DAILY NEWS BULLETIN

LEADING HEALTH, POPULATION AND FAMILY WELFARE STORIES OF THE Day

Tuesday **20260505**

Fatigue in Pulmonary Hypertension Patients

Dr. Shadab Samad
Cardiologist, Delhi

For many a flight of stairs is a routine transition. But for patients living with Pulmonary Hypertension (PH), these same steps can feel like scaling a mountain while breathing through a narrow straw. While shortness of breath is the hallmark of this condition, there is a more pervasive, often misunderstood symptom that dictates the daily lives of patients: profound fatigue.

Pulmonary hypertension occurs when the blood vessels in the lungs become narrowed, blocked, or destroyed. This slows blood flow through the lungs, causing blood pressure in the pulmonary arteries to rise. As a result, the right side of the heart must work significantly harder to pump blood.

Why the Exhaustion?

The fatigue associated with PH isn't the typical tiredness one feels after a long day at the office. It is a systemic "cellular" exhaustion. When the heart cannot efficiently oxygenate the body, the muscles and vital organs are starved of the fuel they need to function. This creates a persistent state of lethargy that rest rarely cures.

Furthermore, the body's compensatory mechanisms—such as an increased heart rate—can leave patients feeling physically drained even while sitting still. Secondary factors, including sleep apnea, side effects from potent medications, and the psychological toll of managing a chronic illness, often compound this exhaustion.

Managing the "Energy Envelope"

In the medical community, we often advise patients on "energy conservation" or the "Spoon Theory." This involves viewing energy as a finite currency to be spent wisely.

- **Prioritization:** Choosing which tasks are essential.
- **Pacing:** Breaking activities into smaller, manageable segments.
- **Planning:** Scheduling high-effort tasks for times of day when energy levels are naturally higher.

A Message to the Public

Because PH is often an "invisible illness," patients frequently face skepticism from others who see a person who "looks fine" but is struggling to stand in a grocery line. Greater public awareness is vital.

Advancements in vasodilator therapies and specialized exercise rehabilitation have improved the quality of life significantly over the last decade. However, acknowledging the crushing weight of fatigue is the first step toward better support. If you or a loved one experiences disproportionate tiredness alongside breathlessness, consult a specialist. Early diagnosis remains our most powerful tool in lightening the load.

Future of Pulmonary Hypertension Care in India

For years, a diagnosis of Pulmonary Hypertension (PH) in India felt like a silent sentence. Patients often spent months, if not years, misdiagnosed with common asthma or general fatigue before discovering that the high pressure in their lung arteries was straining their hearts to the point of failure. However, as we move into 2026, the landscape of PH care in India is undergoing a profound transformation, shifting from late-stage crisis management to a future of precision, accessibility, and hope.

From Imports to "Atmanirbhar" Innovation

Historically, the cost of specialized PH medication was a barrier that few Indian families could scale. Today, the tide has turned. India has emerged as a global hub for affordable PH therapy, with domestic pharmaceutical giants manufacturing everything from Endothelin Receptor Antagonists (ERAs) to PDE5 inhibitors. The Union Budget 2026 has further accelerated this through the "Biopharma SHAKTI" initiative. With a ₹10,000 crore commitment to domestic biologic production, we are moving toward a reality where advanced, life-saving therapies—once only available via expensive imports—are produced right here in India. This, coupled with the recent customs duty exemptions on rare disease medicines, is significantly easing the "out-of-pocket" burden on patients.

Digital Health and Holistic Care

The future is also digital. Under ABDM 2.0 (Ayushman Bharat Digital Mission), we are seeing the rise of patient-controlled health records that allow for seamless monitoring of a patient's progress across different cities.

Furthermore, Indian researchers are leading the world in "integrative" PH care. Ongoing multi-centre trials on yoga as a supportive therapy for PAH are proving that while modern medicine saves lives, holistic wellness improves the quality of those lives.

While challenges in rural infrastructure remain, the message for 2026 is clear: in India, Pulmonary Hypertension is no longer an invisible battle fought in the dark. With early detection and affordable, home-grown innovation, our patients can finally breathe a little easier.

Dr. Shree Vashista
Cardiologist, Delhi

Severe Symptoms of PH

Dr. Arti Kumar
Pulmonologist, Delhi

The Right Heart Under Siege

Pulmonary Hypertension occurs when the arteries in the lungs become thickened and narrow. To compensate, the right side of the heart must pump with increasing force. When the condition reaches a "severe" stage, the heart can no longer keep up. This is known as right-sided heart failure, and its symptoms are distinct and demanding.

Red Flags: The Symptoms of Severity

While mild PH might only cause shortness of breath during a jog, severe PH manifests during the simplest tasks, such as dressing or speaking.

- **Syncope (Fainting):** This is perhaps the most alarming "red flag." Fainting during physical exertion suggests that the heart is unable to pump enough oxygenated blood to the brain.
- **Significant Edema:** When the right heart fails, fluid backs up into the body. This causes noticeable, often "pitting" swelling in the ankles, legs, and eventually the abdomen (ascites).
- **Cyanosis:** A bluish tint to the lips or fingertips indicates that oxygen levels in the blood have dropped to critical levels.
- **Chest Pain (Angina):** This occurs when the overworked heart muscle itself is not receiving enough oxygen, signaling extreme cardiac strain.

The Turning Point in Care

When a patient presents with these severe markers, our clinical approach shifts from "monitoring" to "aggressive stabilization." We often utilize a Risk Stratification model, looking at the size of the right ventricle and the levels of heart stress proteins in the blood.

For patients in this high-risk category, oral pills alone are often insufficient. We move toward advanced therapies, such as continuous intravenous or subcutaneous infusions of prostacyclins. These medications act as a constant "open valve" for the lung arteries, significantly reducing the workload on the heart.

A Message of Urgency

If you experience fainting or swelling alongside breathlessness, do not wait for your next scheduled check-up. Severe PH is a medical emergency that requires a specialized care team. With the aggressive, multi-pathway treatments available in 2026, even patients with advanced symptoms can find a path back to stability—but only if we act before the heart reaches its limit.

Tracking Disease Progression in PH

Dr. Stuti Gupta
Pulmonologist, Delhi

The "Traffic Light" System: Risk Stratification

In 2026, we no longer guess how a patient is doing based on how they look in the exam room. Instead, we use Risk Stratification—a comprehensive scoring system that categorizes a patient's status into "Green" (Low Risk), "Yellow" (Intermediate Risk), or "Red" (High Risk).

Our goal is simple: to get every patient into the "Green" zone and keep them there. To do this, we monitor three primary pillars of health:

1. Functional Capacity: We track how much physical activity a patient can perform before reaching their limit. This is often measured by the Six-Minute Walk Test. A stable or increasing distance is a sign of success; a decline is an early warning.

2. Right Heart Function: Using an echocardiogram or cardiac MRI, we look for changes in the shape and strength of the right ventricle. If the heart begins to enlarge, it tells us the "plumbing" in the lungs is becoming more resistant.

3. Biomarkers: We use blood tests to measure NT-proBNP. Think of this as a chemical "distress signal" sent by the heart muscle when it is stretched too thin.

Why "Stable" Isn't Always Enough

A common pitfall in PH care is accepting a "stable" condition when a patient is still in the intermediate-risk (Yellow) category. Modern guidelines and medical ethics both point to a clear truth: stability at a high-risk level is not success.

If a patient's markers suggest they are not in the "Low Risk" zone, we must be proactive. This often means "escalating" therapy—adding a second or third medication that targets a different biological pathway in the lung's blood vessels.

The Patient's Role in the Map

Monitoring is a partnership. We ask patients to track their daily weight and recognize "red flags" like increased swelling or lightheadedness. By combining these home observations with our clinical tests, we can catch progression in its infancy.

In the fight against PH, information is our most powerful medicine. By tracking every variable, we transform a frightening diagnosis into a manageable journey, ensuring that your heart remains strong enough for the road ahead.

PH with No Known Cause

Dr. Diwakar Kumar
Cardiologist, Delhi

In the world of medicine, we often find comfort in cause and effect. We treat the infection to break the fever; we repair the valve to fix the heart. But for a specific group of patients, the diagnosis is far more baffling. They suffer from Idiopathic Pulmonary Arterial Hypertension (IPAH)—a rare, severe condition where the blood pressure in the lungs rises to dangerous levels for "no known cause."

When we use the word "idiopathic," it is a humble medical admission: we know what is happening, but we don't yet know why.

A High-Pressure Mystery

In a healthy body, the pulmonary arteries are flexible and wide, allowing blood to flow easily from the heart to the lungs to pick up oxygen. In patients with IPAH, these arteries undergo a mysterious transformation. The lining of the vessels begins to thicken and scar, narrowing the path for blood flow.

Imagine trying to force the contents of a fire hose through a straw. The right side of the heart, which pumps this blood, must strain against immense resistance. Over time, this constant "heavy lifting" causes the heart muscle to enlarge and eventually fail.

The Face of the Disease

IPAH is famously difficult to catch early. Because it often strikes young, otherwise healthy individuals—predominantly women in the prime of their lives—it is frequently misdiagnosed as asthma, anxiety, or poor physical conditioning.

Patients often describe a "wall" they hit during physical exertion. A flight of stairs becomes an Everest; a walk to the mailbox feels like a marathon. Other red flags include fainting spells (syncope), chest pain, and swelling in the legs.

Turning the Tide

While the "why" remains elusive, the "how to treat" has evolved remarkably. We have moved from a time of limited options to an era of targeted molecular therapies. By using medications that mimic natural substances to dilate blood vessels, we can now significantly reduce the workload on the heart.

Furthermore, genetic research is beginning to pull back the curtain. We now know that some "idiopathic" cases are actually linked to specific gene mutations, such as BMPR2, which may be triggered by environmental factors we are still identifying.

The journey with IPAH is a marathon, not a sprint. While we continue to search for the ultimate cause, our current goal is clear: early diagnosis and aggressive treatment to ensure that "no known cause" no longer means "no known hope."

Regular Monitoring in Connective Tissue Disease Patients

Dr. Manisha Mendiratta
Pulmonologist, Delhi

For many patients diagnosed with Connective Tissue Diseases (CTD)—such as Scleroderma, Lupus, or Mixed Connective Tissue Disease—the primary focus is often on the visible: the skin rashes, the joint swelling, or the Raynaud's phenomenon in the fingers. However, as a specialist, my deepest concern is often for what we cannot see.

One of the most serious complications of CTD is Pulmonary Arterial Hypertension (PAH), a condition where the blood vessels in the lungs become thick and narrow, forcing the heart to work dangerously hard. Because these changes happen internally and gradually, regular monitoring is not just a medical recommendation—it is a life-saving necessity.

The Window of Opportunity

The challenge with PAH in the context of CTD is that it is a "silent progressor." In its early stages, a patient may feel perfectly normal. By the time symptoms like significant breathlessness, chest pain, or fainting occur, the heart may already be under severe strain.

Our goal is to find the "window of opportunity"—the period where the disease has started but hasn't yet caused irreversible damage. This is why we implement a rigorous screening protocol. For a patient with Scleroderma, for example, an annual Echocardiogram and Pulmonary Function Test (PFT) are essential, regardless of how "well" the patient feels.

Beyond the Breathless Moment

Many long-term patients ask me about catching the disease; it's about managing it with precision. Today, we use a "multi-modal" approach to tracking health:

- The Six-Minute Walk Test: Measuring how far a patient can walk to assess functional capacity.
- Biomarkers: Using blood tests like NT-proBNP to detect early signals of heart stress.
- Right Heart Catheterization: The "gold standard" to confirm pressure levels when screening shows a change.

A Proactive Partnership

The landscape of CTD-associated PAH has been transformed by early intervention. We now have sophisticated therapies that can slow the progression of lung vascular damage, but these treatments are most effective when started early.

To my patients, I offer this advice: treat your monitoring appointments with the same urgency as your treatment. These tests are our "early warning system," providing the data we need to protect your heart and ensure that you remain active, independent, and healthy for years to come.

Why Regular Follow-Ups are the Lifeline for PH Patients

Dr. Vidya Nair
Pulmonologist, Delhi

In the management of chronic illness, there is a dangerous temptation to equate "feeling fine" with "being fine." For patients living with Pulmonary Hypertension (PH), this assumption can be a critical error. PH is a dynamic, evolving condition where the pressure in the lung's arteries can shift quietly, long before the patient feels a single new symptom.

As a physician, I view regular follow-up appointments not as mere "check-ins," but as essential recalibrations of a life-saving treatment plan.

The Hidden Progression

Pulmonary Hypertension is often described as a "progressive" disease. This means that even with the best medications, the heart and lungs are in a constant state of adaptation. The right side of the heart is incredibly resilient, often thickening its walls to push against high lung pressures. However, this compensation has a limit.

By the time a patient notices increased shortness of breath or swollen ankles, the heart may already be reaching a breaking point. Regular follow-ups allow us to use objective tools—like the Six-Minute Walk Test (6MWT), NT-proBNP blood markers, and Echocardiograms—to catch these subtle shifts in real time.

Precision Medicine in Practice

The treatment for PH has transitioned from a "one-size-fits-all" approach to highly personalized therapy. During a follow-up, we aren't just checking vitals; we are assessing Risk Stratification. We categorize patients into low, intermediate, or high-risk groups based on their test results.

If a patient moves from "low" to "intermediate" risk, we don't wait for them to feel worse. We act immediately, perhaps by adding a second or third class of vasodilator medication. This proactive "escalation of therapy" is what has transformed PH from a rapidly terminal diagnosis into a manageable chronic condition.

A Partnership for Longevity

Beyond the data, these visits are a space for dialogue. We discuss side effects, mental health, and lifestyle adjustments. PH management is a marathon, and the "coach" (the medical team) and the "athlete" (the patient) must stay in constant communication to adjust the pace.

To my patients, I say this: Your follow-up is your most powerful medicine. It is the only warning system that protects your heart and ensures that your "good days" continue for years to come.

PH in Connective Tissue Diseases

Dr. Anish
Pulmonologist, Delhi

For patients living with connective tissue diseases (CTDs)—such as scleroderma, lupus, or rheumatoid arthritis—the daily focus is often on joint pain, skin changes, or fatigue. However, there is a "silent" complication that physicians are increasingly watching for: Pulmonary Arterial Hypertension (PAH).

Connective tissue diseases occur when the body's immune system mistakenly attacks its own healthy tissues. While we often see the effects in the hands or face, the same inflammatory process can target the microscopic blood vessels in the lungs.

The Internal Pressure Cooker

In patients with CTD, the walls of the pulmonary arteries can become thick, stiff, and narrow. To visualize this, imagine trying to pump water through a garden hose that is being squeezed tight. The heart's right ventricle must push harder and harder to move blood through the lungs to pick up oxygen.

This constant strain eventually causes the heart muscle to weaken. Because the symptoms—shortness of breath, dizziness, and mild swelling in the ankles—often mimic general fatigue or the aches of your CTD itself, PAH is frequently the "silent masquerader," staying hidden until it has reached an advanced stage.

Why Screening Saves Lives

The marriage of rheumatology and cardiology has never been more vital for conditions like systemic sclerosis (scleroderma), the risk of developing high lung pressure is significant enough that we now recommend annual screening, even if the patient feels perfectly fine.

We utilize a non-invasive tool called an echocardiogram to estimate lung pressures, often followed by a "gold standard" right-heart catheterization if the results are concerning.

A Brighter Outlook

A decade ago, a PAH diagnosis alongside a connective tissue disease was met with limited options. Today, the narrative has changed. We now have a variety of targeted therapies—oral, inhaled, and intravenous medications—that specifically relax the lung vessels and "un-squeeze" that metaphorical hose.

The message for patients is one of empowered vigilance. Communicate any new shortness of breath to your specialist immediately. With early detection and modern dual-therapy approaches, we aren't just treating a set of symptoms; we are protecting the heart and extending vibrant, active lives.

Hospitalisation risk doubles after age of 45: NSO data

Elderly Driving Healthcare Demand Spike

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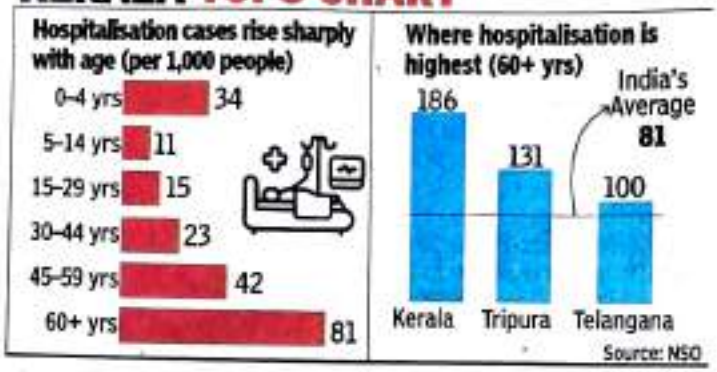
New Delhi: The risk of being hospitalised in India doubles after the age of 45 and rises sharply among the elderly, signalling a shift in the country's healthcare burden, according to the latest National Sample Survey Office (NSO) data.

The survey shows that hospitalisation rates climb from 23 per 1,000 people in the 30-44 age group to 42 per 1,000 among those aged 45-59, and then nearly double again to 81 per 1,000 in those aged 60 and above. In comparison, only 15 per 1,000 people aged 15-29 required hospital care over the year. Hospitalisation among children aged 0-4 (34 per 1,000) is also higher than among adolescents and young adults, pointing to a dual burden at the two ends of the age spectrum.

KERALA TOPS CHART



The data points to a clear transition, with healthcare demand increasingly driven by middle-aged and older populations. Experts say this reflects a rising burden of chronic diseases such as diabetes, heart conditions and respiratory illnesses, which become more common with age and often require hospital treatment.

"The sharp rise in hospitalisation after 45 reflects a systemic gap in preventive healthcare. Lifestyle diseases like diabetes, hypertension, obesity, fatty liver and heart disease are accumulating earlier, but structured screening and risk modification are not keeping pace," said Dr Rommel Tickoo, director, internal medicine, Max Hospital, Saket.

"If India invests in early detection, routine metabolic screening, cardiovascular risk assessment, and primary care strengthening, we can significantly reduce avoidable hospital admissions in later decades," he added.

State-wise differences are stark. Kerala reports among the highest hospitalisation rates, with about 186 elderly persons per 1,000 admitted in a year—more than double the national average. Other regions such as Lakshadweep and Tripura also show elevated levels, while some northeastern states report lower rates. However, experts say that higher rates in states like Kerala may also reflect better access to healthcare and higher detection of illnesses.

Among the elderly, hospitalisation rates are higher for men (93 per 1,000) than women (69 per 1,000), while differences are smaller or reversed in younger age groups.

The trend highlights a growing pressure on hospitals as India's population ages. With more people living longer and developing long-term conditions, demand for inpatient care is expected to rise in the coming years.

The NSO data, based on hospitalisations over the past year (excluding childbirth), underline the need for stronger primary healthcare, early detection and better management of chronic diseases to reduce avoidable hospital admissions.

The findings from the NSO suggest that India's healthcare needs are shifting rapidly towards middle-aged and elderly populations.

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दावा : अधूरी नींद बन रही अस्थमा का बड़ा कारण

विशेषज्ञों ने अस्थमा से जुड़ी बीमारी में नींद को भी माना अहम कारण

विश्व अस्थमा दिवस

भागलपुर, वरीय संवाददाता। आपको मोबाइल, टीबी देखने की लत है और रातों की नींद गायब हो चली है तो ये खबर आपके लिए है। रात में नींद गंवा बैठे युवाओं व अधेड़ों को अस्थमा या एलर्जी का शिकार होना पड़ रहा है।

चिकित्सकों की मानें तो स्लीप डिसआर्डर के शिकार मरीज बड़ी संख्या में इलाज कराने पहुंच रहे हैं, जिनमें एलर्जी व अस्थमा के मामले मिल रहे हैं। ऐसे में इस तरह के मरीजों का स्लीप डिसआर्डर के साथ-साथ एलर्जी या अस्थमा का इलाज किया जा रहा है। इस तरह के मामले बीते पांच सालों में तेजी से बढ़े हैं।

जवाहर लाल नेहरू मेडिकल कॉलेज एंड हॉस्पिटल के मेडिसिन विभाग एवं टीबी एंड चेस्ट विभाग के डॉक्टरों द्वारा किए गए क्रास स्टडी सर्वे में ये मामला देखने को मिला। मेडिसिन विभाग के अध्यक्ष डॉ. राजकमल चौधरी एवं टीबी एंड चेस्ट विभाग के अध्यक्ष डॉ. बीरेंद्र कुमार शर्मा की संयुक्त अगुवाई में दोनों विभागों के ओपीडी में जनवरी 2026 से जून 2026 के बीच इलाज के लिए पहुंचे 6753 मरीजों की जांच की गई। की केस हिस्ट्री खंगाली गई। इन मरीजों को दोनों कटेगरी में बांटा गया। पहले वे मरीज जो कि स्लीप डिसआर्डर के शिकार हैं और दूसरे वे जो कि अस्थमा-एलर्जी के शिकार हैं। फिर पता चला कि 63 प्रतिशत मरीजों में स्लीप डिसआर्डर के साथ-साथ अस्थमा-एलर्जी की बीमारी है। इनमें बच्चे, युवा व किशोर शामिल हैं। मोबाइल के शौक के कारण नींद का तारतम्य बिगड़ने से इनमें एलर्जी और अस्थमा के लक्षण मिल रहे हैं।

- दुनिया में 36 करोड़ लोग अस्थमा से पीड़ित हैं
- नींद पूरी नहीं होने से सूजन बढ़ाने वाले सेल्स बढ़े
- हजारों मरीजों पर हुई स्टडी में सामने आई जानकारी

भारत में 3.5 करोड़ अस्थमा से पीड़ित

अधूरी नींद या स्लीप डिसऑर्डर से अस्थमा और एलर्जी होने की प्रक्रिया को विज्ञान की भाषा में इम्यून-रेस्पिरेटरी लिंक कहते हैं। जब हम सोते हैं, तो हमारा शरीर साइटोकिन्स नामक प्रोटीन बनाता है जो संक्रमण और सूजन से लड़ते हैं। जब नींद पूरी नहीं होती, तो शरीर में रक्षा करने वाले साइटोकिन्स कम हो जाते हैं और सूजन बढ़ाने वाले सेल्स बढ़ जाते हैं। विश्व स्वास्थ्य संगठन के अनुसार, दुनिया में लगभग 36 करोड़ और भारत में लगभग 3.5 करोड़ अस्थमा से पीड़ित हैं।

विश्व अस्थमा दिवस | दस साल पहले के मुकाबले अस्थमा से जान गंवाने वालों की संख्या में 47 फीसदी का इजाफा

बिगड़ती हवा से बच्चों में बढ़ रही सांस की बीमारी

नई दिल्ली, प्रमुख संवाददाता। राजधानी में बढ़ रहे प्रदूषण के साथ सांसों पर संकट भी गहराने लगा है। आंकड़ों के मुताबिक, बीते 10 साल पहले की तुलना में सांस की बीमारी से मरने वालों की संख्या में 47 फीसदी से ज्यादा का इजाफा हुआ है। इसमें भी चौंकाने वाली बात यह है कि इनमें बच्चों की संख्या ज्यादा है। डॉक्टर इसकी वजह एलर्जी, संक्रमण और प्रदूषण को बता रहे हैं।

सांख्यिकी निदेशालय और मुख्य रजिस्ट्रार कार्यालय की मृत्यु पंजीकरण की रिपोर्ट के अनुसार वर्ष 2015 में सांस की बीमारियों से 6239 मरीजों की मौत हुई थी। डॉक्टरों ने इन मरीजों की मौत का कारण सांस की बीमारी बताया था। इनमें से 112 मरीजों की मौत का कारण अस्थमा को बताया गया। इसमें 14 वर्ष से कम उम्र के ज्यादा बच्चे शामिल नहीं थे, क्योंकि अस्थमा से बुजुर्ग अधिक पीड़ित होते हैं। वहीं, वर्ष 2024 के आंकड़े पर गौर करें तो सांस की बीमारियों के कारण 9200 से अधिक लोगों ने जान गंवाई। यह बीते दस वर्ष पहले की तुलना में 47.61 प्रतिशत अधिक है। इससे पहले सांस की बीमारियों से ज्यादा मौतें वर्ष 2021 में कोरोना के डेल्टा वायरस के कारण हुई थीं। इसके बाद सांस की बीमारियों के कारण होने वाली मौतें कम हो गई थीं, लेकिन फिर बढ़ गई है।

सांस की बीमारियों से मौतें

वर्ष	मौतें
2024	9210
2023	8799
2022	7425
2021	14437
2020	8057
2019	8014
2018	8451
2017	7511
2016	8260
2015	6239

अस्थमा से जान गंवाने वालों में 13 फीसदी बच्चे

दस वर्ष पहले की तुलना में वर्ष 2024 में अस्थमा के कारण साढ़े तीन गुना अधिक लोगों ने जान गंवाई। इनमें 14 वर्ष से कम उम्र के 13.52 प्रतिशत बच्चे शामिल थे। इसके अलावा 25 प्रतिशत 15 से 54 वर्ष के लोग शामिल थे।

एलर्जी, संक्रमण और प्रदूषण मुख्य कारण

पटेल चेस्ट अस्पताल के निदेशक डॉ. राजकुमार ने बताया कि मौसम में बदलाव और पोलन के कारण होने वाली एलर्जी, संक्रमण व प्रदूषण अस्थमा का मुख्य कारण होता है। किसी तरह की एलर्जी, संक्रमण और प्रदूषण के कारण सांस की नली में सूजन आ जाती है। इससे सांस फूलने लगती है। ऐसी स्थिति में इनहेलर और सांस के जरिये ली जाने वाली दवाएं नहीं लेने पर कई मरीजों की सांसें बंद हो जाती हैं। इनहेलर को लेकर लोगों में कई तरह की भ्रांतियां हैं। अस्थमा जैसी बीमारी में इनहेलर ही सबसे अच्छा इलाज है।

बच्चे के नामकरण में भी घर थे। अब शादी में शामिल

से पहले दुख... लेकिन दुखभरी सूचना आई है।

काम करता था।

इंसुलिन आई ड्रॉप से आंखों के ज़ख्म तेज़ी से भरने का दावा

AI Image

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- गुरु नानक आई सेंटर के रिसर्च में हुआ खुलासा, दो से तीन हफ्ते में दिख रहे परिणाम
- दावा, आंखों के इलाज में इंसुलिन आई ड्रॉप से देश की पहला रिसर्च
- कॉर्नियल ट्रांसप्लांट, केमिकल चोट जैसे केस में भी असरदार

■ नई दिल्ली: 18 साल की एक लड़की कॉन्टैक्ट लेंस का इस्तेमाल करती थी। सब कुछ ठीक चल रहा था। अचानक उसकी आंख में जलन और लालीपन आ गया। इससे उसे धुंधला दिखाई देने लगा। वह डॉक्टर के पास पहुंची तो जांच में पता चला कि कॉन्टैक्ट लेंस की ठीक तरीके से साफ-सफाई न होने से आंखों में इन्फेक्शन हो गया। डॉक्टरों ने जब घाव के परत की जांच की तो घाव गंभीर नजर आए, जिसको आसानी से ठीक करना मुश्किल था। इसके बाद डॉक्टरों ने इंसुलिन आई ड्रॉप्स की मदद से इलाज शुरू किया। करीब 2 से 3 हफ्ते में घाव आसानी से भर गए। डॉक्टरों ने बताया कि यह तब संभव हो पाया, जब उनकी एक रिसर्च में सफलता मिली। इस रिसर्च ने आंखों के इलाज की नई उम्मीद जगा दी है।

मार्केट में नहीं है अभी इंसुलिन आई ड्रॉप

एक्सपर्ट का कहना है कि आंखों के जिद्दी घावों को मेडिकल भाषा में पर्सिस्टेंट एपिथीलियल डिफेक्ट (PED) कहा जाता है। आमतौर पर आंख की सतह यानी कॉर्निया पर कोई भी छोटा घाव एक से दो हफ्तों में अपने आप ठीक हो जाता है, लेकिन जब यह दो हफ्तों के बाद भी नही भरता, तो उसे PED माना जाता है। यह स्थिति खतरनाक हो सकती है। ऐसे में इंसुलिन आई ड्रॉप से नई उम्मीद जगी है।

गुरु नानक आई सेंटर में आंखों के घाव को आसानी से भरने या इलाज के लिए एक रिसर्च किया। यह रिसर्च क्लिनिकल ट्रायल्स रजिस्ट्री इंडिया यानी सीटीआरआई में रजिस्ट्रेशन के बाद ही किया गया है। रिसर्च में शामिल डॉ पारूल जैन बताती हैं कि यह इंसुलिन आई ड्रॉप पर देश का यह पहला रिसर्च है। जो इंडियन जर्नल ऑफ ऑप्थल्मोलॉजी में प्रकाशित हुई है। कुल 22 मरीजों को शामिल किया गया, जिनकी उम्र 18 साल से अधिक थी और जिनमें पारंपरिक इलाज के बावजूद घाव ठीक नहीं हो रहे थे। इन मरीजों में कॉर्नियल ट्रांसप्लांट के बाद हुए घाव न्यूरोट्रॉफिक केराटाइटिस, केमिकल चोट और अन्य समस्याएं शामिल थीं। सभी मरीजों को इंसुलिन आई ड्रॉप दिन में चार बार दी गई और कुछ महीने तक उनकी निगरानी की गई। नतीजे बेहद उत्साहजनक रहे। करीब 77 प्रतिशत मरीजों के घाव एक महीने के भीतर पूरी तरह भर गए, जबकि 6 हफ्तों में यह आंकड़ा 86 प्रतिशत तक पहुंच गया। औसतन घाव भरने में लगभग 21.5 दिन का समय लगा, जो पारंपरिक इलाज की तुलना में काफी कम माना जा रहा है। रोशनी में भी सुधार देखा गया। यह रिसर्च डॉ पारूल जैन, अवनि हरियानी, डॉ ईशा गुप्ता और डॉ गहन रेड्डी द्वारा की गई।

पैर से उंगली निकालकर हाथ में डॉक्टरों ने की प्रत्यारोपित

अमर उजाला ब्यूरो

नई दिल्ली। दिल्ली के द्वारका स्थित निजी अस्पताल में 18 वर्षीय छात्रा के हाथ में पैर की उंगुली (टो-टू-फिंगर ट्रांसफर) को सफलतापूर्वक प्रत्यारोपित किया गया। छात्रा के बाएं हाथ की उंगली लंबे समय से विकृत हो गई थी। इससे उंगली के टिश्यू सिकुड़ और हलचल बंद हो गई थी। इस कारण छात्रा के रोजमर्रा के सामान्य काम प्रभावित होने लगे थे।

डॉक्टरों की जांच और परामर्श के बाद छात्रा को टो-टू-मिडिल फिंगर ट्रांसफर सर्जरी की सलाह दी गई। यह जटिल माइक्रोसर्जरी अस्पताल के प्लास्टिक और ऑनको-रिकंस्ट्रक्टिव सर्जरी विभाग के प्रमुख डॉ. राहुल कपूर और उनकी टीम ने की। इस प्रक्रिया में पैर की दूसरी उंगली को निकालकर हाथ की क्षतिग्रस्त उंगली की जगह प्रत्यारोपित किया। सर्जरी के दौरान माइक्रोवैस्कुलर एनास्टोमोसिस, टेंडन रिकंस्ट्रक्शन और सॉफ्ट टिश्यू अलाइनमेंट तकनीकों का इस्तेमाल किया गया। डॉ. राहुल कपूर ने बताया कि सर्जरी के बाद छात्रा के हाथ की 80 से 95 प्रतिशत तक कार्यक्षमता वापस आ गई है।

द्वारका के निजी अस्पताल में हुई टो-टू-फिंगर ट्रांसफर सर्जरी

उच्चायुक्त नियुक्त किया गया है।

को पहले ही सूचित कर दिया है।'

अटलांटिक क्रूज पर हंटा वायरस से तीन की मौत, कई बीमार

केपटाउन, एपी : अटलांटिक महासागर में सफर कर रहे एक क्रूज जहाज पर संदिग्ध हंटा वायरस संक्रमण ने दहशत फैला दी है। इस बीमारी से अब तक तीन लोगों की मौत हो चुकी है, जबकि तीन अन्य बीमार हैं। डब्ल्यूएचओ व दक्षिण अफ्रीका के स्वास्थ्य विभाग ने इसकी पुष्टि की है।

डच कंपनी द्वारा संचालित यह क्रूज फिलहाल केप वर्डे तट के पास खड़ा है, जहां स्थानीय प्रशासन ने अभी किसी को जहाज से उतरने की अनुमति नहीं दी है। जहाज पर मौजूद दो गंभीर मरीज क्रू मेंबर बताए जा रहे हैं। इस जहाज में ज्यादातर ब्रिटिश, अमेरिकी और स्पेनिश यात्री सवार हैं। अधिकारियों ने बताया कि तीन लोगों एक डच दंपती और एक जर्मन नागरिक की मौत के बाद लगभग 150 लोग अभी भी जहाज पर फंसे हुए हैं।

चूहों से फैलता है हंटा वायरस : दरअसल, हंटा वायरस एक दुर्लभ व खतरनाक संक्रमण है, जो आमतौर पर चूहों और अन्य कृंतकों के मल-मूत्र के संपर्क से फैलता है। यह वायरस फेफड़े और किडनी को प्रभावित करता है। यह बीमारी जानलेवा साबित हो सकती है व इसका कोई निश्चित इलाज नहीं है।

CSOT). TCL is looking to add two local partners in its Indian entity, with the company retaining a 49% stake

The company has invested more than ₹1,800 crore in the TCL CSOT

rates annual revenue of around ₹1,500 crore, the executives said.

MARCH EXPORTS DROP 23%

Pharma Exports Surpass $31 b in FY26 Despite Global Headwinds

Inventory buildup in US, generics slowdown in China weighed on local exports

Teena Thacker

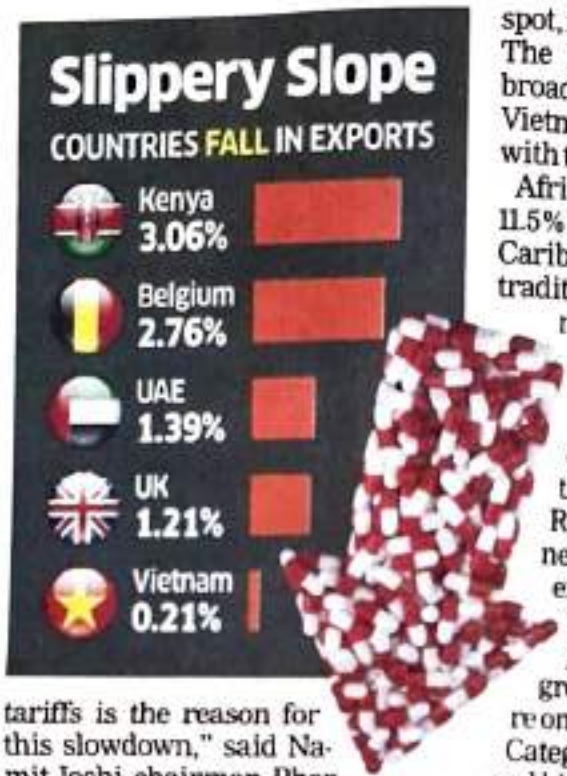
New Delhi: India's pharmaceutical exports crossed $31 billion in FY26, despite a 23% year-on-year decline in March with official data showing that the industry is grappling with a sharp slowdown in the US, among the top export markets.

Shipments to the US fell 10% in March while those to China, another major destination for Indian pharma, contracted 11.54%.

"When compared to exports in March FY25 ($3,681.7 million) during last fiscal, exports in March FY26 ($2,828.6 million) have declined by 23.17%," according to the Directorate General of Commercial Intelligence and Statistics (DGCIS).

Experts attribute the current export slowdown to overstocking in the US ahead of imposition of higher tariffs on India last year, while China is focusing on high-value imports.

"The US inventory buildup due to tariffs is the reason for this slowdown," said Namit Joshi, chairman, Pharmexcil. "Also, in China, the slowdown of generics in the domestic market could have led to this."



Notably, exports in March rose 10.6% over February, suggesting the worst of the inventory hangover may be easing.

Exports to the NAFTA region fell 7.9% to nearly $10.6 billion.

Shipments to the UK, India's third-largest pharma destination, slipped 1.2%, while those to Belgium and Kenya, typically an African bright spot, fell 2.8% and 3.1%, respectively. The UAE—a gateway market for broader West Asia—dipped 1.4%. Vietnam and Nepal were largely flat with the former declining 0.2%.

Africa surged 13%, Oceania rose 11.5%, and Latin America and the Caribbean expanded 10%. Europe, traditionally a slow mover, delivered 7.1% growth.

"However, these markets are more price-sensitive and logistically vulnerable, especially African trade routes that are directly impacted by Red Sea instability," said Dinesh Dua, a pharma industry expert. "This implies that volume growth may not translate proportionately into value growth, putting further pressure on margins."

Category wise, drug formulations and biologicals led pharma exports in the last fiscal year at $23.08 billion. Formulations and biologicals continued to hold the major share of total exports at 74.2% with exports in this category growing by 0.7%.

The real standout, however, was vaccines. At $1.5 billion and a 26.4% rise, the segment was the fastest-expanding category in the entire export basket.

Exports of Ayush and herbal products however fell 7.3% to $638.7 million in FY26.