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लोकाः समस्ताः सुखिनो भवन्तु

Editor:
Dr Anurag Mishra

ARSI Over Years

ASSOCIATION OF RURAL SURGEONS OF INDIA" (A.R.S.I.)

Prof. Sukumar Maiti

Professor & HOD, Department of Surgery

IIMSAR & Dr B C Roy Hospital, Haldia, West Bengal

In India, around eighty percent of the rural population is estimated to lack access to safe, affordable, and timely surgical care because of limited resources. In 1980s Rural India was lagging far behind in the realms of education, transport and health care. Whatever advances that were happening in modern medicine including those in the fields of diagnosis and treatment were beyond the reach of people residing in rural India. Surgical care in places far away from metropolis as well as in the slums of the cities needed to be addressed with passion and priority. However a few NGOs and individuals in their own capacity, with dedication, were giving services at the extreme corners of the country from Kashmir to Kanyakumari and Assam to Gujrat. They became known as rural surgeons.

The Association of the Surgeons of India (ASI) an esteemed parent association of surgeons was formed in 1938. Later within ASI, speciality sections were formed, namely Paediatric, Colorectal, Plastic, Cardiovascular surgery, Trauma section etc. for the improvement in surgical services as well as updating the knowledge in different sub specialities. In 1980s as a junior member of the Association, I have observed that during the General Body meetings of the Annual Conferences of ASI, these rural surgeons asking for programmes for themselves. Some rural surgeon members of ASI led by *Dr R D Prabhu from Shimoga*, Karnataka explained the need, and placed the demand for the formation of a "Rural Surgery Section" within ASI. Unfortunately, the Governing councils in every year sceptically ignored and turned down the request. When this injustice being imposed for several years, some likeminded surgeons sat together in 1992 and decided to form their own association to fulfil the need and aspirations of the surgeons working in rural areas with various constrains and limited resources. Thus, the idea of an "Association of Rural Surgeons of India" (A.R.S.I.) came into existence at Shimoga, Karnataka on 22 November 1992, under the guidance of Dr. Balu Sankaran(Ex. D.G.H.S. GOI) and Dr. N. H. Antia (Senior Plastic Surgeon, Director F.M.R. and adviser to GOI). The ARSI was formally launched at the Mahatma Gandhi Institute of Medical Sciences, Sevagram, during its first conference in 1993. Irony of fact is that few years afterwards, in 1996, the Association of Surgeons of India (ASI) approved a section "The Association of Surgeons of Rural India" (ASRI), a section within ASI. However, our "Association of Rural Surgeons of India" (ARSI.), and "The Association of Surgeons of Rural India" (ASRI), are two different associations. ASRI is a Section of ASI and ARSI is an independent Association. Many great luminaries of the country including Dr. Rangabhasham, *Prakash Baba Amte, Mandakini Amte, Dr Balu Sankaran, Dr N.H.Antia, Dr Tehemton Udwadia,* Father of Laparoscopic Surgery in India, *Dr. B.Ramamurthy, a pioneer neurosurgeon, Dr. Bajaj, Prof. Rajasheksaran, Dr.Sham Prasad* all presidents of N.B.E. were ardent admirers and inspiration for our association.

Association of Rural Surgeons of India (ARSI) prefers to organise its annual conferences every year generally in small towns. First conference was held at Mahatma Gandhi Institute of Medical Sciences, Sevagram in 1993.

International Federation of Rural Surgeons (IFRS)

To spread the philosophy of rural surgery and to bring the rural surgeons from all or as many as possible countries under one body, ARSI took the lead. To initiate the mission, on 25th September, 2005 at Ujjain, India, the International Federation of Rural Surgeons (IFRS) was launched. Signatories include surgeons from Germany, Holland, USA, Kenya, Uganda, Tanzania and India. Later Bangladesh also became part of IFRS. Since then, IFRS annual conferences are being organised every two years in different countries as well as in India where IFRS conferences were merged with annual national conferences of ARSI (ARSICON). The 1st,3rd,5th 6th & 7th conferences of IFRS jointly with ARSICON were held at Ujjain (MP), Pipalia (Rajasthan) and Bhachau (Gujrat), Karad (Maharatra), Chiplun (Maharastra) in 2005, 2009, 2013, 2015 & 2019.

Dr. Antia- Finseth Innovation award"

Association of Rural Surgeons of India offers "Dr. Antia- Finseth Innovation award" of Rs. 10,000/- and certificate for any innovation that is useful for rural health care. The award was an idea of Dr. Finseth, a hand and plastic surgeon from California, US, and ardent pupil of Dr. Antia. The innovations recognised for the

awards so far are Low-cost ventilator, Mosquito Nets for hernia repair, Bio-gas plant for hospital set up, Gasless laparoscopic surgery, simple and safe instrument for pyloromyotomy operation, Laptop video endoscopes and many more.

Shimoga- Jhargram Scholarship

This scholarship was instituted with the money contributed by IMA branches of Shimoga and Jhadgram from the savings from the ARSICONs they had organised. It is offered to any young member of ARSI who wishes to go away and learn newer technologies like ultra-sonology, endoscopies and other useful in rural practice

The Monthly Bulletin of the Association - "Rural Surgery"

"Rural Surgery" Publishes most recent news, association notices, case reports, articles on history of Medicine, report of clinical studies, history of establishment of philanthropic Medical Centres for service and education throughout the country for the benevolence of indigent and poverty-stricken people. For the initiation, development of this publication and making it popular in the country and abroad *Dr Samar K Bassu,* the 1st editor of the Bulletin made immense and dedicated efforts. Dr Bassu is one of the past presidents of ARSI. Very recently he has left us for the heavenly abode. Virtual conferences are organized with participation of association members from the country and abroad.

Fellowship offered by the Association (FARSI)

ARSI gives due recognition to dedicated rural surgeons who qualify as trained rural surgeons, with Fellowship of the Association of Rural Surgeons of India (F.A.R.S.I)

Training for rural surgeons and Paramedics.

Together with Indira Gandhi National Open University ARSI developed a training programme for Rural surgeons- the Certificate in Rural Surgery (CRS). But medical colleges objected to it. National Board of Examinations (NBE) introduced Diploma of National Board (DNB) in rural surgery as a post graduate course from January 2007 to make candidates efficient and capable of facing the severe challenges of rural surgery. This too has failed due to the apathy of medical colleges. Training programmes were organised at Kolkata Medical College, Maulana Azad Medical Collège and some other centres for the training of young surgeons with Laparoscopic surgery, Basic Urology, Spinal anaesthesia etc. to serve rural areas in a more effective and at reasonably low cost.

ARSI and Global Surgery

Presently ARSI is very much a part of the Lancet Global Surgery with the dynamic guidance and leadership of *Dr J Gnanaraj, past president of ARSI , Dr Nobhojit Roy, Dr Anurag Mishra* and others. University of Leeds, UK, and different Universities of India recognise the academic programmes and research works done under the aegis of ARSI. Lancet Commission for Global Health 2030 also appreciated the ARSI for its persistent benevolent works for the improvement of surgical care in rural areas and slums of metropolis.

Membership Strength

Membership criteria – All those who promote the cause of rural surgery and have a post-graduate diploma or degree recognised by the Medical Council of India (MCI) in Surgery or its allied branches like Obstetrics & Gynaecology, Orthopaedics, E.N.T., Ophthalmology, Anaesthesia etc. / MBBS doctors who are actively practicing rural surgical care for at least 5 years and have 50% surgical work qualify for full membership.

At present ARSI has around 705 members in India and 16 Overseas members. The Association of Rural Surgeons of India (ARSI) since 1990s made persistent efforts with its great leadership to bring together medical professionals working with various odds and constrains, yet striving to give safe, affordable and easily available surgical care to a vast population in Rural India as well in slums at outskirts of main cities. For last few years the work flow of the association was in a low web. With the announcement of its 28th Annual Conference at Maulana Azad Medical College, New Delhi the spirit is rejuvenated and rekindled the determination of its members for a cohesive team work.

Acknowledgement: 1.Dr Dr Radhakrishna D Prabhu, Shimoga, Karnataka 2, Dr Rajesh Tangaonkar,

Dondaicha, Dhule, Maharashtra

Presidents and Secretaries of ARSI

Year	President	Secretary
1993- 1996	Dr Balu Sankaran	Dr R.D.Prabhu
1996, 1997	Dr N.H.Antia	Dr R.D.Prabhu
1997-2001	Dr R.R.Tongaonkar	Dr R.D.Prabhu
2001-2004	Dr Sitanath De	Dr S. Shivade
2004-2006	Dr R.D.Prabhu	Dr S. Shivade
2006-2008	Dr J K Banerjee	Dr B D Patel
2008-2010	Dr K C Sharma	Dr B D Patel
2010-2014	Dr S Shivde	Dr Raj.Tongaonkar
2014-2016	Dr S K Bassu	Dr Raj.Tongaonkar
2016-2018	Dr B D Patel	Dr Raj.Tongaonkar
2018-2019	Dr J Gnanaraj	Dr Raj.Tongaonkar
2020- 2024	Dr S Kulkarni	Dr Raj.Tongaonkar
2024- present	Dr Dilip Gupta	Dr Raj.Tongaonkar

Annual Conference (ARSICON) venues

Sr No	Year	Venue	State	Organizing Secretary
1	1993	Wardha	Maharashtra	Narang
2	1994	Shimoga	Karnataka	B.Venkata Rao
3	1995	New Delhi	Delhi	J.K.Banerjee
4	1996	Nagapattinam	Tamil Nadu	K.Dakshinamoorthy
5	1997	Jhadgram	Midnapore	Sitanath De
6	1998	Dondaicha	Maharashtra	R.R.Tongaonkar
7	1999	Udhampur	J & K	K.C.Sharma
8	2000	Manipal	Karnataka	R.P.Pai
9	2001	Puri	Odissa	S. Mishra
10	2002	Vapi	Gujrat	Abhyankar
11	2003	New Delhi	Delhi	S.K.Baasu
12	2004	Sivakasi (+ASRI)	Tamil Nadu	Asokan
13	2005	Ujjain	Madhya Pradesh	V.K.Mehta
14	2006	Patan(+ASRI)	Gujrat	V.D.Raval
15	2007	Pune	Maharashtra	S. Arora
16	2008	Wardha	Maharashtra	D. Gupta
17	2009	Papalia	Rajasthan	S.Arora
18	2010	Kollam	Kerala	Jacob John
19	2011	Shahada	Maharashtra	B.D.Patel
20	2012	Ratlam	Madhya Pradesh	Malviya
21	2013	Bhachau	Gujrat	Manhar Shah
22	2014	Midnapore	West Bengal	Sukumar Maiti
23	2015	Karad	Maharashtra	P. Chaugule
24	2016	Kulu	Himachal Pradesh	Rakesh Gautam
25	2017	Dimapur	Nagaland	J. Gnanaraj
26	2018	Darvan Chiplun	Maharashtra	Netaji Patil
27	2019	Bagalkot	Karnataka	Kalburgi
For four years 2020 to 2023 during COVID Pandemic and afterwards no ARSICON held				
28	2024	MAMC (N Delhi)	Delhi	Anurag Mishra
29	2025	JSS (Ganiyari)	Chattisgarh	Raman Katariya

ARSI-why we are special

Dr. R. D. Prabhu

ASSOCIATION OF RURAL SURGEONS OF INDIA In short, ARSI, is one of its kind in India. And I am very proud of it. It kindles my national pride, and so, would not like to see it change its name. I am sure many of you feel similarly too. I wonder who proposed this strange idea in the firsts place.

I would like to tell you two funny stories.

1. Long ago, in one of our Rotary meetings the speaker told his experience in China. He was vegetarian and he was served non-veg dish. He told the waiter that he eats only veg. Waiter said "no matter sir, I will set it right straight away" He brought some water and sprinkled on the no-veg dish and said "sir now it is veg dish. Enjoy it…" Guest asked,' what are you saying?' and the waiter said "sir last Sunday a padre came to our village and sprinkled some water on my friend's head and told him, now you are not Chinese anymore, you are a Christian ! So I did the same thing"

2. When I had started my first house job in the UK in 1962, some British doctors said my name was 'too complicated' for them to pronounce and would I mind if they address me as John or Bob etc. I said certainly YES, I would mind. I like my name as it is. If I have to learn to pronounce Leicester as Lester, Gloucester as Gloster, Bournemounth as bornmuth, they may as well learn to call me by my simple name Prabhu! Pronounced as written! That was the end of that.

It is said that Britishers did not trust Ayurveda to treat their own people and their army in India. So they closed Ayurveda schools and its thousands of years old practice. They introduced modern medicine and colleges to teach it in its place. However, Ayurveda continued and survived despite all attempts to wipe it off (even now many modern medicine practitioners are against Ayurveda without even understanding its basic principles). Similarly, rural surgery has survived, developed and thrived by the sheer perseverance of practicing rural surgeons like you, despite the antagonism by elders (read professors and medical colleges).

Once we accept the name global surgery, we lose our identity, uniqueness and we become one of the many parts of global surgery. We may need to accept their disciplines, protocols, and concepts replacing our own concepts of our rural surgery. We may have to get consent for each of our programmes and policies. We may even have to carry out programmes that are not agreeable to our country. All that is not acceptable to me. Someone sitting in an office in western hospital or college is not the right person to decide about Indian health needs. Our own professors in India have not been able to fathom them yet, then how may the westerners do it? We have to be able to choose our own priorities for the sake of our patients.

We too have struggled very hard to establish rural surgery as an independent, important, arm of health care. We do not want to see it drowned in a different label. We need to cherish it nourish it to make it a popular cost effective way of health care of low and middle income population.

How do we go about it?

I have a few ideas.

First is to conduct a survey in our own membership to find out what they expect from ARSI. What

programmes, what changes, etc. Focus on them during the annual conferences.

Second is to try and find a teaching institution where special training may be given to rural surgeons (practicing and aspiring) in some of the special skills WHO has listed. This is a tough proposition. But someone like Anurag, Dilip Gupta may apply his mind and try.

Third is wild idea. Whether starting a rural hospital may be in “start up” group for getting financial help.

You all are better placed to discuss these and see what may be done.

R.D.Prabhu

Founder Member

ARSI

Low cost surgery - Concept of rural surgery

Dr. D.P.S. Toor

Since independence the policies priorities, and planning have led to two nations growing side by side - one is India and other is Bharat. People living in Posh cities and bungalows constitute India while rest of the country constitutes Bharat (village and urbanised slums).

The health planning has been well conceived but the results have not been satisfactory. The idea of Primary Health Centre looking after the patients at village level is very good and referring the needy ones to a district hospital or a medical college is sound but has not been properly implemented. Rural inhabitants have been subjected to great physical and economic distress due to inadequacy of the system. In fact, people all over the world desire an improvement in their state of health, greater access to wide range of health and sickness related services and enjoy the benefit of scientific and Technological advances. But in developing countries like India per capita consumption of natural resources of the world is low, people are poor, experience high levels of morbidity, disability and mortality and have little or no access to modern health Services. Ideally, proper medical care should be within the reach of all sections of the population, but the enormity of the problem and numerous financial constraints combine to make this idealistic concept unworkable. Although this is difficult but it is not impossible.

The nature of a country's development is associated with the level of health services and health related activities a country can support. In fact, the health of the population can itself influence economic progress by affecting productivity.

Today we have one large group of people in rural areas who have no access to health care and another group (equally large) who has facilities around them but cannot afford the high cost. So in order to have true development, relevant services have to be developed for all, according to the purchasing power of the people. If purchasing power is less, cost of services must be made low so that people can afford them without losing their dignity and self-esteem. To provide health services at low cost to the people is one such step in economic development.
The medical fraternity ought to play positive role in this direction. If we start having concern for others welfare we can definitely improve the health of the nation. We owe this debt to the country, which spends lakhs in the making of a single doctor.

Large number of people suffering from any illness go to urban institutions for treatment resulting in financial ruin to the family. So, the answer lies in providing good health care including surgical care to the rural areas rather than patient from rural areas being forced to go to the cities.
It is the responsibility of our profession, to whom people look up to in matters concerning health to develop a form of health care, which is in keeping with the needs of our fellow beings.
“In all forms of education, improvement of attitudes is as important as imparting skills.”

Rural Surgery is an alternative concept or practice of surgery in order to reduce the cost of surgery by using locally available human and material resources for providing surgical services and also innovating management systems involving the needs of the community at affordable price. Rural surgery is a concept of providing health care at the doorstep of those who need the most and can

afford the least. It is providing surgery at affordable cost to the people.
But settling in a rural or peripheral setup is not easy.
The demanding problems faced by any doctor to establish himself in a rural area can be grouped under following heading.

a) Qualified and like-minded assistants.
b) Future of the family.
c) Academic isolation.

a) Qualified and like-minded assistants :

The problems of settling and providing health care in a rural area are numerous and for a surgeon they are even more. However motivated he may be with regard to his work, he requires like minded assistants and basic technical facilities. Lack of this support may deter even the most committed, as it is difficult to develop an adequate infra structure and obtain qualified staff to run a reasonable surgical practice. He has to innovate and use the local resources available and train local boys and girls as paramedics.

Also, the best nursing care is provided by the relatives and the patient also feels comfortable when he finds his relatives around.

The village folks do not differentiate between a physician, a surgeon, a gynecologist or a dentist, so a doctor thinking of settling in a rural area ought to have knowledge of everything or should have a team of colleagues. Services of radiologist, ultrasonologist, pathologist and anesthetist are no where available. The training in the medical institutions has led to compartmentalisation of health care, which is available only in urban cities and at a price.

So the doctors thinking of settling in a rural area ought to have a mental attitude to such type of work.

b) Future of family :

This is very crucial question, as how to provide a reasonable environment for the family and adequate education for children. It is natural for a doctor to expect a standard commensurate with his own professional achievement. The future of the family is one of the main reason which deters the doctors from working in a rural area.
But here comes the role of the community. Four to five doctors can from a group and provide services to the rural areas by setting up a small hospital and visiting twice a week and occasionally in emergencies. Let the Centre be looked after by the panchayat. This would help to achieve the goal of "People's health in people's hands".

c) Academic Isolation :

The urban based doctors have grown accustomed to ready availability of medical library, frequent seminar, group discussions and CME's and most important of all a ready access to a professional "Second Opinion". All this makes him cling to the security of a large urban hospital. Seminar & CME's should be conducted in peripheral areas & doctors should have access to libraries of institutions.

These days everybody in our profession is talking of high technology, endoscopic surgery, key hole surgery and all types of endo urology procedures. The young surgeons are swayed by the glamour of these procedures with the result that they want to learn or try these new procedures without learning the basic general surgery.

A nations health care program should be built on a foundation of preventive health and should go side by side with curative work. Both priorities and goals for rural health care has to be determined. The move should be to check the inflow of patients from rural areas to urban areas by providing them facilities.

Also the medical curriculum should have a property planned programme to encourage general surgeons to opt for rural surgical practice, so that comprehensive surgical care should be delivered to outlying areas.

There is no reason why our profession cannot play a large role in the society by taking part in the overall improvement in the health and welfare of our community and the nation. This is now feasible in panchayti Raj where people are increasingly involved in their own welfare. We are in a position to provide knowledge and technology in a variety of ways appropriate to local needs and thus participate in our country's development. Hence a new India will emerge from the villages of Bharat.

Such a participation and involvement would not only be a stimulating experience but would be the most effective way to counter the fear of CPA which threatens our profession. It would also help to regain the love and respect that our profession has had in the past.

Answer – Shift from over specialized surgery to basic surgery for all.

Let's pledge to make surgery at affordable cost to the nation.

Dr. D.P.S. Toor
M.S.
Medical Director & Surgeon
Rural Medicare Centre
Saidulajaib, New Delhi 110030.

Gurukool DOCS Initiative: Reimagining Community-Centred Medical Education in India

Dr Anurag Mishra, Dr Aman Agarwal, Dr Komal Yadav, Dr Garima Singh, Dr Hitakshi, Dr Nishtha Agarwal, All Gurukool Members

Introduction

India's healthcare landscape is defined by striking contrasts. On one hand stand world-class tertiary hospitals, cutting-edge surgical expertise, and globally respected medical professionals; on the other, vast communities continue to grapple with limited access to basic healthcare, poor health literacy, and fragile systems of care. Bridging this divide requires more than technical competence - it demands empathy, contextual understanding, and a deep commitment to community service. It is within this space that "**Gurukool DOCS" (Doctors On Community Service) initiative** was conceived.

Ideally the medical curriculum should play the role of imparting education which inherently inculcates empathy and sense of responsibility in doctors towards the marginalised and underprivileged communities. However the current selection process and further curriculum is objective and rote based and it ignores this essential tenet of being a Doctor.

DOCS is an experiential learning programme under the Gurukool initiative at Maulana Azad Medical College, that takes medical students out of the four walls of teaching hospitals and places them directly within communities across India. It is a journey - geographical, intellectual, and emotional – designed for future doctors to understand what healthcare truly means at the grassroots.

DOCS: Concept and Philosophy

DOCS - **Doctors On Community Service** - is built on a simple yet powerful idea: *"Meaningful medical education must be rooted in lived community experiences"*. Inspired by Gandhi's *Nayee Talim* principle of learning by doing, DOCS emphasizes observation, participation, and reflection over passive instruction.

The initiative seeks to expose medical undergraduates to diverse healthcare roles by immersing them in low-resource and underserved settings. Here, students learn not only about diseases, but also about social determinants of health, cultural practices, communication barriers, and systemic challenges that shape health outcomes.

Community Medicine in the Current Medical Curriculum

The existing undergraduate curriculum in India (MBBS) incorporates elements of *community practice*. Students undergo mandatory Family Adoption Programme (FAP) under their Community Medicine postings, complete rural & urban slum satellite centre postings during internship, and receive training through the AETCOM (Attitude, Ethics, and Communication) module.

Despite these efforts, significant gaps remain. Community exposure is often time-limited and fragmented. Communication skills training is insufficiently experiential. Hierarchical structures and power dynamics frequently restrict student engagement. Most importantly, the curriculum remains heavily skewed toward technical and hospital-based competencies, with limited emphasis on people-centric and community-oriented care.

Identified Shortcomings and the Need for Change

Several challenges in current medical training led to the creation of DOCS:

- Limited duration and depth of community exposure
- Inadequate training in real-world communication and empathy
- Overemphasis on technical skills at the cost of holistic care
- Reduced intent among medical undergraduates to serve underserved communities
- Declining empathy and innovation focused on patient wellbeing

These shortcomings highlight the urgent need for sustained, meaningful grassroots engagement - an area where DOCS plays a transformative role.

Vision and Goals of DOCS

The vision of DOCS is to foster a ***transformative holistic medical education experience*** that empowers students to function effectively across diverse healthcare settings while cultivating compassion and a patient-centric ethos.

Its core goals include:

- Cultivating a committed community of medical undergraduates working toward social change
- Stimulating problem-solving attitudes aligned with community health needs
- Creating holistic healthcare professionals sensitive to social realities
- Establishing long-term engagement with local communities to advance the ideal of "Health for All"

The DOCS Journey So Far

Since its inception, DOCS has steadily expanded its footprint across India. The initiative has organized **five community outreach programmes**, **four surgical camps**, and **two health camps**, while adopting **one community** for sustained engagement.

With a growing family of over **40 volunteers** from premier institutions such as Maulana Azad Medical College (MAMC), AIIMS, and LTMMC, DOCS has directly impacted more than **400 beneficiaries**.

Notable DOCS engagements include:

- Aarohi, Satoli (Multiple 2018- 2025)
- SEARCH, Gadchiroli (2019)
- Anandwan (2019)
- Jan Swasthya Sahyog, Ganiyari (2020, 2022, 2025)
- Tribal Hospitals, Tripura – Surgical Camp (2023)
- Pallium, Trivandrum (2023)
- Cachar Cancer Hospital, Silchar (2024)

Each site offered unique lessons - ranging from rural surgical care and palliative medicine to community partnerships and primary healthcare delivery.

How DOCS Fills Existing Lacunae

DOCS addresses gaps in conventional training through innovative, community-driven models. Students learn by observing and participating in home-based care, community adoption programmes, and low-cost diagnostic innovations. Exposure to concepts such as *Abacus-based community assessment* and devices like the *Breath Counter* for household diagnosis of childhood pneumonia illustrates how simple innovations can save lives in resource-limited settings.

This approach reinforces that effective healthcare solutions need not always be high-tech; they must instead be appropriate, accessible, and community-owned.

Organisational Model and Sustainability

Enrolment: Students, who have completed 1 year of MBBS course are well-versed with basic medical knowledge and skills of history and examinations and vitals measurement are invited to participate in the program by filling up a registration form. Each visit consists of a short group of medical students (maximum 10 students) and a Faculty mentor to ensure expansive exposure and interaction with host institutions and their systems while ensuring the operational feasibility and ease. Interest and preparedness are screened using multiple criteria like:

- A minimum 8 hr duty in Emergency unit of any clinical department and be certifying the presence of required skills like history taking, physical examination and vitals measurement.
- A personal essay regarding their purpose of joining DOCS.
- Commitment towards taking care of their own expenses for the visit.

The Visit: The visit is planned by the DOCS team with a comprehensive day to day plan. Usual duration of a each visit is 5-7 days. The activities include assisting in day to day work at the host institution, interactions with staff and community, understand realities of rural and tribal India, introspection and a lot of fun sessions. Members are encouraged to reflect on their observations as well as their feelings in form of journaling and group discussions.

After Visit: Each member prepares a visit report with their

reflections. The visiting group jointly presents this in Gurukool meeting to whole college, which encourages further participation. A certificate is also provided to each participant.

Financial Model: DOCS is a **non-profit, self-sustained initiative**. All expenses (including travel) are borne by participants and host institutions provide local accommodation and food. Financial support is available for interested students who are not able to afford the visit. Importantly, the programme does not rely on external funding - ensuring independence, transparency, and scalability.

Collaborations with local organisations and community leaders form the backbone of DOCS operations, ensuring cultural sensitivity and continuity of care.

Learning Outcomes and Student Impact

Feedback collected from all participants reveals profound learning outcomes.

DOCS significantly enhanced:

- Empathy development
- Understanding of real-world health problems
- Appreciation of holistic care
- Adaptability in low-resource environments
- Building community partnerships

Overwhelming feeling of participants remains that such experiences should be introduced early in medical training and, in many cases, made compulsory for all MBBS students.

Voices from the Field

Student reflections capture the essence of DOCS:

- “A holistic learning experience - wholesome and soul-nurturing.”
- “An absolutely incredible experience; a must for every MBBS student.”
- “DOCS helped me understand healthcare beyond tertiary hospitals.”

Such testimonials underscore the programme’s deep personal and professional impact.

Future Directions

Looking ahead, DOCS aims to:

- Foster a research-oriented culture during DOCS events
- Increase the frequency to quarterly visits to low-resource regions
- Integrate DOCS experiences with MBBS electives
- Develop structured calendars, detailed itineraries, and robust participant selection processes

These steps are informed directly by participant feedback and reflect the initiative’s commitment to continuous improvement.

Conclusion

Gurukool DOCS represents a powerful reimagining of medical education – a system that places communities at its core. By nurturing empathy, social accountability, and contextual intelligence, DOCS prepares future doctors not just to treat diseases, but to serve society with humility and purpose.

In an era where healthcare challenges are increasingly complex, initiatives like DOCS remind us that the soul of medicine still resides in the community.

For more information, visit:

Instagram: @docs.gurukool

Email: docsgurukool@gmail.com

Website: https://gurukoolmamc.in

Learn. Lead. Inspire.

DOCS
BECAUSE WE CARE...

Proceedings of

ARSICON

2025

Head

Heart

Hand

Jan Swasthya Sahyog

ARSICON 2025

29th Annual National Conference of Association of Rural Surgeons of India (ARSI)

ASSOCIATION OF RURAL SURGEONS OF INDIA 1992

लोकाः समस्ताः सुखिनो भवन्तु

Theme: Equity in Access to Quality Surgical Care

Pre-Conference Workshops

Acute Critical Care
10th-11th February, 2025

Pain Management & Nerve Blocks in the Perioperative Period
12th February, 2025

13-15th

February, 2025

ORGANISED BY

Jan Swasthya Sahyog

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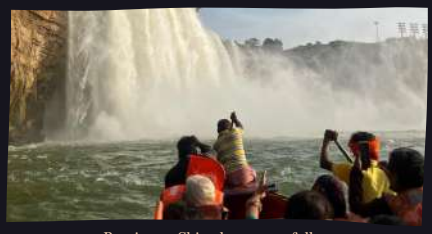
WELCOME TO CHHATTISGARH

Narmada Udgam Temple, Amarkantak

Bhoramdeo Temple

Tirathgarh waterfall

Achanakmar Tiger Reserve Safari



Boating at Chitrakote waterfalls

Kutumsar Cave

Ratanpur Fort

Khudia dam

Kanan Pindari Zoo

ARSICON 2025

Venue: Jan Swasthya Sahyog, Ganiyari, Chattisgarh
Dates: 13.02.2025 – 15.02.2026

PROGRAMME OUTLINE

Pre-conference Workshops

10-11th Feb 2026	**Acute Critical Care** **Patron:** Prof MC Mishra - Emeritus Professor of Surgery and former Director, AIIMS, New Delhi, ACCC Program National Convenor, **Course Convener:** Dr Ajay Kumar Sharma - Deputy Director of Surgical Education Royal College of Physicians and Surgeons of Glasgow **Course Educators:** Dr Shiv Singh - Consultant Anesthetist, Royal Liverpool University Hospital Dr Bhavna Seth - Director of Global Health in Pulmonary and Critical Care Medicine, University of Pittsburgh Dr Akshay Kumar - Additional Professor, Emergency Medicine, AIIMS, New Delhi Dr Sumedh Jajoo - Associate Professor, Critical Care, AIIMS, Nagpur Prof Anurag Mishra - Professor of Surgery, MAMC, Delhi Prof Madhumita Murthy - Anaesthesiology and Critical Care, CIMS, Bilaspur Dr Shilpa Khanna, Consultant Anaesthetist, Ambikapur Dr Monty Khajanchi - Associate Professor, Seth GS Medical College and KEM Hospital, Mumbai Dr Bhakti Sarang - HoD Surgery, Terna Medical College, Mumbai Dr Nalini Bala Pandey - Senior Chief Medical Officer (NFSG), Emergency Medicine, Lok Nayak Hospital, Delhi (Online) Dr. Renaldo Pavrey - Senior Consultant, Emergency Medicine, Nanavati Hospital, Mumbai
12th Feb 2026	**Pain Management and Nerve Blocks in The Perioperative Period** **Course Director: Dr. Shiv Singh - Senior Consultant, Dept. of Anesthesia, Royal Liverpool and Broadgreen University Hospitals, UK** **Faculty: Dr. Shilpa Khanna - Consultant, Anesthesia & Pain Medicine, Sangwari, Ambikapur** **Prof. Dr. R. Nigam - Dept. of Anesthesia, CIMS, Bilaspur** **Prof. Dr. M. Murthy - Dept. of Anesthesia, CIMS, Bilaspur** **Prof. Dr. Subrata Kumar Singha - Dept. of Anesthesia, AIIMS, Raipur** **Prof. Dr. Rampal Singh - Dept. of Anesthesia, AIIMS, Raipur** **Dr Monty Khajanchi - Associate Professor, Seth GS Medical College and KEM Hospital, Mumbai** **Dr Bhakti Sarang - HoD Surgery, Terna Medical College, Mumbai** **Prof Anurag Mishra - Professor of Surgery, MAMC, Delhi**
16th Feb 2026	**JSS Silver Jubilee Mini-Marathon**

ARSICON 2025

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Dates: 13.02.2025 – 15.02.2026

DAY 1 – 13th February 2026 (Thursday)

Hall A

9:00 - 10:00	**Paper presentation (7 papers: 6+2mins each)** Student competitive papers Prof. Dr. Anurag Mishra, Prof. Dr. Monty Khajanchi, Dr. Rajesh Tongaonkar	
10:00 - 12:00	**Panel Discussion: Challenges in management of cancers in remote & rural settings and ways to overcome them** Keynote speaker 1. Dr. Ravi Kannan - Director, Cachar Cancer Hospital and Research Centre, Assam 2. Dr. Rosina Ahmed - Tata Medical Centre, Kolkata 3: Prof. Dr. Sameer Bakhshi - Medical oncologist, AIIMS Delhi Panel: Dr. C. Rahalkar, Dr. Amit Verma, Dr. Saibal Jana, Dr Keduovinuo Keditsu, Dr. Amit Soni, Dr. Devinder Singh, Dr. Sunil Jiwanmall, Dr. Kamlesh Jain	
12:00 - 13:00	**Inauguration** Chief Guest: Dr. Ashok Jindal - Director, AIIMS Raipur	
14:00 - 15:20	**Antia Symposium on Orthopedic problems in resource-constrained settings** Chairperson: Prof. Dr. Sandeep Nema, AIIMS Raipur Dr. Ashish Jaiswal, Apollo Hospital, Bilaspur, Dr. Aditya Kesharwani, Consultant, Neurosurgeon, Bilaspur **Part 1: Sickle Arthropathy (25+15mins)** Prof. Dr. Alok Chandra Agrawal - HOD, Orthopedics & Dean, AIIMS Raipur **Part 2: Pediatric Orthopedic problems in resource-constrained settings (25+15mins)** Prof. Shah Alam, Orthopedics, AIIMS Delhi **Part 3: Spine problems in resource-constrained settings and the Spine Foundation model** Dr. Shekhar Bhojraj, The Spine Foundation, Mumbai	
15:30-16:10	**Difficult Urethral Strictures** Prof. Dr. L.N. Dorairajan, Urologist, JIPMER, Puducherry Dr. Jayant Kanaskar, Apollo Hospital, Bilaspur	
16:20-18:00	**Workshop on Diabetic Foot Management** Prof. Dr. Nobhojit Roy - Senior Consultant Surgeon, WHO, Prof. Dr. Bhakti Sarang - HOD, Dept. of General Surgery, Terna Medical College, Navi Mumbai, Prof. Dr. Monty Khajanchi, Dr. Kunal Chhatbar	
18:00	**Cultural programme followed by banquet at Ganiyari**	Jamunahi Tribal Dance group

Hall B

14:30-16:30	Workshop: Rural Urology Dr Gnanaraj J
14:00 - 18:00	Video Library (walk-in facility) - Personalised viewing & group screening

ARSICON 2025

Venue: Jan Swasthya Sahyog, Ganiyari, Chattisgarh
Dates: 13.02.2025 – 15.02.2026

DAY 2 – 14th February 2026 (Friday)

Hall A

9:00 - 10:00	**Paper presentation (7 papers: 6+2mins each)** Faculty competitive papers Prof. Dr. Dilip Gupta, Prof. Dr. Dhruv Ghosh, Dr. Raman Kataria
10:00 - 12:00	**Panel Discussion: Training and credentialing of surgeons for Rural India with an eye on access to quality surgical care with equity** Keynote speaker: **Prof. Dr. Minu Bajpai - Vice President & Honorary Executive Director, NBE** **Prof. Dr. George Mathew, Former principal, CMC Vellore,** **Prof. Dr. V. Seenu, Retd. Professor of Surgery, AIIMS Delhi** *Panel: Dr. Sushil Sharma, Dr. Regi George, Dr. Gnanraj, Prof. Dr. Anurag Mishra, Prof. Dr. Dilip Gupta, Dr. Puneet Dhar*
12:00 - 13:00	**Lecture: Atonic PPH and Ruptured Uterus - Dreaded Obstetric emergencies in resource-constrained settings** Prof. Dr. Gowri Dorairajan - Obstetrics and Gynecology, JIPMER, Puducherry
14:00 - 14:30	**Lecture: Pre-eclampsia, Eclampsia spectrum** Dr. Rajesh Tongaonkar - Senior Consutant, OB-GYN, Dondaicha, Dr. Meenakshi Deb, Senior Consultant, OB-GYN, JSS
14:30 - 15:00	**Lecture: Challenges in General Surgery for the Rural Surgeon** Prof. Dr. Dilip Gupta - HOD, Dept. of Surgery, MGIMS, Sevagram, Dr. Sunil Kedia, Apollo Hospital, Bilaspur
15:00 - 15:30	**Lecture: Safe anesthesia for low resource settings** Dr. Ann Miriam, Makunda, Assam, Dr. Parineeta Jaiswal, Apollo Hospital, Bilaspur
15:30 - 16:20	**Champions of Rural Surgery Award** Prof. Dr. Anurag Mishra, Dr. Shilpa Khanna, Dr. Deepa K. Veetil
16:20 - 17:00	**Dr. Balu Sankaran Oration** Dr. Regi and Dr. Lalitha George
17:00	General Body Members of ARSI
18:00	**Cultural programme followed by banquet at Ganiyari**

HALL B

14:00 - 18:00	Video Library (walk-in facility) - Personalised viewing & group screening

ARSICON 2025

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DAY 3 – 7th February 2026 (Saturday)

Hall A

9:00-9:30	**Poster presentation (3 mins each)** Poster competition by participants Prof. Dr. Sukumar Maiti, Dr. Ajay Sharma, Dr. Deepa K. Veetil
9:00 - 9:15	**Public Health Knowledge for Surgeons:** The Surgeon as a Public Health Champion Dr. Raman Kataria
9:15-10:00	**A Tale of Three Cities and Rural India: Plastic Surgery in resource-constrained settings - Building a resource manual for general surgeons** Dr. Manish Ghosh, Dr. Arun Sheth, Dr. Vikas Sharma, Dr. Deepak Badhani
10:00-11:30	**Panel Discussion: Weighing in on the evidence - separating the seed from the chaff. Accessing current literature in remote settings and planning and execution of relevant research for rural surgeons** Keynote speaker 1: Prof. Dr. Dhruv Ghosh - Dept. of Pediatric Surgery, CMC, Ludhiana 2. Dr. Ajay Sharma - Dept. of Surgery and Renal Transplant, Royal Liverpool University Hospital, UK Panel: Prof. Dr. Anurag Mishra, Prof. Dr. Monty Khajanchi, Dr. Bhakti Sarang, Prof. Dr. Debajyoti Mohanty, Prof. Dr. Manju Singh, Prof. Dr. Nakul Raykar Prof. Dr. Biswaroop Chatterjee Dr. Jacob John
11:30-12:30	**Lecture: Pediatric Surgery for the General Surgeon in remote rural locations** Dr. Raman Kataria - Senior Consultant General Surgeon, Jan Swasthya Sahyog, Dr. Deepak Chandra Badhani - Senior Resident, General Surgery, Jan Swasthya Sahyog, Dr. Vijay Anand Ismavel
12:30-13:00	**Valedictory**
14:00-17:00	**Community of Practice** **1. Never practice alone again 2. Blood Deserts and coping strategies** Harvard Medical School, Prof. Dr. Nobhojit Roy Prof. Dr. Nakul Raykar **Voices of young surgeons from rural areas/tier-3 cities** Dr. Deepak Badhani, Dr. Dipankan Jana, Dr. Tanmay Motiwala, Dr. Patrick Paul, Prof. Dr. Monty Khajanchi (Moderator) Dr. Priyansh Nathani (Co-ordinator)
17:00-18:30	**Workshop on Leadership Development (Mashaal)** Prof. Dr. Anurag Mishra - Consultant, Dept. of Surgery, Maulana Azad Medical College, Delhi,Prof. Dr. Monty Khajanchi, Prof. Dr. Deepa

Hall B

9:30-11:30	Workshop: GILLS Dr Gnanaraj J
14:00 - 18:00	Video Library (walk-in facility) - Personalised viewing & group screening

Balu Shankaran Oration: A Journey of Health, Trust, and Transformation in the Sittilingi Valley

Speakers: Dr. Regi George and Dr. Lalitha Regi (Tribal Health Initiative, Sittilingi)

Venue: Association of Rural Surgeons of India Conference (ARSICON 2025), Jan Swasthya Sahiyog (JSS), Ganiyari

Date 13th February 2025

Introduction (*Dr. Dilip Gupta and Dr. Raman Kataria)*

Now is the time for the much-awaited Balu Shankaran Oration, and I would request Dr. Regi and Dr. Lalitha—Ji and Tha as they are fondly called—to please come on stage. I have requested Professor Bajpai to stay on for this oration, and he has been very grateful that he has agreed to this. So, without wasting any more time, I will also request Dr. Dilip Gupta to please come on stage.

Dr. Lalitha and Dr. Regi are a true Gandhian couple. They came to know each other during their medical college days in Kerala. In spite of families opposing their marriage, they came together as they believed in a common goal: to serve the underprivileged and the poor of the country. Having studied in a government medical college, they believed that since they studied from public funds, it is their duty to return to society what they gained.

Dr. Regi is an anesthetist, and Dr. Lalitha is a gynecologist. But since their goal was to work with the poor, they equipped themselves with skills that were not essential to work in cities but crucial in remote rural locations—like using ether for anesthesia, making your own gauze and pads and autoclaving them, sterilizing and reusing gloves, etc. The list can go on and on. To say it in one sentence: the real-life requirements to be a rural surgeon. Regi even worked for two years in the surgery department just to learn surgeries, not for a degree.

They initially worked in the Kasturba Hospital in Gandhigram, where they realized that doing clinical work

only is like mopping the floor while the tap is open. Following their passion, they backpacked for a year in 1991, traveling to various remote corners of this vast country. They found that the health and development indicators were the poorest amongst the tribal communities across the country.

Finally, in 1993, they chose to work with the tribals in a remote location in Dharmapuri, a tribal hamlet called Sittilingi, which was 90 kilometers from a telephone at that time. They named it Tribal Health Initiative (THI), which they considered an evolving experiment to improve the health and well-being of the tribal community in Sittilingi.

When the locals built them a small hut to run their clinic in Sittilingi in 1993, little did they know that this couple was going to transform their lives. Regi and Lalitha strongly believed in demystifying medicine with the motto of "helping tribals help themselves". Along with clinical work, they also started community health work by training a cadre of health workers to do nursing care in the hospital and a cadre of health auxiliaries to be the first contact person in the villages for health—all women from the local tribal community.

The vision has always been to work for health and not just for healthcare or for disease. This led to a broadening of their work to address the determinants of health: to involve in organic farming, livelihoods, women's empowerment, and finally into the governance of the local Panchayat. Regi is deeply involved with the Sittilingi Organic Farmers Association (SOFA), while Lalitha is fully engaged with the women's empowerment and craft initiative called Porgai.

Over the past 30 years, their work has been well-recognized and won several accolades. They set up a unique institution where there is no hierarchy. Nobody calls anybody "Sir" or "Ma'am" in THI; people fondly call them Ji and Tha.

So, over to them.

The Oration

Dr. Regi George:

Thank you for giving us the honor of delivering the Balu Shankaran Memorial Oration. We are deeply touched; we are deeply honored. I think this is the first time that a couple has been called for delivering this oration; it's usually a single person. We both have been members since 2001, so it is 24 years since we have been in ARSI.

We will try and take you through our journey. But before that, I would like to pay my reverence and respect to the seniors who founded ARSI. Many of you youngsters don't know the history of ARSI. When ASI (Association of Surgeons of India) were having their conferences in chandeliers and five-star hotels, there were some people who were thinking about the rural areas and who were trying to hold up a candle to their chandeliers. I remember with reverence Dr. N.H. Antia, Dr. Banerjee, Dr. Tongaonkar, and Dr. Prabhu, whom I knew personally. Many of you don't know them personally, but they were filled with fire, and they had the courage to break out from the ASI and form their own thing.

We learned a lot from them by sitting at their feet, especially Dr. Antia, and our journey has followed Dr. Antia's to a large extent. So, if you are not familiar with Dr. Antia, he was one of the first plastic surgeons in India. He used to say: "For the first ten years, I learned my surgery, how to be a very good surgeon. The next ten years, I spent working in the best hospitals in India (JJ Hospital). The next ten years, I was working in the slums of Mumbai, doing plastic surgery for patients with leprosy who could not afford it. The next ten years, I was training health workers in rural Maharashtra. And for the next ten years, I was with Panchayati Raj".

So, when people saw a highly qualified surgeon "going down" in their interpretation, he said, "I was moving closer to the people, not to my profession".

I think our journey in Sittilingi to a large extent reflects that. We are both clinicians; we are not community health people. But as we got closer and closer to the people, we realized that hospital care or even community health does not bring health to a community in its true sense.

The Early Years in Sittilingi

Tribal Health Initiative has been trying to redefine health. Because when you say "health," many people have many pictures in their mind. Most of them think of hospitals. Some of them think of hospitals and community

health programs. Some of them think of livelihoods. But I think it stops there. Our journey with the community in Sittilingi has been that it goes far beyond that. In our journey of thirty-two years working with our people, we have found that as we go deeper and closer to the community, we realize that health means so many other things to them. In our ignorance, we try and limit it to a certain boundary.

Just after we finished studies, we had two options like many doctors: one is to go to the city or the corporate setup, and the other is to go back to the villages. We chose to go back to the villages.

This is the Sittilingi Valley in 1993 when we went there. It is a valley between two hill ranges, the Kalrayan and the Sitteri hills. The nearest doctor was about 50 kilometers away, and the nearest telephone was about 100 kilometers away. It was a truly isolated tribal community. In one way, it was very good because we could try our experiments with them without any external influence. But it also meant a lot of hardship for us because living there in isolation was difficult.

When we went there in 1993, we had no money. So, we sat down with the tribal community and talked to them. They were grateful enough to say, "There is one acre of wasteland there, you take it". Also, they built us a small hut in 1993. For three years, this was our hospital. It had one small room which was our delivery room and our operation theater, and another larger place which was our outpatient and inpatient.

We faced many initial challenges. One was that we had an Infant Mortality Rate (IMR) of about 147. We had not done that study; the study was done by IIT Chennai. There were many mothers who had died in childbirth. As an anesthetist and gynecologist couple, we thought our first target was to try and reduce the infant mortality and the maternal mortality there.

The distances to travel were a major challenge. There was only one road leading to the valley, and bridges were not built. That meant in times of monsoons, it was completely cut off; buses could not come. Anything you want to buy was 100 kilometers away. And the loneliness—because both of us were alone, and we had nobody to talk to when we had our frustrations.

By 1997, we were able to get some amount of funding, so we built a 10-bedded hospital. Because we had money to get a hospital done, we were able to build a small operation theater and a labor room. That was essential for bringing down the infant mortality because we no longer had to refer patients 100 kilometers away and then wait so much time to know what the outcome was.

For about 3 or 4 years, we had just one single steel table, a 100-watt bulb, no Boyle's apparatus, no oxygen, no blood—just ether and an EMO (Epstein Macintosh Oxford) apparatus. You can't imagine the amount of things you can do with that. We were managing ectopic pregnancies, ruptured uterus, acute abdomen, perforated DU—anything which came our way. The people would say, "Even if we die, it's a dignified death here in our own land. We don't want to go to Salem and die where they will treat us so badly".

We did so many things; it was very challenging. We used auto-transfusion when we didn't have blood. My friends used to ask me, "Without oxygen, how can you operate?" And I used to tell them, "It's a forest. We have 20% oxygen in the air. I think this is more than enough for us". And that was actually more than enough.

We saved a lot of pre-term babies with just a 100-watt bulb, clean nursing, and IV fluids. The surgical overload naturally was too much for us to handle. So, the tribal girls whom we had trained as our health workers—Lalitha will tell you more about that—these 8th-standard pass girls were trained to give general anesthesia. I could intubate, give it to them, finish the surgery, and then extubate. They were very good at spinals and minor surgeries like abscess drainage. Because otherwise, there was no way we could manage that surgical load. I know it is a sort of heresy to tell about this now, but at that time we could just manage with only that.

Dr. Lalitha Regi:

The first five years of our work was mainly in setting up the hospital and training the health workers to man the hospital. The biggest school in the valley had only up to the 8th standard. The teachers would stay in the Taluk headquarters 50 kilometers away. Their week used to start on a Wednesday and end on a Thursday afternoon. So, there was no teaching, and because of that, there was no learning.

So, when we got our initial health workers, we had to teach everything right from basic mathematics to phonetics, to how to read and write one sentence in Tamil without mistake. From there, we went to anatomy, pharmacology, medicine, surgery, and obstetrics. But all our initial senior health workers who are with us now had then studied only up to 8th standard. But they had so much common sense and an incredible eagerness to learn. They became the soul of the hospital, managing the outpatient, the inpatient, the labor room, the

operation theater, and the community health program, in addition to training so many young doctors in later years.

The next five years of our life went into training the Health Auxiliaries and setting up the community health program. The health auxiliaries are women of my generation—some older, very few younger. People of my generation in Sittilingi have not gone to school. So basically, we had the so-called "illiterate" people. They are all farmers.

They did a revolutionary change of bringing childbirth from the backyard of the house first into the verandas and then inside the houses. It is these women who put a stop to maternal mortality and brought down the infant mortality, which was 147 when we went there, to 20 in the early 2000s (when the Tamil Nadu average was 31 and the national average was 52). They were the soul of a very vibrant community health program for a decade after that.

Community Health and Beyond Medicine

Dr. Regi George:

Along with training health auxiliaries, we started our community health programs. We would go to the villages and sit with them—mostly antenatal mothers, postnatal mothers—and have a clinic only for them which included nutrition care. Gradually, the community health program shifted from the doctor to the nurses and health workers. The community had built up so much trust for the health workers and accepted their advice.

All tribal villages have "commons," so the meetings would be in the commons. It is mostly a teaching workshop rather than a healing or clinical workshop. Because of this, medical care got delivered at their doorstep. We saw antenatal checkups shoot up and malnutrition go down because we would take millet to the village, show them how to prepare it so they could give it to their children.

We also found that after mother and child, the most vulnerable community were the elderly who could not come to the hospital. So, we built up an insurance system—our own insurance system, not connected with any company. They pay 200 rupees a year, and then it is a cashless system. They can walk into the hospital anytime.

We also have a school health program in 14 schools in the Sittilingi Valley to get the younger generation to learn the basics of health. Nearby is the Kalrayan Hills, which is about 65,000 population with very little healthcare. We currently have a weekly OPD, but we are building a new hospital there. We debated whether to expand our current hospital or start another one. We realized that Kalrayan patients wake up at 4 AM, walk for two hours to get to the road, and then take a bus to come to us. That tilted the balance to take the hospital to them.

What have we achieved in 20 years?

Our IMR is at 8, which is better than the state. A lot of the credit goes to the community health program and the health auxiliaries. We have not lost a mother for the last 20 years. Tuberculosis is very rare to find in our place now, mainly due to improved nutrition levels.

The Sittilingi experiment wanted to show that formal education is not mandatory to run a good health program. You can train anyone to do anything if you have the will and confidence, and they have the will and confidence to learn. We are only catalysts. We stand at the back; they are the front line.

Farming as Health: The Organic Revolution

By 2004, we had brought down infant mortality to around 50-60, and mothers stopped dying in childbirth. So we went around all the 25 villages and asked them, "Now what?".

They said, "We know only agriculture, and we are running at a loss. Can you help us with that?".

As doctors, we knew nothing about agriculture. But as an institution which believes in Gandhian values, we said we can try and help with organic agriculture. Initially, nobody agreed. They said, "Unless you put urea, unless you put pesticide, how can you grow?".

We went on for two years. Finally, out of pity, four farmers agreed. We asked them to keep accounts and grow two plots—one organic, one chemical. Luckily, the organic farming output was better. These four farmers became our advocates. They went from village to village, and that gave much more credibility than what we told.

Today, we have 700 farmers. It is a Producer Company (SOFA - Sittilingi Organic Farmers Association) with a turnover of more than two crores. Farmers are making a lot of profits. They produce their own fertilizers and pest repellents, run their own marketing, and run their own shop. They are organically certified, and their brand name is SvAD.

One of the things we realized is that if you build up the economy, health takes care of itself. If you have money in your pockets, you will not hesitate to access health. I started telling all my friends working in health: "Forget about hospitals. Think economy. Economy makes a huge difference to health".

Dr. Lalitha Regi:

Along with this, we also built up women entrepreneurship groups. We don't call them self-help groups because self-help groups often just collect money. Enterprise groups borrow money to make money. They started off with millet processing. Now the farming enterprise has grown so big.

We also ventured into governance. We told the farmers, "We will put up our candidates. We do not want politicians ruling our Panchayat". I advised caution because we were fighting against two political parties (DMK and AIADMK) that had been there for 50 years. But the farmers said, "No, we have enough strength". We made a rule: No money for votes, no alcohol. We will only talk about the good things we are going to do.

It was amazing to see the people rise up and campaign by themselves. One of our senior nurses, Madheshwari, was the candidate, and she won by a huge margin. She was our Panchayat President for 5 years. It is amazing the amount of change she made. Every village got electricity and water—not just water to the village, but water to every house because she tapped into the Jal Jeevan scheme. She calls school headmasters once a month and asks, "How can we help you educate our children?". If they say there are no toilets and lady teachers don't come, she builds the toilets.

So now I tell my doctor friends: Think Governance. Unless the people govern themselves, do not expect health in a community.

Inspiring the Next Generation

Dr. Regi George:

We realized that many younger doctors were not happy with the present medical system, especially the commercialization of medicine. So, in 2018, we started the Rural Sensitization Program (RSP) inspired by Dr. Abhay Bang's Nirman. It is a three-day workshop where they see a rural hospital working and understand rural populations.

Following that, we devised the Travel Fellowship. This allows people who have finished MBBS to travel for one year all over India. They can choose three or four organizations from our network of 21 centers. We pay them a stipend and travel expenses. It is amazing to see the transformation in simple-minded young doctors who come in knowing nothing about India and transform into "butterflies" ready to work in rural areas.

Our fifth batch is going on. We take seven candidates per year. I don't think they will ever go back to a corporate hospital after seeing the reality of rural India. It is essential for ARSI to open this window. We are having conferences, but what are we doing to promote the younger generation to see what a wonderful life a rural surgeon leads? That is one thing ARSI should take up seriously.

Reflections and Learnings

Dr. Regi George:

After living and working with the people for 32 years, a lot of reflections have happened.

First learning: How crucial a Team is. However disadvantaged a group of people are, if they are together and determined, positive effects will happen.

Second learning: The basis of any work for positive change has to be Trust. Trust in the goodwill, skills, and potential of ordinary people. In our hospital, 95% of our team are men and women from our villages. Our nurses, lab technicians, pharmacists, drivers, accountants—all are from the valley. It is a local-people-run hospital.Third learning: Perhaps the most profound was about my own Ignorance. Ignorance about the lives of the vast majority of the people of my country. Most middle-class people are cocooned in our own circles. We realized that our people in Sittilingi still hold on to a lot of good, essential human values which the "civilized" world has lost. I have learned and benefited the most than anyone else in Sittilingi.

It is a shame that almost 80 years after independence, we are still discussing anemia in pregnancy in every obstetrician's conference. The people of Sittilingi taught me that anemia is not a nutritional disorder; it is a social disorder. It cannot be solved with iron and folic acid or fortified rice. We need agricultural policies to ensure food security. Growing millets and pulses in a multi-cropping system along with uncultivated greens has protected our mothers from anemia.

Dr. Regi George (Concluding thoughts):

The Bhore Committee (1946) said that without active participation of the people, permanent improvement in health cannot happen. The Alma Ata Declaration (1978) dreamt of "Health for All". But in 2025, the inequity in health is worse than in pre-independent India.

It took a paradigm shift to detach myself from the medical community and think of myself as part of the health community. I request the doctor community to realize that health has more to do with socio-economic and political factors than with the human body and mind. As David Werner said, "The opposite of health is greed". Unequal land distribution causes more ill health than the most virulent pathogen.

"Health for All" is a dream. To me, it means health should mean the same to a child in Palestine, a woman in Manipur, a youth in Kashmir, a tribal girl in Chhattisgarh, or any Dalit or Muslim person in India. When the most disadvantaged person has the same rights and access as the most privileged, only then will we call it "Health for All".

Life is not about waiting for the storm to pass; it is about learning to dance in the rain.

On August 14th midnight, 1947, Jawaharlal Nehru said, "We as a country will wipe the tear from every Indian". How far have we got? Infant deaths, malnutrition, health expenditure are phenomenal.

ARSI was born in fire. I remember the fire of Dr. Banerjee, Dr. Prabhu, Dr. Tongaonkar. Are we fighting now? Or are we losing ourselves in the dull, dreary desert of mediocrity? Are we going to stand up and fight for policy?

I will end with a small anecdote. My son observed a shift change at an IT park in Chennai. The IT professionals coming out were all from South India (Kerala, Tamil Nadu, Karnataka). The people manning the gates, the sweepers, the menial workers coming in for the shift were from North India. They were all born at the same time. Why the difference?

That difference happened because one day, Chief Minister Kamaraj saw a student herding cattle and asked, "Why didn't you go to school?". The boy said, "I can't go to school on a hungry stomach". Kamaraj went back and drafted the Noon Meal Scheme. MGR took it to a large scale. That single policy decision changed the destiny of a generation in South India.

That is the power of policy. And that is what we as ARSI should fight for.

Thank you.

Priorities for Rural Cancer Care and Surgical Workforce Training: Proceedings of the 29th Association of Rural Surgeons of India Conference (ARSICON) 2025

Ardra Asok[1], Mudit Joshi[1], Ankitha Tauro[1], Pankaj Tiwari[1], Shirish Rao[2,3], Raman Kataria[1], ARSICON25 Collaborative*

1. Jan Swasthya Sahiyog (JSS), Ganiyari, Chhattisgarh
2. Association for Socially Applicable Research (ASAR), Pune, Maharashtra
3. Travel Fellow in Primary Care, Tribal Health Initiative, Sittlingi, Tamil Nadu

Abstract

The 29th Annual Conference of the Association of Rural Surgeons of India (ARSICON 2025) convened from February 11–15, 2025, at Jan Swasthya Sahiyog (JSS) in Ganiyari, Chhattisgarh. Organized by a core team from the Association of Rural Surgeons of India (ARSI) and JSS, the conference operated under the theme "Equity in Access to Quality Surgical Care." The event brought together a diverse assembly of rural surgeons, oncologists, public health experts, and policymakers to address the critical disparities in surgical access that persist between urban and rural India. Major discussions focused on cancer care in resource-constrained settings, emphasizing patient-centric, low-cost interventions and the decentralization of care. A parallel focus was placed on workforce development, specifically the training and credentialing of rural surgeons through proposed joint accreditation schemes and the recognition of rural surgery as a distinct specialty. The conference also highlighted innovative models of holistic health, demonstrating the intersection of surgical care with community development and livelihood initiatives. This report summarizes the key themes, consensus points, and strategic directions aimed at strengthening the rural surgical ecosystem in India.

Introduction

The 29th Annual Conference of the Association of Rural Surgeons of India (ARSICON 2025) was held between February 11 and February 15, 2025, at Jan Swasthya Sahiyog (JSS) in Ganiyari, Chhattisgarh. The conference was organized by a core team comprising members from ARSI and JSS, bringing together practitioners from across the country to deliberate on the theme "Equity in Access to Quality Surgical Care".

JSS Ganiyari served as a fitting venue for this discourse, representing a successful model of low-cost, high-quality care delivered to marginalized rural communities. The conference agenda was designed to tackle the most pressing challenges facing rural practitioners today, including the rising burden of non-communicable diseases, the critical shortage of trained surgical specialists, and the need for holistic health models that address social determinants. The scientific program was comprehensive, spanning pre-conference workshops, symposia, panel discussions, and orations that collectively aimed to chart a path toward a more equitable surgical ecosystem in India. A detailed session-wise program agenda is provided in **Table 1**. Major discussions during the conference focused on two key sub-themes. Firstly, on cancer care in resource-constrained settings, emphasizing patient-centric, low-cost interventions and the decentralization of care. A parallel focus was placed on workforce

development, specifically the training and credentialing of rural surgeons through proposed joint accreditation schemes and the recognition of rural surgery as a distinct specialty.

Challenges in the Management of Cancers in Remote and Rural Settings and Ways to Overcome Them

The second day of the conference was marked by a deeply engaging and thought-provoking session centered on the theme "Challenges in managing cancers in remote and rural settings and ways to overcome them." The session featured distinguished speakers, Dr. Ravi Kannan, Dr. Rosina Ahmed, and Prof. Sameer Bakhshi, whose vast experience and nuanced understanding of ground-level realities captivated the audience. The discourse navigated through the complexities of delivering equitable oncology care, addressing the burden of disease, financial toxicity, and the imperative for context-specific research and innovation.

Patient Centric Care and Innovative Service Delivery: The Cachar Experience Dr. Ravi Kannan commenced the session by reflecting on his personal and professional journey in delivering cancer care to underserved populations. He posited a fundamental principle: all treatment must be inherently patient-centric. He argued that if a patient lacks the resources for treatment, the onus falls upon the treating physician to identify pathways for support. In a poignant observation, Dr. Kannan noted that the impoverished patient often copes with out-of-pocket expenditure (OOPE) not by borrowing or distress selling assets, but by simple non-compliance and abandonment of treatment, a harsh reality that resonated deeply with the audience.

Dr. Kannan detailed a suite of innovative strategies employed at the Cachar Cancer Hospital to surmount these barriers. These included the implementation of low-cost services, pro-poor branding, and policies designed to enhance community access and acceptance. He outlined specific initiatives such as reducing waitlists, providing home care visits, establishing satellite clinics, and utilizing telemedicine. Furthermore, the hospital minimizes costs by waiving repeat charges and actively linking patients with government insurance schemes.

To further reduce the financial burden, Dr. Kannan discussed structural strategies, including group negotiations for medicine procurement and active participation in the National Cancer Grid (NCG). He highlighted the critical role of support from funders and partner organizations for patient care, infrastructure, and research. Operational cost reduction measures included the provision of low or no-cost boarding and lodging, maintaining a "no frills" facility with a poor-friendly façade, ensuring non-differential pricing for all services, and eliminating hidden costs. The workforce model relies on multitasking staff and active participation from patient attendants.

Dr. Kannan candidly discussed the iterative nature of these interventions, acknowledging that some strategies failed and required adaptation. He emphasized that human resources are the most valuable asset in healthcare, with technology serving as an equalizer. He described the nursing workforce as the backbone of the system and suggested innovative workforce solutions, such as training local birth attendants (*dais*) as nurses. A resounding message of his address was that monetary compensation alone is insufficient to retain staff in the healthcare sector; only a value-driven work culture can foster long term dedication.

He advocated for a shift from "fundraising" to "friendraising," prioritizing relationship building for patient support programs, education, and prevention activities. He stressed that the organization's philosophy of inclusive health, wellness, and happiness must permeate every level of the staff, from the director to the doorman. Finally, Dr. Kannan highlighted the NCG's role in promoting uniform standards, developing trained human resources, and facilitating multicentric research. He reiterated the need for resource-stratified guidelines that categorize treatment into essential, optimal, and optional levels, ensuring that bare minimum standards are never compromised. He concluded by endorsing task shifting and sharing, such as training general surgeons to perform cancer surgeries, and left the audience with the powerful maxim: "The secret of caring for the patient lies in caring for the patient".

The Burden of Cancer and Financial Toxicity Dr. Rosina Ahmed followed with a comprehensive analysis of the epidemiology and unmet needs in Indian oncology. Citing GLOBOCAN data, she illuminated the alarming rise in India's cancer burden, noting that a new breast cancer case is diagnosed every three minutes, with a death occurring every six minutes Demographic projections indicate a potential 50% increase in incidence and a 60% increase in mortality in the coming years, underscoring the urgent need for robust data collection and a proper cancer registry system.

Dr. Ahmed dissected the geographical and economic disparities in care, pointing out that while the majority of patients reside in rural areas, advanced cancer care remains concentrated in urban metropolitan centers. She identified the high cost of treatment as a critical barrier. In India, where insurance coverage is low compared to nations of similar economic standing, the combination of high OOPE and low coverage pushes many families into debt and "financial toxicity". She critiqued the categorization of healthcare as consumer expenditure and noted that many vulnerable individuals resort to microfinance loans to cover medical costs.

Emphasizing that infrastructure alone is insufficient, Dr. Ahmed argued that the ability to deliver high-quality care is paramount. She stressed that early detection is critical to enabling cost-effective, successful interventions. Delayed or incorrect treatment often converts curable malignancies into incurable ones, wasting scarce resources. She advocated for a return to basic, effective, and low-cost clinical interventions, such as thorough clinical examinations and rigorous infection control using simple measures like soap and water. Additionally, she flagged antibiotic resistance as an emerging healthcare crisis.

Concluding her address, Dr. Ahmed emphasized the necessity of interdisciplinary teamwork and addressed prevalent myths, such as the belief that biopsies spread cancer or that the disease is invariably painful. She also highlighted the indispensable role of psycho oncology in supporting patients through their treatment trajectory.

Contextual Research and Clinical Innovation Prof. Sameer Bakhshi addressed the imperative of conducting meaningful research within resource-constrained settings. He argued that selecting research topics grounded in local needs can lead to impactful outcomes, regardless of resource limitations.s He challenged the notion that successful research requires prestigious institutions or massive grants, asserting that novelty, contextual relevance, and the willingness to innovate are far more critical. To illustrate this, he cited historical examples, such as Dr. Kawasaki, whose seminal

work initially faced rejection, reinforcing that the absence of funding does not preclude quality research.

Dr. Bakhshi advocated for decentralizing cancer care, noting that distinct regions and institutions (e.g., Ganiyari vs. AIIMS) face unique challenges necessitating tailored strategies. He shared personal experiences where constraints at a tertiary care center led to improved outcomes. For instance, a shortage of beds prompted a Randomized Controlled Trial (RCT) comparing oral antibiotics and outpatient management for low-risk febrile neutropenia against standard inpatient care. This approach not only reduced nosocomial infections and antibiotic usage but also lowered costs for patients.

A compelling segment of his presentation focused on utilizing simple, everyday diagnostic tools as biomarkers. Dr. Bakhshi argued that common investigations like Complete Blood Counts (CBC), Liver Function Tests (LFT), and Kidney Function Tests (RFT) can serve as powerful clinical tools. He highlighted that a high Neutrophil Lymphocyte Ratio (NLR) is associated with increased cancer mortality and serves as an advanced prognostic factor, thereby reducing reliance on expensive molecular tests. He also discussed the potential of drug repurposing, such as using olanzapine to mitigate chemotherapy-induced nausea, and the use of oral metronomic therapy in palliative settings as cost-effective alternatives. Furthermore, he touched upon the potential of traditional medicine, such as ginger as an antiemetic, while calling for more rigorous research to gain mainstream acceptance . Reflecting on the COVID 19 pandemic, Dr. Bakhshi noted it as a turning point that taught the healthcare system valuable lessons in adaptability. The shift to teleconsultations, online meetings, and shared care models emerged not as temporary fixes but as opportunities to redefine standards of care. He concluded with a call to action for clinicians to embrace their limitations and work towards care models that are both effective and equitable.

Synthesis and Strategic Directions: The subsequent panel discussion synthesized the wisdom of the speakers, like Dr. C. Rahalkar, Dr. Amit Verma, Dr. Saibal Jana and Dr Keduovinuo Keditsu offering thought-provoking insights into systemic reform. A critical concern identified was that over 70% of Indian cancer patients present at an advanced stage, significantly compromising outcomes due to treatment complexity and lack of specialist access. The panel unanimously prioritized early detection to reduce this percentage. While acknowledging that true population-based screening is not yet feasible in India, the panelists emphasized symptom awareness campaigns and community engagement to identify early warning signs.

The conversation underscored the value of research in low-resource settings, starting with diligent data recording. The panel highlighted that even information regarding treatment abandonment is valuable and must be captured. The appointment of dedicated data managers was recommended to reveal patterns and generate evidence for care delivery. The importance of publishing this data to bring rural realities into the scientific limelight was also stressed.

Collaboration with the government was identified as a non-negotiable strategy, as no private entity can match the scale of the public health system. Leveraging ASHA workers, district health authorities, and bodies like the ICMR can significantly enhance outreach. Partnerships with community clubs and societies were also encouraged.

Regarding clinical management, the panel discussed the overuse of mastectomies in breast cancer, noting that conservative management is often viable. Surgeons in rural areas must be empowered to communicate effectively with patients about these options. The discussion reinforced that patient well-being must always supersede medico-legal concerns, particularly in underserved regions where access is limited. The example of JSS, managing 700 cancer cases and 450 surgeries annually, illustrated that general surgeons in settings like Ganiyari or Cachar often perform complex oncological procedures out of necessity, an imperfect but essential solution.

Finally, the panel addressed financial sustainability. It was noted that if infrastructure costs are met through grants, CSR funding, and partnerships rather than loans, hospitals are not pressured to seek financial returns from patients. Practical cost-saving measures discussed included the use of generic drugs, group negotiations, and technologies like telecobalt machines that allow for efficient, seven-day radiation schedules. The discussion concluded by reinforcing the need for cross-sector collaboration, innovation, and a shared commitment to equitable cancer care.

Training and Credentialing of Surgeons for Rural India with an Eye on Access to Quality Surgical Care with Equity

The workforce crisis in rural India was the focal point of the second major panel discussion, titled "Training and credentialing of surgeons for Rural India with an eye on access to quality surgical care with equity." This session featured Prof. Dr. Minu Bajpai and Prof. George Mathew, who presented structural and academic reforms to address the acute shortage of surgical specialists in peripheral regions. The discussion navigated through high-level policy interventions by the National Board of Examinations in Medical Sciences (NBEMS) to the granular academic restructuring required to define rural surgery as a distinct discipline.

The Joint Accreditation Scheme and Workforce Expansion Prof. Dr. Minu Bajpai opened the dialogue by quantifying the stark disparity in workforce distribution He highlighted that India currently faces a specialist deficit of 1.5 million (15 lakhs), with a concerning geographical skew where 67% of specialists operate in urban centers compared to only 33% in rural areas .n certain states, Reserve Bank of India data indicates that the deficit of specialist doctors reaches as high as 90% He posited that organizations like JSS cannot be omnipresent, necessitating systemic changes driven by national bodies like the National Medical Commission and NBEMS .

To address this, Dr. Bajpai detailed the "Joint Accreditation Scheme" conceptualized by NBEMS . This innovative model addresses the infrastructure limitations of individual rural hospitals by allowing two hospitals to pool their resources, caseloads, and faculty to collectively meet accreditation criteria . The scheme mandates three core criteria: caseload, case mix, and teacher eligibility . Under this framework, extensive resident rotation ensures exposure to diverse clinical environments . Dr. Bajpai noted the immense potential of this initiative; while NBEMS currently accredits 1,700 hospitals offering 17,000 postgraduate seats, India possesses over 70,000 hospitals . Engaging merely 30% of these additional facilities could potentially yield an additional 2.25 lakh postgraduate seats annually . The scheme supports four specific collaborative arrangements: Government to Government, Government to Private, Private to Private, and Stand alone diagnostic centers paired with hospitals .

Credentialing for Procedural Competence A significant portion of Dr. Bajpai's address focused on the "case for certificate courses" to empower general surgeons and physicians working in isolation . He argued that traditional two year fellowships are often impractical for busy practitioners . Instead, he advocated for robust, litigation proof certification courses ranging from three to six months . While citing emerging urban needs like non invasive cardiovascular imaging, the discussion notably pivoted to the specific procedural needs of rural practitioners. There was a strong consensus on the potential inclusion of credentialed courses for general practitioners and rural surgeons in essential, life saving procedures such as spinal anesthesia, diagnostic and therapeutic cystoscopy, and Gasless Laparoscopy (GILLS). Formalizing training in these specific skills would legally and clinically empower surgeons to deliver comprehensive care in resource limited settings without fear of litigation .

Dr. Bajpai emphasized that professional bodies like the Association of Surgeons of India (ASI) must also advocate for these specific courses along with ARSI. To ensure quality amidst expansion, he proposed leveraging digital tools, uniform Standard Operating Procedures (SOPs), and smartphone based learning applications . Furthermore, he introduced a novel "Tripartite Agreement" proposal to increase undergraduate MBBS seats . Modeled on successful Caribbean systems, this approach involves NBEMS handholding corporate hospitals that lack pre clinical departments to partner with medical colleges, thereby utilizing unexploited clinical capacity for undergraduate training .

Rural Surgery as a Distinct Specialty Prof. George Mathew presented the academic argument for recognizing "Rural Surgery" as a distinct specialty rather than a subset of general surgery . He defined the rural surgeon as a specialist operating in a small community with limited urban influence, required to manage life threatening emergencies across a broad spectrum of disciplines including obstetrics, orthopedics, and urology . Prof. Mathew argued that traditional general surgery training is increasingly inadequate for rural needs due to its focus on advanced technologies like robotics and therapeutic endoscopy, often at the expense of fundamental, broad based skills . Consequently, residents trained in high tech urban centers often lack the competence to perform open surgeries or manage obstetric emergencies essential for district level practice . To bridge this gap, he proposed the establishment of an "Academy for Collaborative Training in Rural Surgery (ACTRS)," sponsored and supported by the Association of Rural Surgeons of India (ARSI) .

The ACTRS Training Tracks The proposed Academy would oversee four distinct training tracks to formalize the rural surgical workforce . Track I targets graduates of the Family Medicine diploma, offering them an additional fellowship to acquire essential rural surgical skills . Track II focuses on existing specialists, such as general, orthopedic surgeons or gynecologists, providing a two year distance learning fellowship to broaden their competency into general rural surgery . Track III is designed for qualified general surgeons (MS/DNB) to obtain accredited certification in specific high yield procedures like GI endoscopy, general ultrasonography, basic urology, and pediatric procedures . Finally, Track IV is a "Train the Trainer" program aimed at standardizing education and establishing online learning modules to familiarize mentors with distance education pedagogies .

Task Shifting and Technological Integration The panel also addressed "Task Shifting" as a pragmatic, albeit controversial, strategy to meet rural surgical needs . Defined as the rational redistribution of tasks to health workers with shorter training, this approach allows nurses and technologists to handle specific responsibilities in accident and emergency care or intensive care,

thereby alleviating the burden on the rural surgeon . Complementing this, the role of technology in training was highlighted. Tele mentoring was identified as crucial for intra operative guidance, while Virtual Reality (VR) platforms, such as those used by VRiMS (Virtual Reality in Medicine and Surgery), were proposed as scalable solutions to deliver immersive surgical training to geographically dispersed practitioners using affordable equipment .

Panel Consensus and Strategic Way Forward The open panel discussion, featuring Dr. Raman Kataria, Dr. Sushil Sharma, Dr. Regi George, Dr. Gnanraj, Prof. Dr. Anurag Mishra, Prof. Dr. Dilip Gupta, and Dr. Puneet Dhar, deliberated on the structural barriers to rural training. A primary focus of the discussion was the urgent need to relax accreditation norms by the National Board of Examinations (NBE). The panel argued that limiting training to large institutions excludes the very centers that serve the rural majority. They advocated for allowing smaller hospitals, specifically those with fewer than fifty beds, to participate in training programs. To address the shortage of resident teachers in these smaller settings, the panel proposed relaxing faculty norms to formally recognize and allow visiting or traveling trainers from urban centers and central institutes. This model would allow urban experts to complement rural training, ensuring academic rigor without geographical displacement.

Significant debate emerged regarding the current policy shift towards a 1:2 Undergraduate to Postgraduate training spot ratio. The panelists expressed concern that this aggressive push might inadvertently wipe out the role of General Practitioners and further dilute the competency of fresh MBBS graduates. The discussion emphasized that the "Bachelor of Surgery" degree must be justified by a tangible set of essential and emergency surgical skills that a graduate can perform independently. Consequently, there was a strong call to improve the skills based competency of MBBS training, ensuring that general practitioners remain a viable and capable first line of defense in the surgical ecosystem. To bridge the exposure gap, the panel placed heavy emphasis on implementing structured, skill based rural postings within both undergraduate and postgraduate training curricula.

Highlighting existing successes, the discussion noted that the Government of India has already initiated certified, skill based courses like the National Emergency Life Support program . The session concluded with a mandate for ARSI to actively advocate for these educational reforms with the NBE and National Medical Commission, ensuring that the rural surgeon is not just a product of necessity, but a product of specialized, high quality training.

Holistic Health and Community Development

The philosophy that surgical care cannot exist in isolation from community well-being was captured in the *Balu Shankaran Oration*, delivered by Dr. Regi George and Dr. Lalitha George from the Tribal Health Initiative (THI), Sittilingi. They shared their decades-long journey in the Sittilingi Valley, detailing efforts to reduce neonatal and maternal mortality. Their model illustrated that sustainable health outcomes require a holistic approach, integrating medical and surgical care with agricultural, livelihood initiatives, participatoy democracy and local governance to address the social determinants of health.

Specialized Surgical Sessions

The conference commenced with intensive pre-conference workshops on February 11 and 12, designed to transfer critical skills relevant to the rural context. These included an Acute Critical Care course directed by Dr Ajay Sharma, Dr. Akshay Kumar and Dr. Sumedh Jaju; a Pain Management and Nerve Blocks workshop led by Dr. Shiv Singh. Further, during the conference, specialized sessions on Rural Urology and Diabetic Foot Management were facilitated by Dr Gnanraj Jesudian and Dr Monty Khajanchi ans Dr. Bhatki Sarang respectively. Finally, a workshop on Leadership Development ("Mashaal") was facilitated by the team led by Prof. Dr. Anurag Mishra.

The main conference days featured a diverse array of clinical symposia covering essential rural surgical disciplines. An Orthopedic Symposium addressed orthopedic problems in resource-constrained settings, covering topics such as sickle arthropathy, pediatric orthopedic challenges, and sustainable models for spine care. Complex urological challenges were addressed in dedicated sessions on rural urology and the management of difficult urethral strictures. Significant attention was given to reconstructive surgery, highlighting the necessity of equipping general surgeons with basic plastic surgery techniques and resource manuals to manage trauma and burns in specialist scarce regions. Expanding the scope to maternal and child health, the program heavily emphasized obstetric emergencies, with lectures dedicated to managing atonic postpartum hemorrhage, ruptured uterus, and the pre eclampsia eclampsia spectrum in low resource environments. Additionally, sessions on pediatric surgery focused on empowering the general surgeon to handle common pediatric conditions in remote locations. Furthermore, the evolving role of the rural practitioner was explored in sessions positioning the surgeon as a "Public Health Champion," integrating public health knowledge into daily surgical practice.

Research and Global Surgery

The intersection of research and rural practice was explored in a panel titled "Weighing in on the evidence," featuring Prof. Dr. Dhruv Ghosh and Dr. Ajay Sharma. Prof. Ghosh focused on the work of the NIHR India Hub, highlighting opportunities to partner with rural surgeons for grassroots-level primary research. He issued a strong call for multicentric collaborations to conduct Randomized Controlled Trials (RCTs) and mixed-methods research relevant to rural contexts. Complementing this, Dr. Ajay Sharma focused on the practical application of evidence-based medicine, teaching delegates how to critically understand and apply research evidence within the unique constraints of rural surgical settings.

Community of Practice, Young Voices and Awards

The conference featured sessions led by Dr. Nakul Raykar and the team from the Program in Global Surgery and Social Change (PGSSC) at Harvard Medical School, facilitating a Community of Practice. This initiative was conceptualized as a peer network for facilitated collective learning, designed to foster shared professional growth and support among rural practitioners. The team also conducted a consultation to develop research and policy priorities focused on workforce strengthening and blood banking. Simultaneously, the Voices of Young Surgeons session provided a platform for early-career professionals to share their lived experiences and challenges in rural areas, featuring insights from Dr. Deepak Badhani, Dr. Dipankana Jana, Dr. Tanmay Motiwala, and Dr. Patrick Paul. The conference also recognized exemplary service through the "Champions of Rural Surgery" awards. The academic rigor of the meeting was supported by numerous papers and poster

presentations delivered by students, residents, and early-career professionals. Competive presentations also received awards.

Conclusion

The proceedings of ARSICON 2025 reflect a pivotal moment in the movement for rural surgical equity in India. The discussions moved beyond problem identification to the formulation of concrete solutions. The consensus on cancer care emphasized that low-cost, patient-centric protocols and early detection are as vital as advanced therapeutics. Simultaneously, the dialogue on workforce development laid the groundwork for structural reforms, specifically the Joint Accreditation Scheme and the formalization of rural surgery training tracks via ACTRS. By integrating these clinical and educational strategies with holistic community development models, the conference charted a comprehensive roadmap for the future. The Association of Rural Surgeons of India remains committed to driving these initiatives forward, ensuring that quality surgical care becomes a reality for every citizen.

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Declaration of Generative AI and AI-assisted technologies

During the preparation of this work, the authors used Google Gemini for generating summaries from session transcripts as well as for improving the language readability and formatting of the manuscript. The authors have reviewed and edited the content and take full responsibility for the content of the publication.

ARSICON Collaborative

* Dr. Ajay Kumar Sharma – Consultant Surgeon and Renal Transplant, Royal Liverpool University Hospitals, UK
* Dr. Akshay Kumar – Assistant Professor, Emergency Medicine, AIIMS New Delhi
* Prof. Dr. Alok Chandra Agrawal – HOD Orthopedics & Dean, AIIMS Raipur
* Prof. Dr. Anurag Mishra – Professor of Surgery, Maulana Azad Medical College (MAMC), Delhi

* Prof. Dr. Arun Sheth – Consultant Plastic Surgeon
* Dr. Bhakti Sarang – HOD Surgery, Terna Medical College, Mumbai
* Dr. Bhavna Seth – Dept. of Global Health, Pulmonary and Critical Care Medicine, University of Pittsburgh
* Prof. Dr. Debajyoti Mohanty – Association of Rural Surgeons of India
* Dr. Deepak Chandra Badhani – Sr. Resident, General Surgery, Jan Swasthya Sahyog
* Dr. Deepa K – Consultant, General Surgery, Max Hospital, New Delhi
* Prof. Dr. Dhruv Ghosh – Dept. of Pediatric Surgery, CMC Ludhiana
* Prof. Dr. Dilip Gupta – HOD Dept. of Surgery, MGIMS, Sevagram
* Dr. Dipankan Jana – Fellow in Onco-Surgery, Tata Medical Center, Kolkata
* Dr. George Mathew – Former Principal, CMC Vellore
* Dr. Gnanraj – Rural Surgery Innovations Pvt Ltd.
* Prof. Dr. Gowri Dorairajan – Obstetrics and Gynecology, JIPMER, Puducherry
* Dr. Jacob John – Asthamudi Hospital and Trauma Care Centre, Kerala
* Prof. Dr. L.N. Dorairajan – Urologist, JIPMER, Puducherry
* Dr. Lalitha George – Tribal Health Iniative
* Prof. Dr. M. Murthy – Dept of Anesthesia, CIMS, Bilaspur, Faculty (Acute Critical Care)
* Dr. Manish Mukul – Consultant plastic surgery
* Dr. Meenakshi – Senior Consultant OB-GYN, JSS
* Prof. Dr. Minu Bajpai – Vice President & Honorary Executive Director, NBEMS
* Prof. Dr. Monty Khajanchi – Associate Professor, Seth GS Medical College and KEM Hospital, Mumbai
* Dr. Nakul Raykar – Senior Consultant Surgeon, WHO Collaborating Centre, PGSSC, Harvard Medical School
* Prof. Dr. O.P. Narayan – Association of Rural Surgeons of India
* Dr. Prateek Pal –Association of Rural Surgeons of India
* Dr. Priyanash Nathani – WHO Collaborating Centre for ECO care
* Dr. Puneet Dhar – Association of Rural Surgeons of India
* Dr. Rajesh R. Tongaonkar – Senior Consultant OB-GYN, Dondaicha
* Prof. Dr. Rampal Singh – Dept. of Anesthesia, AIIMS Raipur
* Dr. Ravi Kannan – Director, Cachar Cancer Hospital and Research Centre, Assam
* Dr. Regi George – Tribal Health Initiative
* Dr. C. Rahalkar – Senior consultant, surgery, JSS.
* Dr. Rosina Ahmed – Tata Medical Cente r, Kolkata
* Prof. Dr. Sameer Bakhshi – Medical Oncologist, AIIMS New Delhi
* Dr. Saibal Jana – Senior surgeon, Shaheed hospital, Dalli Rajhara
* Prof Dr. Shah Alam – Pediatric Orthopedics, AIIMS Delhi
* Dr. Shekhar Bhojraj – Spine Foundation, Mumbai
* Dr. Shilpa Khanna – Consultant, Anesthesia & Pain Medicine, Sangwari, CG Faculty Pain management workshop.
* Dr. Shiv Singh – Senior Consultant, Dept of Anesthesia, Royal Liverpool and Broadgreen University Hospitals, UK
* Prof. Dr. Subrata Kumar Singha – Dept of Anesthesia, AIIMS Raipur
* Prof. Dr. Sukumar Maiti –Association of Rural Surgeons of India
* Dr. Sumedh Jaju – Associate Professor, Critical Care, AIIMS Nagpur
* Dr. Sushil Sharma – Arohi, Uttarakhand

ARSICON 2025

Abstracts

An oft repeated axiom- "hyperthyroid glands are generally not malignant, and hyperfunctioning thyroid tumors are usually benign", was examined closely.

Dr Deepak Chandra Badhani, Dr Dev Sao, Dr C Rahalkar, Dr Raman Kataria
Jan Swasthya Sahyog

Abstract:
Background: As per GLOBOCAN 2022, thyroid malignancy is 18th most common malignancy in India, and the most common endocrine carcinoma. Initially hyperfunctioning of thyroid gland association with thyroid malignancies was believed to be a rare event and it was reported that hyperthyroidism had a protective role against thyroid neoplasms. As per recent literature from last few decades, it was observed that hyperthyroidism and thyroid neoplasms can coexist and variable degree of aggression and invasiveness has been reported which has an impact on overall management. Originally, due to rare coexistence of both variables, Basedow-Graves was even described as an "insurance against thyroid cancer". In 1970, Shapiro et al reported a rate of 8.7% among patients with hyperthyroidism and 2-20% as per various reports available in literature. Hyperfunctioning thyroid gland in thyroid malignancies can occur in 2 settings- primary thyroid carcinoma and metastatic thyroid carcinoma. Thyroid metastasis is a rare event as thyroid activity and hypothalamic-pituitary-thyroid axis play pivotal roles at modulating the function of the immune system.
Methods: We have analysed retrospective data from hospital-based cancer registration system and recorded total number of thyroid malignancies in last 4 year (1st January 2021-31st December 2024) and association of hyperthyroidism was noted. Various types of thyroid malignancies were noted down along with their histopathological characteristics.
Results: Total 43 patients are identified with thyroid malignancies during above mentioned duration. Out of 43, 36 were females and 7 were males. Papillary thyroid Carcinoma was the commonest variant with follicular as commonest subtype. 18.60% had hyperthyroidism. 4.65% had hypothyroidism. Follicular carcinoma was 2nd commonest followed by anaplastic carcinoma thyroid. Medullary Carcinoma was least common. Pre operative neomarcazole and beta blockers along with Lugol's iodine was given wherever needed. Post-operatively, hyperthyroidism was controlled in all except three patients who had follicular carcinoma with large metastases to the skull.
Conclusion: It is recommended for future guidelines to reconsider a detailed radiographic evaluation or a thyroid scintigraphy at the initial presentation in patients with no palpable nodules and not just in patients with nodular thyroid disease and thyroid receptor antibody negative disease. Delayed interpretation of thyrotoxicosis with thyroid malignancy can lead to inappropriate treatment and worsen the overall prognosis including perioperative management. Ours as a rural setting, this is first such description which highlights the importance of adequate pre operative work up while dealing with thyroid malignancies. Our study repudiates the notion that hyperthyroidism is an insurance against thyroid malignancy and the need for proper evaluation before surgery.
Key words: Thyroid malignancy, hyperthyroidism, radiographic evaluation, GLOBOCAN.

Effect of Palliative Care on Adult Cancer Patients Presenting to a Tertiary Care Hospital in Rural India

Dr. Sharon, Ms Shramana Roy, Dr C Rahalkar, Sister Deepika , Sister Maheshwari, Dr Raman Kataria
Jan Swasthya Sahyog

Abstract:
Introduction: Cancer care in rural India is often constrained by late-stage diagnoses, limited healthcare access, and significant socioeconomic barriers. Palliative care plays a crucial role in alleviating pain, improving quality of life, and supporting patients holistically. This study evaluates the impact of early palliative care integration- including symptom management, psychosocial support, and palliative surgeries on adult cancer patients at Jan Swasthya Sahyog (JSS), a tertiary care hospital in rural Chhattisgarh.

Methods: A prospective longitudinal cohort study was conducted among adult cancer patients presenting to JSS's outpatient department. Patients were assessed at baseline and during follow-ups using validated tools measuring pain intensity, functional status (ECOG scores), and health-related quality of life (EORTC QLQ-C15 PAL). Standard oncological treatments were complemented by early palliative interventions, including opioid-based pain management, psychosocial support, and palliative surgeries for symptom relief.

Results: Of 269 enrolled patients, 176 completed all three follow-ups. Pain was the most commonly reported symptom (91.4% at baseline), with a significant reduction following palliative care interventions (mean pain score decrease from 4.6 to 2.07, $p < 0.001$). Strong opioids like morphine were administered in 38% of those with pain complaints. Functional status improved, with a statistically significant reduction in ECOG scores ($p = 0.021$), indicating better daily activity levels. Emotional well-being and overall quality of life showed marked improvements on the EORTC scale (mean increases of 17 and 14 points, respectively). The tool based scores were complemented with subjective patient reported relief through few case stories. Palliative surgeries provided symptomatic relief to 53 patients such as diversion stoma, bypass surgeries, feeding stoma, toilet mastectomy, salvage surgeries, etc. Socioeconomic analysis revealed that 66% of patients belonged to the upper lower income group, the majority (58%) relying on unskilled labor for livelihood, and a median travel distance of 150 km, highlighting accessibility challenges. Despite these barriers, structured palliative interventions improved symptom control, emotional well-being, and treatment adherence.

Conclusion:
Early integration of palliative care significantly benefits cancer patients, even in advanced stages. The study underscores the critical role of rural practitioners including surgeons in palliative interventions and highlights the need for decentralised, home based palliative care models such as Kerala's community driven approach to reduce travel burdens and enhance accessibility. Strengthening state-supported palliative care services at the grassroots level is imperative for improving patient outcomes in resource-limited settings.
Key words: Early palliative care integration, Rural oncology care, Palliative surgeries, Symptom management

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Long term outcomes following mosquito net mesh repair for inguinal hernia in a rural hospital

Shaba Fathima, Dr Ravi Kumar, Dr Sneha Sunil Thachil
Tribal Health Initiative, Sitlingi, Tamil Nadu

Abstract:
Objective: To assess long term outcomes following inguinal hernia repair using mosquito net mesh in a rural secondary care hospital

Background: Inguinal hernias are amongst the most commonly performed general surgical procedures across the world. But the cost of commercial prolene mesh is prohibitive for hospitals operating in low resource settings.

Methods: Patients who underwent primary inguinal hernia repair using mosquito net mesh in our hospital in the years 2011-15 were evaluated for recurrence and chronic pain.

Results: A total of 120 participants were operated in the years 2011-15. 105 patients were seen in follow up. The overall recurrence rate and chronic pain rate was comparable to that of open repairs using commercial prolene mesh.

Conclusion: Mosquito net mesh is a innovative way to address the high cost of commercial prolene mesh. We advocate the use of mosquito net mesh not only in resource poor hospitals but also in resource rich centres.

Key words: Mosquito net mesh, Inguinal Hernia, Low resource settings

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Navigating Surgical Management of Pott's Spine: Experience from Rural Hospital in Central India

Dr Killol Borad, Dr Aditya Kesharwani, Dr Gajanan Phutke, Dr Raman Kataria
Jan Swasthaya Sahyog

Abstract:
Pott's spine, a manifestation of tuberculosis constitute 50% of skeletal tubercular infections and poses significant challenges, especially in rural settings where access to healthcare can be limited. This case series explores the surgical management of Pott's spine in a rural tertiary care hospital, highlighting the resilience of patients and their outcome.
We reviewed the medical records of patients diagnosed with Pott's spine who underwent surgical intervention. The study utilized a combination of clinical evaluations, imaging studies, and postoperative assessments to evaluate outcomes. Despite the challenges posed by geographical barriers and resource constraints, our findings indicated a positive trajectory in patient recovery, with notable improvements in pain relief and mobility. Three patients who had bladder and bowel dysfunction at presentation improved following the surgical intervention. The results underscored the importance of timely surgical intervention, even in resource-limited settings, and illustrated how dedicated healthcare teams can lead to successful outcomes.

Key words: Pott's spine, Tuberculosis, Surgical intervention, Rural setting

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Our experience in the management of empyema thoracis in children : A retrospective study.

Agrawal Yash Sanjay, Dr Manasa Ranjan Dash, Dr Rajinder Kumar Mishra,
MKCG, MCH, Berhampur, Odisha.

Abstract:
Title : Our experience in the management of empyema thoracis in children: A retrospective study

Objective: The objective of this study is to evaluate the effectiveness of early decortication through open posterolateral thoracotomy in the management of empyema thoracis and to assess the feasibility of performing this procedure in a general surgery setup.

Methods: This retrospective study was conducted in a Pediatric Surgery Department of a single center from March 2019 to December 2024. Records of all the patients diagnosed with empyema thoracis were assessed. Those patients who underwent open thoracotomy with decortication during the study period, were included in the study. Their records were assessed to look for the selection criteria for surgical management, operative details, post operative period, complications and treatment outcomes on follow up. Outcome was assessed based on treatment duration, postoperative complications, symptom resolution, and return to pre-illness functionality.

Results: A total of 35 patients underwent successful open thoracotomy with decortication for empyema thoracis, with a median age of 6 years. The youngest being 10 months and oldest being 14 yrs. Patients diagnosed with stage III empyema or stage II empyema not responding to conservative management for 15 days were selected for open thoracotomy with decortication. All the surgeries were performed by the same team of a paediatric surgeon and a general surgeon, with 15 of them performed independently by a general surgeon under the supervision of a paediatric surgeon. Posterolateral muscle-splitting technique was used in all cases. Surgery duration ranged from 70 to 120 minutes. No patients required postoperative ventilatory support/inotrope support. Recovery was uneventful for all patients, with complete lung expansion on x ray at discharge. All except 2 patients were discharged at an average of 7-10 days postoperatively. One patient with necrotizing pneumonia required prolonged ICD drainage for 28 days, while another had a persistent air leak requiring ICD manipulation and was discharged on post operative day 21.There was no incidence of wound infections. One patient had shoulder movement restriction at 15 day follow up, which had resolved with physiotherapy. No other complications were reported in any other patient on follow up at 2 weeks and 1 month. No additional follow-up was reported, suggesting recovery.

Conclusion: Open thoracotomy with decortication is an effective and safe treatment for pediatric empyema thoracis, offering a definitive cure with minimal complications. The procedure can be performed successfully by a trained general surgeon without the need for specialized ICU care or advanced pediatric surgical equipment. Early diagnosis and timely intervention are essential to reduce morbidity and reduce the avoidable socio-economic burden on patients and their families.

Key words: children, empyema thoracis, thoracotomy, decortication

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Prospective closed loop audit on adherence of operative notes in tertiary care surgical unit in central India

M Mohammed Imran, Dr Pawan Agarwal
Non Academic Junior resident doctor, department of Neurosurgery

Abstract:
Introduction Medical record keeping forms a crucial and important aspect of good clinical practice .Surgical documentation is necessary for patient's post operative care , academic training, research and medico legal purposes

Aim
Main goal of this surgical audit is to evaluate the quality of operative notes against Royal college of surgeons England good surgical practice guidelines released in 2014 ,to recognise the problems and make necessary changes in a tertiary care center in India.

Materials and methods
A prospective closed loop Audit with the first cycle of audit being conducted in June-July 2023 ,operative notes of 150 patients were assessed by a checklist comprising 19 variables of RCS England good surgical practice guidelines. A proper analysis of the findings was presented to the surgical team emphasizing on the problems and scope of improvement.Changes were made in operative notes proforma .A second cycle of audit of 150 operative notes was conducted in August-September 2023 and results was analyzed

Results
In the first cycle an overall 53.4% of all parameters were documented in operative notes.Time of procedure, Elective/Emergency Procedure,Name of theater anesthetist, anticipated blood loss and DVT prophylaxis were not documented (0%). In re-audit there was significant improvement in several parameters such as Elective/emergency procedure(78%), anticipated blood loss(44.6%)Name of theater anesthetist(44%) ,time of procedure (34%), antibiotic prophylaxis (22.7%) and Legibility improved by 16% . Overall 72.4% of all the parameters were documented in the second cycle with an improvement of nearly 19% compared to previous cycle.

Conclusion
Our audit has demonstrated a positive impact and has led to improvement in knowledge among the surgical team regarding the surgical documentation. Such closed loop audits should be conducted regularly to further improve and ensure continuation of good surgical practice.

Key words: Surgical education, good surgical practice, closed loop audit, operative notes documentation

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Xanthogranulomatous inflammation involving different organ in different patients- Diagnostic and operative challenges, learning from a secondary care hospital in rural Central India

Dr Dev Sao, Dr Deepak Chandra Badhani, Dr C Rahalkar, Dr Raman Kataria, Dr Nitin Agarwal (Consultant Pathologist)
Jan Swasthya Sahyog

Abstract:

Background: Xanthogranulomatous inflammation (XGI) is a rare but well described disease process first reported in the genitourinary tract.[1] It can involve any organ, but the most common sites are kidney and gallbladder. Other possible locations include endometrium, ovary, fallopian tubes, vagina, testis, epididymis, gall bladder, stomach, bone, skin, appendix, urinary bladder, thyroid and adrenal glands. It is an uncommon variant of chronic inflammation and a well-established pathological entity which may be associated with infection and obstruction, defective lipid transport, immunological disturbances, and often confused as a malignant neoplasm, and the diagnosis is usually confirmed on histopathology. Its importance lies in the fact that clinically and radiologically, it can be confused with carcinoma. Awareness of this inflammatory lesion is important to the pathologist and treating surgeon to prevent extensive surgery and also over diagnosis as malignancy. Although a correct diagnosis is chiefly made through histopathology, a suggestive preoperative and intraoperative diagnosis of XGI could lead to less radical surgery. The radiologic findings are usually nonspecific and it may be difficult to recognise sometimes and to comment on final diagnosis preoperatively.

Methods: In the Department of General Surgery who attended OPD from 1st January 2023 to 31st December 2024, 8 different patients were diagnosed to have xanthogranulomatous inflammation of colon, ovary, kidney, gallbladder, and lung of different age groups. Description of diagnostic and intraoperative challenges have been discussed along with case description separately.
Results: Out of 8 patients, 5 were males and 3 were females. There is one mortality in xanthogranulomatous involvement of lung in post operative period due to severe sepsis. This patient had already received antitubercular treatment three times over a duration of 3 years on clinicoradiological basis and there was no improvement in complaints of chronic cough, breathlessness and occasional haemoptysis. One patient who had xanthogranulomatous involvement of ovary had received neoadjuvant chemotherapy as well.
Conclusion: Xanthogranulomatous inflammation of any organ especially kidney, colon, and gall bladder have to be differentiated from malignancy and tuberculosis radiologically, intraoperatively as well as histopathologically to arrive at a confirmed and appropriate diagnosis as well as to avoid over and under management of these illnesses. The radiological interpretation is often difficult because it mimics malignancy with presentation as a mass and loss of fat planes with adjacent structures, due to extensive inflammation and fibrosis. Hence, a multidisciplinary approach is needed including surgeons, radiologists, and histopathologists while managing these conditions. It is important for a surgeon who is working in the rural parts of the country to know about the pathology and how it usually presents where there is usually limited facility of investigations.
Key words: Xanthogranulomatous inflammation (XGI), malignancy, tuberculosis, histopathology.

Evaluating the Usefulness of Umbilical Vein Catheterization via extraperitoneal approach in newborn.

Dr Agrawal Yash Sanjay, Dr Manasa Ranjan Dash, Dr Rajinder Kumar Mishra
MKCG MCH, Berhampur, Odisha.

Abstract:
Title - Evaluating the Usefulness of Umbilical Vein Catheterization via extraperitoneal approach in newborn.

Objective
1. To observe the outcomes and potential pitfalls of umbilical vein catheterization in neonates.
2. To assess the feasibility of performing the procedure in low-resource settings.

Methodology: This is a single-center, retrospective study conducted over the period from January 2021 to June 2022. Records of all neonates who underwent umbilical vein catheterization were assessed. Those neonates who underwent catheterisation through the umbilical stump were excluded from the study. Selected records were assessed for the indication, procedure, and early complications.The average duration of the catheter was noted. Records were assessed to look for long term complications.

Results: A total of 27 neonates underwent umbilical vein catheterization during the study period. Of these, 12 were preterm and 15 were term, with an average catheterization age of 7 days (range: 3–32 days). The most common indications for catheterization were exchange transfusion (65%) in term infants and difficulty

accessing peripheral lines in preterm infants (80%). Other indications included sepsis (4 cases), and surgical needs (2 cases each of meconium ileus and jejunal atresia). All the procedures were performed with an extraperitoneal approach. Peritoneal breach occurred in 15 cases, repaired with Vicryl 4-0, with no peritonitis reported. 5 Fr feeding tube was used in both the term and preterm neonates. Feeding tube was fixed at the 5-6 cm and 4-5 cm mark for term and preterm infants respectively. X Ray was used in stable patients to confirm the catheter position. All the procedures were performed by a general surgery resident, after training by a paediatric surgeon. 100% of the catheter were successfully functional. The average catheterization duration was 7 days, with 2 patients requiring prolonged catheterization of 10 and 14 days each i/v/o prolonged IVF requirement and no peripheral venous access. Complications included catheter dislodgement (2 cases), blockage 1 case, and 1 case of sepsis. One patient had developed portal vein thrombosis at 3 months follow-up.

Conclusion: Umbilical catheterization is a safe and easily accessible method of venous access in neonates, requiring minimal instrumentation and can be successfully performed by junior doctors in low-resource settings with proper training. However, due to the potential serious complications, it should be considered only when all other methods of venous access have failed.

Key words: umbilical vein catheterisation, vascular access

Global Surgery Community Of Nurses, Novices, Experts, Clinicians, & Technicians (CONNECT): A Pilot WhatsApp Community of Practice for Frontline Surgical Providers

Isaac G. Alty, MD, Priyansh Nathani MBBS; Radzi Hamzah MD; Harshit Arora MBBS; Riya Sawhney MBChB; Roopa Rawat RN; Anurag Mishra MD; Bhakti Sarang MD; Monty Khajanchi MD; Anita Gadgil MD; Nobhojit Roy MD; Nakul P. Raykar MD MPH
Harvard Program in Global Surgery and Social Change

Abstract:
Background: Little has changed for frontline surgical practitioners (or their patients) in rural corners of the world in the 10 years since The Lancet Commission on Global Surgery. There has been a limited influx of newly trained surgeons, anesthesiologists, or obstetricians to low-resource rural areas, where patients are often too poor to travel to cities for care. In 2025, the frontline practitioner still remains the first and last line of hope for the impoverished patient with a surgical problem. Despite the critical access role filled by the frontline practitioner, they have largely been neglected by the broader global surgery community. Frontline surgeons in LMICs report high rates of professional isolation with scant contact with peers and the broader global surgery network, limited capacity for research and scholarly activity, and scarce access to educational resources for professional development. In the absence of community, the result is high rates of burnout and departure from the already-overextended rural surgery workforce. And while robust communities of practice (COPs) exist for specialists such as burn surgeons or critical care nurses, no such resource exists for the broad range of individuals that comprise frontline surgical providers.

Methods: This pilot implementation study employed the WhatsApp Communities platform as a virtual COP for surgical nurses, technicians, and physicians across diverse hospital contexts in India, including academic medical centers and primary rural hospitals across multiple regions. Polls were administered to participants to characterize institutional clinical resources and practices for sterilization, blood availability, and referrals. Participation metrics were recorded anonymously in aggregate, and analyzed using descriptive statistics.

Results: Over 6 months, the community grew to 146 members. Over a total of 32 clinical consultations, the median time to first response was 15 minutes (IQR=67 min). The average number of poll respondents was 13 (9% response rate) for blood availability, and 8 (5%) for referrals. Most respondents (73%) were from hospitals with >40 patients/ward, 20% were from hospitals with 10-20 patients/ward, with 75% at tertiary hospitals, 6% at secondary hospitals, and 19% at primary hospitals. Participants most commonly administered 6-10 transfusions per week (42%), with 75% of participants reporting advanced blood screening capacity, and 93% having on-site blood banks. Blood availability was an issue, mostly being “occasionally unavailable” (44%), and occasionally “almost always unavailable” (11%). 40% of participants

reported directed blood donations from patient friends/family members, and 60% from non-directed voluntary donors. Regarding referrals, participants most often referred patients multiple times per week (67%), most frequently due to need for advanced treatments (58%). Barriers to transfer included transportation (21%), communication barriers between healthcare personnel (36%), and patient finances (43%).

Conclusion: Frontline surgical hospital workers engaged to variable degrees with the WhatsApp community platform through clinical case discussions, educational polls, and webinars. Although poll response rates were low, they revealed that frontline providers face blood shortages and multifaceted barriers to patient referrals. Strategies to increase provider engagement in the future may include recruitment of local champions, customization of COP platform, and profession-specific communities to reduce hierarchical barriers.

Key words: Global Surgery, Frontline Surgical Provider, Rural Surgery, Community of Practice, Implementation Science

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Making it work, A model for high-quality maternity care in a tribal hospital in Tamil Nadu.

Adhithya Raj PK, Dr. Pravin Singarayar, Dr Ravikumar, Dr Arthy Shakthi Bala C R
Tribal Health Initiative, Sittilingi, Tamil Nadu, India

Abstract:

Introduction: Rural obstetric services are quintessential for providing respectful and high-quality maternity care for rural communities across the nation. Identifying and describing common factors and best practices of hospital-based obstetric units in rural communities is important as rural hospitals continue to face multiple challenges nationwide. The objective of this study is to describe the obstetric and neonatal outcomes of a Tribal hospital, in southern India in the year 2024. Identify the key factors that underlie a successful model of rural maternity care in the tribal hospital.

Methodology: It was a retrospective analysis, of mothers who had come for antenatal check-ups and had given birth at the tribal hospital for a duration of one year (January 2024 to December 2024) which also involved data collection from registers and case files. %). Further audit and classification of the Caesarean section as per Robeson's criteria was done. We also audited the labour induction rates, perineal tear incidence, anaemia prevalence, and neonatal outcomes amongst other quantitative variables. This was followed by a qualitative analysis to identify factors that have contributed to the high-quality obstetric and neonatal outcome, which included the field visit program, collaborative care involving health staff and midwives, antenatal education & nutritional program, antenatal exercises, Customised growth charts(Customised perinatology charts for India). Alternative birthing positions. Bereavement care programs.

Results: A total of 471 women gave birth at the Tribal hospital for one year. Out of the 471 births, 413 had vaginal births (87.6%); this included 364, full-term normal vaginal births (77.2%), and 39 vacuum-assisted terms vaginal delivery (8.28%). Outlet forceps birth at term for 7 women (1.48%) & 3 term breech births (0.63%) (Opti-breech technique). Mothers who underwent lower segment Caesarean section births were 58 (12.3%), out of which 26 (6.23%) mothers underwent elective repeat Caesarean section births for previous Caesarean section. Mothers who underwent primary Caesarean sections were 32 (6.7%).

Conclusion: Based on our study, we found out that we had a lower chance of Caesarean section and overall better maternal and neonatal outcomes. Owing to strict adherence to evidence-based practices and adaptation of protocols as per the resource capabilities, one-on-one midwifery care, community outreach programs, antenatal education, use of appropriate technology, and respecting the age-old traditions of the community.

Key words: Rural obstetrics, Respectful maternity care, Reducing Caesarean sections.

Overcoming Challenges in Reconstructive Surgery for Oral Cancer in a Rural Tertiary Care Setting: The Role of PMMC and Flap Conditioning

Dr. Sharon, Dr. Chandrasekhar Rahalkar, Dr Raunak Kalwani
Jan Swasthya Sahyog

Abstract:
Background: At JSS, a rural tertiary care hospital in central India, over 700 new cancer cases are diagnosed annually, with oral cancer constituting more than 30% of these cases. Many patients present at advanced stages, particularly with oral cancers, requiring extensive resections that result in significant deformities. While microvascular surgery is considered the gold standard for reconstructions, its implementation is constrained by factors such as limited access to specialist surgeons, high surgical costs, prolonged procedure times, crucial planning, and a heavy surgical workload.

Methods: A retrospective analysis was conducted of 320 oral cancer cases treated at JSS from 2022 to 2025. Of these, 43 patients underwent reconstruction with pectoralis major myocutaneous (PMMC) flaps, and 5 patients with free fibular flaps, with the first free flap reconstruction performed in July 2023. Due to inaccessibility of offering microvascular reconstructions, PMMC flaps remained the primary reconstructive approach at JSS. Flap conditioning/flap priming in PMMC was innovated at JSS to improve flap perfusion and survival, by a process that involves raising the flap without severing its pedicle which can improve perfusion of the flap especially in patients with severe undernutrition, poor muscle mass, or large defects, and in female patients where additional challenges are faced.

Results: Out of the 43 patients who underwent PMMC reconstruction, for 12 patients, flap conditioning was done prior to definitive surgery. Of the 43 PMMC flaps, only 5 patients had complete flap necrosis, requiring another surgical procedure with alternative flaps, while 2 out of the 12 conditioned flaps had partial necrosis. These failures could also be largely attributed to factors such as severe undernutrition or extensive defects. For Mid-mandibular resections requiring reconstruction, we used split-reversedrib graft as struts alongwith PMMC flap. In selected cases we did free fibular myocutaneous flaps for this purpose.

With microvascular surgeries, we encountered several challenges, including the need for significant surgical expertise, long operation times in a busy theatre, and the requirement for additional workforce, specialized instruments, detailed planning and coordination. Furthermore, the demands of post-operative care posed additional strain on resources. Among the 5 patients who underwent microvascular reconstruction, 1 had partial flap loss, requiring a split-thickness skin graft. The average hospital stay for microvascular patients was 14-18 days, comparatively longer than those who underwent PMMC reconstruction, resulting in delays to receiving adjuvant radiotherapy.

Conclusion: In rural settings with resource constraints, PMMC flaps remain the workhorse of reconstructive surgery for oral cancer. The introduction of flap conditioning has expanded the applicability of PMMCs, offering a viable alternative to microvascular surgery, and helping address the gap in access to advanced reconstructive techniques. This approach is particularly beneficial in managing complex cases in settings with high patient volumes and limited resources.
Key words: PMMC flap conditioning, Oral cancer management, Surgical innovation, Reconstructive surgery, Addressing access gap

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Patient demography and disease characteristic in breast cancer in patients presenting to a tertiary rural hospital in central India

Vignesh, Dr C Rahalkar, Dr Dev Sao, Dr.Raman Kataria
Jan Swasthya Sahyog

Abstract:
Background: Breast cancer is a significant public health concern, with variations in patient demographics and disease characteristics across different regions. Understanding these factors in rural tertiary care settings is essential for improving diagnosis and treatment strategies.

Objective: This study aims to analyze the demographic profiles and disease characteristics and IHC profile of breast cancer patients in a tertiary care hospital in rural India.

Methods: A prospective observational study was conducted, including all breast cancer patients treated at JSS,Ganiyari from july 2022 to july 2024 . Data on age, socioeconomic status, tumor stage, histopathological subtypes, including IHC and treatment modalities were collected and analyzed using MS Excel sheet.

Results: The median age of patients was 50 years, with belonging to 51% upper lower socioeconomic backgrounds. The most common histopathological subtype was infiltrating ductal carcinoma, and 3% of patients presented with early-stage disease. Details of IHC profile are provided.

Conclusion: The study highlights a high prevalence of late-stage presentation, emphasizing the need for enhanced screening programs and awareness campaigns in rural areas. These findings provide valuable insights for policymakers and healthcare providers in tailoring breast cancer management strategies.

Key words: Patient demography,disease characteristic in breast cancer

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Randomized Controlled Trial Comparing VAC Therapy Alone and VAC Therapy Combined with Local Oxygen Delivery for the Management of Diabetic Foot Ulcers

Dr Keval Dhone, Dr. Rajiv Sonarkar
Assistant Professor, Dept of Surgery,Datta Meghe Medical College,Nagpur.DMIHER

Abstract:
Diabetic foot ulcer is soft tissue infection characterized by rapid tissue destruction, systemic toxicity, and high mortality rates. Effective management involves prompt surgical debridement, antibiotic therapy, and advanced wound care techniques to promote healing and minimize complications. Vacuum-Assisted Closure (VAC) therapy is widely used in managing complex wounds, including those resulting from DM foot, as it enhances granulation tissue formation, reduces edema, and promotes wound contraction.

This study aims to compare the efficacy of VAC therapy versus VAC therapy combined with local oxygen delivery in the management of DM foot ulcers. Local oxygen delivery is hypothesized to enhance wound healing by improving tissue oxygenation, thereby stimulating angiogenesis, reducing bacterial load, and supporting cellular repair mechanisms.

The project involves a randomized control trial with two groups: one receiving VAC therapy alone and the other receiving VAC therapy with local oxygen delivery. Outcomes such as wound healing rates, granulation tissue formation, bacterial clearance, and overall treatment duration will be assessed.

This comparative analysis seeks to determine whether the addition of local oxygen delivery to VAC therapy offers significant clinical benefits, potentially establishing a more effective treatment protocol for patients with DM foot ulcers

Key words: diabetic foot, VAC, Local oxygen therapy, Healing rate

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Mycetoma, a Neglected Tropical Disease: Understanding of various determinants-diagnostic challenges, financial burden and psychosocial impact of a chronic disease, learnings from Rural Central India.

Dr Deepak Chandra Badhani, Mr Ramcharan, Dr Dev Sao, Dr Raman Kataria
MCh Paediatric Surgery Trainee, AIIMS New Delhi, Ex SR Jan Swasthya Sahyog

Abstract:
Background: Mycetoma is a chronic, specific, granulomatous, progressive, destructive inflammatory disease caused by bacteria (actinomycetoma) or fungi (eumycetoma). It is a devastating, neglected tropical disease characterised by extensive tissue destruction, deformities, and disabilities in the affected patients. Because

of the variation in the climate, socioeconomic factors, and the variations as well as lack of reporting of cases in the literature, epidemiology of the disease is undetermined. Scarcity of reports or underreporting of cases from the Chhattisgarh causes ambiguity in predominance of eumycetoma or actinomycetoma due to which there is no data on exact number of cases from these geographical terrains. The commoner sites involved are lower limb and upper limb. The lesser common sites include trunks, buttocks, eyelids, lacrimal glands, paranasal sinuses, nails, mandible, scalp, neck, perineum and testes. Early diagnosis followed by treatment (surgical intervention wherever required) is required in most of the cases to avoid relapses. There are only 1-2 case reports from Chhattisgarh (Pratibha Sharma et al, 2020) in which the description of various determinants related to overall management has not been discussed.
Methods: We have evaluated patients with chronic discharging sinuses over limbs and extremities from 1st January 2023 to 31st March 2024. We have diagnosed total 7 cases of Mycetoma during this time duration and assessed them for various challenges namely diagnostic, financial, and psychosocial impact of their illnesses on them and their families.

Results: Our learning during management of these cases were diagnostic dilemmas related to the management of these conditions (radiological and histopathological), financial burden due to long hospital stay for frequent debridement under anesthesia and drugs for management of these conditions (Voriconazole as per PM Jan Aushadhi Yojana 3150 INR for 6 months and 80,000 INR from other sources and availability has always been a concern). Frequent hospital visits also increase overall out of the pocket expenditure and sometimes associated disabilities which can vary from limited amputation (ray amputation) to major limb loss (below knee amputation in a patient requiring repeated debridements over 7 months and prolonged hospitalisation, begged for amputation to get over his treatment exhaustion).

Conclusion: With this study our focus will be on how to make appropriate diagnosis in the earliest possible time (open biopsy under general anaesthesia is the recommendation), to offer them drugs at lowest cost possible by means of advocacy and the availability and accessibility of surgical care in the district hospital by appropriate teaching and training measures to reduce the burden of these illnesses from the community.

Key words: Mycetoma, Neglected Tropical Disease, biopsy, surgical intervention, voriconazole.

How is India Increasing its Surgical, Anesthesia, and Obstetrics (SAO) Workforce Production Capacity: A Comparative Analysis of Postgraduate, and Super-specialty Training Spots between 2018-2023

Shirish Rao, Poorvikha Gowda, Bhavya Ratan Maroo, Siddhesh Zadey
Research Volunteer, Association for Socially Applicable Research (ASAR)

Abstract:
Background: In 2009, India had 31,560 surgeons, 20,280 anesthetists, and 29,310 obstetricians (SAO) making up the SAO workforce density of 6.5 per 100,000 people, depicting a severe shortage. An accompanying analysis demonstrated that India needed 291,824 more SAO personnel to meet the target density of 20 by 2030. We assessed India's SAO workforce production capacity in terms of postgraduate (PG) and super-specialty (SS) spots for 2023 and the 5-year spot scale-up rates.

Methods: We conducted a secondary data analysis of PG and SS SAO spots for 36 Indian states for 2023 from the National Medical Commission and mid-year census-based population projections. We calculated state-wise and national PG & SS SAO spot density per 10 million people for programs (MD/MS/DNB & DM/MCh) and super-specialties. Ratios of PG spots per 100 UG spots and SS spots per 100 PG spots were calculated to assess competitiveness. We compared the percentage change in the spot densities from 2018 to 2023.

Results: As of 2023 India had 19,865 PG and 2,379 SS SAO training spots leading to densities of 143 and 17 spots per 10 million people respectively. SAO PG spot densities were as follows: Anesthesia (31), General Surgery (30), OBGYN (25) Orthopedics (18), Ophthalmology (14), and Otorhinolaryngology (10). SAO

SS spot densities were 2 per 10 million people for Neurosurgery, Urology, and Plastic Surgery, 1 for Pediatric Surgery and Surgical Oncology, and <1 for other super-specialties. From 2018, PG spots increased by 56% and SS spots by 47%. Spot density increased by 49% for PG and 39% for SS. There were 18 SAO PG spots per 100 UG spots (reduced by 10% from 2018), making it more competitive to secure SAO PG training admissions. The spot distribution as well as the increase in SAO spots were disproportionate across states with some states even reporting a reduced number of spots for certain specialties compared to 2018.

Conclusion: Despite significant growth in SAO spots, India's workforce production capacity is much below global standards. The distribution of spots is inequitable across states and specialties. Further research should focus on estimating the required scale-up rate to produce an adequate workforce to meet global targets.

Key words: Global Surgery, Workforce, Education and Training, Health Planning and Policy, Capacity Building

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A case series of management of Fournier's gangrene in rural tertiary care

Chinmaya mishra, Dr Dev Sao, Dr Raman Kataria
Jan Swasthya Sahyog

Abstract:

Fournier's gangrene is a synergistic polymicrobial gangrenous infection of the perineum, scrotum and penis which is characterised by obliterative endarteritis of the subcutaneous arteries, resulting in gangrene of the subcutaneous tissue and the overlying skin. Fournier's gangrene affects all ages and both genders, with a male preponderance. It is a rare but life-threatening disease, and despite therapeutic advances in recent years the mortality is high, Anorectal, genitourinary and cutaneous sources of infection are the most common causes of FG, with diabetes mellitus being the most common risk factor. The clinical condition presents evolution from 2 to 7 day which is characterised by uneasiness, local swelling and discomfort, fever, crepitus and sometimes frank septic shock. Current imaging techniques for initial evaluation of the disease include radiography, Ultrasonography , Computed Tomography and Magnetic Resonance Imaging . However, the diagnosis of FG is usually clinical and imaging can be helpful in uncertain diagnosis and when clinical findings are ambiguous. This case series covers 4 gentlemen of 65 yrs ,80 yrs, 51 yrs , 30yrs presented to ER with fournier's gangrene along with sepsis and septic shock and after initial management with fluid resuscitation and antibiotics is then followed by extensive debridements and resections in order to remove all necrotic and infected tissue. Nutrition was improved simultaneously and this was followed by reconstruction with locoregional flaps or grafts. All four had good recovery and reasonably good cosmesis and function. However, despite all the advances in treatment today, FG remains a surgical emergency, hence, early recognition with aggressive haemodynamic stabilisation, parenteral broad spectrum antibiotics and urgent surgical debridement are the mainstay of treatment.

Key words: Fournier's gangrene , septic shock, debridement ,antibiotics , locoregional flap

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Chronic abdominal pain, multiple abortions and assumption of cancerous growth leading to social relegation- Adult Hirschsprung's Disease with Tabes mesenterica.

Dr Deepak Chandra Badhani, Dr Raman Kataria, Dr Meenakshi Deb (Consultant OBGY), Dr Nitin Agarwal (Consultant Pathologist)
MCh Paediatric Surgery Trainee, AIIMS New Delhi, Ex SR Jan Swasthya Sahyog

Abstract:
Background: Abdominal lumps arising from pelvis with primary and secondary infertility are a common presentation in Obstetrics and Gynaecology clinics. Most commonly these lumps are diagnosed to have benign or malignant ovarian pathology involving either one or both ovaries. The malignant ones usually

progress rapidly and the associated frailty which accompanies, gives a clinical clue to arrive at a diagnosis. Tuberculosis also known as Consumption disease can also present in a similar manner. But to have two, probably inter-related diagnosis in our patient was a srprise and rarity. The final diagnosis was possible only after a laparotomy. Hirschsprung's disease, is a congenital disorder identified by the absence of ganglion cells in the Meissner's plexus of the submucosa and Auerbach's plexus of the muscularis. It is usually characterized by nonspecific symptoms such as chronic constipation and one of the rare but still common causes of constipation in adults where there is scarcity of health care facilities. The diagnosis is made before the age of 1 month in 65% of the total cases and before the age of 1 year in 95% of the total cases.
Methods: It is a description of social exclusion faced by a young lady who had history of multiple abortions, gross abdominal distension and chronic constipation without any confirmatory diagnosis despite multiple hospital visits. She presented to the Obstetrics and Gynaecology OPD of JSS with gross abdominal distension and further events are described- intraoperative findings, post operative stay, and follow up.
Results: We have highlighted the social impact of chronic illnesses on a rural patient due to misinterpretation of symptoms by multiple clinicians. And also described the importance of intra operative clinical judgement so that a diagnosis of mesenteric TB lymphadenitis along with Hirschsprung's disease could be made and the patient was managed with a 9 month of anti-tuberculous treatment along with 3 staged surgery- decompression and diversion stoma followed by Duhamel pull through and stoma closure as the final step, once she had regained nutritional deprivation.
Conclusion: This case illustrates the phenomenon of the 'seven blind men and the elephant', where after multiple hospital visits and no diagnosis was made even after 15 years of being symptomatic and seeking care at multiple hospitals and clinics. Explanation for this Case Report of Adult Hirschsprung's disease depriving nutritional status badly leading to tabes mesenterica (tuberculous mesenteric adenitis) and its devastating social impact.

Key words: Adult Hirschsprung's disease, Tabes Mesenterica, Roshomon Effect.

Congenital anamolies of female genital tract and surgical options

Vignesh, Dr Meenakshi Deb, Dr Raman Kataria
Jan Swasthya Sahyog

Abstract:
Background: Congenital anomalies of the female reproductive tract, such as Mayer-Rokitansky-Küster-Hauser (MRKH) syndrome and anorectal malformations, can significantly impact reproductive and psychosocial well-being. Surgical reconstruction, particularly vaginoplasty, plays a crucial role in restoring function and improving quality of life.

Case Series: We present four adolescent females who underwent vaginoplasty for congenital anomalies:

1. Case 1: A 19-year-old female with primary amenorrhea and hypogastric pain was diagnosed with partial MRKH syndrome, with ultrasound findings of uterine agenesis, a fused vaginal canal, and normal ovaries. She underwent colonic interposition vaginoplasty.

2. Case 2: A 13-year-old female with anorectal malformation, rectovaginal fistula, and right renal agenesis underwent vaginoplasty using an ileal loop as part of her reconstructive surgery.

3. Case 3: A 14-year-old female presenting with primary amenorrhea was diagnosed with MRKH syndrome and underwent vaginoplasty to create a functional neovagina.

4. Case 4: A 21 year old girl with recurrent lower abdominal pain was found to have an absent vagina and a hemiuterus with hematometra. She underwent a Colonic segment interposition vaginoplasty.
At last follow up ranging from 3 years to five months, all these girls had normal calibre vagina and no significant complaints.
Conclusion: This case series highlights the varied presentations and surgical management of congenital vaginal anomalies. Early diagnosis, comprehensive evaluation, and individualized surgical approaches are

essential for optimal anatomical and functional restoration. Vaginoplasty using colonic or ileal segments provides a viable reconstructive option, ensuring satisfactory long-term outcomes.

Key words: MRKH,colonic interposition,vaginoplasty

Exploring Diagnostic and Therapeutic Approaches in Breast Tuberculosis

Khushboo Panchal, Dr Bhakti Sarang
Intern, HBT Medical college and Dr R N Cooper hospital

Abstract:
Title - Exploring Diagnostic and Therapeutic Approaches in Breast Tuberculosis

Introduction
Tuberculous mastitis is an uncommon manifestation due to resistance of mammary tissue against tubercular bacillus. However in India tubercular mastitis has a prevalence of 1-4%.
It is commonly seen in young lactating multiparous women of age 20-40 years. Its clinical presentation can mimic chronic breast lumps, ulcers, abscesses , chronic mastitis or breast malignancy . Due to its varied presentation it leads to diagnostic challenges and delayed treatment.
Diagnosis of tubercular mastitis is made on the basis of positive AFB on histopathological sample, Fnac specimen, TB PCR or GeneXpert.However these investigations vary in their specificity and sensitivity in detecting mycobacterium tuberculosis in extra pulmonary tissue such as breast tissue. A definite diagnosis of Tubercular mastitis through a thorough workup can help prevent misdiagnosis and over treatment.

Aims & Objective
Hence with this study we aim to understand
Varied clinical presentation of breast tuberculosis
Diagnostic Challenges and treatment outcomes in breast tuberculosis .

Materials & Methods
Study Design - observational case study
Sample size - three women
Study site - Terna Medical College & Hospital
Participants Inclusion Criteria:
patients diagnosed with breast tuberculosis .
Participants Exclusion criteria:
All other patients with breast pathology other than breast tuberculosis .

Conclusion
A multidisciplinary approach is required for the management of breast tuberculosis. A clinical should have a high index of suspicion in non healing breast lesions especially in patients with a history of tuberculosis or HIV.Traditional methods like ZN staining along with advanced diagnostic tools such as PCR and GeneXpert increase diagnostic accuracy and help provide timely treatment.

Key words: Breast tuberculosis, diagnostic challenge, global surgery

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Hepatic Cyst Masquerading as Gallbladder Duplication : Unravelling a Diagnostic Challenge

Binthaf P P, Dr PARAG GUPTA , Dr K H RAMESH
JLN HOSPITAL AND RESEARCH CENTRE

Abstract:
Abstract
Gallbladder duplication is a rare congenital anomaly often identified incidentally during imaging or surgery. However, other intra-abdominal pathologies, such as hepatic cysts, can mimic this condition, leading to diagnostic confusion. We present a case of a 65-year-old female who was evaluated for persistent right upper

quadrant abdominal pain. Contrast enhanced CT imaging and MRCP revealed a cystic structure adjacent to the gallbladder, initially raising possibility of gallbladder duplication. Radionuclide scan revealed preserved hepatic function, no significant biliary obstruction and normal gallbladder contraction.The patient's liver function tests were within normal limits, and there were no signs of obstructive jaundice.Intraoperative findings, however, revealed a solitary hepatic cyst closely adherent to the gallbladder, rather than a duplicated gallbladder. Laparoscopic cholecystectomy was done Histopathological examination confirmed the diagnosis of chronic cholecystitis.The patient had an uneventful recovery and was discharged on postoperative day three with complete resolution of symptoms.
This case highlights the importance of considering hepatic cysts in the differential diagnosis of gallbladder duplication, particularly in cases where imaging findings are inconclusive. Accurate preoperative diagnosis is essential to guide surgical planning and prevent unnecessary procedures. Surgeons should be aware of this potential diagnostic pitfall to ensure appropriate management and improve patient outcomes.

Key words: duplication of gallbladder, hepatic cyst, laparoscopic cholecystectomy.

Huge chylo-lymphatic cyst masquerading as intractablechylous ascites: report of a case

Ravindra, Dr Anju Kataria, Dr Raman Kataria
Jan Swasthya Sahyog

Abstract:
A 39 year old man presented with huge abdominal distension and fluid thrill which on further investigation was diagnosed to be chylous ascites. He received conservative treatment with TPN, nil orally, Octreotide and repeated ascitic taps. There was transient improvement despite multiple admissions over a period of 18 months. At this time he presented with abdominal pain and features of intestinal obstruct, which on exploration was found to be due to a band. There was a huge chylolymphatic cyst that was removed. The patient did well postoperatively and had gained weight at follow up 6 months later. Chylo-lymphatic cyst is a benign mesenteric cyst, arising in congenitally misplaced lymphatic tissue, and this is a case report of 39 year old man.

Key words: Chylous Ascites, intestinal obstruction, Chylo-lymphatic cyst

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MULTIPLE METACHRONUS PRIMARY MALIGNANT NEOPLASMS IN A YOUNG FEMALE: A CASE REPORT AND LITERATURE REVIEW

RADHIKA PILLAY, Dr C Rahalkar, Dr Dev Sao, Dr.Raman Kataria
JAN SWASTHYA SAHYOG

Abstract:
BACKGROUND: Bilroth's initial reference to the idea of Multiple Primary Malignant Neoplasms was made in 1869, more than 150 years ago. Multiple primary malignant neoplasms are defined as two or more primary malignancies diagnosed in an individual which can further be classified into synchronous and metachronous cancers depending on the time of diagnosis. Non-synchronous or Metachronous lesions are those that have been diagnosed at least 6 months apart.
PRESENTATION OF CASE: A 22 year young female who presented over the span of 4years with primary ovarian cystadenocarcinoma, papillary carcinoma of thyroid and GIST, undergoing individualized treatment protocol for each, including multiple surgical interventions and chemotherapy.
CONCLUSION: This case report is to highlight the occurrence of multiple primary malignant neoplasms with its diagnostic challenges and treatment options with a brief overview of the literature.

Key words: MULTIPLE PRIMARY MALIGNANT NEOPLASMS, GIST

PRIMARY BILATERAL NECROTIZING MASTITIS IN A YOUNG LACTATING MOTHER: A CASE REPORT

RADHIKA PILLAY, Dr Raman Kataria
JAN SWASTHYA SAHYOG, GANIYARI

Abstract:
BACKGROUND: According to WHO, Mastitis is defined as "Inflammation of the breast, which may or may not be accompanied by infection,". Necrotising fasciitis was first defined by Wilson in 1952 as "Necrosis of the fascia and subcutaneous tissue with sparing of the muscle." Primary necrotizing infection of breast is an uncommon occurrence. Necrotizing infections of the breast, as opposed to necrotizing fasciitis, cause the subcutaneous and parenchymal tissue to necrose while preserving the muscle and fascia. Since no fascia is involved, the term necrotizing breast infection or mastitis is more suitable than the more widely used necrotizing fasciitis.
PRESENTATION OF CASE: A non-diabetic 26-year-old, lactating mother with no prior history of trauma or any surgical intervention with contiguous necrotizing mastitis involving bilateral breasts. She presented in state of systemic septic shock with extensive local mutilation and loss of architecture of both breasts. Patient was managed with prompt surgical intervention accompanied with aggressive resuscitation and antibiotics with serial wound debridement and eventually with a partial thickness skin graft along with preservation of partial breast tissue.
CONCLUSION: Discussing the details of the case, the treatment approach in a rural healthcare setting, the outcome and also briefly reviewing the literature.

Key words: NECROTIZING, BILATERAL MASTITIS, PRIMARY, LACTATING

SUCCESSFUL OUTCOME OF A LARGE MEDIASTINAL PSEUDOCYST PANCREAS PRESENTING AS A NECK SWELLING

Killol H. Borad, Dr Raman Kataria
Resident

Abstract:
A pancreatic pseudocyst is a localized fluid collection adjacent to the pancreas, often arising as a complication of chronic pancreatitis. This case report describes a rare instance of large mediastinal pancreatic pseudocyst, extending into the neck on the left side, in a 36-year-old male patient with a history of alcohol-induced chronic pancreatitis. After prolonged conservative management, complicated by several medical challenges, the patient required surgical intervention. Despite postoperative complications the patient successfully recovered. This case highlights the rarity of mediastinal pancreatic pseudocysts presenting as neck swelling and the challenges and complexities faced during management in achieving a favorable outcome in rural healthcare setting.

Key words: Pancreatic pseudocyst Mediastinal Cystojejunostomy Alcohol pancreatitis

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Uterine torsion in a multigravida pregnant female- An intraoperative finding, delivered with a posterior hysterotomy incision and description of concerns associated with it, a learning from a rural hospital.

Dr Deepak Chandra Badhani, Dr Meenakshi Deb
MCh Paediatric Surgery Trainee, AIIMS New Delhi, Ex SR Jan Swasthya Sahyog

Abstract:
Background: Uterine torsion is a rare condition and defined as a rotation of more than 45° around the long axis of the uterus and most of the time it is around 180° (complete torsion). It can be associated with a spectrum of symptoms which include abdominal pain (out of proportion), vaginal bleeding and possible shock (hypotensive as well as neurogenic shock). However, 11% of women with torsion of the uterus are asymptomatic at the time of presentation. It is a rare complication in pregnancy that is termed a "once-in-a-

lifetime" diagnosis for obstetricians and gynaecologists. Torsion during pregnancy can occur due to myoma uteri, abnormal fetal presentations or uterine malformations.
Methods: It is a description of a case report in which a multigravida lady coming from a forest fringe village of Chhattisgarh who was transported to the associated secondary care hospital after significant persuasion and counselling. No associated causes and risk factors for the uterine torsion were found.

Results: Due to rarity of condition, uterine torsion is mostly an intraoperative diagnosis due to gravid changes in the uterus and has to be managed at a centre where facility of caesarean along with neonatal care is adequately available. Our patient was short statured, multigravida lady living around 60km away from associated secondary care hospital who was counselled along with attendants for the need of emergency surgical intervention to avoid maternal morbidity and mortality along with poor neonatal outcomes. The baby was delivered after a posterior hysterotomy incision, and detorsion performed after the closure of the uterine incision. The mother and the newborn did well.

Conclusion: Proper assessment during labour and carefully observing the findings at cesarean section are important.

Key words: Uterine torsion, obstetric emergencies, maternal mortality, public health.

The Spine Foundation journey - The 25 years experience !"

Shekhar Bhojraj, Nil
Life member of The ARSI and the Founder President and Chairman of The Spine Foundation

Abstract:

The Spine Foundation is a registered trust, set up in 1998 by the renown Mumbai-based spine surgeon, Dr. Shekhar. Y. Bhojraj. The Spine Foundation (TSF) originally started as the social arm of the spine unit at KEM Hospital, Mumbai, with which it is still affiliated today to treat underprivileged patients. TSF soon realised that the need to reach out to rural and tribal patients was acute in the absence of any spine speciailists outside urban areas. Hence, over the years, TSF has built a network in rural and tribal areas with government colleges, hospitals run by foundations, local doctors and phsyiotherapists keen to be trained in spine care management to develop Rural Spine Care Centers (RSCCs) based on a sustainable model, allowing regular follow-ups with all patients. You will find a list of TSF's current RSCCs enclosed. The spine surgeons associated with TSF waive their professional fees for all the patients treated by TSF.

Key words: @Spinecare @ Rehabilitation @Surgery @Rural

Champions of Global Surgery 2025

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Anaesthetist	Dr Asha Bansal, Prof Anaesthesia, Ambikapur
Nursing professional	Ms Mona Sahu, Balod
Operation theatre technician	Mr Babuchum Rongmei, Cachar Cancer Hospital, Silchar
Pain and palliative care provider	Dr Nibedita Parmanik, Evangelic Hospital, Nuapada
Community level worker	Ms Monika Paikra, Surguja
Researcher/Field of advocacy	Mr Naresh Kumar Uikey, Saheed Hospital, Balod
Innovator	Dr Dilip Gahankari Mahan Trust, Melaghat
Allied surgical services	Dr Himanshu Gupta Clinical Oncologist, Ambikapur
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