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by

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Second Issue

Dr Vishal Gabale

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Shweta Sawant

"Falling in love with medicine one quiz at a time"

Priyanshu Dutta

"Elevating medical quizzing to a new standard."

Preetam Pal

"I'm the one who keeps the code bug-free and the transitions frame-perfect, ensuring our quizzes look as sharp as the people taking them."

THE SYLLABUS *Nobody Gave You*

Somewhere between the 2,844 pages of Harrison's and the fourth coffee of a 30-hour call, most of us forget one small thing: we are still human beings.

Medicine will teach you how to intubate a crashing patient at 3 AM. It will teach you Light's criteria, the APACHE II score, the difference between a Type 1 and a Type 2 MI. It will not teach you how to call your mother back. It will not teach you that the girl who smiles at you every morning near the library is slowly becoming the person you might want to spend the rest of your life with. It will not teach you that the helmet costs ₹1,200 and your skull costs everything.

This is the syllabus nobody gave you. Consider it photocopied notes from a senior who made most of these mistakes first, so that maybe — just maybe — you won't have to.

CHAPTER 1
BE A DOCTOR. BUT FIRST, BE A HUMAN

There is a dangerous myth in Indian medical colleges that if you are not buried inside Harrison's at 2 AM, you are wasting your life. I am here to tell you that this is pharmacologically incorrect.

The best doctors I know are not the ones who read the most. They are the ones who noticed the most. And you do not learn to notice by staring at a textbook. You learn it by playing cricket with the same guys every Sunday, by dancing badly at the cultural fest, by picking up a guitar you cannot play, by writing a bad poem, by running until your knees file a formal complaint. Art, sport, dance, content creation — these are not distractions from medicine. They are the reason medicine will ever make sense to you.

Here is my prescription, and it is evidence-based from a sample size of one (me):

- One sport. One hour. Any sport. Badminton, gym, football, even a daily walk with loud music in your ears.
- One art. Any art. Write. Paint. Make reels. Sing in the bathroom. Learn piano on YouTube. Nobody needs to see it.
- One book a month that has nothing to do with medicine.

That is it. One plus one plus one. About twelve hours a week. You already waste more than that scrolling Instagram while pretending to revise Robbins.

And here is the secret nobody tells you in first year: the extracurriculars are what get you remembered. The dean does not remember the boy who got 78% in Pathology. He remembers the boy who hosted the farewell. The HOD does not recall who attended every ward round. She recalls who organised the CME. Recognition, connections, references, opportunities — they all live in the world outside Harrison's, and you actually have to show up for them.

WHAT MEDICINE WON'T TEACH YOU ABOUT ACTUALLY LIVING

CHAPTER 2

BE THE SENIOR YOU NEVER HAD

Let me tell you about a junior I once saw being "corrected" by a senior in front of the entire ward. The kid was holding a file. His hand was shaking. The senior was smiling. The patient was watching. The junior apologised for something he had not done, because that is what you do when you are nineteen and terrified and two thousand kilometres away from home.

I saw that kid again, two years later. He was still apologising. For things he had not done. To people who did not deserve it. Something had broken in him that nobody could suture back together.

Ragging is not a tradition. It is not character-building. It is not "how we learned." It is a slow, lazy cruelty dressed up as seniority — and every one of us who has watched it happen without saying a word has contributed to it. Including me.

I will be honest. I did not always have the best seniors. Some were kind. Some were indifferent.

Some were cruel in small, casual ways they probably don't even remember anymore. I could have grown so much faster, so much straighter, if even one of them had said: "Hey, you are going to be okay. Here is how you present a case. Here is how you survive a night call. Here is what to say when a patient dies."

So be that senior. Not the Gyaan Baba of the college who gives unsolicited lectures at every chai tapri — nobody likes Gyaan Baba, not even Gyaan Baba's mother. Be the senior who notices. The one who says "come, sit, let me show you" when a first-year is struggling with an IV line. The one who walks a trembling intern through their first bad death. The one who says, almost in passing, "You're doing fine," when someone looks like they are about to cry in the corridor.

It costs you nothing. It will cost them everything if you don't.

And harassment — of any kind, from any senior, towards any junior — ends the moment you

choose not to laugh at it. That is the entire playbook. You do not have to be a hero. You just have to stop clapping.

CHAPTER 3
HEALTH IS WEALTH, AND YOU ARE STARTLINGLY BAD AT IT

The funniest, saddest running joke in medicine is how many doctors are terrible patients.

In my short career I have personally seen:

• A cardiologist admitted with his own MI at forty-two.

• An orthopaedic resident with a head injury because he was "just going to the chemist" and had left the helmet at home.

• A gastroenterologist with a fatty liver so advanced his own USG made him wince.

• A diabetologist with an HbA1c he would have absolutely scolded his own patient about.

Pick up the joke. It writes itself. It stops being funny the moment it is you inside the CT gantry.

Real wealth, real freedom, is a body that lets you do what you want. Every single disease you prevent is a future year you get to spend with the people you love, doing things that make you smile. That is the entire math. There is no deeper secret.

Your daily non-negotiables as a doctor-in-training:

• Sleep — six hours minimum. Yes, even in DNB. No, chai is not a substitute for sleep, it is a bridge loan.

• Movement — thirty minutes a day. Walk, if nothing else.

• Food — stop eating samosas at 11 PM in the duty room and calling it dinner.

• Water — carry a bottle. Fill it. Drink it. Repeat.

• One annual check-up. You write them for everyone else. Get one yourself.

You cannot pour from an empty cup. You definitely cannot resuscitate from a diseased one.

CHAPTER 4
DO NOT DIE FOR STUPID REASONS

I need you to sit with this one for a minute. Put the phone down. Just read.

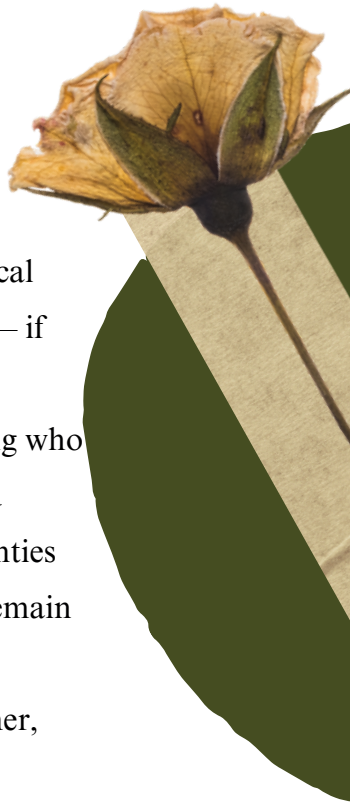
I have accepted, like all of us eventually do, that everyone dies. That part is not negotiable. But there is a difference between a 50–50 death and a 98–2 death, and you — young, brilliant, in the absolute prime of your life — keep choosing the 98–2.

You are riding a bike on the Mumbai–Pune expressway at 1 AM. No helmet. Because the helmet "messes your hair." Because you are "only going for two minutes." Because "nothing ever happens." I promise you, with a certainty I rarely have about anything in medicine: something happens. And when it does, there is no reversal. No second attempt. No "next time I'll be careful." Your mother will be sitting at the dinner table with your plate still laid out, and a phone call will change her life forever.

Rules I wish someone had screamed at me in first year, which I am now screaming at you:

- **Wear the helmet. Every single time. Even for "just the chemist."**
- **Seatbelts. Every seat. Every time.**
- **Do not drink and drive. Ever. Not "only two beers." Not "I can handle it." No.**
- **Do not text and ride. A WhatsApp reply is not worth your frontal lobe.**
- **Do not rush. Whatever you are late for, being dead is later.**

Your parents are sitting at home waiting for you. That is the entire reason to slow down. Not fear. Love. Someone is waiting. Do not make them wait forever because you wanted to save four minutes.



CHAPTER 5
LOVE LIFE IN MEDICAL COLLEGE

Let me say something your college handbook will never say: relationships in medical college are not the enemy. They can be one of the best things that happen to you — if you do them right.

The wrong way, you already know. Mind games. Jealousy texts at 2 AM. Checking who liked whose story. Cruel little tests. Silent treatments. "If you really loved me, you would skip your posting." Abuse dressed up as passion. Wasting each other's twenties on drama that neither of you will remember at thirty, but whose scars somehow remain like this:

- You study together. Actually study. Not "study." Open Harrison's, quiz each other, explain the difficult chapters out loud.
- You eat together. Real food. Not Maggi at midnight forever.
- You remind each other to sleep, to drink water, to call home.
- You celebrate each other's wins without keeping score.
- You fight fair. No abuse, no name-calling, no leveraging each other's insecurities for the cheap high of "winning" a fight. You do not win fights with someone you love. You both lose — just at different speeds.
- You respect each other as doctors, as colleagues, as people who have a whole life outside of you.

THE FINAL PRESCRIPTION

Here is what I want you to take away, written in the only format our brains still recognise after five years of training — the discharge summary:

Diagnosis: Medical student or resident, high-functioning, at significant risk of forgetting to live.

Advised:

• Pursue one sport, one art, one non-medical hobby. One hour a day, lifelong.

• Be kind to juniors. Ragging — refused, always.

• Sleep, eat, move, hydrate. You are a human body, not a 24/7 pharmacy.

• Wear the helmet. Every ride. No exceptions. No negotiation.

• Love like an adult. Study like a student. Fight like neither.

• Call your parents. Today. Right now, if possible. They are waiting.

Follow-up: For the rest of your life.

Prognosis: Excellent — if advice is followed.

Medicine is the most beautiful profession in the world. It will also swallow you whole if you let it. The trick is to let it shape you without letting it erase you. Harrison's has an index. Your life does not. You have to write your own.

See you in the wards. Helmet on, heart open, Harrison's in the bag — in that order.

~ Dr Vishal Gabale

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The mind is not a vessel to be filled,
but a fire to be kindled."
– Plutarch

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PREVIOUS YEAR QUESTIONS

NEET PG

A middle-aged obese male presents with excessive daytime somnolence, poor attention span, and memory issues. His BMI is 42 kg/m² and blood pressure is elevated. Arterial blood gas while awake shows $PaCO_2$ of 52 mm Hg and bicarbonate of 29 mEq/L.
What is the most likely diagnosis?
A. Obstructive sleep apnea
B. Central sleep apnea
C. Obesity-related hypoventilation
D. Narcolepsy

A 34-year-old female complains of progressive skin tightening, proximal muscle weakness, and Raynaud's phenomenon. Investigations reveal elevated CK, positive ANA, and features of overlap myositis with systemic sclerosis.
Which antibody is most characteristic?
A. Anti-centromere
B. Anti-Jo-1
C. Anti-PM-Scl
D. Anti-dsDNA

An elderly patient develops gradual cognitive decline along with bradykinesia, rigidity, and postural instability. Which pathology most likely explains this combination?
A. Normal pressure hydrocephalus
B. Vitamin B12 deficiency
C. Lewy body deposition
D. Hypothyroidism

Which of the following is NOT routinely included in the screening evaluation of a patient diagnosed with Turner syndrome?
A. Cardiac evaluation by echocardiography
B. Hearing assessment
C. Blood glucose monitoring
D. Antinuclear antibody testing

A defect in CD40-CD40L interaction in B lymphocytes leads to which immunological pattern?
A. Reduced NK cell numbers
B. Impaired cytotoxic T-cell function
C. Elevated IgM with reduced IgG
D. Neutrophil dysfunction

PREVIOUS YEAR QUESTIONS

NEET PG

A patient with type 2 diabetes has persistently elevated fasting glucose levels. Which dietary recommendation is most appropriate?

A. Daily sodium intake above 6 g

B. Fat contributing less than one-third of total calories

C. Cholesterol intake below 50 mg/day

D. Fiber intake exceeding 90 g/day

A chronic smoker undergoes spirometry. His FEV1/FVC ratio is markedly reduced and shows significant improvement after bronchodilator administration.

What is the most appropriate interpretation?

A. Restrictive lung disease with reversibility

B. Obstructive lung disease with reversibility

C. Restrictive lung disease without reversibility

D. Vascular pathology affecting lungs

Which of the following drugs is NOT considered a first-line disease-modifying agent in rheumatoid arthritis?

A. Methotrexate

B. Hydroxychloroquine

C. Sulfasalazine

D. Azathioprine

Regarding inflammatory bowel disease, which statement is correct?

A. Crohn's disease involves only mucosa

B. Ulcerative colitis shows transmural inflammation

C. Skip lesions are characteristic of Crohn's disease

D. Surgery cures Crohn's disease permanently

A patient with prolonged fever tests negative for malaria and dengue, but shows positivity for rK39 antigen. What is the most appropriate treatment?

A. Dapsone

B. Amphotericin B

C. Hydroxychloroquine

D. Griseofulvin

PREVIOUS YEAR QUESTIONS

INI-CET

A 40-year-old man presents with daytime sleepiness and impaired concentration and memory. On examination, his BMI is 41 kg/m2, and his BP is 160/100 mm Hg. His awake ABG analysis is given: PaO2 = 66 mm Hg, PaCO2 = 50 mm Hg, and HCO3 = 28 mEq/L. What is the most likely diagnosis?

1. Obstructive sleep apnea
2. Narcolepsy
3. Obesity hypo-ventilation syndrome
4. Central sleep apnea

An elderly patient was brought to the OPD with complaints of tremors, stoop posture and slow movements. His son also gives a history of forgetting day-to-day activities. What is the possible cause of this condition?

1. NPH
2. Hypothyroidism
3. Lewy body
4. Vitamin B12 deficiency

What is the antibody linked to the condition in which a 35-year-old woman experiences skin thickening, muscle weakness, pale peripheries upon cold exposure, increased creatine kinase with positive ANA, and biopsy revealing scl-70 positivity and perifascicular infiltration?

1. Anti PM scl antibody
2. Anti Jo1 antibody
3. Anti centromere antibody
4. Antinuclear antibody

All of the following are tests done for screening in patients with Turner's syndrome, except?

1. ANA
2. Audiometry
3. Echocardiography
4. Fasting blood glucose

What immunological abnormality is observed due to the absence of CD40 in B cells?

1. Total lack of NK cells
2. Lack of CD8-mediated cytotoxicity
3. Decreased IgG and increase in IgM PrepLadder
4. Inability of neutrophil to act against infections

PREVIOUS YEAR QUESTIONS

INI-CET

What recommendations would you give to a diabetic patient with a fasting blood glucose level of 160 mg/dL in terms of non-pharmacological management?

1. At least 80 mg of dietary fibre
2. <5 g sodium intake every day
3. <30% of the calories should come from fat
4. Cholesterol <100 mg

Which of the following is not a first-line drug for the management of a patient with rheumatoid arthritis?

1. Sulfasalazine
2. Hydroxychloroquine
3. Methotrexate
4. Azathioprine

Mark the correct statement regarding inflammatory bowel disease.

1. Skip lesions are present in Crohn's disease
2. Mucosal layers are involved in Crohn's, while transmural involvement seen in ulcerative colitis
3. Inflammatory bowel disease doesn't have a genetic predisposition
4. Crohn's is curable through surgical resection of the affected segment

A patient arrives at the hospital with symptoms of fever and chills. A fever profile test is conducted, which rules out malaria and dengue as the cause. However, the rK39 test comes back positive. What is the preferred treatment for this condition?

1. Amphotericin B
2. Griseofulvin
3. Dapsone
4. Hydroxychloroquine

Which of the following statements correctly describes an ideal candidate for a renal graft transplant in a patient with diabetic nephropathy?

1. The survival rate of graft is 95% in the first year
2. The transplantation is cost effective after the second transplant year
3. The life expectancy is doubled in a diabetic patient with renal transplant
4. The treatment of chronic rejection has improved over the last 10 years

NEONATAL JAUNDICE

Neonatal jaundice is one of the most important and frequently tested topics in pediatrics—and clinically, it's something you must approach systematically because missing a pathological cause can have serious consequences (like kernicterus).

I'll break it down in a clear clinical approach format so you can actually use it in exams and wards.

1. What is Neonatal Jaundice?

Definition:

Yellow discoloration of skin and sclera due to serum bilirubin >5 mg/dL

Appears first on face → progresses caudally (Kramer rule)

Neonates are prone due to:

↑ RBC turnover

Immature liver (↓ UDP-glucuronyl transferase)

↑ enterohepatic circulation

2. Types of Bilirubin

A. Unconjugated (Indirect)

Lipid soluble

Neurotoxic → kernicterus risk

Causes:

Hemolysis

Physiological immaturity

Breastfeeding issues

B. Conjugated (Direct)

Water soluble

3. Classification (VERY IMPORTANT)

A. Physiological Jaundice

B. Pathological Jaundice

Approach to Neonatal Jaundice (EXAM GOLD)

Step 1: Age of onset

Step 2: Clinical evaluation

Step 3: Lab Investigations

Step 4: Determine Type

Quick Clinical Algorithm

1. When did jaundice start?
2. Check total + direct bilirubin
3. Sick or not?
4. Look for hemolysis signs
5. Decide:

Physiological ↠ observe

High indirect ↠ phototherapy

Direct ↠ investigate urgently

Management

A. Phototherapy

B. Exchange Transfusion

C. Treat underlying cause

8. Key Exam Pearls

Jaundice <24 hrs = pathological

Direct bilirubin = always abnormal

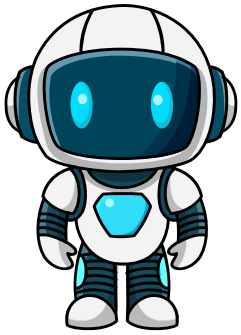
Biliary atresia → pale stool + dark urine

Breast milk jaundice → baby otherwise healthy

ABO incompatibility → Coombs positive

Rh incompatibility → more severe

Frontline Medicine



Diagnostic Odyssey

For many people living with MS, the road to a diagnosis is exhausting. It often involves months of uncertainty, multiple specialist visits, expensive MRI scans, and painful procedures like lumbar punctures (spinal taps). Canary Speech is trying to replace that stress with something as natural as human breath. By partnering with Intermountain Health, they've launched a study to see if AI can "hear" MS in a patient's voice long before physical symptoms become obvious.

->How it Actually Works (The "Human" Element)

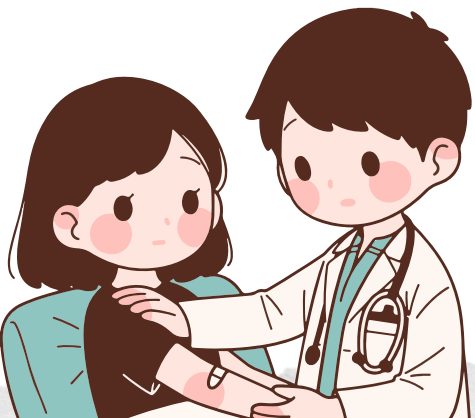
When we speak, we aren't just sharing words; we are using a complex coordination of our lungs, vocal cords, tongue, and brain. MS affects the central nervous system, and even microscopic changes in how the brain sends signals to those muscles can alter the way we speak—changes so subtle a human ear could never hear them.

The technology analyzes over 2,500 tiny vocal biomarkers—things like the micro-pauses between words, the steady (or shaky) quality of a vowel, and the strength of muscle coordination. It's like a "digital stethoscope" for the brain.

->Why This Matters for Real People

• Time is Brain: In the world of neurology, every month matters. The sooner a patient starts treatment, the more damage to the nervous system can be prevented. This technology could flag MS in a primary care office during a routine check-up, getting patients to specialists much faster.

• A New Safety Net: With nearly 3 million people worldwide affected by MS, this provides a scalable way to monitor health. Whether it's over a telehealth call or in person, your voice becomes a living record of your neurological health.

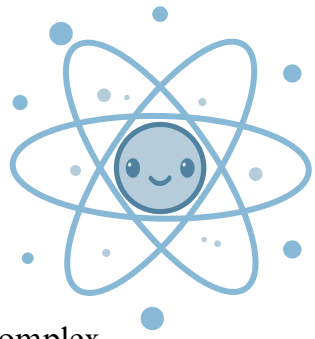


Vocal Biomarkers: The "Voice Print" Check-up

Your voice is becoming the next vital sign. New AI-driven diagnostic tools can now detect Vocal Biomarkers—microscopic changes in speech patterns, pitch, and breath—that are invisible to the human ear but indicate diseases like Parkinson's, Alzheimer's, or even COVID-19. By early 2026, these tools are being integrated into smartphones, allowing for non-invasive, remote screenings during a simple phone call. In the future, your virtual assistant might suggest a doctor's visit simply because it "heard" an early sign of heart failure in your morning greeting.

The Era of "In Vivo" CRISPR Therapy

Gene editing has reached a historic milestone: we can now edit DNA directly inside the human body. In a groundbreaking 2025 case, doctors used Lipid Nanoparticles to deliver CRISPR tools via a simple IV infusion to treat rare genetic liver diseases. Unlike earlier methods that required removing and "fixing" cells in a lab, this "in vivo" approach makes gene therapy as easy as receiving a standard medication. This paves the way for a future where we can "program" out hereditary diseases like sickle cell anemia and cystic fibrosis with a single injection.



Quantum Computing: The Next Revolution in Medicine

Quantum computing is an emerging technology that uses qubits to perform complex calculations far beyond the capability of classical computers. In medicine, it holds immense promise in accelerating drug discovery by accurately simulating molecular and protein interactions. This could significantly reduce the time required to develop treatments for cancer, infectious diseases, and rare genetic disorders. It also enhances genomic analysis, paving the way for truly personalized medicine based on an individual's DNA. When integrated with artificial intelligence, quantum computing can improve diagnostic accuracy and predictive disease modeling. Although still in early stages, this technology represents a transformative shift that could redefine the future of healthcare and medical research.

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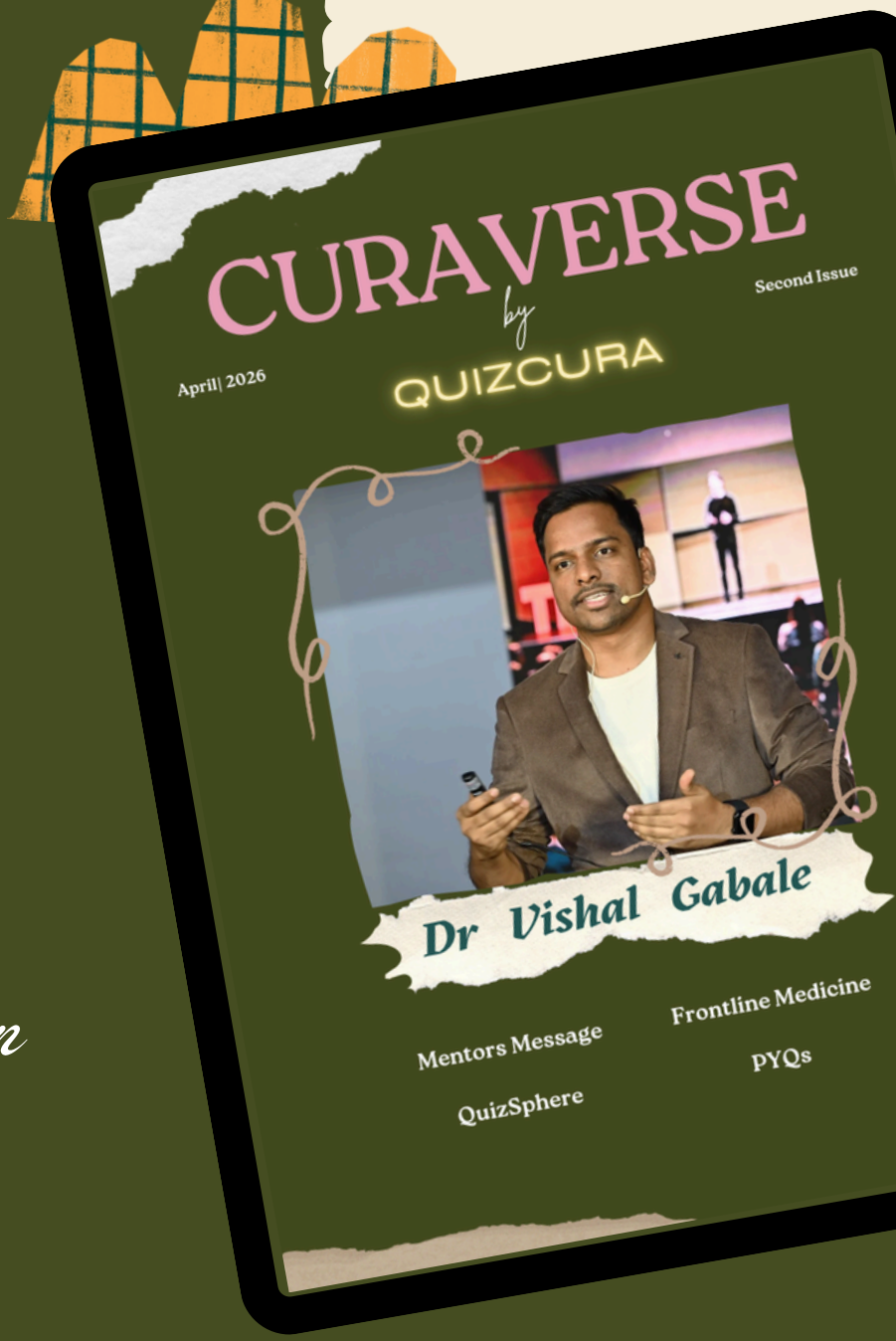

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