TNOA DIGITAL TIMES

ISSUE 5

DR SUJATHA MOHAN
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DR PRASANNA V RAMESH
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CO-EDITOR

President's Message

Dear Colleagues and Friends,

It gives me immense pleasure to present the 5th edition of TNOA Times, a vibrant reflection of the academic spirit and creative talent within our ophthalmic fraternity.

This edition beautifully showcases the numerous activities and enriching webinars conducted during April and May, highlighting the dedication of our members towards continuous learning and professional excellence. The enthusiastic participation and exchange of knowledge truly exemplify the strength of our association.

What makes this edition even more special is the inclusion of outstanding ophthalmic photographs, along with inspiring prose and poetry that reveal the artistic side of our colleagues. These contributions remind us that ophthalmology is not only a science, but also an art enriched by observation, compassion, and creativity.

I congratulate the editorial team and every contributor for bringing together such an engaging and meaningful publication. May TNOA Times continue to inspire, connect, and celebrate the talents of our community.

With warm regards,

Dr. Sujatha Mohan
President
Tamil Nadu Ophthalmic Association

Editor & Co-Editor's Message

Dear TNOA members,

Every edition of TNOA Digital Times is more than a compilation of events and articles — it is a living archive of the thoughts, experiences, creativity, and academic energy of our ophthalmic community. As we present the 5th edition, we are delighted to witness how this platform continues to evolve into a space where science and storytelling coexist beautifully.

This issue captures a remarkable journey through the academic initiatives of April and May 2026, featuring insightful webinars, postgraduate training programs, international collaborations, and practice development initiatives that reflect the progressive vision of TNOA. Equally inspiring are the contributions to the Ophthalmic Visual Museum, where clinical images transform into lessons in observation, diagnosis, and curiosity.

What truly gives this edition its soul, however, are the voices behind the prose and poetry. Through personal reflections, patient encounters, and narratives from everyday ophthalmic practice, our contributors remind us that medicine is deeply human at its core. These pages celebrate not only what we see through the slit lamp or microscope, but also what we perceive through empathy, resilience, and compassion.

We sincerely thank every contributor, reviewer, and member of the editorial board for their enthusiasm and support in shaping this edition. We hope these pages educate, inspire, and strengthen the sense of community that binds us together as ophthalmologists.

With warm regards,

Dr Prasanna V Ramesh
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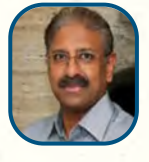

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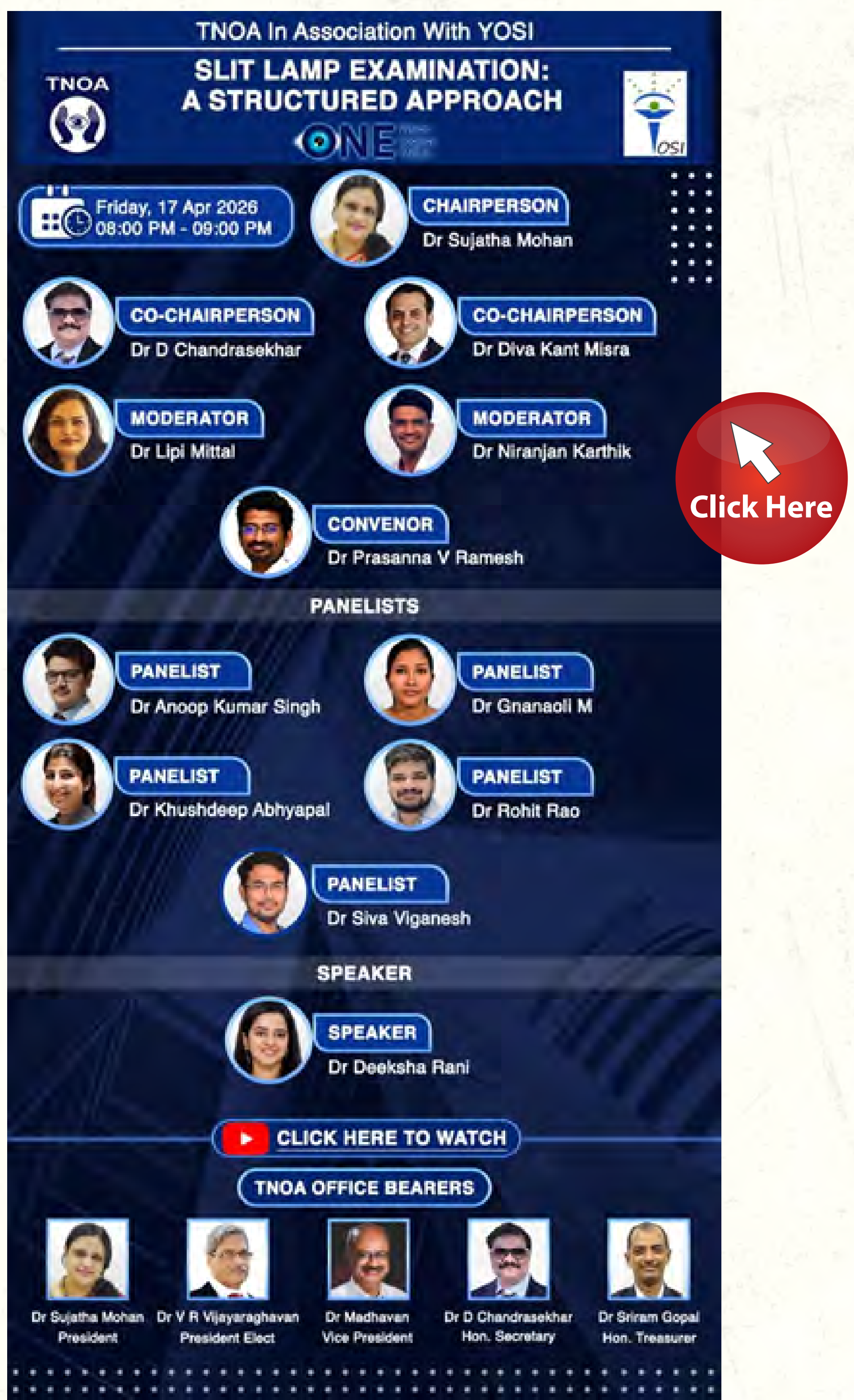
Slit Lamp Examination: A Structured Approach



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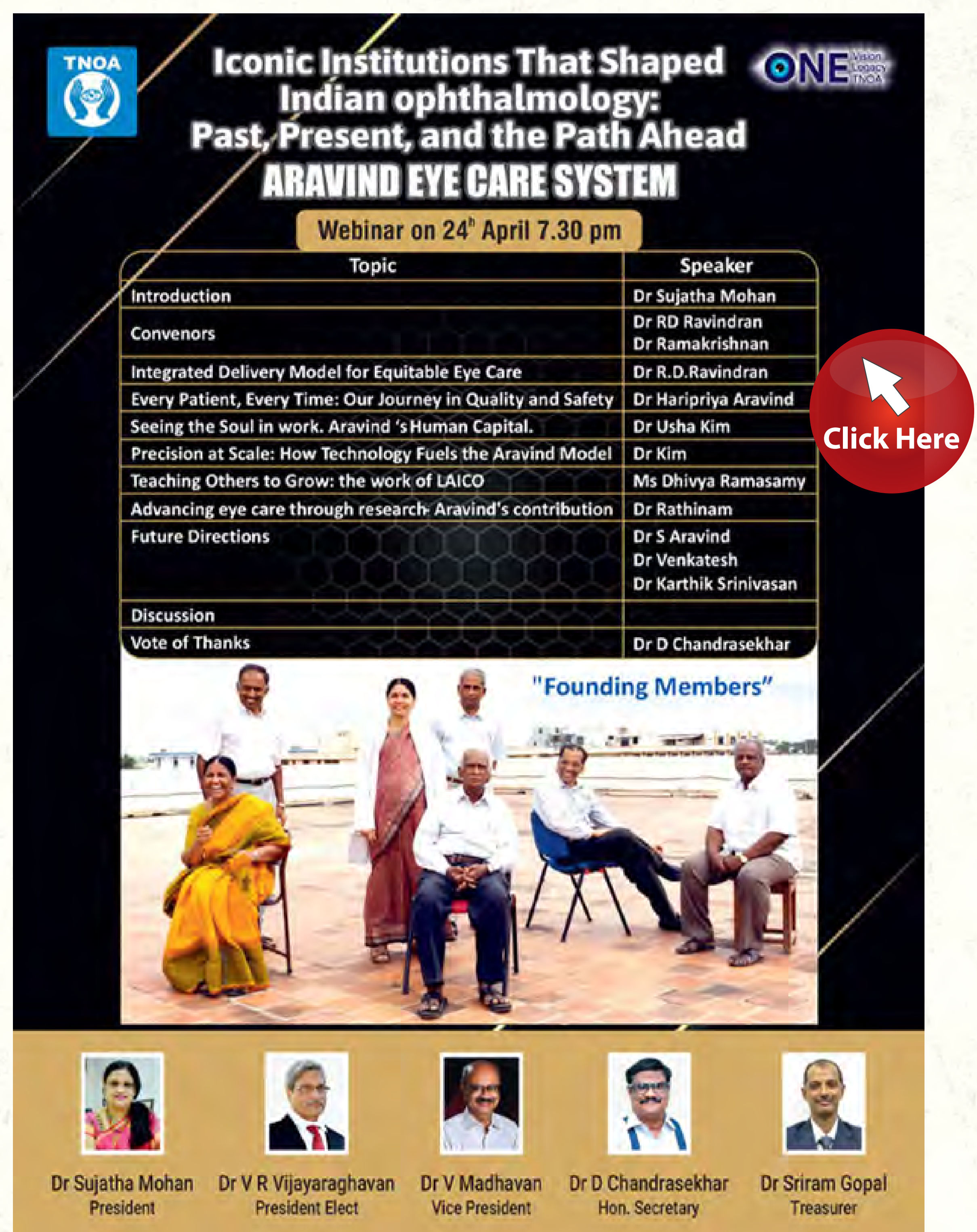
Iconic Institutions That Shaped Indian Ophthalmology: Aravind Eye Care System



MAY 2026

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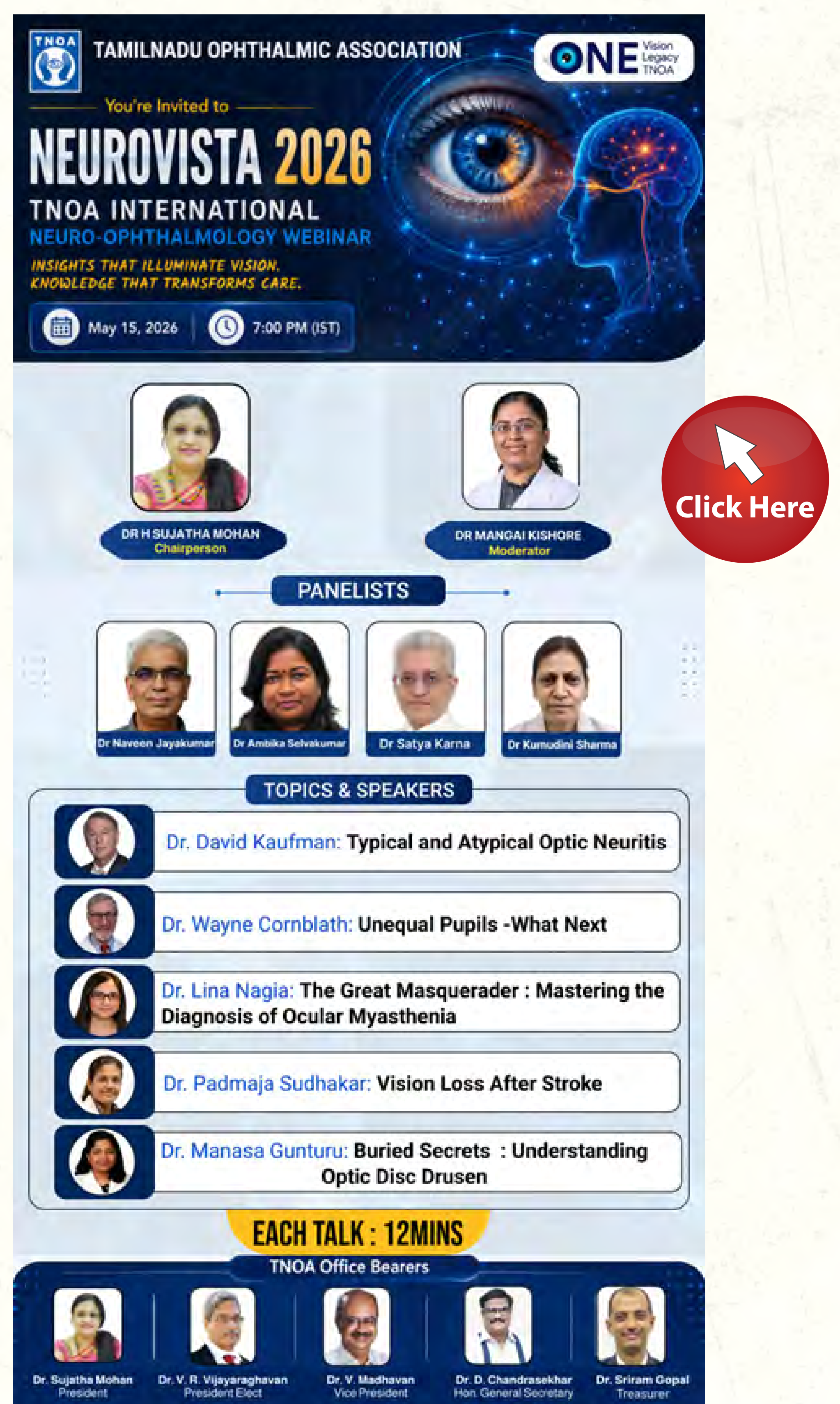

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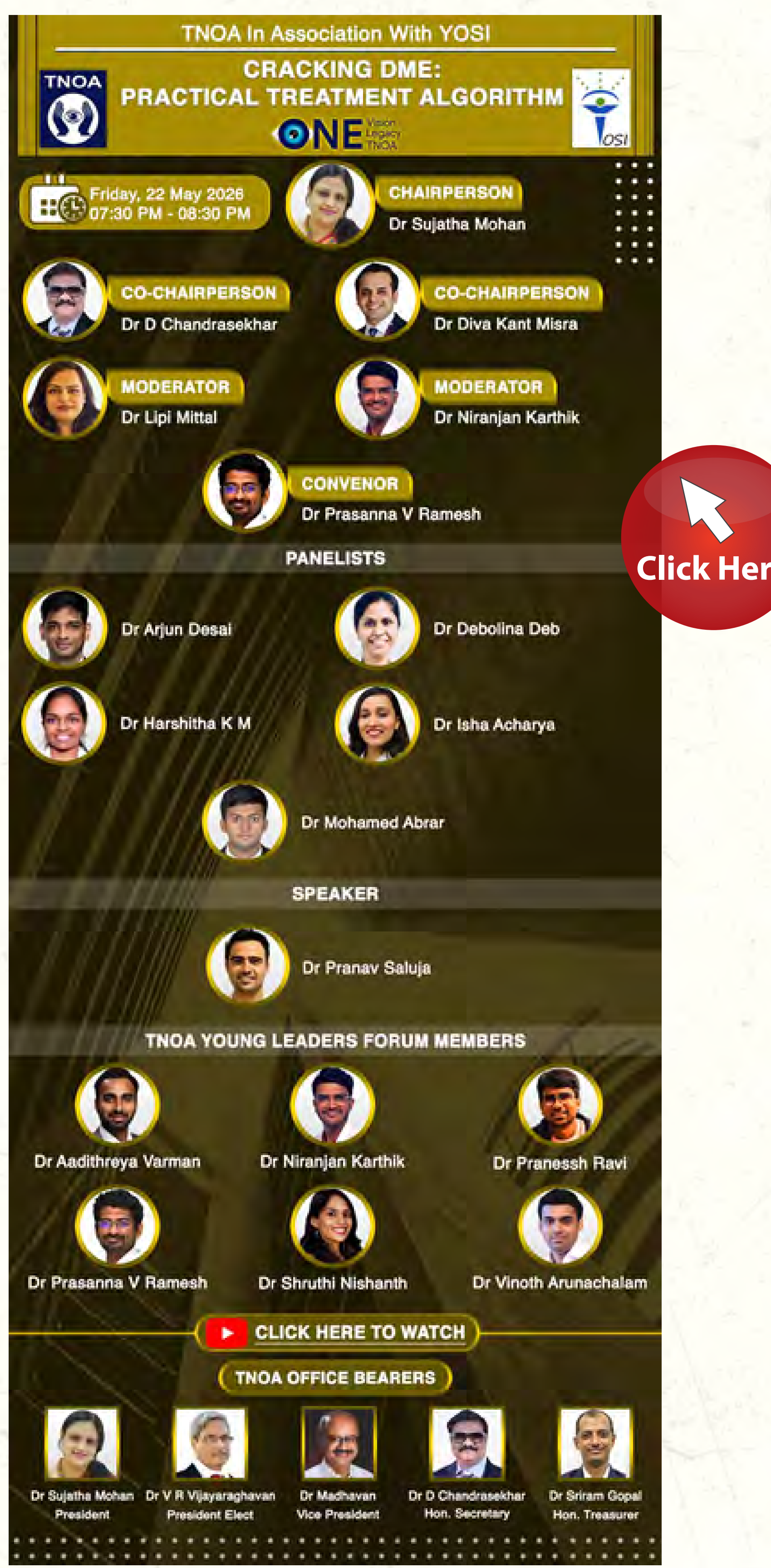
Cracking DME: Practical Treatment Algorithm



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OPHTHALMIC
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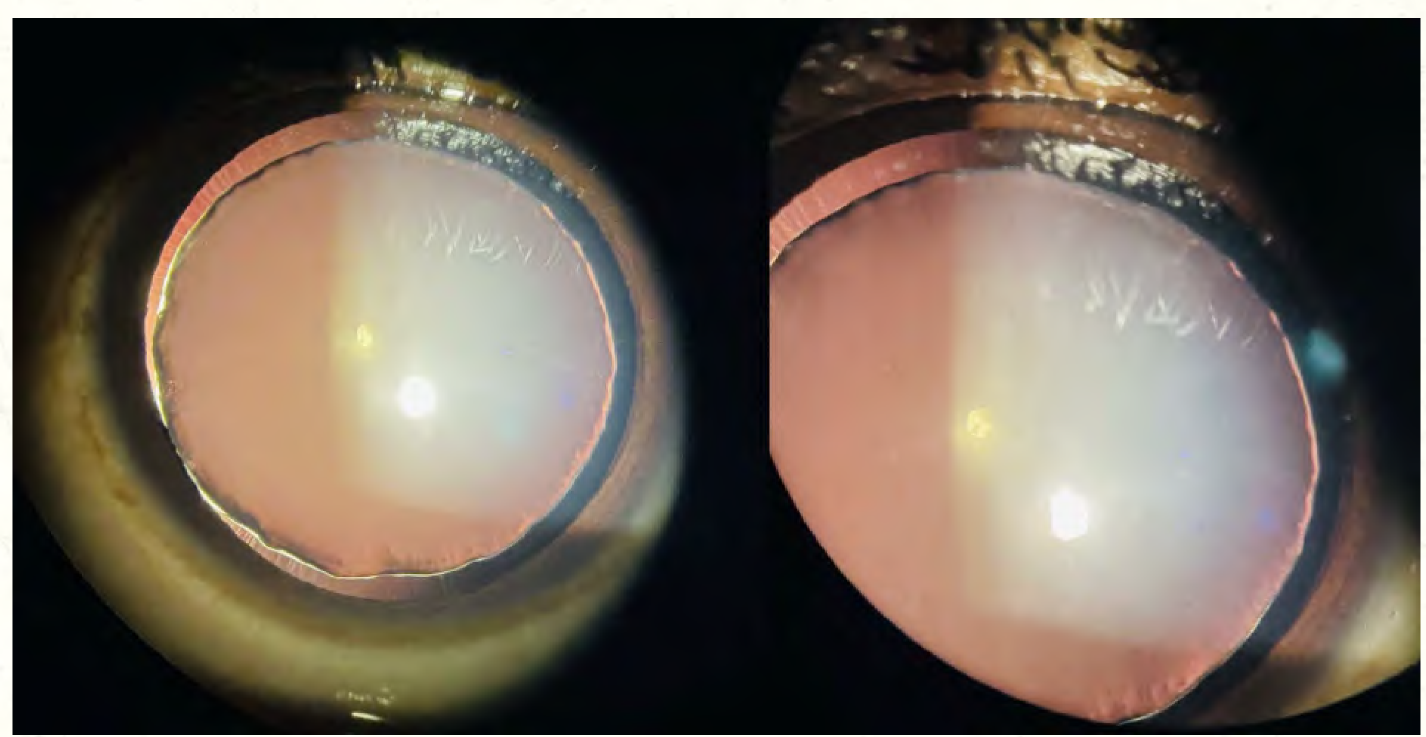
Orb Of Light; The Celestial Lens In Microspherophakia

Dr Arut Priya. A MBBS., DO., DNB
PSG Institute Of Medical Science And Research

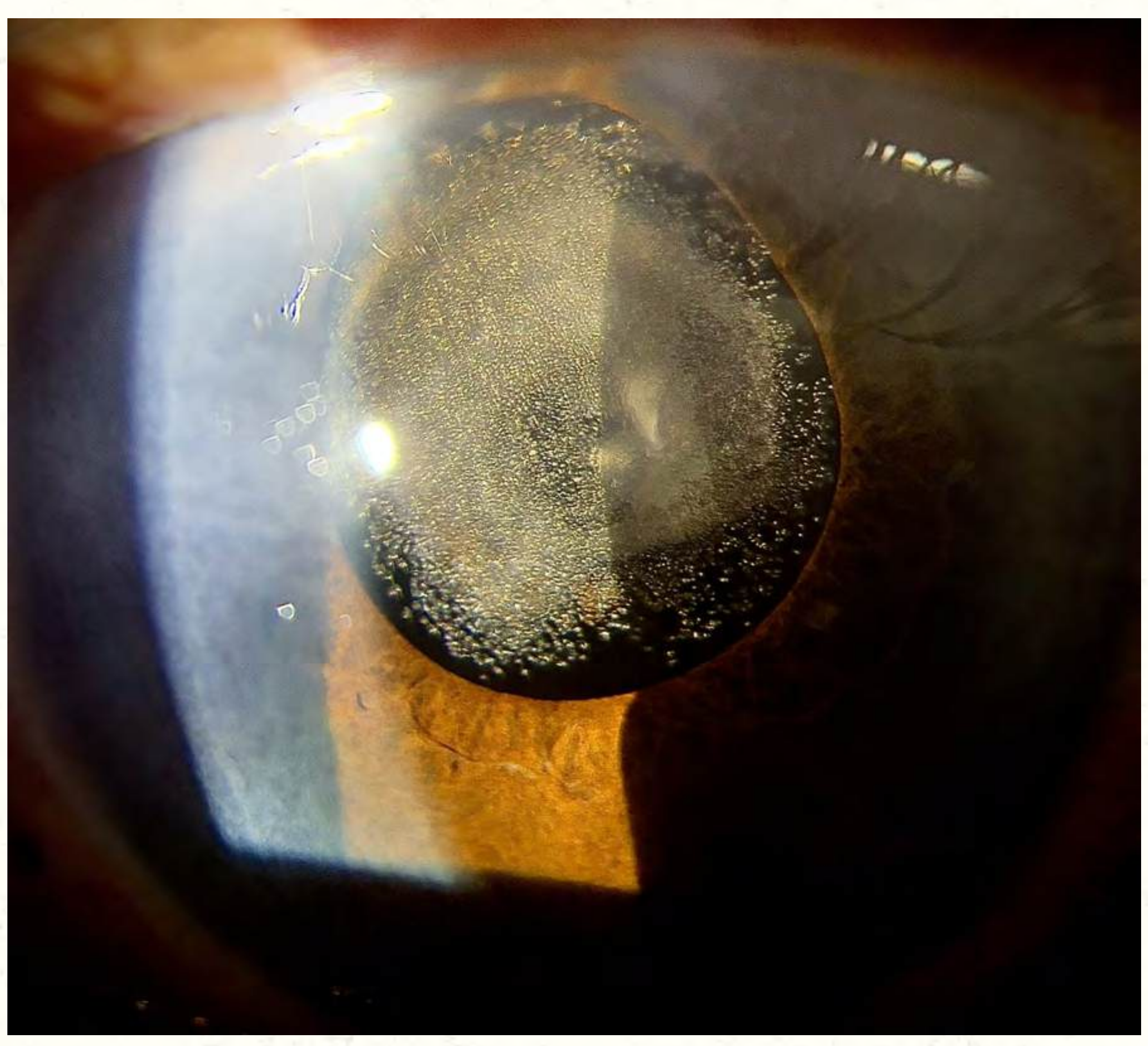
Microspherophakia is a rare abnormality of crystalline lens usually bilateral, marked by reduced equatorial diameter and increased anteroposterior thickness giving the lens a spherical configuration. It occurs as an isolated entity or in association with systemic disorders like Weil-Marchesani syndrome, Marfan syndrome, Homocystinuria, Alport syndrome. The lens is small, highly convex, edges of these small diameter lenses can be observed when pupils are fully dilated which appears like orb of light. Complications include zonular laxity which predisposes to subluxation or dislocation, high lenticular myopia, pupillary block, crowding of angle and chronic glaucoma without pupillary block. Clinicians should suspect Microspherophakia in cases of high myopia and shallow anterior chambers, and search actively for systemic associations to inform prognosis and management.



From Transparency To Turbidity – The Calcified IOL

Dr Hitisha Mittal, Dr Ammar Hussain, Dr Swati Verma,
Dr Harinder Singh Sethi
VMMC and Safdarjung Hospital, New Delhi

A 75 year old patient presented with gradual painless diminution of vision in left eye for 1 year. He underwent cataract surgery in the same eye 20 years ago with good postoperative vision gain. On examination, there were numerous fine, whitish granular deposits distributed across the IOL surface giving it a frosted appearance. The deposits appear to involve the substance of the optic rather than the posterior capsule. The pattern and distribution of these deposits is characteristic of dystrophic calcification, commonly associated with hydrophilic acrylic IOLs. Such opacification significantly degrades visual quality by increasing light scatter and reducing contrast sensitivity, thereby necessitating IOL explantation for visual rehabilitation.



Mode of Photography - Iphone 15 smartphone photography and Appasamy Slit lamp

Incidental Bilateral Persistent Pupillary Membrane In An Asymptomatic Adolescent

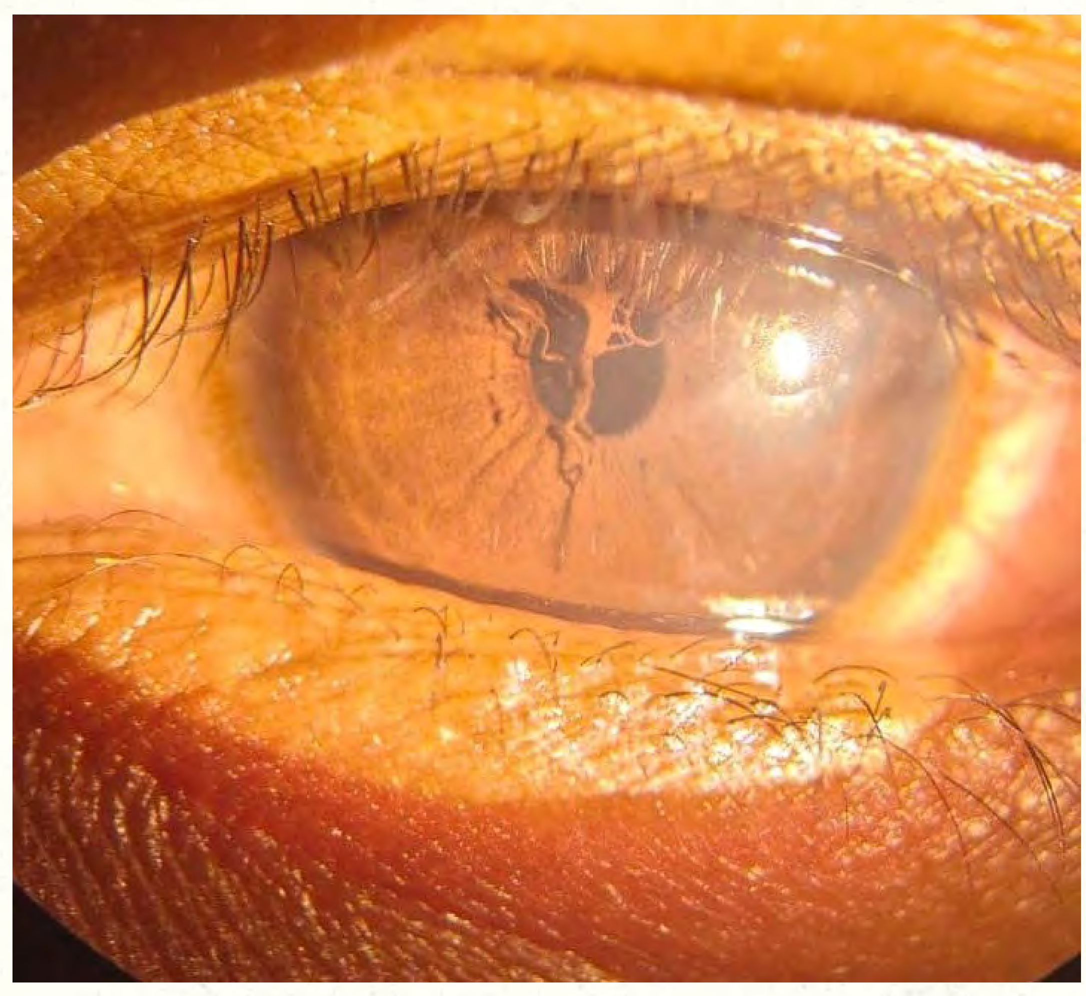
Dr Jagadeeswari, Dhanalakshmi Srinivasan Institute of Medical Sciences and Hospital, Perambalur

Case Description:

A 17-year-old male presented for routine ophthalmic evaluation and was incidentally found to have bilateral persistent pupillary membrane (PPM). He was asymptomatic with an uncorrected visual acuity (UCVA) of 6/12 in both eyes, improving to 6/6 with correction.

Slit-lamp examination revealed thread-like strands arising from the iris collarette and traversing the pupillary area in both eyes. The anterior segment was otherwise unremarkable, with clear lens and no associated ocular anomalies.

Persistent pupillary membrane represents remnants of the anterior tunica vasculosa lentis and is a common congenital anomaly. It is usually benign and non-progressive, rarely affecting vision unless dense or associated with other abnormalities. In this case, the visual axis was not significantly obscured, and no intervention was required.

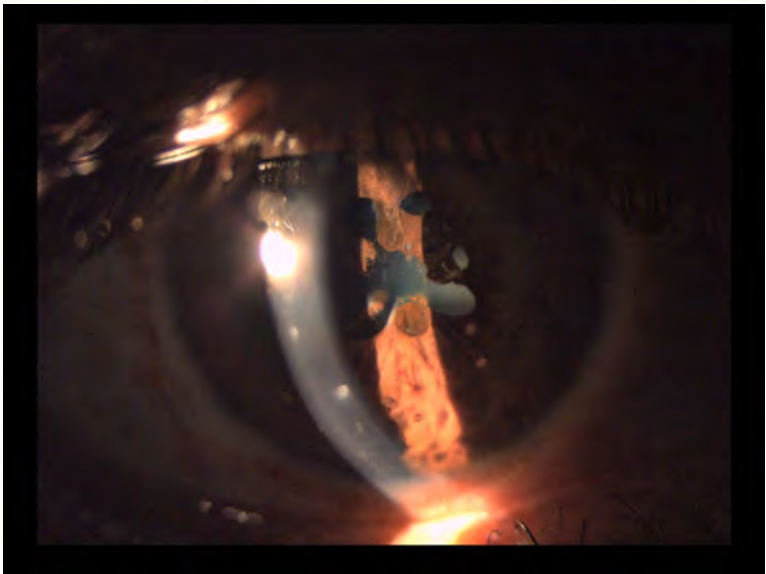


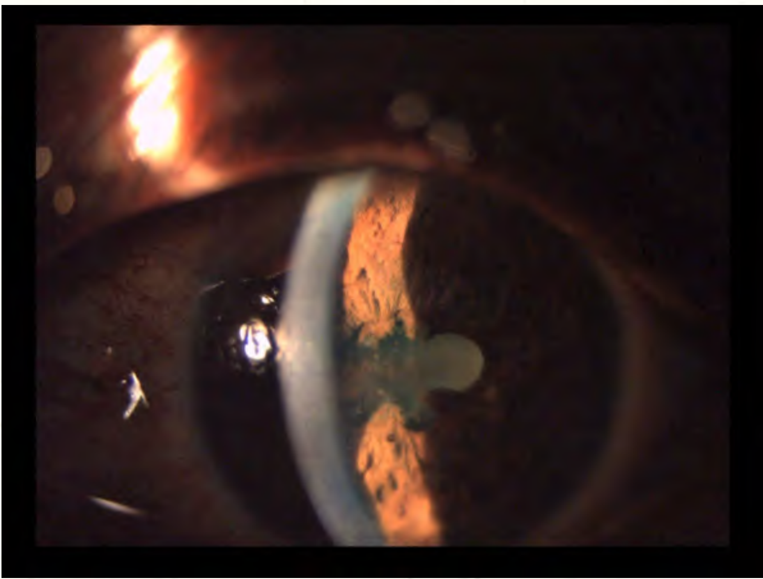
Slit-lamp photograph of the left eye showing delicate, filamentous strands of persistent pupillary membrane crossing the pupillary area, attached to the iris collarette. The image was captured using a smartphone through the slit-lamp eyepiece, demonstrating a simple and effective method for documenting anterior segment findings.

When Both Eyes Speak: Bilateral Granulomatous Uveitis as a Systemic Marker

Dr Jayashankary S, Assistant Professor, Sri Manakula Vinayagar Medical College and Hospital, Puducherry

A case of bilateral granulomatous anterior uveitis demonstrating classic yet striking slit-lamp findings: the right eye shows mutton-fat keratic precipitates, a festooned pupil, and multiple posterior synechiae, suggestive of chronic inflammation, while the left eye reveals circumcorneal congestion, fibrinous exudates in the anterior chamber, iris nodules, and a similarly irregular, synechiae-bound pupil, indicating active severe disease. The coexistence of granulomatous signs (KPs, iris nodules) and structural sequelae (posterior synechiae) highlights both activity and chronicity, and importantly, the bilateral involvement serves as a clinical clue to an underlying systemic etiology such as tuberculosis, sarcoidosis, VKH, or sympathetic ophthalmia. This image underscores a key clinical takeaway: recognizing granulomatous features early and initiating prompt anti-inflammatory therapy with systemic evaluation is crucial to prevent irreversible complications like seclusio pupillae, secondary glaucoma, and vision loss.



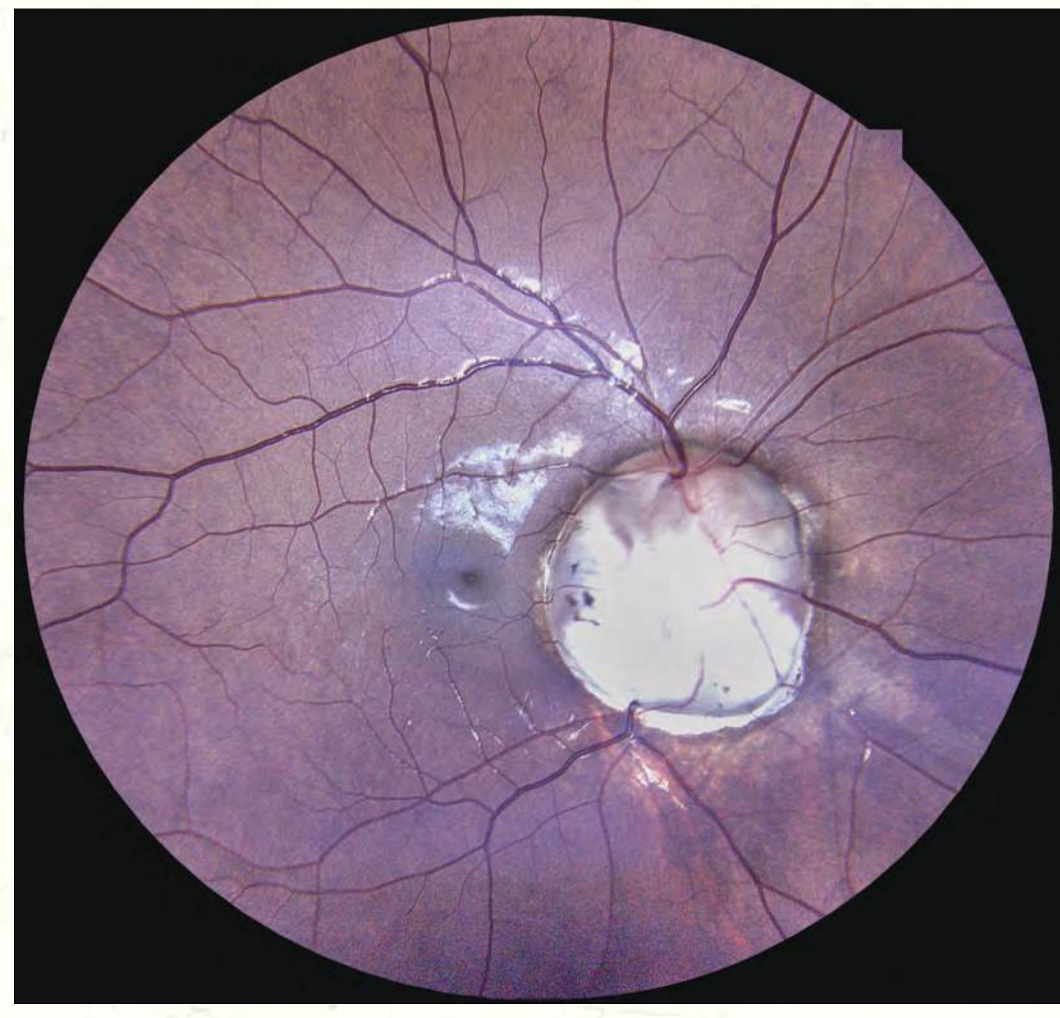


Distinctive Fundoscopic Features of Isolated Optic Disc Coloboma

Dr Maheshkumar S, DO, DNB - Chief and Senior Consultant
Dr Samarth Kacker, MBBS - Resident
Dr Esha Garg, MBBS - Resident
Dr Kowsalya A, DO, DNB - Senior Consultant
Aravind Eye Hospital And Postgraduate Institute Of Ophthalmology, Madurai

Fundus photograph of the right eye of a 14-year-old female presenting with a best-corrected visual acuity of 6/18, demonstrating a striking, large, well-circumscribed, bowl-shaped excavation at the optic disc consistent with an isolated optic disc coloboma. The colobomatous disc is markedly enlarged, with retinal vasculature arising from its margins. Notably, the surrounding retina and choroid remain intact, with no inferior extension of the coloboma, distinguishing this as a pure optic disc coloboma without associated retino-choroidal involvement. The fellow eye was entirely unremarkable, confirming the unilateral and isolated nature of this developmental anomaly.

This image underscores the importance of careful fundoscopic evaluation in young patients with unexplained visual impairment, as isolated unilateral optic disc coloboma without retino-choroidal extension represents a distinct and uncommon clinical entity.

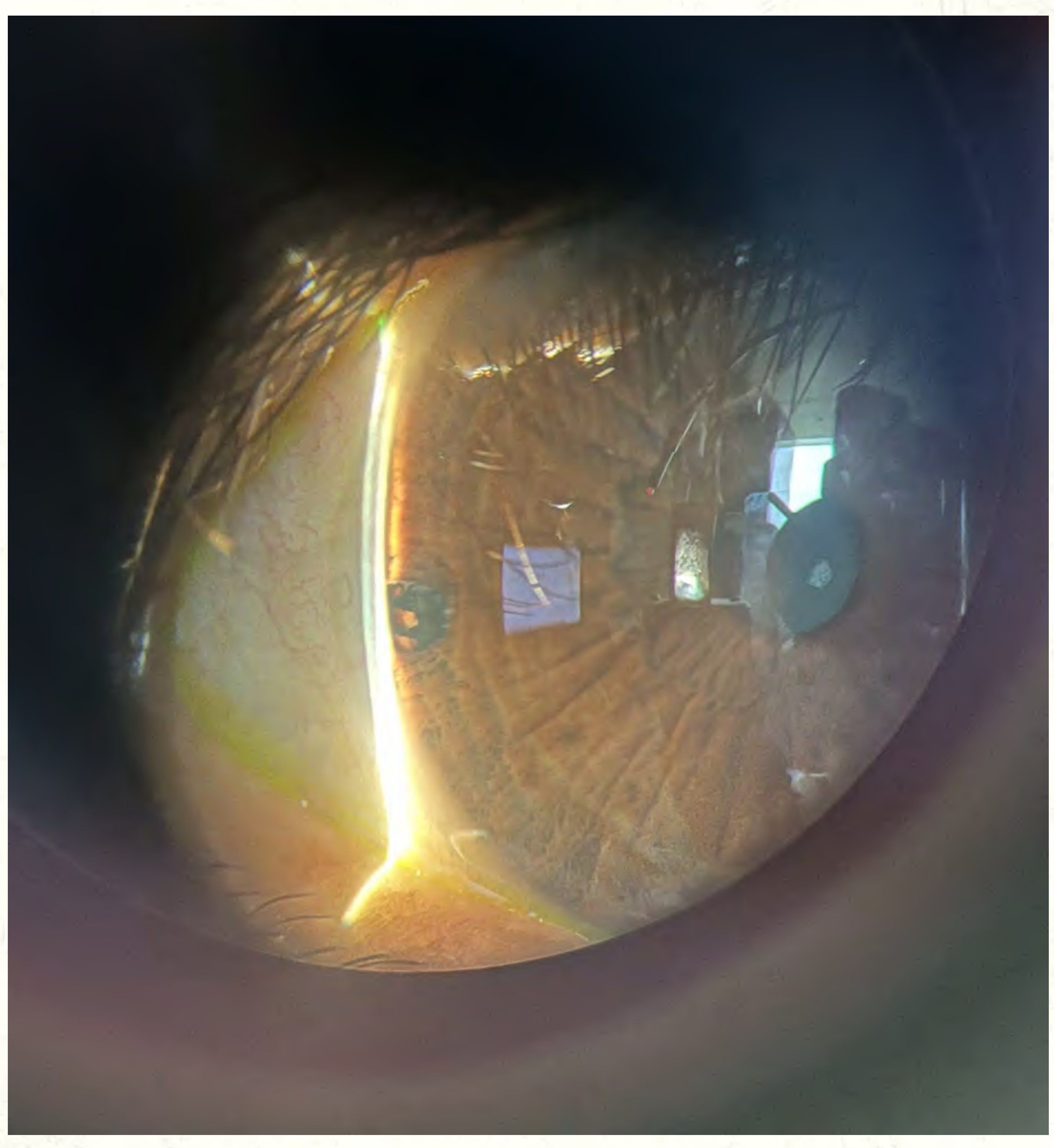


Peek-a-Boo
The Backstage Superhero Gets The Spotlight For Once

Dr Mansi Pankaj, Netrodaya - The Eye City, Varanasi, Uttar Pradesh

The ciliary body — the backstage superhero. While the iris shines in the spotlight, the ciliary body runs the house from within, it brews the aqueous, tunes the lens, holds the stage together. And it's happy with its job.

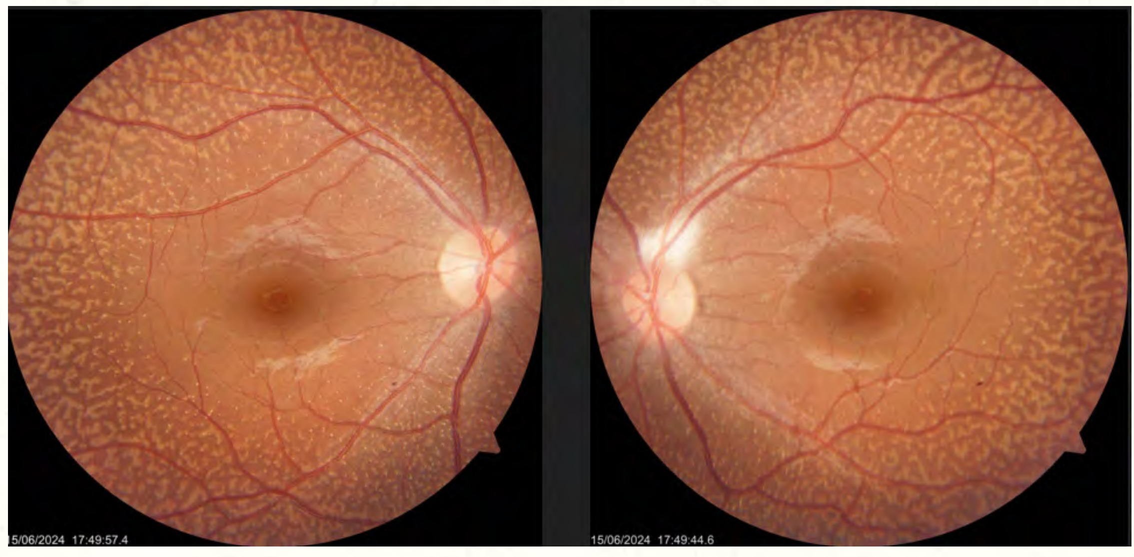
But once in a while in the midst of daily life, comes the PI through which the ciliary body gets to see the world and the world gets to see our backstage superhero.



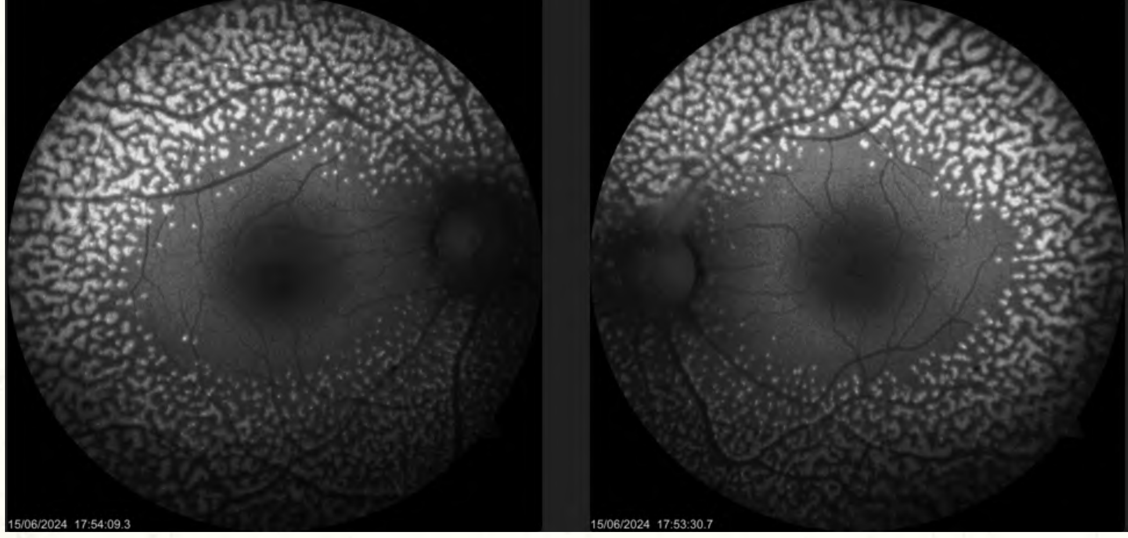
A Rare Case Of Benign Familial Fleck Retinopathy

Dr Meenal Soni, ASG eye hospital, Jodhpur, Rajasthan

A 15-year-old female presented for a regular ophthalmic examination, her BCVA was 6/6 in botheyes. Anterior segment evaluation was unremarkable in both eyes. Fundus examination in both eyes revealed multiple, small, discrete, yellowish white flecked lesions extending from the arcades to the periphery involving theentire fundus and sparing the macula. She reported no complaints of night blindness. Although a family history of consanguinity was present, siblings and parents were unaffected. Colour fundus photography, fundus autofluorescence and OCT imaging were performed to confirm the diagnosis and for documentation. The flecks appeared hyperautofluorescent on FAF and the OCT scan revealed multiple small sub-RPE elevations corresponding to flecks with overlying photoreceptor disruption.



Colour fundus photograph of both eyes of a patient showing multiple, small, discrete, yellow flecks extending from the arcades up to the periphery, typically sparing the macula



Autofluorescence images of both eyes shows hyperautofluorescent lesions corresponding to the retinal flecks

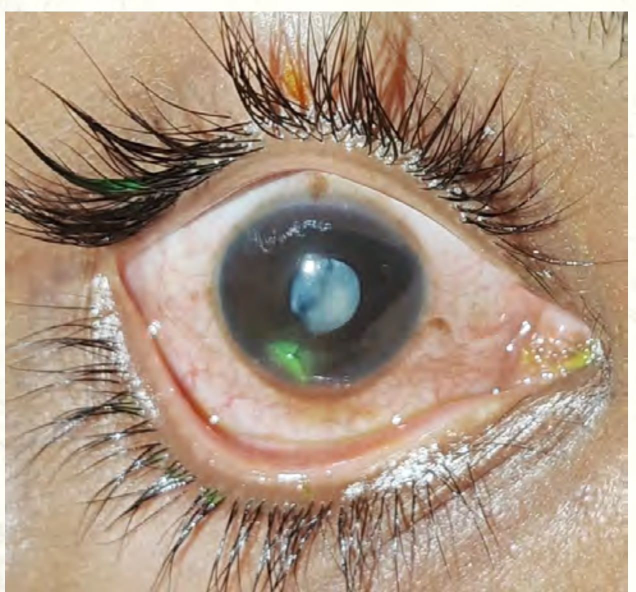
Open at First Glance: A Classical Image of Penetrating Ocular Trauma with Intraocular Foreign Body

Dr Preethi, Junior Resident, AIIMS Nagpur

Case Description:
A 30-year-old man presented in the emergency department of AIIMS Nagpur with chief complaints of sudden painful loss of vision in the right eye following penetrating trauma tothe right eye from an iron chip during welding, which occurred 2 hours prior to presentation. On examination, Visual acuity was no perception of light. Anterior segment showed circumcorneal congestion with a full-thickness corneal laceration at 7 o'clock with vitreousprolapse. The anterior chamber was collapsed. The pupil was irregular due to a sphincter tear from 6 to 7 o'clock. The lens showed a traumatic cataract, consistent with an anteriorcapsular breach. Further posterior details were not visualized. NCCT Orbit showed a hyperdense metallic intraocular foreign body in the vitreous cavity, with increased vitreous attenuation suggestive of vitreous hemorrhage. According to the Birmingham Eye Trauma Terminology System (BETTS), this is an open-globe injury: a penetrating injury with aretained intraocular foreign body (IOFB).

Management:
Management is in accordance with standard open globe injury protocols. Immediate care consists of rigid eye shield placement, avoidance of ocular pressure, and keeping the patient nil per oral. Intravenous broad-spectrum antibiotics (Cephalosporin + Aminoglycoside) restarted with tetanus prophylaxis. Antiemetics and analgesics are administered to prevent extrusion induced by Valsalva. Immediate primary repair, preferably within 24 hours, comprises careful closing of the wounds and anterior vitrectomy for prolapsed vitreous. Once globe integrity is restored, cataract surgery or lensectomy will be needed to render the media clear and allow further proceeding with pars plana vitrectomy, IOFB removal, clearance of vitreous hemorrhage, and management of posterior segment pathology.

Clinical Implication:
Metallic IOFBs, particularly iron, may also lead to siderosis bulbi if left in place. Prognosis depends on initial visual acuity and posterior segment involvement; a lack of perception of light indicates a poor outcome. The corneal laceration, vitreous prolapse, shallow anteriorchamber, and irregular pupil all point to an open globe injury. The goal of treatment is globe salvage, primarily followed by visual rehabilitation in cases of penetrating trauma. This image serves as a powerful educational resource as it contains several classical signs of penetrating ocular trauma.



Smartphone clinical photograph of penetrating ocular trauma showing inferotemporal corneal laceration with vitreous incarceration, with collapsed anterior chamber and traumatic cataract

Myelinated Nerve Fibre

Dr Savithiri Palanivel, MBBS, DOMS, DNB, Specialist Ophthalmologist
Dr Varadharajan Rajendran, MD (Physician)
Dr Rajendran Palaniandy MBBS, MD, DM (Neurology)
Al Hayat Medical Center, Umm Al Quwain

Myelinated nerve fibers of the retina are a congenital variation in which myelin extends into the retinal nerve fiber layer instead of remaining behind the lamina cribrosa. This occurs when the normal barrier that limits myelination fails during development.[1]

They appear as white, feathery patches on the retina, typically near the optic disc, following the pattern of nerve fibers[3]. (Figure 1) The condition is usually unilateral and asymptomatic, often detected during routine eye exams. [1,2]

When extensive, these fibers can reduce vision by obscuring retinal details. They are sometimes associated with high myopia and amblyopia, a combination referred to as Straatsma syndrome, likely due to disrupted visual development.[2]

The condition is believed to result from abnormal presence of myelinating cells within the retina [3].

Imaging methods like optical coherence tomography help assess its extent.

No treatment is required in most cases, but associated visual problems—especially in children—should be treated early to improve outcomes.[2]

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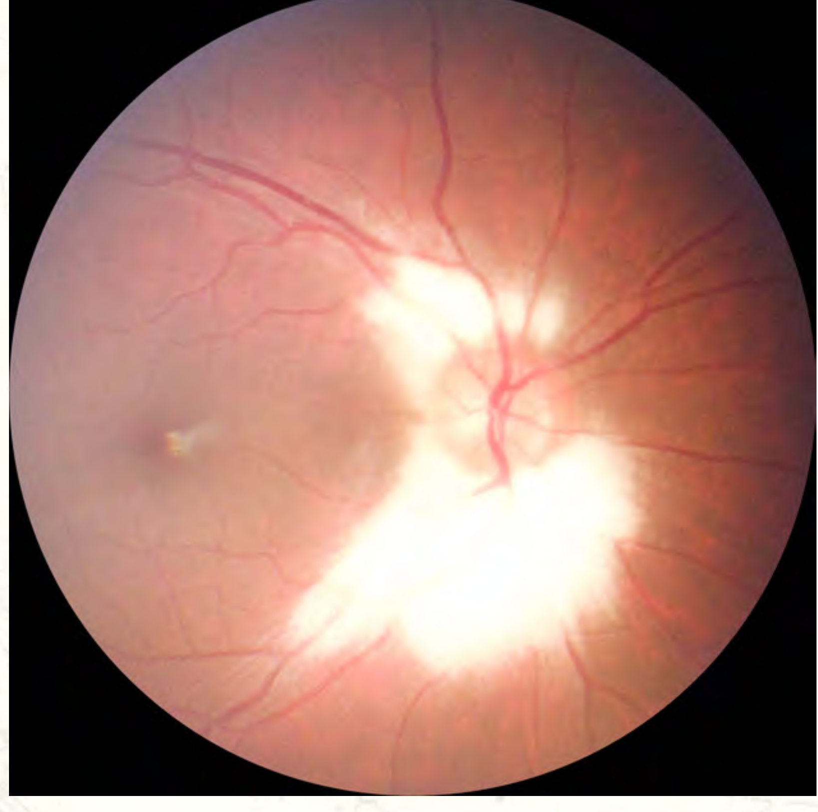

Color fundus image demonstrating myelinated retinal nerve fibers characterized by opaque, striated white lesions with feathered margins, following the distribution of the retinal nerve fiber layer and partially obscuring retinal vessels. (Superior, inferior and nasal)

Bilateral Chorioretinal Scar In Congenital Ocular Toxoplasmosis

Dr Shaziaa. RB, Dr Sangeetha. V, Dr Subha. R
Lotus Eye Hospital & Institute, Salem

Case Report

A 9-year-old female patient had presented with complaints of diminution of vision in both eyes since childhood. On Ocular examination, the best corrected visual acuity was 6/60 in both eyes. Anterior segment examination showed bilateral pendular nystagmus. Dilated fundus examination in both eyes revealed a darkly pigmented, atrophic, chorioretinal scar involving the macula (Figure1a &b). The vitreous was clear with no signs of active inflammation or infection. No treatment was prescribed as it was an inactive, long standing ocular toxoplasmosis in both the eyes, requiring periodic eye examination every six months.

Discussion

Toxoplasma gondii is an obligate intracellular parasite. The three main forms of the parasite are: oocyst (spore form that is excreted in cat feces), tachyzoite (actively proliferating) and bradyzoite (inactive form that becomes encysted It is caused by maternal infection during pregnancy, whereby the parasite is ingested by the mother or, alternatively becoming exposed to oocysts, tissues). The congenital form through ingestion of raw or undercooked meat or exposure to cat feces.[1] These then are transmitted to the fetus through the placenta. In cases of congenital infection with macular involvement, the patient will most likely experience a reduction in visual acuity, strabismus, nystagmus or leukocoria.[1] The classic triad of findings consists of chorioretinitis, hydrocephalus, and intracranial calcifications. The hallmark of reactivation of ocular toxoplasmosis is **satellite lesion** that develops directly adjacent to an old, pigmented, and inactive chorioretinal scar. Serological testing, MRI or CT imaging of the brain, and a comprehensive eye exam should be performed for infants with suspected congenital toxoplasmosis. Active ocular toxoplasmosis is treated with anti-parasitic drugs such as pyrimethamine, sulfadiazine and folinic acid. Inactive phase of this disease requires no treatment. However, the risk of recurrent episodes requires patient education and periodic follow up.

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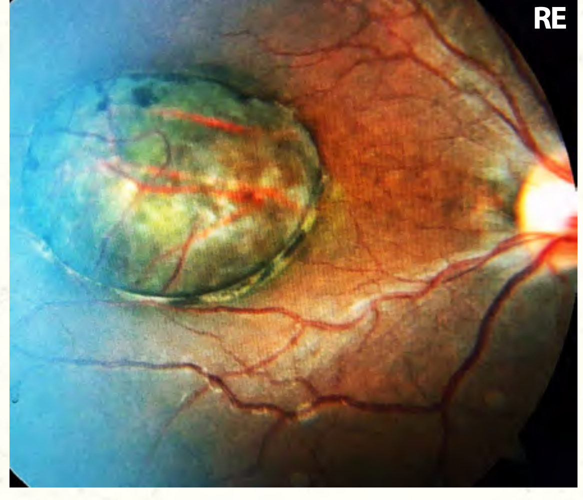
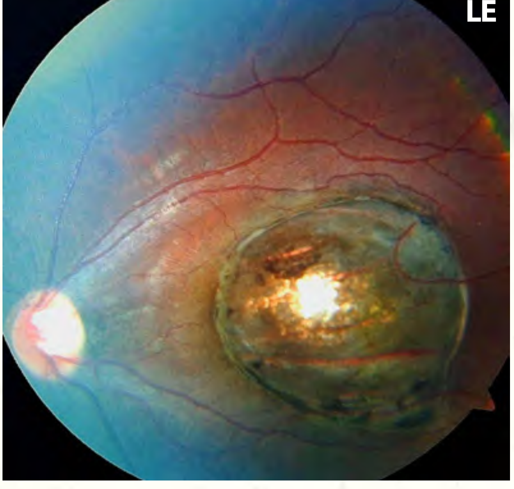




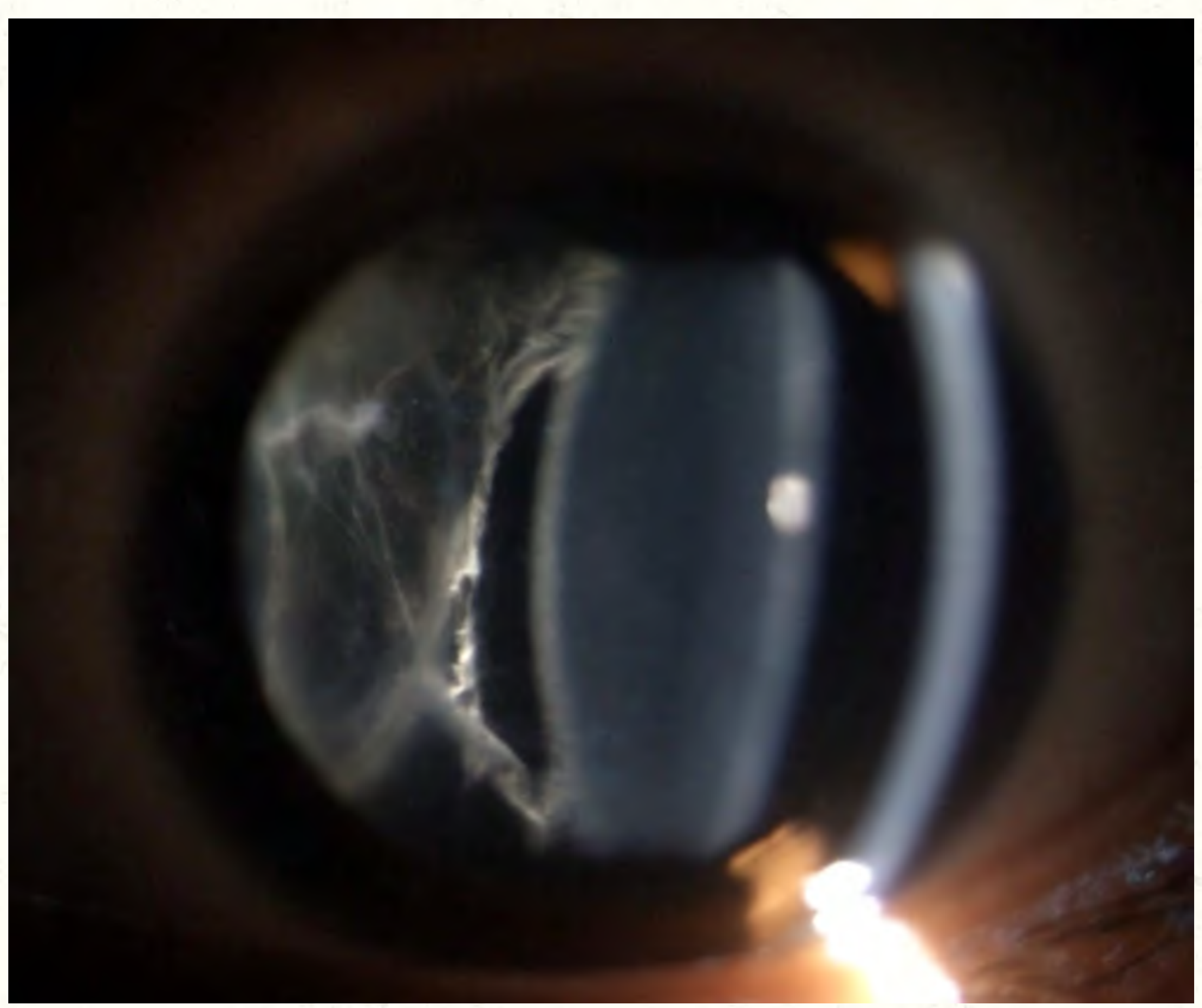
Fundus images shows darkly pigmented, atrophic, chorioretinal scarring in the macular area, secondary to a toxoplasmosis.

Berger's Space - The Space of Safety

Dr Sudhakar Naidu Laveti, VisionTree Eye Hospital, Visakapatinam

In this 8-year-old boy with bilateral ocular cysticercosis, the slit-lamp image shows dense vitritis filling the vitreous cavity. However, the retrolenticular space immediately behind the posterior lens capsule remains clear and uninvolved. This clear zone corresponds to Berger's space, the potential space between the posterior lens capsuleand the anterior hyaloid face.

Because the intense inflammatory exudates have not entered this retrolenticular space, it appears as a distinct clear crescent behind the lens despite severe surrounding vitritis. Clinically, this uninvolved Berger's space is often referred to as the "space of safety," since it indicates that the inflammatory process has not breached the anterior hyaloid face and the lens–vitreous interface is still preserved. This space may also provide a relatively safer surgical plane during vitrectomy.



Curvularia: The Black Corneal Threat

Dr Tushar Agrawal, Dr Shishir Agrawal, Dr Jaya Agrawal
Dr. T.P. Agrawal Eye Hospital, Meerut, Uttar-Pradesh

A 60-year-old man came to the outpatient clinic with reduced vision and eye discomfort after sustaining an injury from a sugarcane leaf. On slit-lamp exam, a 4×4 mm pigmented corneal ulcer with a thick overlying slough was noted [Figure 1]. Corneal scrapings were obtained for microbiological analysis. KOH preparation and culture confirmed Curvularia lunata as the causative organism. The patient was treated with 1% atropine, 5% natamycin, and moxifloxacin eye drops. Over a period of three weeks, the ulcer showed gradual healing, leaving behind a corneal scar.

This infection is caused by a melanin-pigmented dematiaceous fungus. It typically appears as a slowly progressing corneal ulcer with irregular, feathery borders, surrounding satellite infiltrates, and a characteristic brown-black pigmentation in the stroma [which makes it a distinctive image]. The pigmentation is a distinguishing feature due to melanin in the fungal hyphae. Corticosteroids are generally avoided as they can worsen the infection. Surgical management, such as therapeutic keratoplasty, is reserved for cases with impending perforation or poor response to medical therapy. [1-3]

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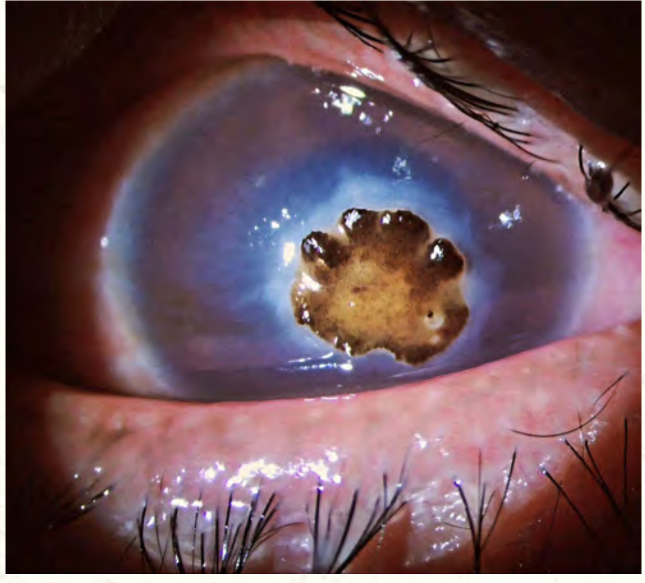

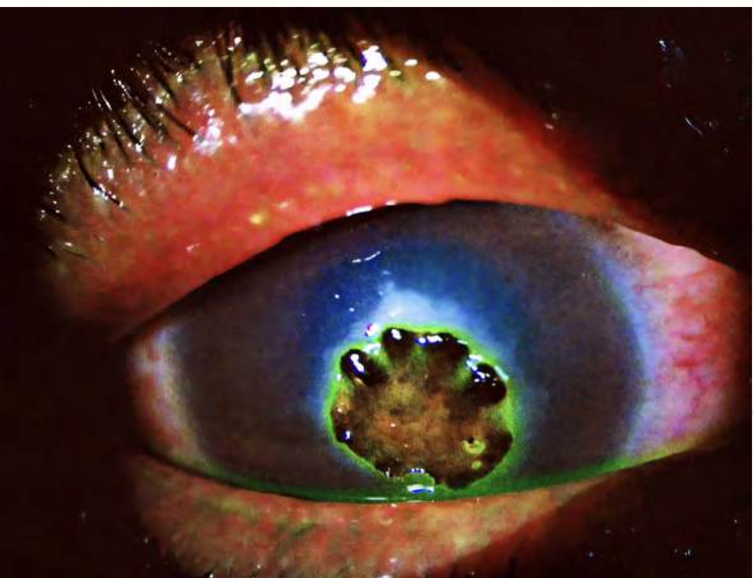

Fragile Barrier, High Stakes: Posterior Capsular Dehiscence

Dr Uttkarsha Thakre, MS, FAEH
Dr Mahesha S, DOMS, DNB
Dr Shivangi Sharma, DNB, FICO
Sankara Eye Hospital, Shimoga

A 44-year-old male presented with diminution in both eyes since 2 years. His best corrected visual acuity was 3/60. The slit lamp examination of both eyes revealed senile cataract. On further examination after pharmacological dilatation anterior segment examination of both eyes revealed posterior polar cataract with posterior capsular dehiscence (figure a, c). The disturbance in the regular convex appearance of the capsule and localised protrusion on slit lamp examination marked towards posterior capsular dehiscence (figure b, d). Posterior polar cataract is associated with dehiscence of the posterior capsule in 11-26% of cases, resulting in a significant risk of capsule rupture and concomitant consequences [1]. Identifying the defect preoperatively not only helps with intraoperative care, surgical planning but also helps for better postoperative visual outcome [2].

Keywords: posterior polar cataract, posterior capsular dehiscence, posterior capsular rupture.

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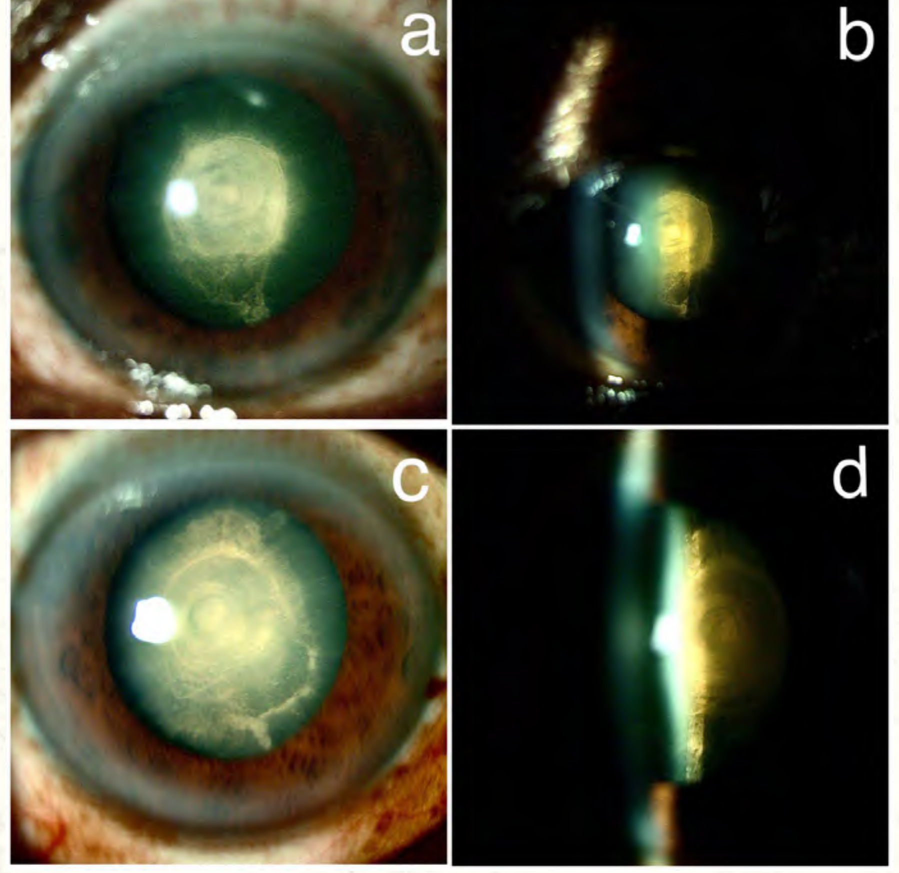
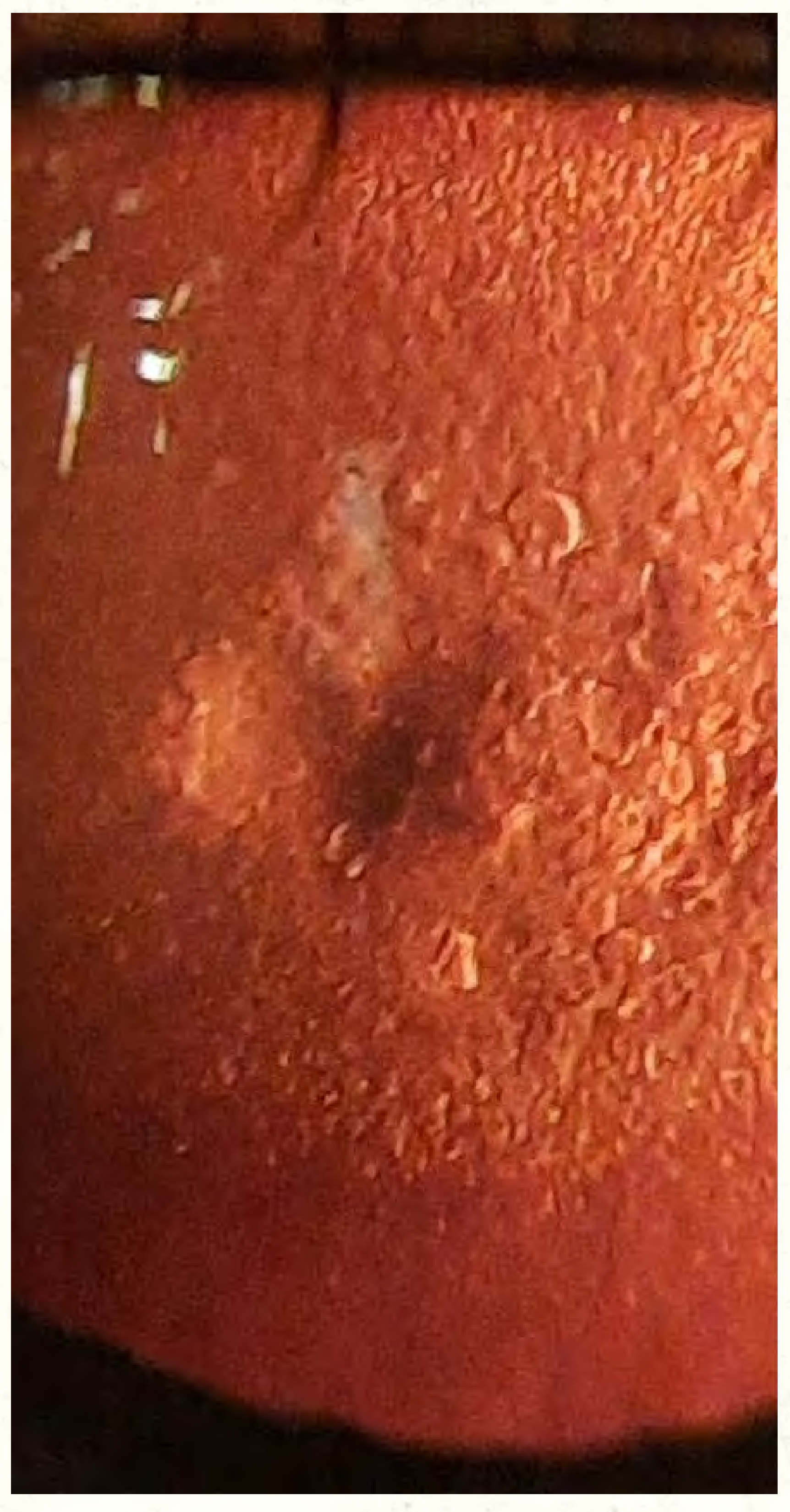


The slit-lamp examination showing posterior polar cataract (Figure a, c). The disturbance in the regular convex appearance of the capsule and localised protrusion on slit lamp examination indicating posterior capsular dehiscence (Figure b, d).

Hammered To A Beaten Bronze Appearance Revealed

Dr Susil Pani - Consultant, Raghu Eye Clinic, Pondicherry

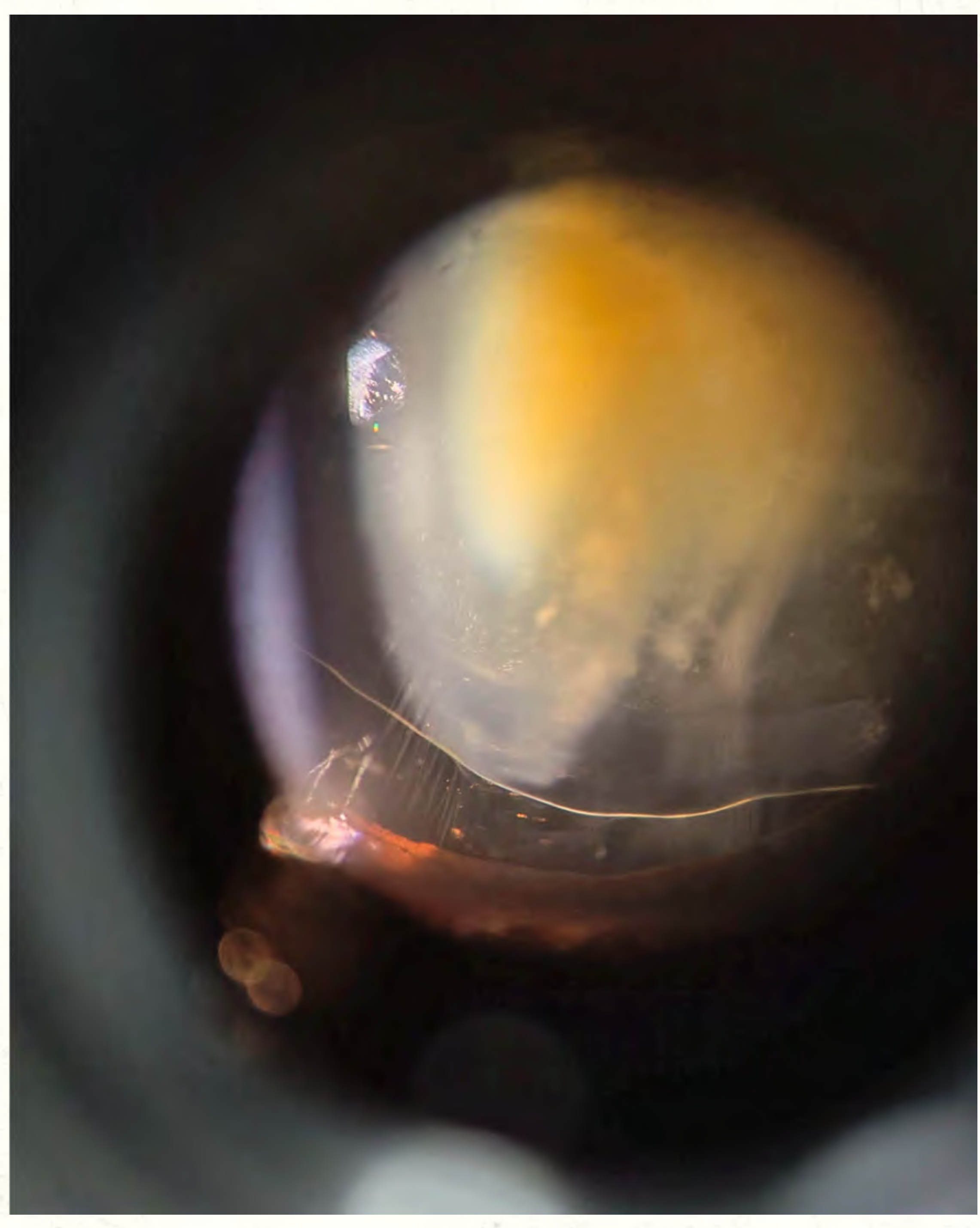


Subluxated Lens

Dr Josephine Moni Sneha - Medical Consultant, Aravind Eye Hospital

Lens on the edge - held by threads:

A blink after trauma, and the lens lost its center stage. Slit-lamp biomicroscopy revealed superior subluxation of the crystalline lens with stretched yet intact zonular fibres. The lens equator was clearly visible within the pupillary axis, with subtle phacodonesis appreciated on dynamic examination. The picture captured a classic post-traumatic lens subluxation - balanced delicately between stability and dislocation.



PROSE & POETRY

Between Precision and Pause

Dr Sai Dheera Mulasthanam, MS, DNB, FICO, MRCSEd, FGL
Assistant Professor, Department of Ophthalmology
Saveetha Medical college and Hospital, Chennai

In ophthalmology today, change is clearly underway. More women are being seen across clinics, operating rooms, and academic platforms—contributing with skill, consistency, and growing visibility. It would seem, at first glance, that the balance has begun to shift.

And yet, in everyday practice, certain contrasts continue to be felt. Around maternity, for instance, time away is still quietly interpreted in ways that differ. A pause may be necessary, but the return is not always seamless. Expectations may remain unchanged, while opportunities sometimes feel subtly fewer. It is rarely overt, but often understood.

Alongside professional responsibilities, the mental load beyond the workplace continues to exist. The planning, organizing, and anticipating that keeps a home running is still, more often than not, carried in the background. It is not something that is spoken of in reviews or reflected in CVs, yet it shapes energy, time, and focus in very real ways.

What feels more relevant now is that these experiences are no longer being dismissed or internalized as individual limitations. They are being acknowledged—as part of a larger structure that is still evolving. There is a growing clarity that equity is not only about access, but also about continuity, support, and shared responsibility.

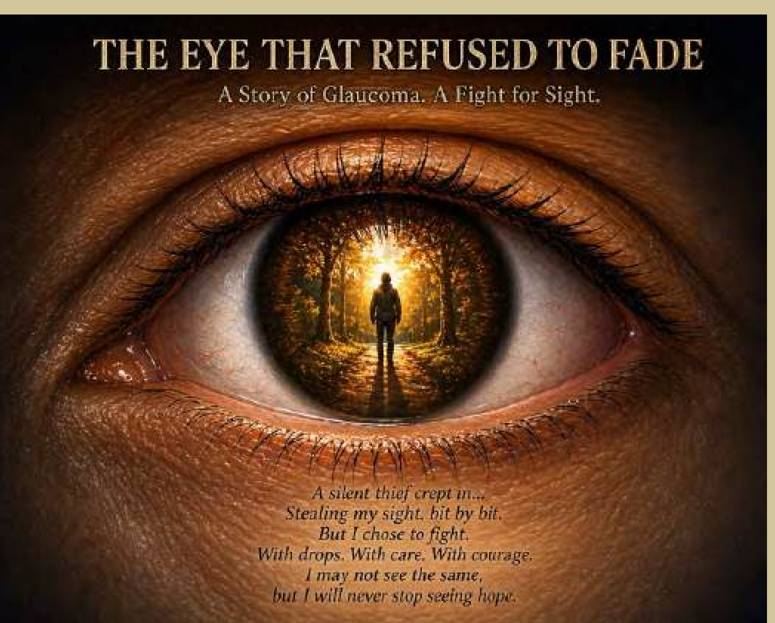
The field is changing, without question. But perhaps the more meaningful shift lies in how these nuances are being recognized. Not as complaints, but as realities that deserve space in the conversation.

In that space, a different kind of progress is beginning to take shape—quieter, more honest, and, hopefully, more sustainable.

The Eye That Refused To Fade

Dr Roma Johri

Glaucoma Consultant,
Sri Shankara Nethralaya, Pixel Eye Hospital, Hyderabad



I was once a window—clear, effortless, alive. Light danced through me, painting the world in color. I blinked without thought, focused without effort.

Then came the pressure.

At first, it was a whisper—silent, subtle. No pain, no warning. Just a slow tightening from within. My optic nerve, my lifeline, began to strain. Signals blurred… shadows crept in from the edges.

But no one noticed. Not even me.

Until the alarm began to ring.

Every morning, every night—beep… beep…

A reminder: the drops.

Cool liquid fell onto me—tiny warriors in a bottle, fighting to push back the pressure. Some days brought relief. Other days, the darkness lingered.

"Follow-up is everything."

So we returned—again and again. Machines measured me. Fields were tested. Nerves were watched like fragile threads. I was no longer just an eye—I was a battlefield.

And then… the decision.

Surgery.

A strange truth—that to save me, I had to fight not just disease, but my own healing.

In every other wound, the body rushes to repair. But here, healing too well could mean failure—sealing the only escape I had.

So a new doorway was created—a delicate path for the pressure to leave. Fragile. Precious. A path that must remain open, even when my body tries to close it.

I wasn't being destroyed—I was being given a second chance.

Recovery was slow. Guarded. Drops returned—now to protect that balance. Follow-ups became checkpoints in a long war.

I may not see as widely. Some shadows remain.

But I have learned—glaucoma is silent, but I am not helpless.

With every drop, every alarm, every visit…

I fight.

And as long as I fight—

I see.

The Kinship Crucible

Dr Tejaswi Ragolu, MS, FAICO (Phaco)
Sankara Nethra Chikitsalaya, Vijayawada
Andhra Pradesh

In the hushed, antiseptic stillness of the operating theatre, the air usually hums with clinical detachment. As the cool water rushed over my forearms, I wasn't just rinsing away pathogens, but was trying to wash away the mounting pressure in my chest. The patient waiting on the table was my maternal uncle, the man who had watched me grow, now entrusting his sight to my hands. In the dawn of my surgical career, the emotional gravity of the room felt tectonic. To keep the niece from trembling, the surgeon had to take ironclad composure.

As I sat at the microscope, the "what-ifs" began to clamor in my mind. To silence them, I turned to the sanctuary of professional routine. I began to speak to him delivering the polite, rhythmic instructions of a standard procedure. "Keep your head still," “Look straight into the light," "You’re doing well”. By talking, I occupied the space in my head where anxiety usually grows, forcing my brain to focus on the cadence of the surgery rather than the fear of the stakes.

I had my backup plans ready, not out of doubt, but out of discipline. Yet, I knew that true composure comes from a higher source. I leaned into my faith, trusting that these God-gifted hands were guided by a Grace far beyond my own years of experience. When the intraocular lens finally perfectly centered, a wave of relief washed away the morning's shadows. The niece was silent so the surgeon could be absolute.

To my peers standing at the dawn of your vocations, when the day comes to operate on your kin, will be your greatest crucible. “Trust your tireless preparation; keep your faith.” When we heal our own, we are guided by a Grace that far exceeds our own experience.

Seeing Beyond The Eyes

Dr Karthikeyan S
2nd Year Postgraduate
Karpagam Faculty Of Medical Science And Research, Coimbatore

During the first year of my postgraduate training, on a busy OPD day, I met a young girl with complaints of blurred vision. On examination, her vision was around 6/36 in both eyes, improving to 6/9 with refraction. During history-taking, I asked how long she had difficulty seeing and whether she used spectacles regularly. Quietly, she said she had never used glasses. When I asked if she could read the blackboard at school, she replied that she had been unable to do so for nearly three years.

She was sitting alone in the OPD, and I wondered how her parents or teachers had not noticed her poor vision. I asked her to call her parents because I wanted to speak with them. She hesitated and softly said, "Only my brother brought me here."

Later, I learned the truth — she was from an orphanage. Suddenly, her hesitation made sense, and I felt deeply emotional. At that moment, I realized how easily we sometimes assume things without knowing the struggles behind a patient's silence.

I asked whether spectacles could be arranged for her, but since they had come only for a check-up, it was not possible through the hospital. So, I took her to the optical shop and asked her to choose a frame she liked. I still remember the happiness on her face while selecting different designs and colours. I bought her the spectacles, and that smile remains one of the most satisfying moments of my career.

That day, I truly understood why I chose ophthalmology. I realized how a simple pair of spectacles could change a child's confidence, education, and quality of life. More importantly, I learned that beyond treating disease, we must understand our patients' emotions and speak to them with kindness and compassion.

Ophthalmologist From Another Eyes

Dr Janhavi Dhumale
1st Year Postgraduate
Saveetha Medical College and Hospital, Chennai

Not every day in residency
Feels extraordinary.
Some days are only long queues,
Dilating drops, crowded OPDs,
Case sheets stacked like unfinished stories.

We say,
"Fifty cases today."
As though lives can be counted
So easily.

But somewhere behind every token number
Is a person who rearranged their world
To sit before us for five minutes.
Someone who applied for leave weeks ago.
Someone who woke before sunrise
To catch the first bus.
Someone who chose their best clothes carefully,
Because meeting the doctor
Felt important enough for that.

Someone whose family waits at home
Asking, "What did the eye doctor say?"

An old man arrives holding his wife's hand,
Not because he cannot walk,
But because after forty years together
They have learned to move as one.
A woman comes for cataract surgery
And her son takes leave from work
To sit outside the operating theatre,
Checking the clock every few minutes.

They plan weddings, journeys, festivals,
And the smallest details of living
Around an operation date
We write casually on a prescription sheet.

And then there are the simple miracles.
The labourer who finally sleeps peacefully
After the foreign body is removed from his eye.
The child who stops crying
After the burning eases with one drop.
The teacher who reads clearly again.
The grandmother who sees her granddaughter's face
Sharply after years of blur.

To us,
It may have been another patient,
Another prescription,
Another busy clinic day.
But to them,
It was the day something changed.
The day pain ended.
The day hope returned.
The day the world became visible again.
And when they go home,

They will tell the story of that visit
Over dinner tables, phone calls, evening walks.
Their families may remember it too.
That is what residency slowly teaches us:
We are never just treating eyes.
We are entering people's lives
At vulnerable, frightened, hopeful moments.
We become small parts
Of stories they may carry forever.

So perhaps we should pause
Before calling them "cases."
Because today was not fifty cases.
Today,
We were trusted with fifty human lives,
Fifty fears,
Fifty hopes,
Fifty quiet battles.
And honestly,
What greater privilege could there ever be
Than helping someone see the world again?
Than becoming part of people's life they will remember for a lifetime?

Who Gets To See Clearly..?

Dr Vaishali Sahana Malavathu, MS Ophthalmology
KAPV Govt. Medical College and Hospital, Trichy

Who Gets To See Clearly..?
An elderly who has been through all shades of life..
A middle aged who balances thyself and everyone around them..
A teenager brimming with ideas for what lies ahead..
A child who is excited for the summer holidays..
An infant waiting to see thy mother..

They all get to see.. very well!

For we hold.. the privilege to help them See beyond the veil..
For we chose.. to uphold visions beyond ours..
A daring yet humbling adventure.. every single day!