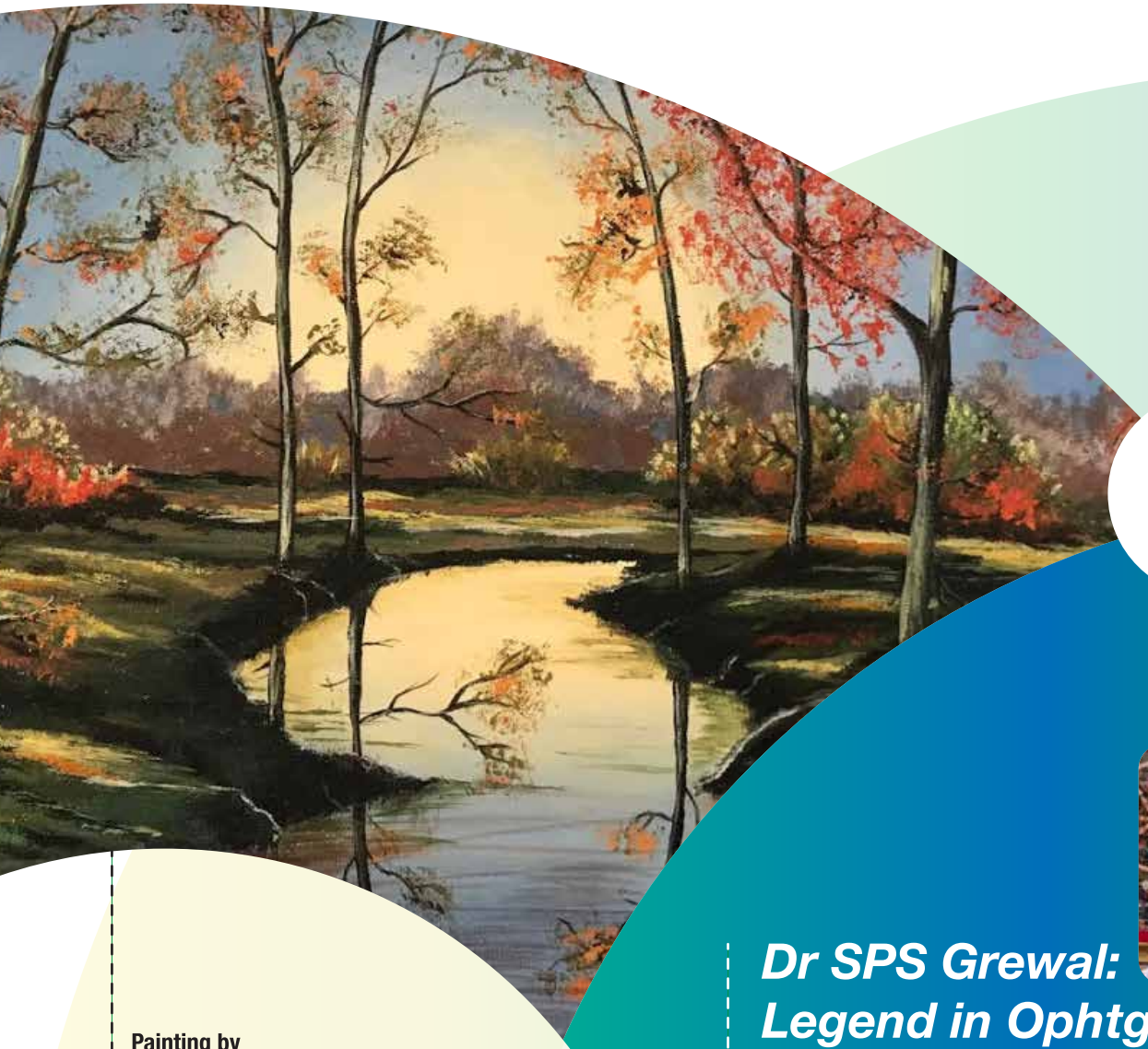
COS Newsletter



2025

Painting by

Dr. Navya Naveen Kalra

PG 1st year GMCH 32

Dr SPS Grewal: Legend in Ophtgalmology

Interview

Pondering resident training, being a physician in the era of social media and much more...

Message from the President

Dear Colleagues and Friends,

As I pen down this final note as President of the Chandigarh Ophthalmological Society, I do so with a deep sense of pride, gratitude, and optimism. Over the past year, our Society has continued to grow not just in numbers, but in the quality and depth of our academic and professional exchanges.

This newsletter also, in its own way, reflects the growth of the COS. The 'COS Times' has evolved into a vibrant platform — informative, engaging, and reflective of the collective energy of our fraternity. This progress would not have been possible without the enthusiasm of our contributors, the commitment of our editorial team, and the unwavering support of our members. This edition is particularly special, with its inspiring feature on Dr. SPS Grewal, a true legend of ophthalmology whose journey exemplifies vision, determination, and excellence. Dr Sonam Yangzes, editor, COS Times deserves special congratulations for thoughtfully raising the bar of the newsletter this year, along with Dr Parul Ichhpujani, as well as all the contributors including Dr Manu. Saini, Dr Surya Prakash Sharma, Dr Khushdeep, Dr Navya Naveen Kalra, Dr Gaurav Sanghi, Dr Ramandeep Singh, Dr Vipasha Sharma, Dr Savleen and others.

I am especially proud of the teamwork and camaraderie that have marked my tenure. Together, we have upheld the spirit of learning, sharing, and supporting each other in our common goal — to advance ophthalmic care in our region. The COS executive team also deserves a special thanks for all their contributions – Dr Harpreet Kapoor, Dr Gurdeep Boparai, Dr Deeksha Katoch, Dr Archana Malik, Dr Sumeet Kalra, Dr Ashish Ahuja, Dr Aditi Mehta Grewal, Dr Tanu Singh, Dr Irwinder Pal Singh and Dr Amanpreet Kaur.

As I hand over the baton to my worthy successor, I am confident that the Society and the newsletter will continue to flourish. I look forward to contributing in new ways and being part of our shared journey ahead.

Thank you for the trust, encouragement, and friendship you have extended to me during this memorable tenure.

With heartfelt thanks and best wishes,

Prof Amit Gupta

President,
Chandigarh Ophthalmological Society

Secretary's Address

Dear Esteemed Seniors, Colleagues and Young friends,

It is with great pleasure that I extend warm greetings to all members of our esteemed Ophthalmological Society. As we navigate the ever-evolving landscape of eye care, it is inspiring to witness the dedication, innovation, and collaboration that define our community.

The past few months have been marked by significant advancements and achievements by our members, in both clinical practice and research. Our annual conference, EYECONIC COS 2025, will showcase the groundbreaking work across various sub-specialties and reaffirm our collective commitment to improving patient outcomes. I would like to express my heartfelt gratitude to all who have and will contribute to the success of this event—speakers, attendees, and organizers alike.

Looking ahead, let us all aim at not only enhancing our professional growth but also at strengthening our network across the ophthalmological fraternity.

I encourage each of our members to stay engaged, contribute actively, and share your insights through articles, case reports, or feedback for the subsequent newsletters. Together, let us continue to uphold the highest standards of eye care and knowledge sharing.

"Excellence is never an accident; it is the result of high intention, sincere effort, and intelligent execution."

— Aristotle

My heartfelt thanks to Dr. Sonam for her editorial stewardship and for ensuring that our newsletter reflects the voice and spirit of our community.

Dr. Parul Ichhpujani

Honorary Secretary

From the Editor's Desk

Dr. Sonam Yangzes

Editor, COS Times

It gives me immense joy and satisfaction to present to you the latest edition of the COS Newsletter—my third as Editor. Each issue has been a labor of love, and this one is no exception.

> ***I am deeply grateful to my colleagues, juniors, and contributors who have supported and enriched this journey with their ideas, efforts, and enthusiasm. Their unwavering commitment has made this edition possible.***

Our vision for this newsletter was to create more than just a record of academic events—we aimed to curate a space that blends knowledge with creativity. An amalgamation of academics, literature, art, and free thought, this issue reflects the diverse spirit of our ophthalmic community.

I hope you find inspiration, learning, and joy in its pages. As always, your feedback and contributions are welcome and vital for our continued evolution.

In loving memory of

Dr. Kanwar Mohan

Date: Monday, February 24, 2025
Venue: Community Centre
Sector 43, Chandigarh
Lungar: 1:00pm - 2:00pm
Rasam Pagri: 2:00pm - 3:00pm

Fondly Remembered By
Dr. Reenu Kanwar(Wife) & Family

Legend in Ophtgalmology

Dr. SPS Grewal

From a small rural dispensary in Punjab to founding one of North India's most dvanced eye hospitals, Dr. SPS Grewal's journey is a powerful example of grit, vision, and lifelong commitment to excellence. In this candid conversation, he shares insights on entrepreneurship, technology, fitness, and what it takes to build a legacy in ophthalmology.

Q: You had a successful career as a faculty member at PGIMER. What inspired you to leave that secure path and enter private practice?

Dr. Grewal: I wouldn't call it the comfort of a government job — I see it more as the insecurity of staying within your limits. After returning from a fellowship in Moorfields, I was inspired by their work environment. When I suggested air-conditioning the PGI OPD, the director said, "Even my OPD isn't air-conditioned." That's when I knew I wanted to create a place with better working conditions — for both patients and staff. It took four years of planning. I left PGI with ₹20,000 in my account, borrowed from friends, took a loan, and started a practice in a garage.

Q: Were there any moments of self-doubt during this transition?

Dr. Grewal: Never. Yes, there were ups and downs — days when not a single patient walked in. But once you take a decision, the journey begins to prove it was the right one.

Q: What was your early practice like?

Dr. Grewal: It began in a 9x26 ft. converted garage. One side was the OPD with a slit lamp and autorefractor, the other side was a waiting area. There was a small one-bed OT and a recovery area outside. I would often perform 1–2 surgeries a day. But I kept investing in better equipment, building a system slowly.

Q: You're known for staying ahead in adopting new technologies. Has this always been your approach?

Dr. Grewal: Yes — even in medical college, I built speakers and developed black-and-white photos. I bought one of the first computers in Chandigarh. I've always been inclined toward technology. I keep upgrading our systems, including our EMR, which I personally work on. But I make decisions based on data, not marketing. Conferences and scientific literature help me decide what's worth investing in.

Q: Tell us about the new Grewal Eye Institute in New Chandigarh. How is it different?

Dr. Grewal: This centre is built with two priorities: the experience of the patient and the comfort of the staff. We've addressed every limitation we had before. It has 39 consultation rooms, multiple diagnostics and retina labs, a dedicated injection room, and spacious waiting areas. It's designed to support high-volume, multi-specialty care while maintaining a premium feel.

Q: Many view you as both a surgeon and an entrepreneur. Do you believe entrepreneurial skills can be learned, or are they innate?

Dr. Grewal: It's a mix of both. Some traits are inbuilt, but a lot can be learned. I've read extensively — Peter Drucker, management books, leadership strategies — but reading only helps if you have the desire to improve. At 70, I still have the drive to build something better.

Q: You seem incredibly fit and centered. How do you maintain work-life balance and manage stress?

Dr. Grewal: I devote one hour a day to my body, and 30–40 minutes to my soul — meditation or mindfulness. Stress, in my view, comes from living in the past or worrying about the future. Stay in the present moment, and stress disappears.

"If you can define your present as a single moment, you're already meditating."

Q: What qualities do you think are essential for young ophthalmologists today?

Dr. Grewal:

Consistency

Repeatability

Avoiding distractions

Distractions are the biggest hurdle for young professionals. Stay focused — like a horse with blinders — and build habits that you can repeat with precision.

Q: Despite being in private practice, you've remained connected to academics. How do you manage that?

Dr. Grewal: It's possible — you just need a system. Read regularly, attend conferences, and stay in touch with literature. That's how I've stayed ahead of technology. Most innovations appear in papers before they hit the market.

Q: If given the chance, is there anything you'd do differently in your career?

Dr. Grewal: No. I have no regrets. Every step shaped the journey.

Q: What kind of legacy would you like to leave behind?

Dr. Grewal: I'd like to be remembered as someone who believed nothing is impossible — and lived that way.

Rapid Fire with Dr. Grewal

Favourite surgery: Retinal surgeries — I still enjoy them, though now I do a lot of cataract and SMILE.

Go-to gadget in the OR: RTO (Rescan Tunable Optics) microscope system . I was the first to bring it to North India. It's my comfort tool.

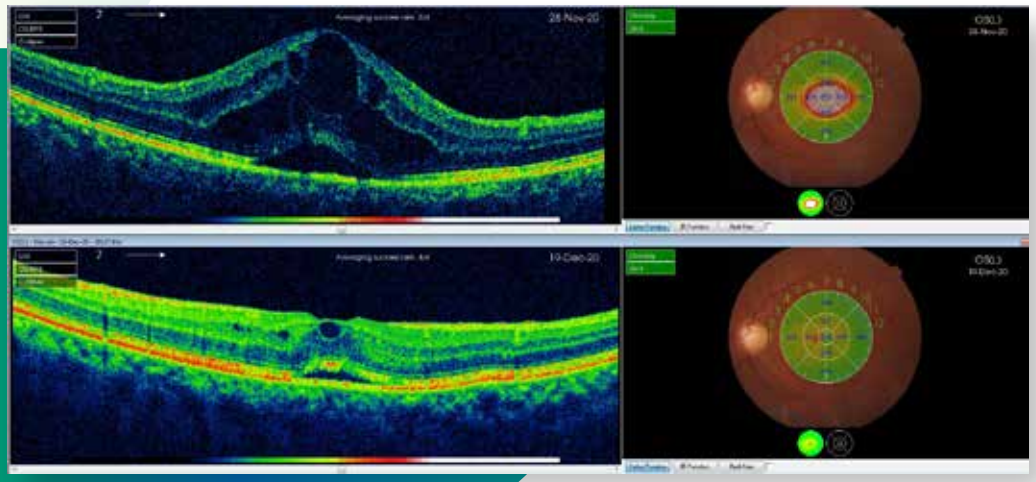
Miss about PGI: Nothing.

Quote that inspires: Nothing is impossible.

Recent reads: Steve Jobs biography, books on spirituality, management, and leadership.

Dr. SPS Grewal's story is one of quiet determination, thoughtful risk-taking, and a lifelong pursuit of excellence — a true legend in Indian ophthalmology.

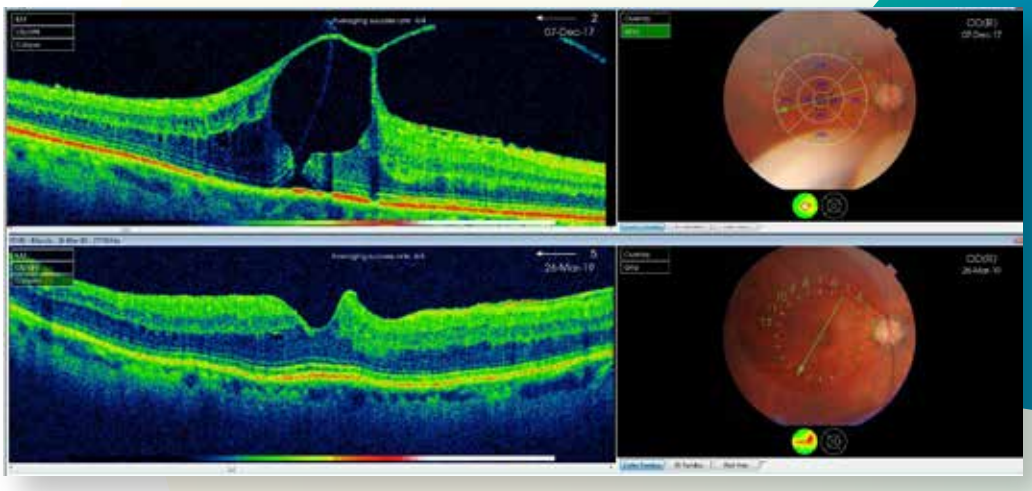
The Importance of Medication History



Author:
Dr. Gaurav Sanghi
Sangam Netralaya, Mohali

In our clinic, we all come across patients with coexisting complex ocular pathologies. Many of these patients are on a cocktail of topical drops. Adding to the list are the oral medications for multiple systemic illness, which may have a bearing on the eye conditions. Two cases from our interesting case archives, highlight the importance of ocular and systemic medication history. This valuable part of history is often overlooked in our busy clinical practices.

Case 1: A 59-year-old gentleman presented to us in November 2020 with chief complaint of decreased vision in left eye since last 6 months. He had a refractive keratotomy (RK) done many years earlier. He subsequently developed glaucoma in both eyes. He underwent a right eye Phacoemulsification+ IOL+trabeculectomy and left eye Phacoemulsification +IOL elsewhere in 2018. However, he subsequently developed endophthalmitis and retinal detachment in right eye for which a vitrectomy and a later a silicon oil removal was done. During the previous 6 months, he had received multiple intravitreal injection of bevacizumab in left eye elsewhere for cystoid macular edema (CME). On examination, his best corrected visual acuity was 6/60 right eye (OD) and 6/12 left eye (OS). Intraocular pressures were 11 mm hg OD and 18 mm hg OS. Anterior segment exam both eye revealed RK cuts and pseudophakia. Right eye had a diffuse trabeculectomy bleb in addition. Fundus exam OD showed a Cup disc ratio (CDR)of 0.9 and good buckle effect with attached retina, while OS had CDR of 0.8 and CME. CME was confirmed on optical coherence tomography (OCT)(Figure 1). A drug history from previous prescriptions revealed that patient was using both eyes travoprost and brimonidine + timolol combination for glaucoma. Travoprost and other prostaglandin analogues have been known to cause CME. We stopped travoprost for the patient. Topical ripasudil and brimonidine+ brinzolamide combination was started. No topical steroids were added for CME. Fortunately for us, the CME in left eye recovered in 3 weeks' time (Figure 1). The patient regained a visual



acuity of 6/6 in left eye. This case highlights the importance of recognising ocular side effects of topical drops. A simple intervention of replacing the eye drops improved the vision and saved the patient unwarranted intravitreal injections. To this date the patient follows up with us. He maintains 6/6 unaided visual acuity and stable glaucoma in this eye.

Case 2: One Sunday morning, a 70-year-old one eyed male came to see me at my home with blurred vision in his only seeing eye. This eye, the right one, I had operated 4 years earlier for vitreomacular traction. He also had a previous history of glaucoma for which prior bilateral trabeculectomy had been done. Since the last 4 years after vitrectomy (Figure 2), his visual acuity was stable at 6/9. On dilated examination, the fundus seemed fine. I called him next day to my clinic. Visual acuity was 6/9. Intraocular pressure was 12 mm hg (on timolol). I thought probably the glaucoma part has worsened and ordered a visual field. Visual field, although unreliable was not worse as compared to the previous visit. Remembering another patient who presented a few weeks earlier with vague visual complaints and visual hallucinations, I asked the patient what systemic drugs he was on. History revealed that the patient was on metoprolol for hypertension since last 4 months. Metoprolol is a commonly used beta blocker, which has been reported to cause blurred vision and visual hallucinations as a side effect. We asked the patient to stop metoprolol and shift to another class of anti-hypertensive drug after consulting a physician. The visual symptoms disappeared after a couple of days of stopping the drug. On further questioning the patient also revealed having vivid hallucinations (seeing dead people sitting beside him) and walls and green dots in the field of vision, which subsided after stopping metoprolol. A simple medication history saved us any ocular intervention

The above two cases illustrate that we should be aware of side effects of both systemic medications and topical drops. A thoroughly elicited systemic and medication history can sometimes make a great difference, especially when we are not making much headway with our examination and investigations. Furthermore, it saves the patient unwarranted intervention.

LEGENDS: Figure 1: Top Panel: Baseline OCT scan shows massive cystoid macular edema (CME) and serous fluid left eye. The central foveal thickness (CFT) is 663 microns. Bottom Panel: Near resolution of CME and serous fluid 3 weeks after stopping travoprost. The CFT has decreased to 306 microns.
Figure 2: Top Panel: Baseline OCT shows right eye focal vitreomacular traction (VMT) and a small macular hole. Visual acuity was 6/18. Bottom Panel: Normal foveal contour maintained after pars plana vitrectomy+ VMT removal+ ILM peel and c3f8 gas tamponade. Visual acuity at this juncture is 6/9.

A Hymn Through the Lens

In the quiet of the lab, under sterile light,
I peer into the depths of a corneal smear.
Beneath the glass, I see a hidden world—
Bacteria shaped like berries and rods,
Radiating filaments stretching like delicate threads of life.

Stains paint them vibrant
Colors that turn the unseen into a living masterpiece.

Fungi reveal their forms:
Budding yeasts, elegant in their simplicity,
Filamentous hyphae branching endlessly,
Acanthamoeba's double-walled cysts, armored and mysterious,
While Pythium weaves its ribbon-like threads
Neither bacteria nor fungi,
But a marvel caught in between.

Each form, each shape,
More beautiful than words can say,
A testament to a Creator's artistry,
Who shaped the smallest details with infinite care.
When the eye cannot see,
I turn to the Word written in genes.
Through PCR, I search the sacred scripts
Of bacteria, fungi, and viruses
Not just to diagnose,
But to witness the wisdom coded in creation.

Inside the eye, flow Cytometry lights up the invisible:
A sacred arrangement of immune cells
T cells and B cells, messengers of the immune command
Forming a divine army, poised and precise,
Guarding the delicate temple of vision,
Keeping it pure, pathogen-free, alive.

IL-6 and IL-10 whisper in their balance,
The story of inflammation and peace
A molecular prayer of defense and healing.

Even here, in the molecules of response,

I see intention.
I see design.

This is more than science.
It is reverence in action.

In every smear I stain,
Every genome I amplify,
Every cytokine I quantify—
I am not departing from faith.
I am walking deeper into it.

For the Creator, who set stars in the sky,
Also designed the cell.
He gave us sight, not only to observe,
But to understand
To heal, to comfort, to restore.

Let my microscope be my altar.
Let my reagents be my offerings.
Let my data be a song of gratitude.
Let my science be a hymn.
Let every discovery glorify the One
Who gave us the wisdom to seek,

And the heart to care.

Author:
Dr. Surya Prakash Sharma
Ph.D. Microbial Biotechnology.
Advanced Eye Centre, PGI Chandigarh

Art Gallery

Painting by:
Dr. Manpreet kaur

Paintings by:
Dr Anchal Gera ,
Senior resident , AEC PGIMER

Painting by:
Dr. Navya Naveen Kalra,
PG 1st year GMCH 32

Postgraduate surgical training in India- Is it fair to Judge?

When I was invited to write about resident surgical training, it took me a while to decide what to write. As a vitreoretinal surgeon, the retina unit of the Advanced Eye Centre was the first to start one of the MCh courses in ophthalmology, which provides structured training to residents with entry and exit examinations. But being me, someone who loves his postgraduates even more, and has been associated with postgraduate surgical training for the last decade. So, I will still write about postgraduate training. No matter how much super-speciality training we impart, we must first build a good, comprehensive ophthalmologist.

When discussing postgraduate surgical training, the discussion inevitably turns to cataract. In India, the postgraduate training in Ophthalmology is mainly judged by its cataract surgery program, or what they say now, the middle-segment surgery program. Besides cataract surgery, fields like retina, glaucoma, cornea, etc., and their surgical techniques, are familiar to postgraduates during their postgraduate studies. However, they are expected to learn and hone these through fellowships or senior residency in these fields. Cataract surgery has also evolved and become more of a refractive procedure. Also, in the last decade, the surgical management of aphakia has significantly evolved with iris and scleral fixated lenses and newer techniques.

My first experience of being judged about this program came through a phone call. I was asked how many cataract surgeries his ward would do once he joins the program. As usual, I harped about making them good clinicians first, teaching them when and where not to use a knife, the usual dialogues I use, and then told him the approximate number of surgeries he would get. I failed, as his ward did not pick up our program.

I do not know the magic number or percentage by which we failed. There is so much disparity in the postgraduate Ophthalmology training across India, so the All-India Ophthalmological Society of India has set some guidelines to make these programs even in India, but they do not give any desirable number of surgeries. Providing definite numbers and achieving these targets in a diverse country like ours is always challenging. Preventable blindness due to cataract is not the same from state to state. Getting the desired numbers for cataract surgery becomes difficult for even the best programs. There is diversity among trainers as well. I have heard

about a trainer who used to put an intraocular lens and explant it before you, then ask you to do the same on the patient's eye. That was off course in the extracapsular surgery era.

Cataract surgery still attracts most young postgraduates to take up as a career, because of the vast numbers, reasonable remuneration and patient satisfaction, among other reasons. Beyond doubt, cataract surgery is considered one of the minimum skills a postgraduate requires. A program must make them confident in this skill to face the world, as the mother bird teaches the kids to fly and pushes them out of the nest to face the world. She does not count their flying hours, or there are no set numbers. She, like a true trainer, sees the skill and approves. Every student is different and will learn at their own pace. Training programs should provide them equal and consistent opportunities throughout the three-year program. So, every program must devise its skill standards, define numbers and expose its postgraduates to small incision cataract surgery, phacoemulsification, or both by using various hand-holding methods, starting from wet lab, simulation, and eventually to the human eye.

Postgraduates should not lose their heart until we reach the same platform in India. They should learn as much as possible from the existing training program, wherever they are. They must remember that there is a flip side to this superspecialist era, which is good. More and more new specialities and opportunities, other than cataract surgery, have emerged in Ophthalmology, from which postgraduates may choose to pursue a successful career. There is always a door that is open for you. I have met postgraduates who have saved money to learn or hone their cataract surgery skills by doing short-term attachments with cataract surgery centres catering to high volumes. There is nothing wrong with it. We have always seen international students coming to India for the same purpose. Being wise about your own money and investing is a good habit that one should imbibe as early as possible in one's career.

Ultimately, I would like to finish by quoting Charles Darwin: "It's not the strongest of the species that survives, nor the most intelligent, but the ones most resilient and responsive to change"

Author:

Prof. Ramandeep Singh

Advanced Eye Centre, PGI. Chandigarh

Beyond the Hashtag: A Balanced Look at Physician Advertising Online

We all have long adapted to changes in how patients seek care—from print directories to Google reviews. As social media becomes increasingly integrated into our professional lives, many of us are re-evaluating its role in how we communicate, educate, and promote our practices. In ophthalmology, where patient decisions are often driven by elective procedures and technology, the use of social media advertising has grown significantly. While the tools are new, the underlying questions are familiar, "How do we balance visibility with professionalism?" and "How do we ensure our messaging remains ethical and evidence-based?"

"As surgeons, we've come to realize that we must meet patients where they are—and social media is where they are looking for information."

—Dr. Steven Williams, President of the American Society of Plastic Surgeons *

Patients are increasingly using platforms like Instagram, YouTube, and even TikTok as part of their healthcare research – whether we participate or not, we are already part of that conversation. Importantly, social media use is no longer limited to younger audiences. Increasingly, elderly patients—many of whom are dealing with chronic eye conditions or exploring surgical options—are active on platforms like Facebook and YouTube. This demographic is now regularly consuming content online. Nearly 80% of people aged 16–64 are expected to use social media by 2025—showing a narrowing digital divide.# This shift underscores the value of using social media not just to promote, but to educate and support aging patients in a way that's accessible, respectful, and informative. A brief video explaining intraocular lens (IOL) options or a post clarifying the signs of age-related macular degeneration can now reach retirees browsing their newsfeeds just as easily as it reaches younger audiences. The key is to craft content that is clear, empathetic, and free of jargon—recognizing that digital literacy varies across age groups. Social media offers undeniable benefits. It provides a direct line to current and prospective patients, allows us to share "accurate" medical information, and helps distinguish our practices in a competitive market. For subspecialties like refractive surgery or aesthetics, visually compelling content can effectively illustrate outcomes and innovations that might otherwise be hard to communicate. From a business standpoint, social media can be particularly valuable for early-career physicians or those in private practice. It offers a relatively low-cost platform to build recognition, share thought leadership, and connect with communities.

However, this opportunity also brings responsibilities. The line between education and promotion can blur quickly, especially when metrics like engagement and reach become central goals. There's a risk that content prioritizes popularity over accuracy or clinical relevance. We've all seen examples where posts emphasize dramatic outcomes or aesthetic appeal without full context, which can distort patient expectations and potentially undermine trust.

We also must remain vigilant about consent, patient confidentiality, and compliance with national medical board regulations. Testimonials, before-and-after photos, and video content can be powerful – but only when shared with proper safeguards and transparency. Clear disclosures around sponsorships, paid partnerships, or affiliations are not just ethical, they are increasingly expected by both patients and peers.

As physicians, our role on social media should reflect the same standards we uphold in clinical practice: honesty, clarity, and patient-centered care.

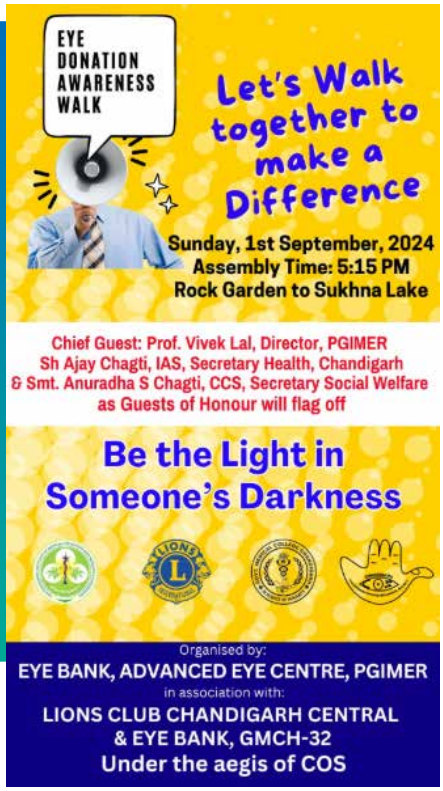
Advertising must never come at the expense of professional integrity. The challenge is to use these platforms thoughtfully – to inform rather than influence, to attract without exaggeration, and to lead by example in a space that is still finding its ethical footing.

Social media is neither a threat nor a cure-all; it's a medium. When used responsibly, it can extend the impact of our work beyond the exam room. But our professional ethics must guide our digital presence just as they do our clinical practice.

affiliates:
www.drjohnm.org/2013/11/
the-enormous-power-of-social-media-in-health-care/)
https://pixezy.com/social-media-statistics/

Author:
Dr Parul Ichhpujani
Professor, GMCH, Chandigarh,
Secretary COS

Activities 2024-2025



MOU with MEOM, 2024

Memorandum of Understanding (MOU) Renewal

Between
MEOM (Middle East Ophthalmology Meeting) Academy
And
"Chandigarh Ophthalmological Society"

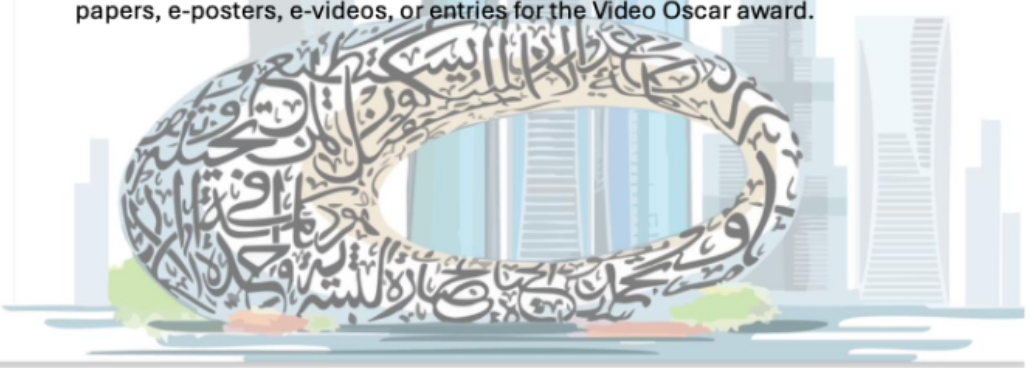
This Memorandum of Understanding (MOU) Renewal is entered into by MEOM Academy and **"Chandigarh Ophthalmological Society"** (hereinafter referred to as "The Society") to extend and reaffirm the partnership established previously. This renewal reflects a mutual commitment to continued collaboration and engagement in advancing the field of ophthalmology.

Purpose

To build upon the successful collaboration during the previous MEOM conferences and to further enhance opportunities for knowledge exchange, networking, and professional development in ophthalmology.

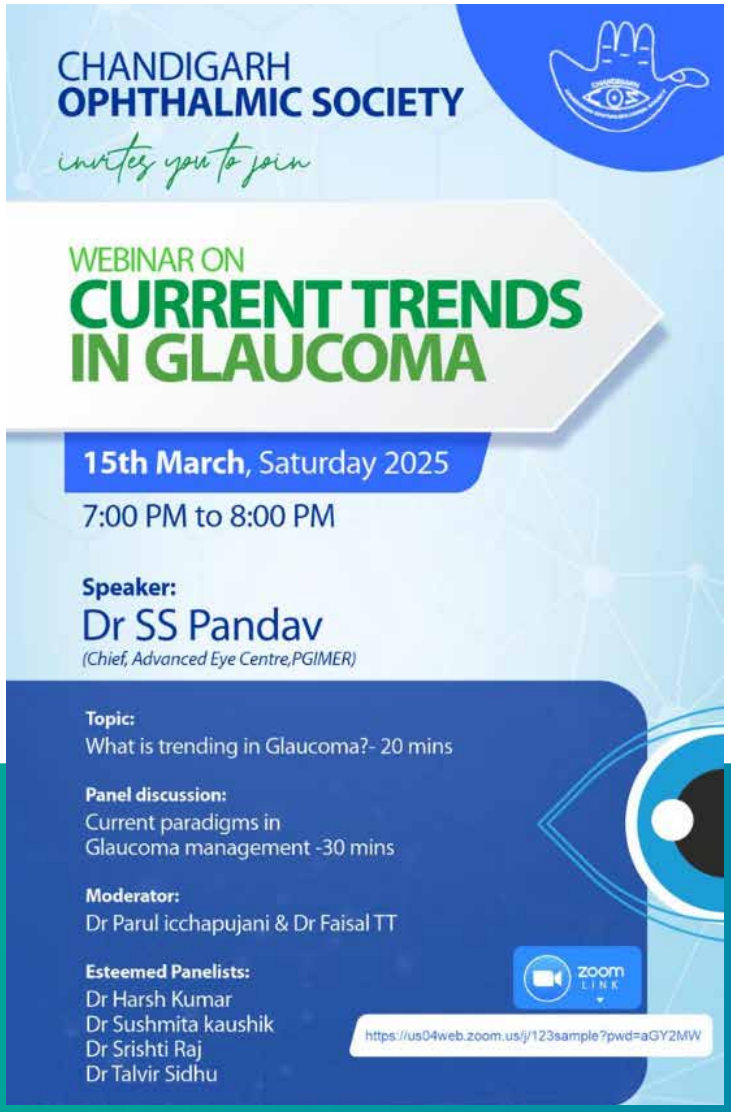
Terms of Renewal

1. **Continued Participation in the MEOM Conference**
   - The Society will continue its active participation in the 7th MEOM Conference, scheduled for October 31–November 2, 2025, in Dubai.
   - Members of the Society are invited to attend and submit their work as free papers, e-posters, e-videos, or entries for the Video Oscar award.




World
Glaucoma
Week

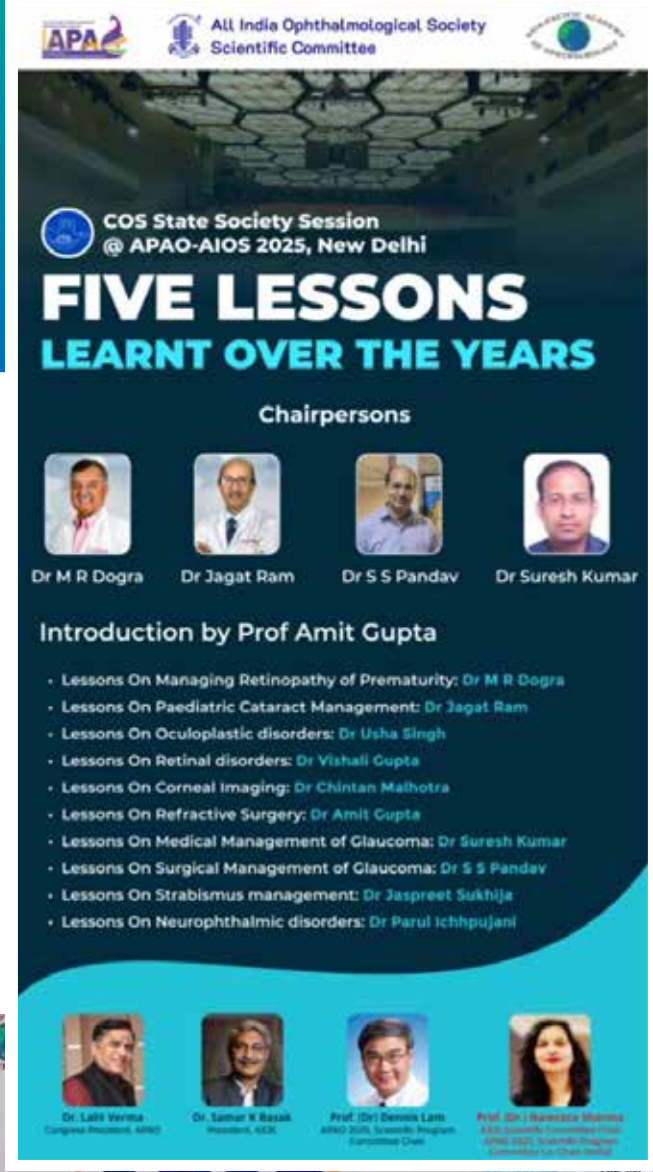

WALK FOR GLAUCOMA
AWARENESS
World
Glaucoma
Week
March 9 - 15, 2025
Uniting for a Glaucoma-Free World



Webinar on Current Trends in Glaucoma

World Glaucoma Week

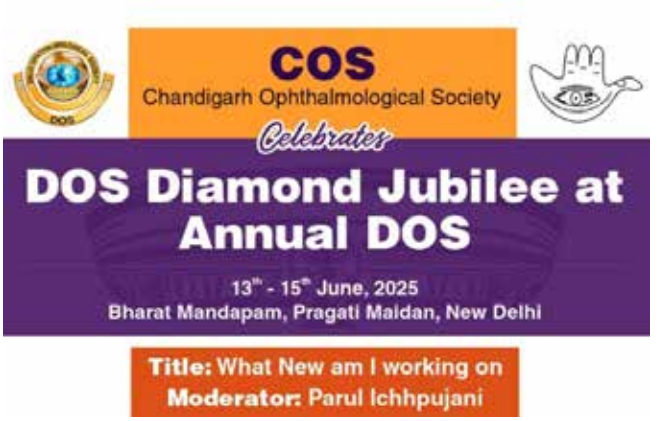
COS Session at APAO-AIOS



The 40th Asia-Pacific Academy of Ophthalmology Congress

2025 APAO

In Conjunction with
The 83rd Annual Conference of the All India Ophthalmological Society



COS Session at 75th Annual DOS

AIOS PRYOGSHALA CONNECT

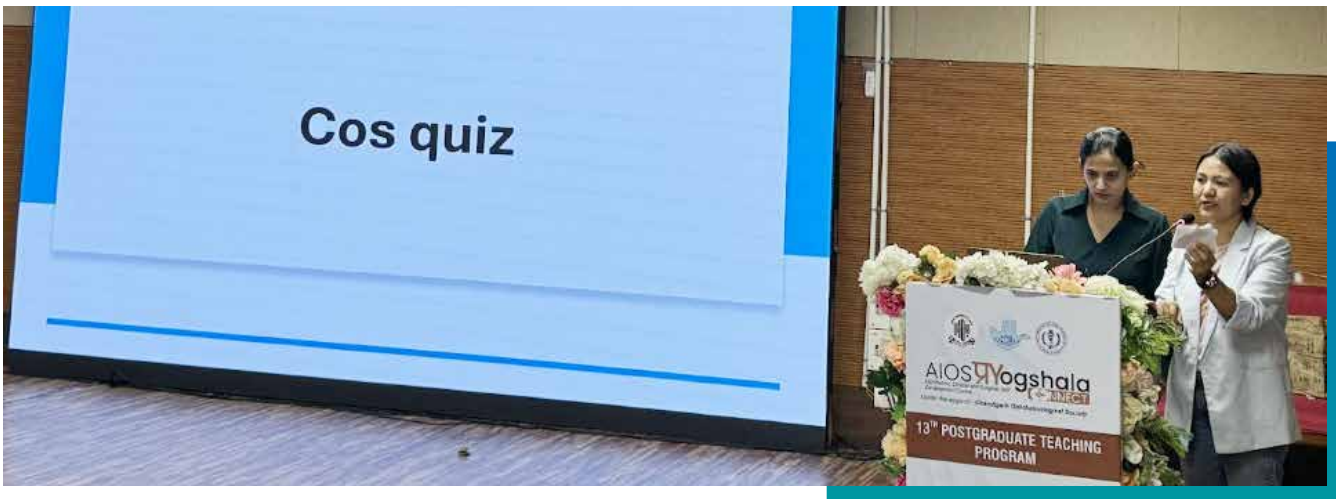
AIOS प्रYogshala CONNECT

Ophthalmic Clinical and Surgical Skill Development Centre

In Collaboration with

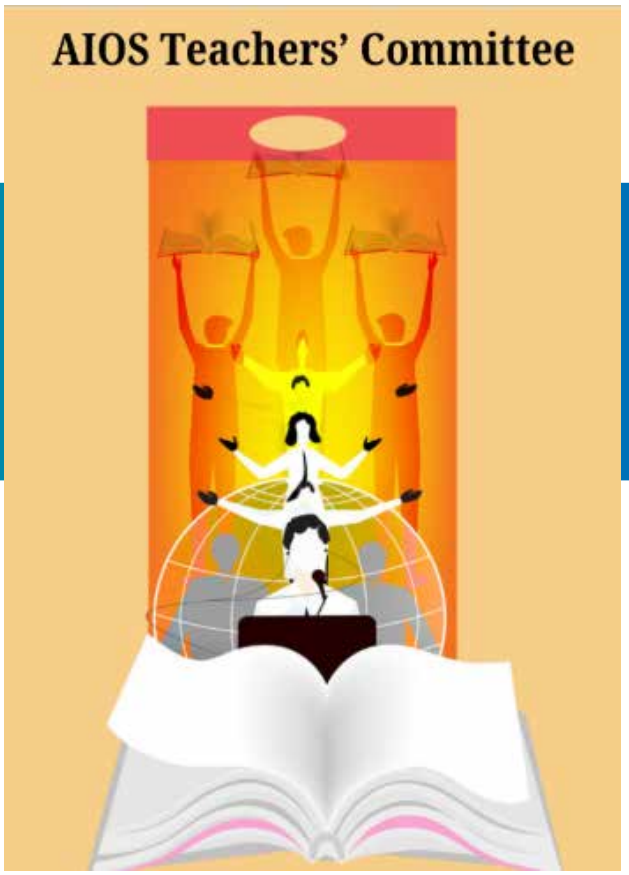
Government Medical College & Hospital, Chandigarh

Under the aegis of Chandigarh Ophthalmological Society




Dr. Ashok Sharma's
CORNEA CENTRE
Chandigarh Eye Film
Fest & Quest
CEFF 2024
3rd Edition


Dr. Ashok Sharma's
CORNEA CENTRE
Punjab Medical Council
Chandigarh Eye Film
Fest & Quest
CEFF 2024
3rd Edition



AIOS
Presidential Committee of Teachers in Ophthalmology

Volunteered and Nominated
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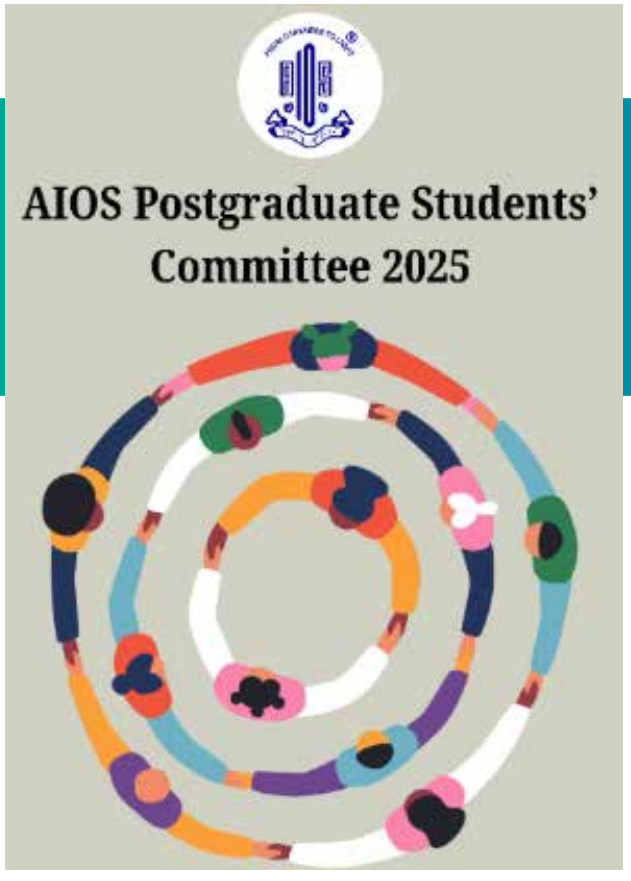
- **Dr Parul Chawla Gupta**



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Generational gap in Ophthalmology

When I was a resident in Ophthalmology, I often heard my seniors say "You are lucky to do surgery under the microscope, we did surgery with loops!"

Or " You are very lucky to be in this era of antiVEGFs, we used to struggle with our surgical cases". There were further many instances when my seniors used to compare the generational change in Ophthalmology.

I never realised the importance or the relevance of the statement. On rare occasions, I took it as an inspiration, often exclaming my seniors at the commendable job they did. Very rarely, I was awed by their journey. But mostly I used to pass the statement indifferently. It's a story of the past, I used to wonder. Why should I be bothered by what happened to our oldies. It's never gonna happen to me! Because you never realise the importance of something until it happens to you.

Now that I am on the other side, as a teacher, I notice myself often quoting "You guys are lucky to have slit lamps". "You guys are lucky to have access to articles". 'You guys are lucky to have the best phaco machines, we used to operate on the oldest!" And the series of self proclamation at the hurdles we crossed.

So now what, it's just an age related degeneration happening to me too? Or is that I am following a traditional change that is bound to happen? I am behaving exactly as I didnt want to , or never related to. Or is it that we need to look just outside the box and think whether we want to repeat what our seniors did?

The problem is that we compare students with our own times. We compare the resources we had and the resources they do. We look at the numbers of all their problems but we forget the denominators have changed too. We were two or three residents with a faculty of six. Now we are thirty residents with a faculty of twenty six. We saw 200-300 patients a day. Now we see 1500 in a day. We read three four textbooks with photocopies of maybe ten more. They are reading, what our generation wrote, from those textbooks only. We followed our seniors and changed our surgical practices along the way, the present generation is following our techniques but mending them for the good.

The question is do we our subsequent generation to do everything at our pace, in an era where our pace is actually the slowest?

So let's just compare within the zone. Compare their generation with themselves. We need to look at their resources and how to best utilise it for them. The problem of plenty is juggled with the problem of completion. Let them read from ipads or PDFs. Let them play video games and help learn on simulators. Let them do work quickly on their digital devices. Let us not force them to jot down long notes. Let them keep the work life balance and not be "just doctors". Let them be themselves. They need not struggle simply because we did it. The next generation can also be great, even if they have different clothes or tatoos and read ophthalmology in the gym. Do we need to be judgemental if they are not doing what we did?

So let's take a pause. The only condition we should have is reaching a standard of professional competence. We don't have to compare generations with each other. We have to look at things from the outside. Each generation is a different planet following their own path. Let them define their own pace, in their own journey. Don't ask them to cross paths with yours, otherwise it might lead to another Big bang.

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Monochromatic Vision

Crimson painted evening skies
Red powerful war cries
Pondering purples
Green guilty frowns
Dynamic blue ocean ripples
The warmth of oranges
Here, I stand engulfed in colours of life,
with my blurred vision.
Dreaming of monochromatic rainbows.
Keep looking,
till you see the colours of monochromatic.
It's not black and white
It's the colour of my visons
It's the colour of my dreams
It's the colour of truth
It's calm and storm
Full of bright
It's warm and cold
It's dream and reality
All in all
It's the most polychromatic ever

The Gateway to Vision

I am clear and compact,
I have no preconceptions.
No prejudice, no bias.
Whatever I see, I refract it immediately,
to make you see.
I am the major power of the eye,
Yet, I am vanity free.
I am so easy going and chill,
that a little surgery on me,
can make you spectacle free.
But, mind it, I am not free,
neither, any money can buy me.
So, remember to donate me,
to make others see.
I am your cornea,
The gateway to vision!

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Through Her Eyes: Motherhood in the Life of a Woman Ophthalmologist

Author:

Dr. Khushdeep Abhaypal

Ex-SR, Advanced Eye Centre, PGIMER

I never knew how much love my eyes could hold until I looked into the eyes of my child. As an ophthalmologist, I thought I understood vision — its clarity, its precision, the way it shapes our world. But it wasn't until I became a mother that I truly saw.

Motherhood changes everything. Overnight, your priorities shift. The microscope, the slit lamp, the OR – they all take a back seat. Conferences are missed, papers lie unfinished, and even a routine OPD can feel like a mountain to climb when your body is still healing and your baby needs you. The white coat, once a symbol of purpose and pride, starts to hang a little heavier with the weight of guilt and exhaustion.

For many women in medicine, especially in a field as demanding as ophthalmology, motherhood feels like a full stop in a career that's barely begun. We watch our male counterparts move forward, uninterrupted. No one asks them, "Who's with the baby?" or "Are you coming back full time?" No one assumes they'll have to choose. But for us, the choice feels forced — even when we're giving our best to both roles.

Yet, somewhere in those quiet night feeds and stolen moments of sleep, something changes. You soften. You grow. You begin to see your patients differently — as someone's child, someone's parent. Empathy deepens. Priorities sharpen. Efficiency becomes second nature. And in a way only motherhood can teach, you learn that stepping back doesn't mean stepping away.

I was raised by a working mother, a woman of grace and grit. She taught me that being true to your profession is the biggest prayer to God. She never sat down to pray, but I saw her devotion in her work, in her hands, in her heart. Today, I share a bond with her that only motherhood could deepen. I now understand her silences, her sacrifices, and her strength. I walk in her footsteps, grateful and humbled.

So no, my publications haven't doubled. My surgical numbers aren't soaring. But my heart? It's fuller than ever. And when I walk into my clinic after a sleepless night or return home after a long OT day to a little hand reaching for mine — I know I'm exactly where I'm meant to be.

This journey isn't easy, and the system isn't always kind to mothers in medicine. But I wouldn't change a thing. Motherhood didn't pause my life; it reframed it. It didn't weaken me; it made me whole.

A Dynamic Tableaux

I see the brilliant skies
And the good old lake frozen dead;
It's just you, me and time
And the things unsaid.
The wind with all its musings,
Passes by but a leaf or two might fall;
The goodwill that it brings along,
Is just a moment or maybe none at all.
The seasons come and go,
Soothing our childish whims,
Teaching us how to change with the hour,
And wake up like a storming tide.
The river changes it's course with years,
Oh Lord! With what force it paves it's way.
Even though the nightingale sings at night,
Still the magpie adorns the day.
The ship sails over the horizon,
Endlessly waiting for its fall,
Nothing but the waters change,
A sailor reborn stands tall.
Changes are a law of nature,
Beautiful, with time they unwrap themselves;
Just smile thinking of the things that passed
And laugh when riding your dreams instead.
It's the glitter in the black that counts,
Amidst the clouds of your eyes;
Savour the unfolding of the delicacy,
Which deep inside your life hides.
And yet again on a new dawn,
I see the brilliant skies and the frozen lake,
The day is the same but time another,
Still a smile lightens up my face.
It was just you, me and time
And the beautiful silence with things unsaid.

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Foreign Body Conjunctival Granuloma in Dog Bite Repaired Canalicular and Lid Laceration

A 19-year-old male present in the tertiary eye center emergency services with a one-day history of the right eye both canalicular and full-thickness eyelid laceration (Fig. 1A) sustained from his pet dog bite during playing.

Ophthalmic examination revealed bilateral Snellen visual acuities of 20/20 with normal pupillary reactions and full extraocular movements. Anterior and posterior segment examinations were unremarkable.

Tetanus toxoid, antibiotics, anti-rabies vaccination, and anti-rabies serum infiltration were given before primary repair. The lower canalicular laceration was repaired with self-retaining lacrimal mini-monoka stent, however, an upper canalicular tear was not identified, therefore primary lid laceration repair was performed. The patient received topical antibiotics, tear substitutes, and steroids in tapering dose for six weeks. Fourteen weeks after the repair, medial conjunctival protuberant granuloma formation (Fig. 1C), measuring 6mm X 5mm at the polyglactin suture site (bold arrow) and inner border of the mini-monoka stent (dashed arrow) (Fig. 1B) was observed. Topical fluorometholone and tobramycin sulphate ophthalmic suspension was started with tear substitutes. Foreign body granuloma started regressing, shown in Fig. 1D, 1E at two weeks, four weeks respectively, and completely resolved (Fig.1F) following removal of the mini-monoka stent. Severe foreign body reactions after ocular surgery are often associated with non-absorbable sutures. Polyglactin suture causes mild foreign body reaction for around 45 days of surgery. Complete improvement of foreign body granuloma, following absorption of polyglactin suture and removal of the mini-monoka stent, connotes polyglactin suture and self-retaining mini-monoka stent is the causative agent for delayed granuloma formation in our case.

LEGENDS: Fig.1. (A) Dog bite injury at presentation with medial upper and lower eyelid full-thickness laceration involving both canaliculi, (B) 4 weeks post-operative clinical photograph showing self-retaining mini-monoka stent in place (dashed arrow) and persisting polyglactin suture (bold-arrow), (C) An elevated protuberant foreign body conjunctival granuloma at the polyglactin suture site (arrow) and near the inner border of the mini-monoka stent, significant clinical improvement with topical steroids at 2 weeks (D), 4 weeks (E) and completely resolved (F) with the removal of the mini-monoka stent.

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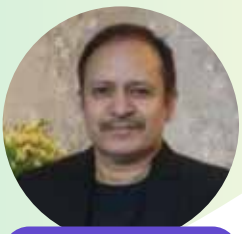

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