No Longer an Orphan Disease	17th April 2024	https://youtu.be/1cArdtCdn4g
21	MGIT-DST TB Guardianship Certification Program	24th April 2024	https://youtu.be/FyIb-xhLsQM

22	CTD-ILD All that you need to know	8th May 2024	https://youtu.be/L1GkvSyrNms
23	Difficult to treat Asthma - The Best Approach	15th May 2024	https://youtu.be/rQ6qND164yo
24	TB Guardianship Certification Program - Navigating Complexity : Special Cases in TB Diagnosis and Management	5th June 2024	https://youtu.be/oK9AfQGhEmY
25	Occupational ILD & Drug Induced ILD - The Best Approach	12th June 2024	https://youtu.be/_xyPg5Ej-cM
26	True Severe Asthma - Diagnosis and Treatment Options	19th June 2024	https://youtu.be/79o71fLRtpk
27	Thoracic Ultrasound Masterclass	26th June 2024	https://youtu.be/HfuFNxEYoIQ
28	Tech it Easy - Digital innovations in Lung Health Management	03rd July 2024	https://youtu.be/gOCBMHFI8Fc
29	Oxygen Therapy - From A to Z	10th July 2024	https://youtu.be/zlxfP3ztj2c
30	COPD Management in 2024 - State of the Art	17th July 2024	https://youtu.be/X9K_x39bXIA
31	Progressive Pulmonary Fibrosis - The Best Approach	24th July 2024	https://youtu.be/1NoFPfUkxag
32	Ventilator Associated Pneumonia - Improving the Outcomes	31st July 2024	https://youtu.be/521P3t7f5Eg
33	Asthma COPD Overlap - All That You Need To Know	14th August 2024	https://youtu.be/EB--w2ORPFs
34	Shingles Prevention in COPD & Asthma	21st August 2024	https://youtu.be/aujT4NKmUNI
35	AIP, LIP, DIP, RD-ILD & PPFE from A to Z	28th August 2024	https://youtu.be/uhlxPSSPpK0
36	Newer Concepts in COPD Management	03rd September 2024	https://youtu.be/7oBUKw04v-U
37	Phenotyping Bronchiectasis - Revolutionizing Management	18th September 2024	https://youtu.be/XFTLdOQ1Id4
38	Cystic ILDs: The Best Approach	25th September 2024	https://youtu.be/KjbS8ZGRgYs
39	Viral Pneumonias and Complications	09th October 2024	https://youtu.be/ZDTSSfzXGQc
40	COPD and the Heart - the Notorious Nexus	16th October 2024	https://youtu.be/wlvHTxihccY

41	Lung Transplant - All That You Need To Know	27th November 2024	https://youtu.be/ZDMzfb7qXqc
42	COPD GOLD 2025 - What You Need To Know	4th December 2024	https://youtu.be/kSLhv5zPPfM
43	Fungal Infections in ICU	11th December 2024	https://youtu.be/yGUdDGPd7Ko
44	Single Inhaler Triple Therapy : The Best Way Forward	18th December 2024	https://youtu.be/lkN8EWmC_PM
45	Approach to a patient with ILD	26th February 2025	https://youtu.be/IHNkOKpDhnc
46	ARDS in 2025 - What is New	12th March 2025	https://youtu.be/am3udyln8B0
47	RA ILD - From A-Z	19th March 2025	https://youtu.be/34-rwYhpwVs
48	Progressive Pulmonary Fibrosis - The Best Approach	26th March 2025	https://youtu.be/rldqVYxw9ys
49	Management of DRTB	28th March 2025	https://youtu.be/feRRKJM2LXk
50	ABPA - From A-Z	14th May 2025	https://youtu.be/Ttc80NKK8So
51	ICS Sleep Certification Course : Module 1-Sleep Physiology and Approach to Sleep Disordered Breathing	21st May 2025	https://youtu.be/_LRMqVV2xOg
52	ICS Sleep Certification Course : Module 2-Clinical Features and Systemic Manifestations of OSA	28th May 2025	https://youtu.be/nlVVLJPo15s
53	Smoking, Vaping and the Lungs	4th June 2025	https://youtu.be/v4m1CqZdD94
54	ICS Sleep Certification Course : Module 3-OSA Diagnosis - Questionnaires, Sleep Studies and Beyond	11th June 2025	https://youtu.be/BrY_nOgmMAA
55	Pulmonology Forum - 1	15th June 2025	
56	ICS Sleep Certification Course : Module 4-Management of OSA with PAP and non-PAP Therapy	18th June 2025	https://youtu.be/Hta0LF0x5-Y
57	ICS Sleep Certification Course : Module 5-UARS, CSA, OHS - From A to Z	2nd July 2025	https://youtu.be/gethoB70t4Y
58	ICS Sleep Certification Course : Module 6-Hypersomnia and EDS-Approach and Management	9th July 2025	https://youtu.be/Amg8pxjRg3M
59	Pulmonology Forum	16th July 2025	
60	ICS Sleep Certification Course : Module 7-Parasomnia The Fascinating world of Sleep	23rd July 2025	https://youtu.be/t9DjwyWdB7E

61	ICS Sleep Certification Course : Module 8-RLS and PLMS - From A to Z	30th July 2025	https://youtu.be/d0wohcox2Ew
62	ICS Sleep Certification Course : Module 9-Impact of Sleep Disorder on Respiratory & Pediatric Diseases	13th August 2025	https://youtu.be/EIDsnA7sCvg
63	ICS Sleep Certification Course : Module 10-PAP Devices, OSA Patient Follow-up, Sleep Lab Setup	20th August 2025	https://youtu.be/h-UxvgVcp4I
64	Progressive Pulmonary Fibrosis - The Best Approach	3rd September 2025	https://youtu.be/XRDISq7RO08
65	Pulmonology Forum	24th September 2025	
66	Pulmonology Forum	11th October 2025	
67	Biologics in Asthma - The Real Game Changer	15th October 2025	https://youtu.be/MRXdlrwCPKk



ICS Travel Grants Calender

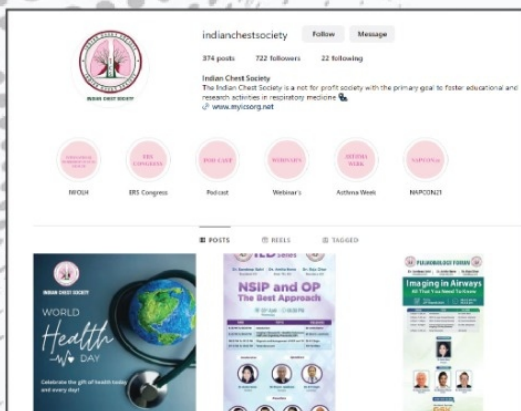
Sr. No.	Type of Conference	No. of Grants	Amounts Sanctioned	Last date for Receiving Applications (Every Year)	Results on or Before (Every Year)	Documents Required
1	ATS USA	TWO	Rs. 1,00,000/-	15th FEB	28th FEB	Before - 1. Acceptance Certificate from ATS 2. Resume 3. Covering letter signed by the HOD 4. Age Proof
						After - 1. Certificate of Attendance 2. Poster/Paper Presentation Letter from ATS 3. Receipt of travel tickets
2	ERS EUROPE	SEVEN	Rs. 75,000/-	15th JUNE	30th JUNE	Before - 1. ERS Application 2. Application forwarded by HOD 3. Resume 4. Selection Letter from ERS 5. Age Proof
						After - 1. Certificate of Attendance 2. Poster/Paper Presentation Letter from ERS EUROPE 3. Receipt of travel tickets
3	CHEST ACCP USA	TWO	Rs. 1,00,000/-	30th JUNE	15th JULY	Before - 1. CHEST ACCP Application 2. Application forwarded by HOD 3. Resume 4. Selection Letter from ACCP 5. Age Proof
						After - 1. Certificate of Attendance 2. Poster/Paper Presentation Letter from CHEST ACCP USA 3. Receipt of travel tickets
4	International Workshop on Lung Health	TWO	Rs. 75,000/-	15th November	15th December	Before - 1. IWLH Application 2. Application forwarded by HOD 3. Resume 4. Selection Letter from IWLH 5. Age Proof
						After - 1. Certificate of Attendance 2. Poster/Paper Presentation Letter from IWLH 3. Receipt of travel tickets

*Please note that dates of submitting applications may vary due to unprecedented times.

*Keep in touch with us at icsofficeexecutive@gmail.com.

ICS Social Media

ICS SOCIAL MEDIA



 / indianchestsociety

Posts : 420

Followers : 1080

Following : 21



 / Indian Chest Society

Posts : 374

Followers : 3.3K

Likes : 2.8K



 / ICSNagpur

Posts : 374

Followers : 657

Following : 105

Indian Chest Society Membership Benefits

1. Dual Membership of Indian Chest Society (ICS) and European Respiratory Society (ERS).
2. Access to online content on ERS website like Journals, Monographs, Breath Magazine, etc.
3. Receive lifelong printed copies of Lung India (An Indexed Publication) - six times a year.
4. Receive lifelong printed copies of Respire, the ICS Newsletter, three times a year.
5. A chance to get various ICS Travel Grants (ACCP, ERS, ATS), Short Term Fellowships and training, research Fellowships.
6. Discounted ICS Membership rates for CME / Conferences.
7. Discounted ICS Membership rates for ERS Conference.
8. Opportunity to participate in ICS research activities / Indian Registries for respiratory diseases and contribute to building robust data for the nation.
9. Participate in the ICS Kothari Young Researcher (PG) Award Session at NAPCON every year.
10. Can apply for the FIC - Fellowship of Indian Chest Society Awarded at Annual Conference.
11. Take part in the ICS Leadership Election conducted via e-voting.
12. Apply for various Awards, Fellowships, Orations given by the ICS at NAPCON.
13. Avail reduced registration fee for members at Annual ICS Conference.
14. Participate in the Annual General body and be a part of the decision making process of ICS.
15. Become a part of the electoral process of ICS e-voting rights to all life members.
16. Opportunity to become an office bearer of this prestigious society.
17. Enhancing knowledge by attending workshops and events under the ICS Banner

18. Association / Networking with Top Notch Doctors and Academicians in the field of Respiratory Industry.
19. Avail exclusive deals for ICS Members for International Conferences & other Medical Events.
20. ICS has exclusive tie up with Lung Health Organisation for travel grants, Rising Star programme and discount for their Lung Health Workshops.
21. Avail ICS-ERS Clinical and Research Fellowship ranging from 1-6 months.
22. Benefit of Short Term Fellowship in various Centre of Excellence within India in Interventional Pulmonology, Critical Care, Sleep Medicine, etc.
23. Ever increasing tie up with international societies with ACCP BTS on the anvil.

You can become our member online by going to www.myicsorg.net filling in your details and making an online payment. It's hassle free and gets completed in less than 5 mins. Go green and become an ICS member online today !!!

ICS Goals and Objectives

1. Promoting research and academic activities.
2. Organising periodic academic meetings and conferences at international, national, zonal and local level and to bring together periodically, the medical fraternity interested in Respiratory Medicine, at a common meeting point.
3. Organising periodic patient awareness and educational programmes to promote understanding about the important respiratory diseases.
4. To assist in creating technical manpower required to handle various diagnostic and therapeutic equipments related to Respiratory Medicine.
5. To assist in creating trained medical manpower required to handle various patient related activities.

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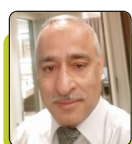
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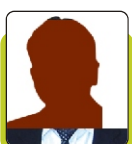
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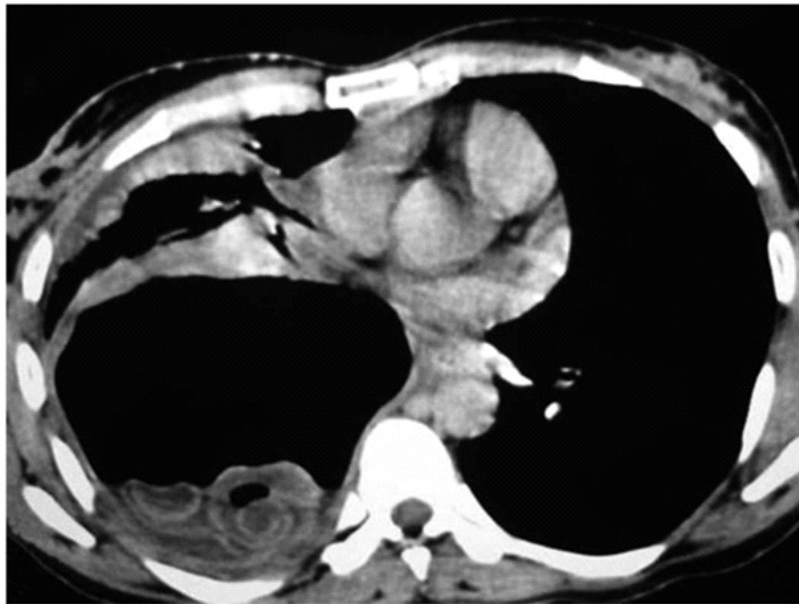
Dr. A. G. Ghoshal
Chairperson
Awards Committee
agghosal@yahoo.com

RESPIRE QUIZ

(September - December 2025)

Read this CT picture and answer the following -

- Q1. Name this CT sign
- Q2. Spot the diagnosis.
- Q3. What is the principal therapeutic approach for this condition?
- Q4. Name the most effective combination of drugs for this condition.



Please send correct answers to Dr. Neeraj Gupta
at E-mail : drneerajajmer@yahoo.com and cc to icsofficeexecutive@gmail.com
First three correct winners stand a chance to feature in the next issue of Respire Quiz Section

A New Chapter Begins : Handing Over the Baton

A heartfelt Note from the Outgoing Secretary & Treasurer

After more than a decade, of being part of the Governing Body of the Indian Chest Society - as Secretary and Treasurer - it's time for us to step aside and pass the baton. As we do, our hearts are full: of pride in what we've built together, of deep gratitude for the friendships and memories made, and yes, of a touch of sadness that this incredible chapter is coming to a close.

When we first joined the Governing Body, the ICS was already a respected society - but we could see the untapped potential waiting to unfold. Those early days were filled with excitement and energy. Together, we reimagined what the ICS could be: a society with a modern, vibrant face and a confident global voice. We designed a new logo, launched a dynamic website, and stepped into the digital world with social media - making Indian pulmonology visible and heard far and wide.

We also dreamt bigger - beyond our borders. We introduced international grants to help our young colleagues travel, learn, and bring back new perspectives to India. We made it possible

for Indian pulmonologists to take the prestigious European HERMES exam right here at home. These weren't just projects; they were statements of intent - proof that the ICS was stepping onto the world stage with confidence and credibility.

Of course, every journey has its challenges. We still remember the time when very few were willing to take up leadership roles, and how we took it upon ourselves to strengthen the society - both academically and financially. Those were demanding years, but also incredibly rewarding ones.

The recent times, though, have tested us all. The events surrounding the 2022 election were painful to witness and, in many ways, heartbreaking. It's deeply distressing to see our society - built on knowledge, friendship,



and shared purpose - caught in conflict and courtrooms. But we remain hopeful. We believe that integrity, fairness, and the collective wisdom of our members will guide the ICS back to calm waters.

As we hand over our roles, this isn't a goodbye. The ICS is, and always will be, part of who we are. We stand beside the new Governing Body in spirit - ready to help, cheer, and support in any way we can. We see in them a team full of talent, commitment, and fresh energy. We're confident they will heal, rebuild, and lead the society to even greater heights.

The ICS has always been more than any one person - it's a shared dream, a collective mission to advance lung health in India. That mission continues.

With full hearts and hopeful smiles,

We step aside - but never away.

Dr. Raja Dhar

Dr. Rajesh Swarnakar

Outgoing Secretary and Treasurer ICS





Zydus Tower. CTS No., 460/6, I B Patel Road, Village Pahadi,
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In COPD Management

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