



ISNR Office Bearers

The Indian Society of Neuroradiology is guided by an experienced leadership team responsible for governance, academic direction, member engagement, and the continued growth of neuroradiology initiatives across India.

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Dr. Nihar Kathrani (DM Course Coordinator)

The executive team works together to strengthen collaboration, promote academic excellence, and support the Society's mission through leadership, communication, and service.

Theme

Neuro-infections

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Message from the Secretary, ISNR



Warm regards,
Dr. Navin Mulimani
Secretary, ISNR

It is with great honor that I assume the role of Secretary of the Indian Society of Neuroradiology (ISNR). Our society has consistently strived to advance the field of neuroradiology in India through academic excellence, collaborative research, and innovative clinical practice. As we move forward, my focus will be on strengthening educational initiatives, fostering interdisciplinary partnerships, and enhancing opportunities for young professionals to engage meaningfully in our activities. Together, we will continue to build on ISNR's strong foundation, ensuring that our community remains at the forefront of scientific progress and patient care. I look forward to working closely with all members to further elevate the impact and reach of ISNR.

Words from past Secretary, ISNR

Last two years as Gen secretary for esteemed society of ISNR were very much happening and fruitful for the society with the Guidance of ISNR Presidents Prof S Gaikwad & Dr Mathew Cherian and support of all the Executive members. Multiple tasks were achieved during this period for betterment of the society. There were issues with fast communications with members same was addressed by creation of What's app group. Another thing was upgradation of old ISNR website to all new one. Young neuroradiologist Forum (YNRF) was also introduced which is very well functioning and taking care of different ongoing academic activities. Long pending task of starting the NEWS LETTER of the society also sorted, two issues of same has already been published. Many a time it felt difficult handling clinical work, social, personnel, administrative responsibilities & Duties of ISNR secretary together however due to passion & love for ISNR made it easy and enjoyable.

I feel very much happy, confident & proud to pass on this batten to the Dynamic new Gen Secretary Dr Navin Mullimani and wish him & entire EC very all the best.



Warm regards,
Prof. Dr. Ajay Kumar
Past Secretary, ISNR

CASE REPORT 1- When Fat-Sat Fails: Off-Isocenter Artifact Mimicking Infective Marrow Changes in Cervical Spine MRI

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Background

Fat-suppressed MRI sequences play a pivotal role in the evaluation of neuro-infections, particularly in detecting early marrow edema in conditions such as spondylodiscitis and vertebral osteomyelitis. T1 fat-suppressed (fat-sat) imaging improves lesion conspicuity by suppressing normal marrow fat, thereby highlighting pathological signal alterations.

However, in the cervical spine—especially in patients with a short, thick neck—fat-sat sequences are prone to a well-recognized but underappreciated pitfall: off-isocenter fat-saturation failure. This can introduce signal alterations that may mimic or obscure early infective marrow changes, potentially leading to diagnostic uncertainty.

The Pitfall

Apparent diffuse or patchy hypointensity of cervical vertebral bodies on T1 fat-sat images may simulate marrow pathology, including infective involvement. This occurs when the region of interest lies away from the magnet isocenter, leading to:

- B0 inhomogeneity - frequency mismatch
- B1 field non-uniformity - uneven RF excitation

Result: incomplete or heterogeneous fat suppression

The visual outcome is pseudo-marrow signal abnormality, which can be misleading in patients being evaluated for spinal infection.

Why It Happens

Fat-saturation techniques rely on precise resonance frequency targeting of fat protons.

Away from isocenter:

- Local magnetic field variations shift fat resonance frequency
- Fat suppression becomes non-uniform or fails entirely

Signal from marrow fat is inconsistently suppressed false hypointensity pattern

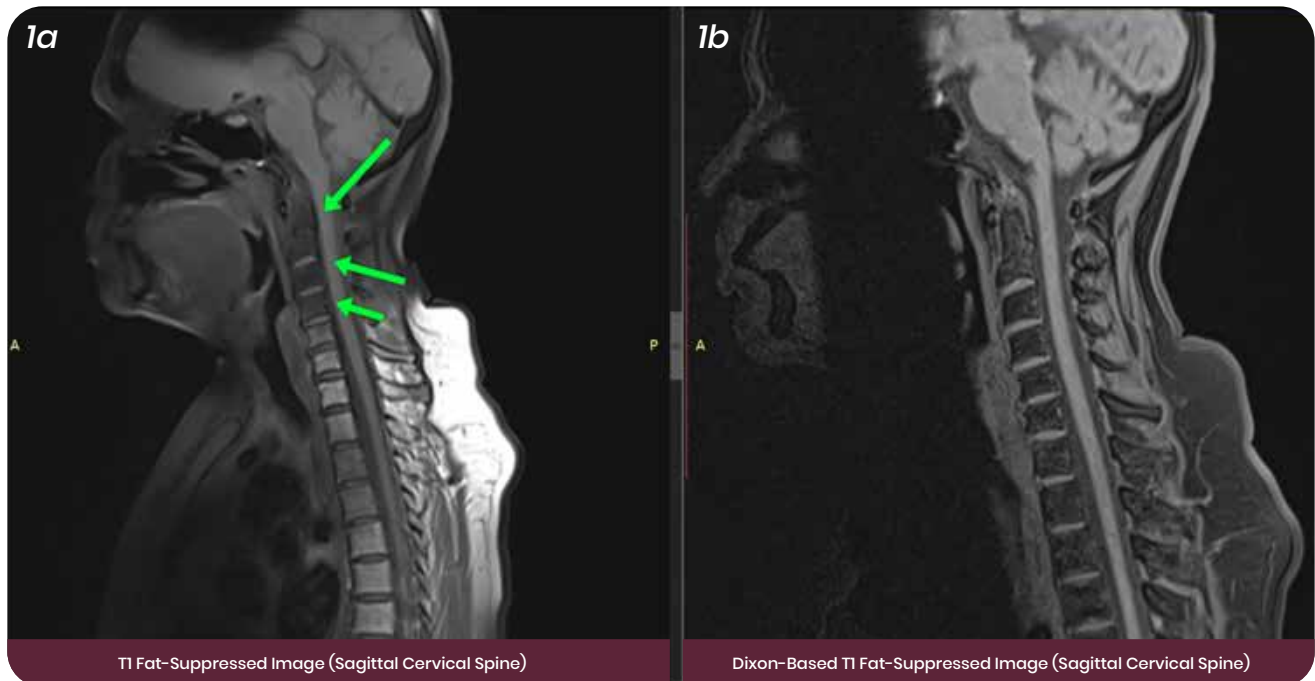


Figure 1a: T1 Fat-Suppressed Image (Sagittal Cervical Spine)

Sagittal T1-weighted fat-suppressed image of the cervical spine demonstrates apparent diffuse hypointensity of multiple cervical vertebral bodies (arrows). This appearance may simulate marrow infiltration or metastatic disease. The finding is due to off-isocenter fat-saturation failure, resulting from B0/B1 field inhomogeneity and non-uniform fat suppression in regions distant from the magnet isocenter.

Figure 1b: Dixon-Based T1 Fat-Suppressed Image (Sagittal Cervical Spine)

Corresponding sagittal Dixon-based fat-suppressed image shows uniform marrow signal without abnormal hypointensity, confirming the absence of true marrow pathology. Dixon technique, being less sensitive to field inhomogeneity, helps differentiate artifact from true disease and serves as a reliable problem-solving sequence in such cases.

Imaging Clues to Recognize Artifact

- Signal abnormality limited to fat-sat sequences
- Normal signal on non-fat-suppressed T1-weighted images
- Lack of corresponding abnormality on:
 - T2/STIR (true infective pathology usually shows marrow edema)
 - Dixon-based fat suppression sequences (more robust)
- Often symmetrical or gradient-like signal drop-off

How to Avoid Misdiagnosis in Suspected Infection

- Always correlate with non-fat-sat T1 images
- Use STIR or Dixon-based sequences for confirming marrow edema
- Look for associated features of infection:
 - Endplate irregularity
 - Disc space involvement
 - Paravertebral or epidural soft tissue component

Technical Prevention

- Ensure proper patient positioning and centering at magnet isocenter
- Avoid imaging regions too far from coil center when possible
- Prefer advanced fat suppression techniques (e.g., Dixon) in challenging anatomies
- Be cautious in patients with short neck or large body habitus

When to Call the Engineer

Sometimes, poor fat saturation isn't the patient's anatomy—it's the machine. Suspect system instability if you notice:

While off-isocenter fat-saturation failure is typically attributed to geometric and field-related factors, persistent, exaggerated, or atypical patterns—particularly when newly observed in a previously stable system—may, in rare instances, warrant consideration of underlying system performance issues.

Such patterns may present as:

- Fat-saturation inhomogeneity disproportionate to patient anatomy
- Increased variability between sequences
- Progressive degradation in fat suppression quality

In these situations, correlation with system performance logs and technical evaluation may be useful, particularly when imaging findings are discordant with clinical expectations.

Take-Home Message

- Not all fat-suppressed signal abnormality represents infection.
- In the cervical spine, off-isocenter fat-saturation artifact can closely mimic early infective marrow changes, potentially leading to overdiagnosis or diagnostic confusion.
- Careful sequence correlation and awareness of technical limitations are essential—especially in the evaluation of suspected neuro-infections.

CASE REPORT 2- When Dementia Progresses too Fast: A Case of Creutzfeldt–Jakob Disease

Author

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Clinical History

A 65-year-old lady, presented with a rapidly progressive cognitive decline with parkinsonian features over a period of 4 months suggested by forgetfulness, poor speech and tremors. Patient was a known hypertensive on medication for 5 years. Patient had no other complaints and known co morbidities. EEG and MRI Brain was advised to look for intracranial pathology.

Imaging Findings

Brain MRI demonstrated bilateral cortical and deep gray matter signal abnormalities typical of Creutzfeldt–Jakob disease. The most striking finding was gyriform cortical hyperintensity along the cerebral cortex on DWI, with corresponding low signal on ADC maps, consistent with true diffusion restriction and the cortical ribbon sign. Additional cortical hyperintensity was seen on T2WI in the bilateral parietal lobes.

There was also abnormal hyperintensity on T2 and FLAIR involving the bilateral medial thalami and pulvinar nuclei, producing the classic hockey stick appearance. These thalamic abnormalities also showed diffusion restriction. In the appropriate clinical context of rapidly progressive dementia, these imaging features strongly suggested sporadic CJD.

Detailed Imaging Description

DWI: Gyriform hyperintense signal was seen along the cerebral cortex, especially in the high parietal regions and bilateral postcentral sulci, representing the cortical ribbon sign. Similar cortical diffusion restriction was also noted in the bilateral inferior parietal lobules and parietal opercula.

ADC: The areas of cortical hyperintensity on DWI showed corresponding low signal intensity on ADC maps, confirming true restricted diffusion rather than T2 shine-through.

T2WI / FLAIR: Cortical hyperintensity was present in the bilateral parietal lobes. In addition, the bilateral medial and posterior thalami showed abnormal hyperintensity on T2WI and FLAIR, producing the hockey stick sign. The pulvinar region was involved, with associated diffusion restriction.

Diagnostic significance: The combination of cortical ribboning, bilateral parietal cortical involvement, and pulvinar/thalamic signal abnormality is highly suggestive of CJD, particularly when accompanied by rapidly progressive dementia and supportive EEG and CSF findings.

Figure 1[DWI and ADC - Inferior Parietal Lobule]

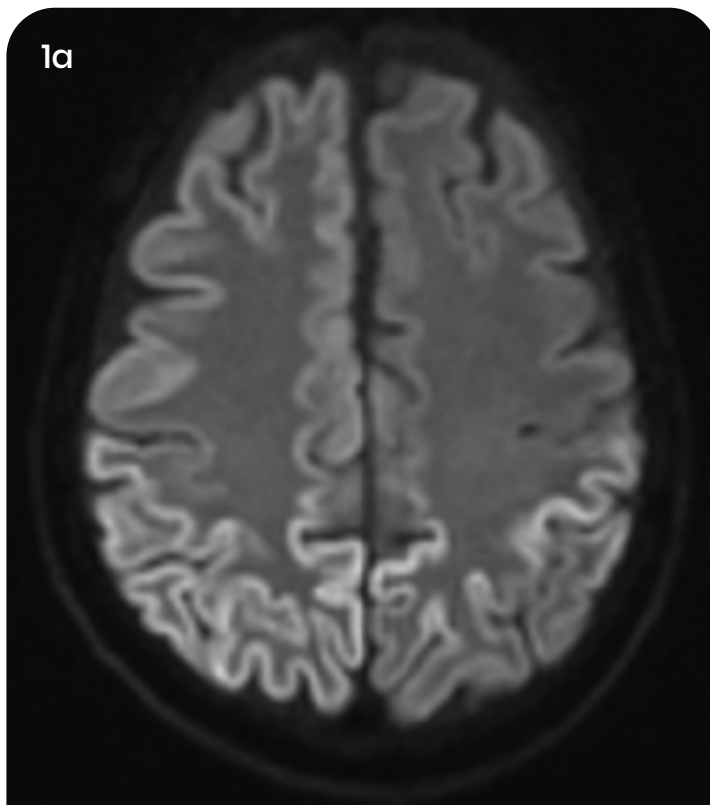


Figure 1a: Gyriform hyperintense signal (cortical ribbon sign) along cerebral cortex on DWI in high parietal region involving bilateral post central sulcus.

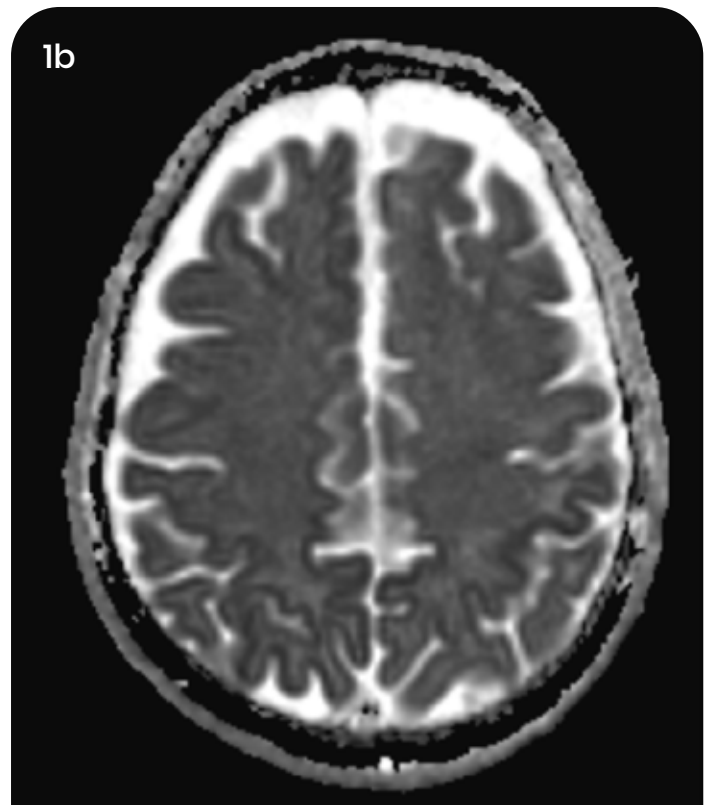


Figure 1b: Cortical low signal intensity along post central sulcus bilaterally and in parietal lobes on ADC to suggest true diffusion restriction

Figure 1[DWI and ADC - Inferior Parietal Lobule]

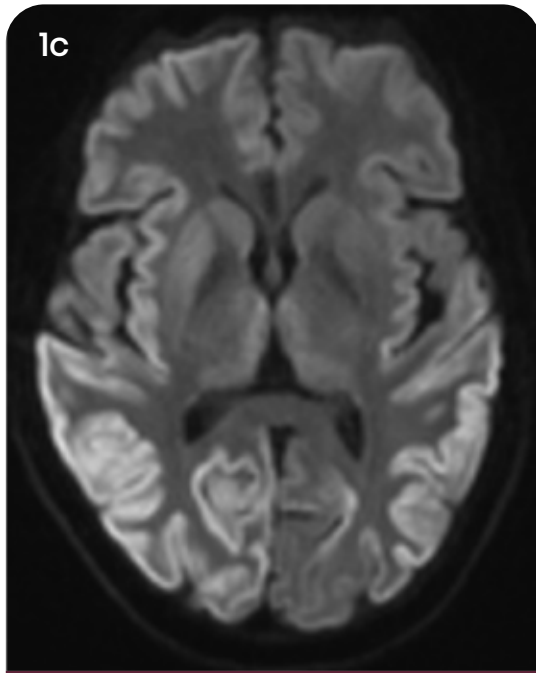


Figure 1c: Gyriform hyperintense signal along cerebral cortex on DWI in bilateral inferior parietal lobule and parietal operculum.

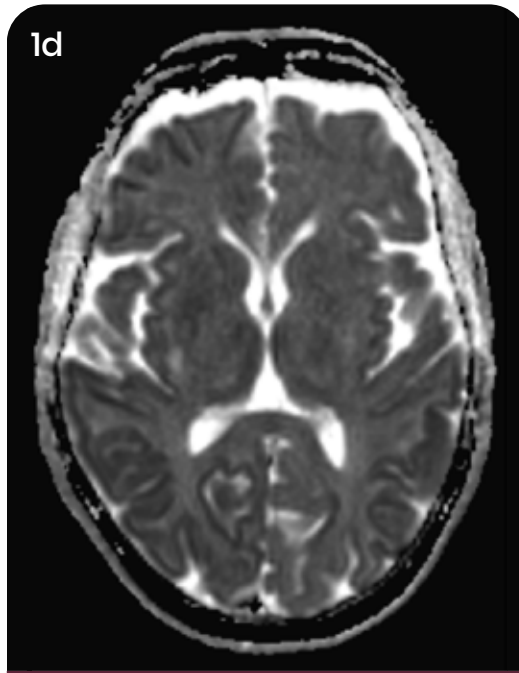


Figure 1d: Corresponding low signal intensity on ADC in bilateral inferior parietal lobule and parietal operculum.

Figure 2[T2 and FLAIR - Hockey Stick Sign]

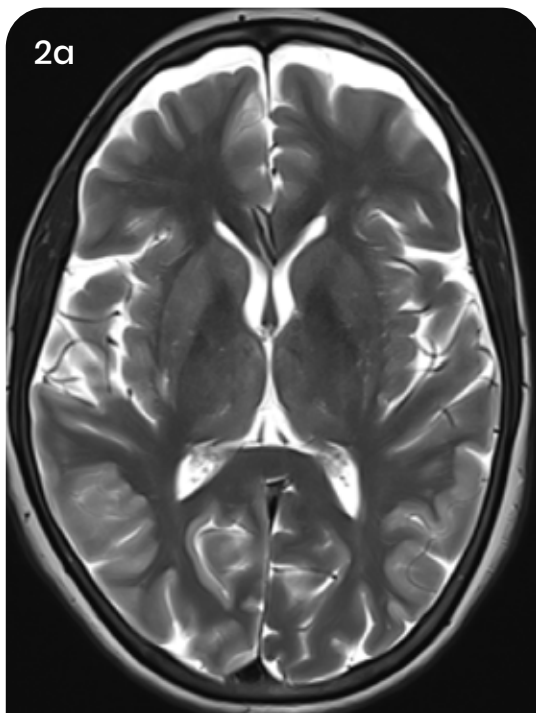


Figure 2a: T2 hyperintensity bilaterally involving medial and posterior aspect of thalami giving hockey stick appearance

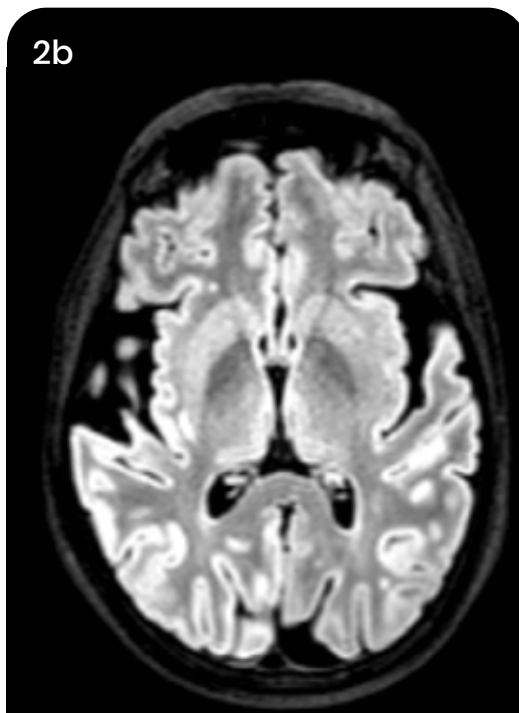


Figure 2b: Hockey stick sign on FLAIR

Discussion

Background:

Creutzfeldt–Jakob Disease (CJD) is the most common spongiform encephalopathy in humans. It is a neurodegenerative disorder that is progressive and invariably fatal [1]. It is a prion disease caused by misfolded protein [2]. Various forms of CJD including sporadic, familial, variant and iatrogenic CJD have been recognised [3].

Clinical Perspective:

CJD is characterised by rapid cognitive decline, progressive dementia with or without pyramidal and extra pyramidal symptoms [4]. This symptomatology is common amongst various neuro-cognitive disorders including potentially treatable ones like autoimmune encephalitis, paraneoplastic syndrome and other causes of dementia that may have acute onset of symptoms similar to CJD [5]. However, CJD is progressive, non-treatable and hence fatal. Differentiating this entity from other treatable causes help in appropriate treatment and counselling for the expected outcome.

Imaging Perspective:

Our patient presented with memory loss with speech abnormalities and tremors rapidly progressing over a period of 4 months. EEG demonstrated abnormal theta waves slowing with occasional triphasic waves. Possible clinical differentials of encephalitis syndrome, autoimmune encephalitis and paraneoplastic syndrome were kept. MRI brain was advised to look for intracranial pathology which confirmed findings consistent with CJD. CSF analysis for autoimmune encephalitis, paraneoplastic antibodies, VDRL, gram staining, ZN staining, India ink staining were all negative, however 14-3-3 protein gamma quantification confirmed its level to be 45312 AU/ml. Based on typical clinical features with disease duration < 2 years, EEG abnormalities, MRI findings and absence of evidence to suggest any alternative diagnosis, Patient was diagnosed as a probable case of sporadic CJD.

Sporadic CJD most commonly involves cerebral cortex as was seen in this case where it was predominantly bilateral parietal lobe involvement. Cortical hyperintensities are seen on T2WI and FLAIR however DWI is considered more sensitive in early presentation. Symmetric or asymmetric involvement of bilateral gray matter nuclei is seen, thalamic involvement being more significant in pulvinar region (pulvinar sign) without or with medial thalamic involvement giving hockey stick appearance.

Outcome:

Patient was kept on symptomatic treatment but her condition rapidly deteriorated. Patient subsequently died eleven months after her first symptom onset.

Take Home Message/ Teaching Points:

Wide range of metabolic, infective and autoimmune encephalopathy syndromes affect and should be evaluated in the backdrop of appropriate clinical history and laboratory investigations. Prompt radiological investigation in cases of acute presentation is necessary to rule out other possible aetiologies.

Final Diagnosis

Probable Creutzfeldt–Jakob disease

Differential Diagnosis List

Metabolic encephalopathy, autoimmune encephalitis, paraneoplastic syndrome, hypoxic brain injury

References

- [1] R. K. Fulbright, C. Hoffmann, H. Lee, A. Pozamantir, J. Chapman, and I. Prohovnik, 'MR Imaging of Familial Creutzfeldt–Jakob Disease: A Blinded and Controlled Study', *AJNR Am J Neuroradiol*, vol. 29, no. 9, pp. 1638–1643, Oct. 2008, doi: 10.3174/ajnr.A1217.
- [2] H. D. Au, N. T. Lan, N. T. Binh, L. T. Linh, M. M. Hien, and N. M. Duc, 'Sporadic Creutzfeldt–Jakob disease: Brain MRI lesion features from 2 cases reports', *Radiology Case Reports*, vol. 19, no. 3, pp. 939–943, Mar. 2024, doi: 10.1016/j.radcr.2023.11.082.
- [3] D. A. Collie, R. J. Sellar, M. Zeidler, A. C. F. Colchester, R. Knight, and R. G. Will, 'MRI of Creutzfeldt–Jakob Disease: Imaging Features and Recommended MRI Protocol', *Clinical Radiology*, vol. 56, no. 9, pp. 726–739, Sep. 2001, doi: 10.1053/crad.2001.0771.
- [4] D. A. Collie et al., 'Diagnosing variant Creutzfeldt–Jakob disease with the pulvinar sign: MR imaging findings in 86 neuropathologically confirmed cases', *AJNR Am J Neuroradiol*, vol. 24, no. 8, pp. 1560–1569, Sep. 2003.
- [5] M. Lorent, W. Verwimp, and S. Dechambre, 'MRI in Early Onset of Creutzfeldt Jakob Disease', *J Belg Soc Radiol*, vol. 105, no. 1, p. 33, Jun. 2021, doi: 10.5334/jbsr.2352.

CASE REPORT 3- When Cystic Parotids Are Not Infection: The Role of Multi-Gland MRI Coverage in Avoiding Diagnostic Anchoring

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Background

Bilateral cystic changes in the parotid glands—often described as a “honeycomb” pattern—classically trigger a narrow differential diagnosis dominated by:

- HIV-associated benign lymphoepithelial cysts
- Chronic granulomatous infections (e.g., tuberculosis)

In regions where neuroinfections are prevalent, there is a natural tendency to anchor prematurely on infectious etiologies. However, this imaging pattern is not pathognomonic, and such anchoring can delay the correct diagnosis.

The Diagnostic Pivot: Think Beyond the Parotid

A critical but often underutilized step is expanding MRI coverage beyond the parotid glands.

When bilateral cystic parotid changes are identified, systematic evaluation of:

- Submandibular glands
- Lacrimal glands (via orbital sequences)

can significantly alter the diagnostic trajectory.

Imaging Pattern That Changes Everything

In the presented case :

- Parotid glands- Bilateral enlargement with cystic (“honeycomb”) changes
- Submandibular glands- Symmetrical enlargement with subtle cystic involvement
- Lacrimal glands- Bilateral enlargement without focal lesion or diffusion restriction

This tri-glandular involvement forms a recognizable pattern:

Parotid + Submandibular + Lacrimal = Systemic autoimmune sialadenitis pattern

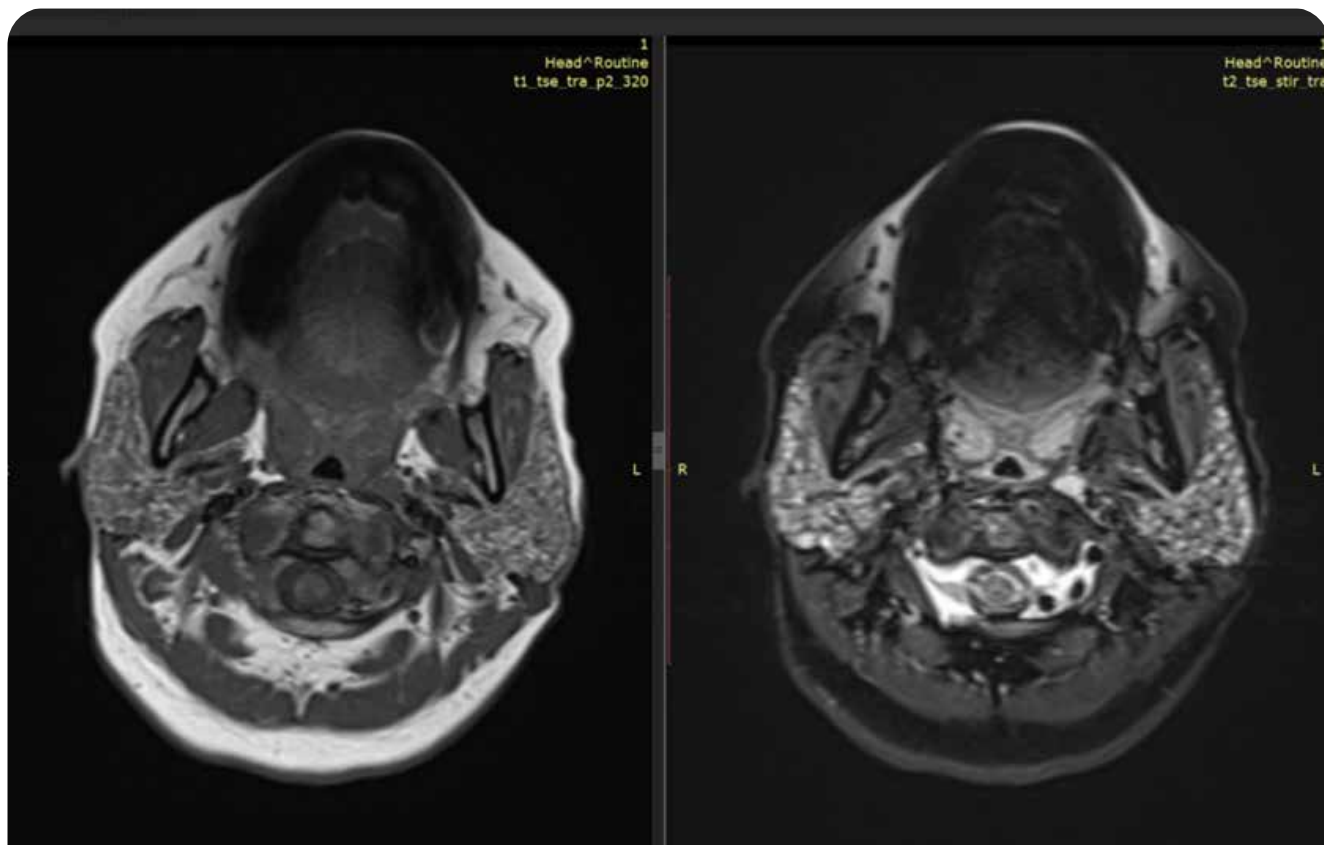


Fig 1: Axial T1 and T2 sequences showing bilaterally symmetrical cystic changes in bilateral parotid glands.

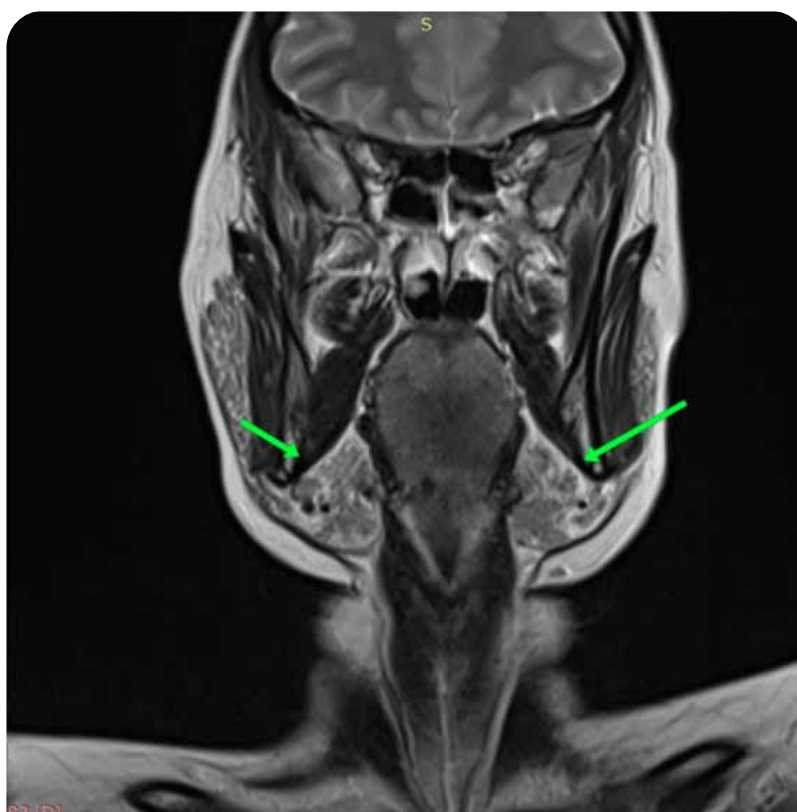
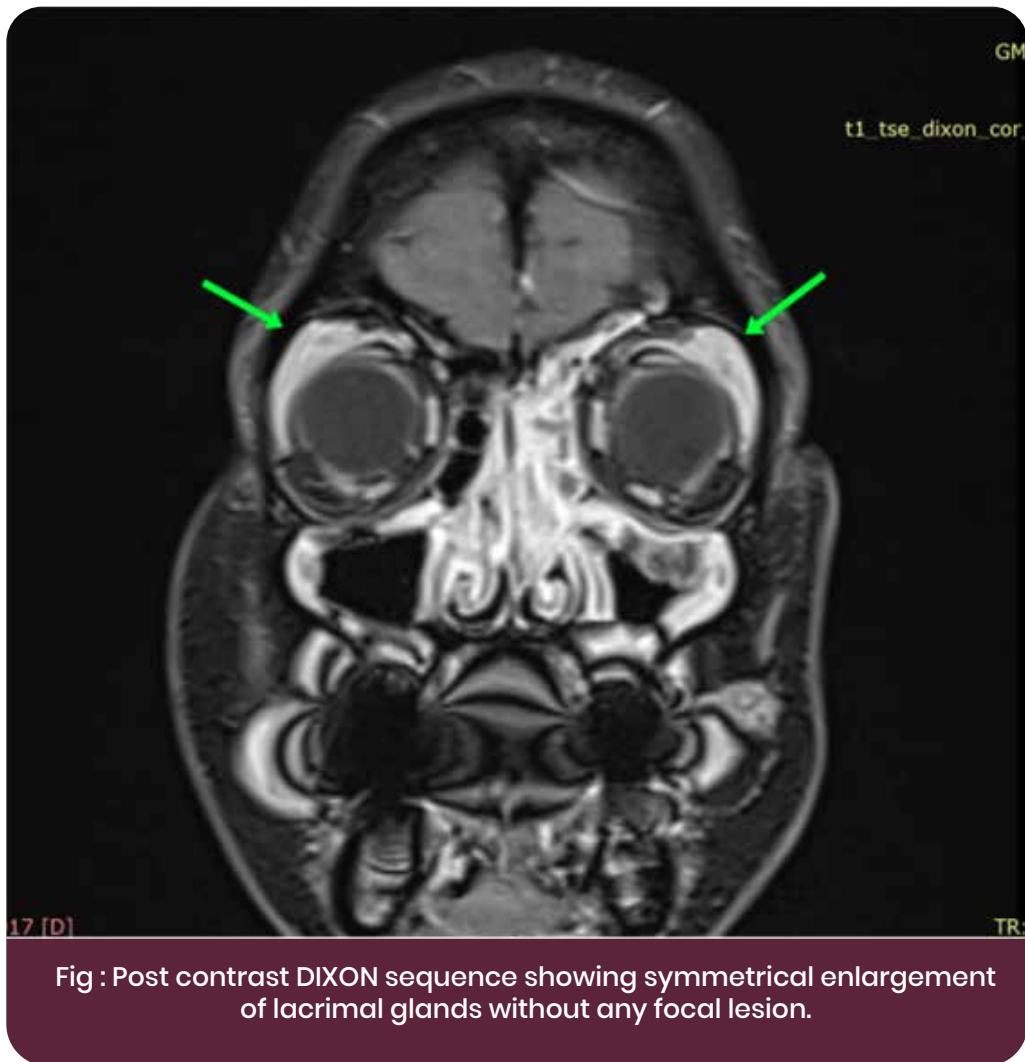


Fig 2: coronal T2 sequence showing symmetrical cystic changes and fatty atrophy in bilateral submandibular glands.



Why This Matters in Neuroinfection Practice

Common Pitfall

Jumping directly to:

- HIV-related pathology
- Tuberculosis
- Sarcoidosis

Especially when imaging is interpreted in isolation

What Multi-Gland Imaging Prevents

- Unnecessary infectious workup escalation
- Delayed recognition of systemic autoimmune disease
- Misclassification as chronic infection

What Multi-Gland Imaging Prevents

When cystic parotid disease is seen:

Add:

Orbit MRI sequences- to evaluate lacrimal glands

Extended salivary gland coverage- include submandibular glands

Look for:

Symmetry of involvement

Signal heterogeneity (fatty replacement vs active inflammation)

Absence of focal mass or necrotic nodes

Pattern Recognition Over Single-Organ Thinking

This case highlights a key radiological principle:

In glandular pathology, distribution matters more than morphology alone.

- Isolated parotid cysts- Think infection, HIV
- Multi-gland symmetrical involvement- Think autoimmune (e.g., Sjögren's syndrome)

Correlation That Seals the Diagnosis

Once the imaging pattern is recognized, subtle clinical clues become decisive:

- Dry eyes
- Dry mouth
- Chronic, painless glandular enlargement

These features, when integrated with imaging, point toward:

Sjögren's Syndrome rather than infection

Take-Home Message

- Do not anchor prematurely on infection when faced with cystic parotid glands
- Always expand the field of view—literally and diagnostically
- Include lacrimal and submandibular glands in MRI evaluation
- Recognize the tri-glandular pattern as a strong indicator of autoimmune disease

Conclusion

In the era of high-resolution imaging, the challenge is no longer detection—but interpretation without bias.

A simple addition of orbit sequences and extended gland coverage can prevent misdiagnosis and redirect clinical thinking away from infection toward systemic autoimmune

CASE REPORT 4- Pediatric Rhinocerebral Mucormycosis with Mycotic A2 Aneurysm: Rescue by Contralateral Approach

A Case of ACAitis Leading to Giant Mycotic Aneurysm in a 7-Year-Old

Author

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Clinical History

A 7-year-old child presented with rhino-oculo-cerebral mucormycosis complicated by an unusual and life-threatening neurovascular sequela. Initial MRI (Figure 1) demonstrated a small mycotic aneurysm arising near the region of left anterior cerebral artery, embedded within the evolving fungal cerebritis. Given the small size and the child's overall condition, a decision was made for conservative management with aggressive antifungal therapy. However, three-month follow-up MRI (Figure 2) revealed interval significant enlargement of the aneurysm, now appearing as a large outpouching within the fungal abscess cavity — a finding that fundamentally altered the management strategy. This interval growth, despite ongoing antifungal therapy, underscored the relentless angiodestructive nature of mucormycosis and the inability of medical therapy alone to arrest fungal arteritis once the vessel wall is invaded. The enlarging aneurysm within the abscess cavity represented a high rupture risk lesion, as the surrounding necrotic fungal tissue provided no structural support to the already weakened arterial wall — a scenario distinct from conventional saccular aneurysms where normal brain parenchyma and arachnoid provide some containment. This progression mandated urgent endovascular intervention. DSA (Figure 3) confirmed a large mycotic aneurysm arising from the A1-A2 junction of the left anterior cerebral artery (ACA), a manifestation we term ACAitis — fungal arteritis of the anterior cerebral artery.

Imaging Progression

Three-month follow-up MRI revealed interval significant enlargement of the aneurysm, now appearing as a large outpouching within the fungal abscess cavity. This interval growth, despite ongoing antifungal therapy, underscored the relentless angiodestructive nature of mucormycosis and the inability of medical therapy alone to arrest fungal arteritis once the vessel wall is invaded. The enlarging aneurysm within the abscess cavity represented a high rupture risk lesion, as the surrounding necrotic fungal tissue

provided no structural support to the already weakened arterial wall.

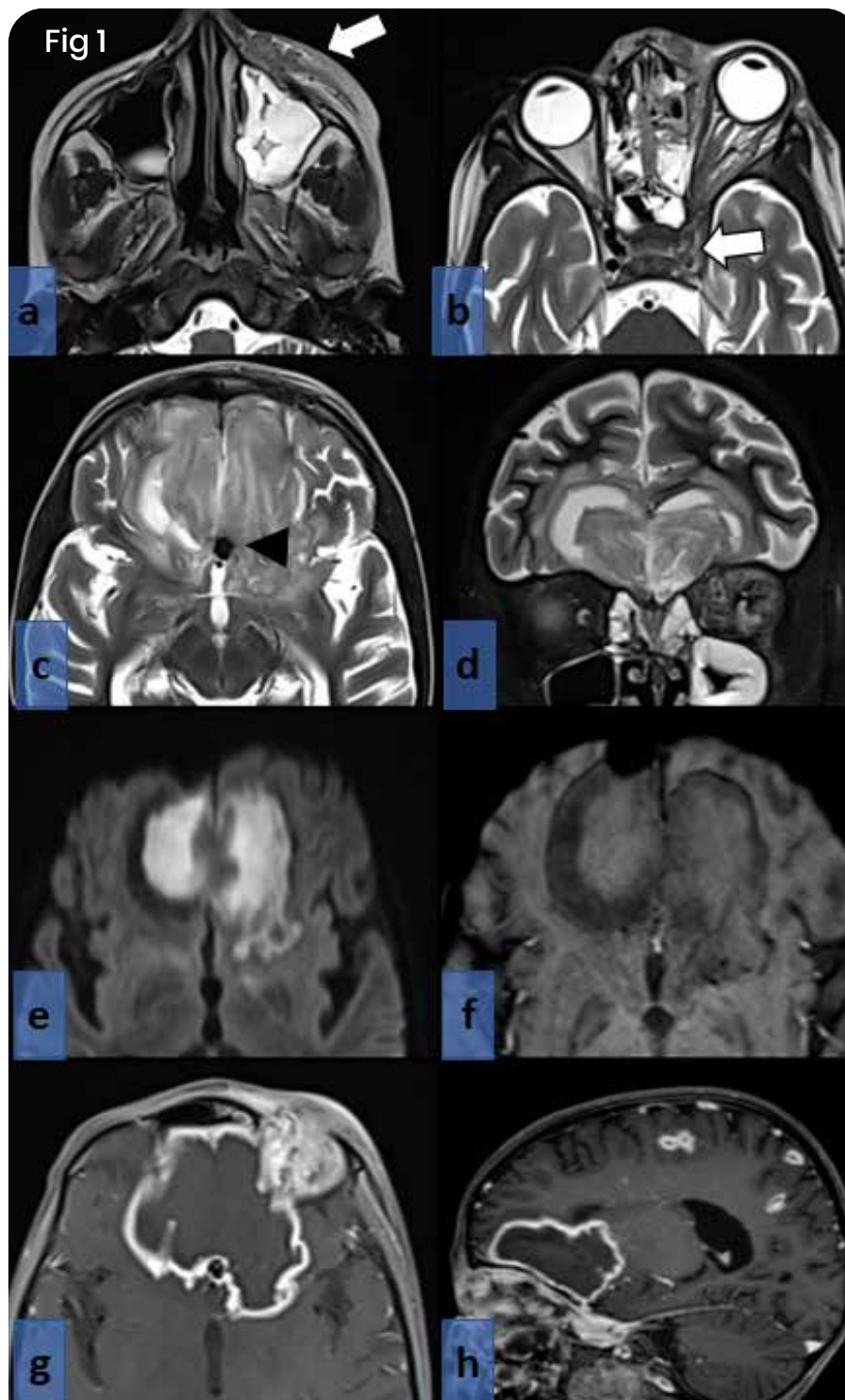


Fig 1. Rhino-oculo-cerebral mucormycosis. Left Maxillary sinusitis with T2-hypointense soft tissue in preaural fat pad (white arrow, a) with orbital, nasal and left cavernous sinus extension (note the absence of T2 flow void, arrow, b). Extensive cerebral involvement in basifrontal area with T2 hypointense rounded lesion in region of anterior communicating artery (c & d). Note the heterogenous central pattern of diffusion restriction (e) and haemorrhages in the wall of the abscess (f) with peripheral enhancement (g). Multiple other lesions are also seen scattered in the brain suggestive of the angioinvasive nature.

Fig 2

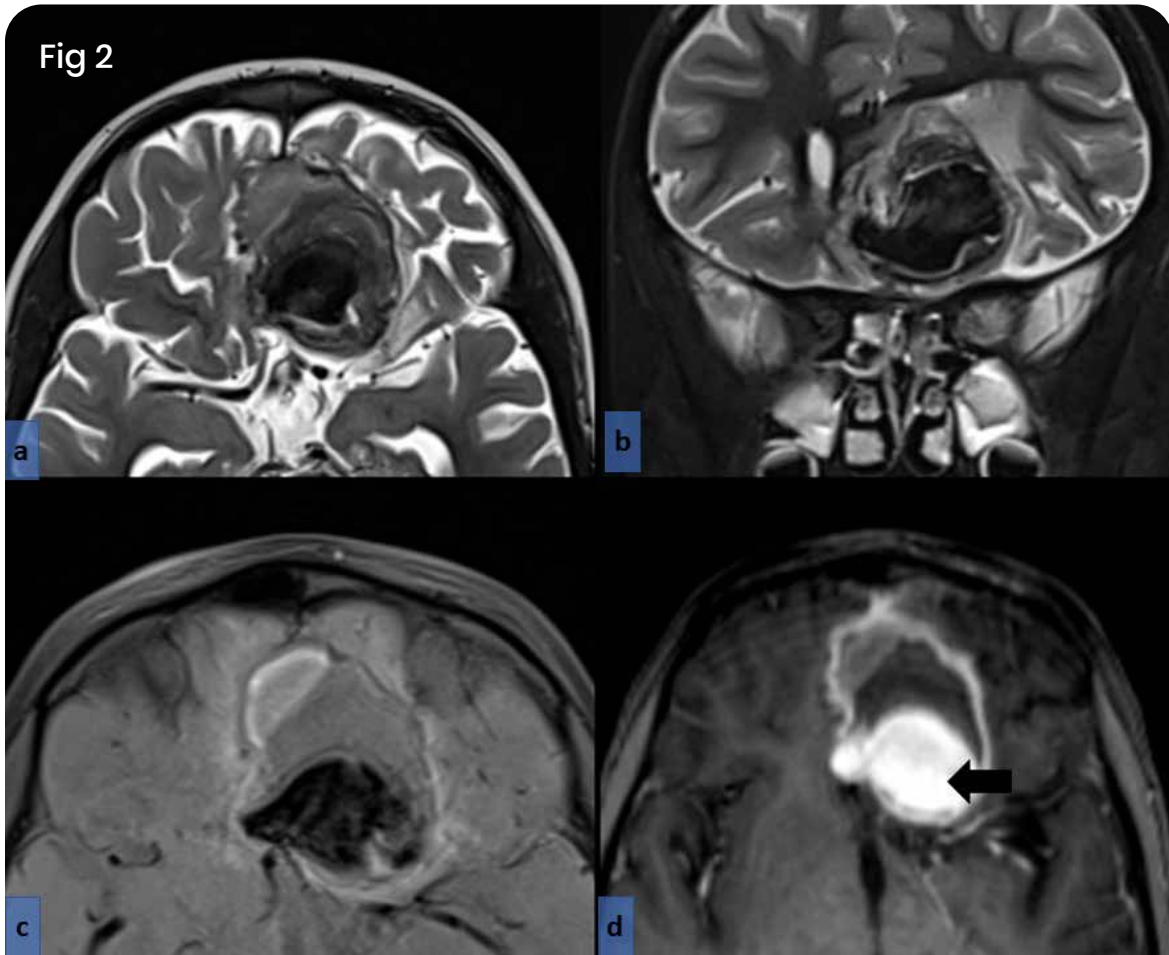


Fig 2. 3 month follow up MRI after antifungal therapy showed interval response in size of cerebral component of infection with interval increase in T2 “flow void”. Note the intense enhancement of the intra-abscess aneurysm (arrow)

Fig 3

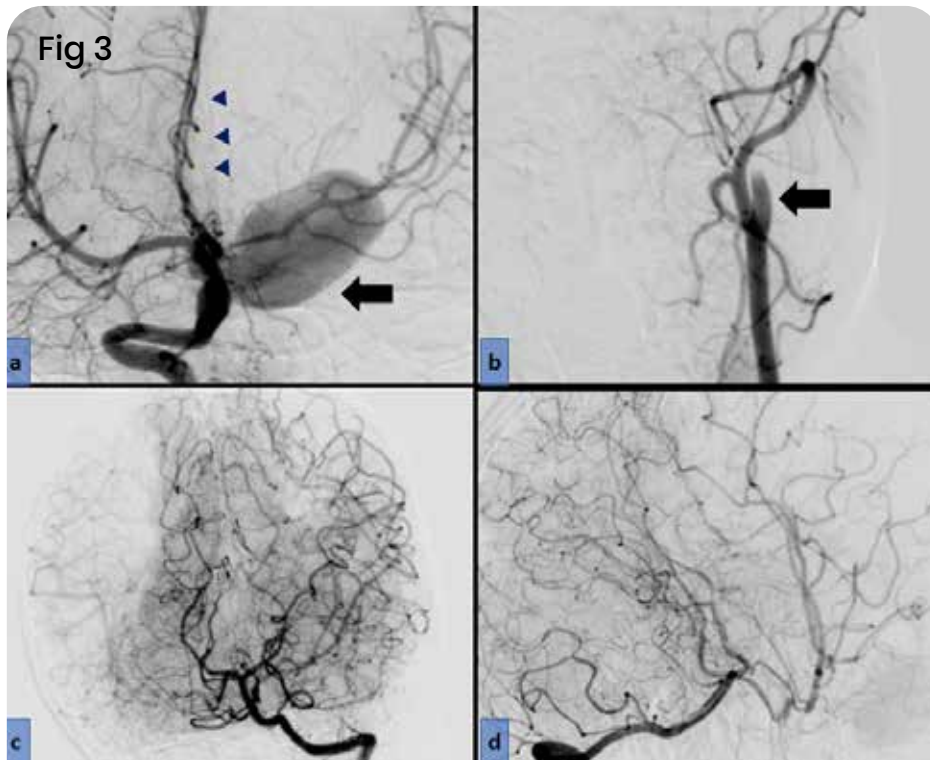


Fig 3 a) Large aneurysm (arrow) from left A1 – A2 junction with mass effect (arrowheads). B) shows left ICA occlusion. C) and D) show reformation of left MCA across left posterior communicating artery.

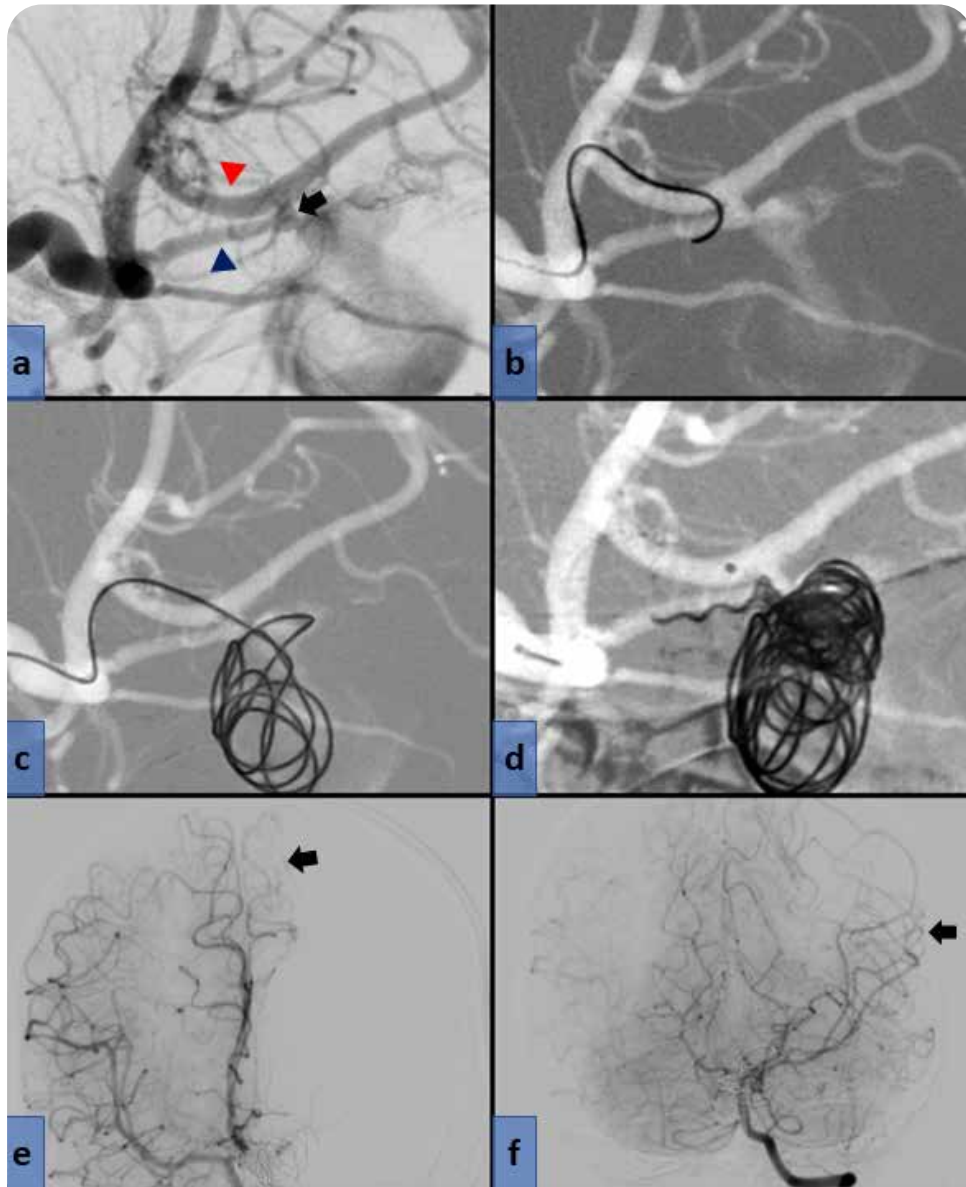


Fig 4. a) Shows contralateral (to the side of aneurysm) A1 ACA (red arrowhead), ACOM (black arrow) and ipsilateral A1 ACA (blue arrowhead). B) Microwire cannulation from contralateral to ipsilateral A1 ACA. C) and D) shows parent artery occlusion from left A1 ACA to neck of aneurysm being performed. E) and F) show post procedure runs with preserved flow in left ACA distal branches and left MCA across PCOM (black arrows).

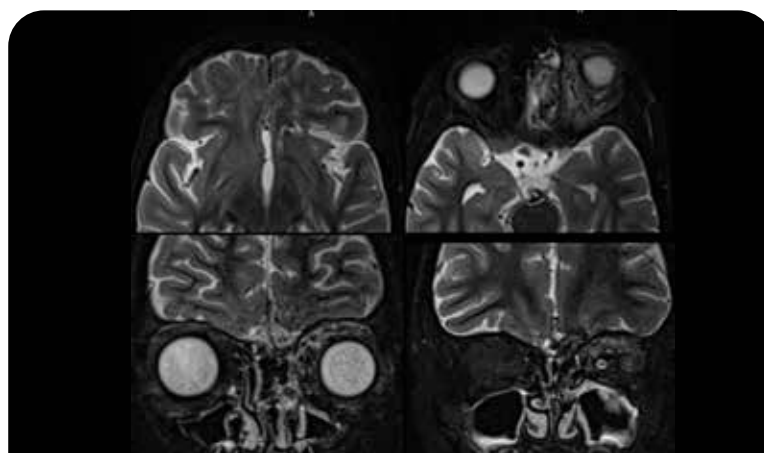


Fig5. 2 months follow up from interventional procedure and medical management with Amphotericin B coverage shows significant resolution of the disease process.

The Challenge

Endovascular management was significantly complicated by occlusion of the ipsilateral internal carotid artery (ICA) due to the angioinvasive nature of the fungal infection and cavernous sinus thrombosis. The natural access route to the aneurysm was precluded. With no direct ipsilateral approach available, the team devised a strategy of contralateral transarterial navigation – crossing the anterior communicating artery (ACoA) to access the A2 aneurysm from the contralateral ACA.

The Procedure

Under general anesthesia, transfemoral access was obtained. Following contralateral ICA injection confirming cross-filling via the ACoA, the microcatheter was navigated from the contralateral A1 across the ACoA into the ipsilateral A1 – directly into the aneurysm's parent artery. Parent artery occlusion (PAO) was performed at the A1 segment and at the aneurysm neck, effectively excluding the mycotic aneurysm from circulation.

Outcome

Follow-up imaging demonstrated:

- Significant reduction in intracranial extension of the fungal disease
- Complete occlusion of the mycotic aneurysm
- Good neurological prognosis – a remarkable outcome in what is universally considered a high-mortality condition in the pediatric age group

The child was continued on systemic liposomal amphotericin B and showed clinical and radiological improvement.

Teaching Points

- Rhinocerebral mucormycosis can cause ACAitis with mycotic aneurysm formation even in immunocompetent children
- ICA occlusion by fungal invasion need not preclude endovascular treatment – contralateral ACA approach via ACoA is a viable rescue strategy
- PAO remains a valid option for mycotic aneurysms where reconstruction is not feasible
- Aggressive combined medical-endovascular management can achieve favorable outcomes even in pediatric mucormycosis



YNRF Academic Update: A Season of Global Perspectives and Thematic Learning

The Young Neuroradiologists Forum (YNRF) has successfully spearheaded an outstanding series of monthly academic webinars over the past four months, bringing highly relevant, diverse, and globally informed perspectives to the Indian Society of Neuroradiology (ISNR) community. Carefully curated to align with corresponding monthly awareness themes, these sessions have fostered robust academic exchange by featuring esteemed national and international speakers.

Monthly Webinar Series

February: In a dedicated YNRF-themed session, Dr. Mesha L. Martinez delivered an insightful presentation focused on pediatric CSF pressure disorders and CSF leaks.

April: In observance of Parkinson's Disease Awareness Month, Dr. N. Senthil Kumar shared extensive clinical experience regarding the applications of Magnetic Resonance-guided Focused Ultrasound (MRgFUS) in the care of movement disorders, accompanied by case discussions moderated by Dr. Vinay Goel.

May: Recognizing Brain Tumor Awareness Month, the forum welcomed prominent international expertise with Dr. Rajiv Mangla from SUNY Upstate Medical University. Moderated by Dr. Sabha Ahmed, Dr. Mangla provided a comprehensive look at MR perfusion patterns that matter, specifically focusing on the practical applications of rCBV and PSR in evaluating brain lesions.

June: Aligned with Alzheimer's and Brain Awareness Month, Dr. Jitender Saini from NIMHANS delivered a compelling talk unpacking the Proteinopathy Paradigm, featuring topical discussions moderated by YNRF Convenor Dr. Shriram Varadharajan.

Looking Ahead

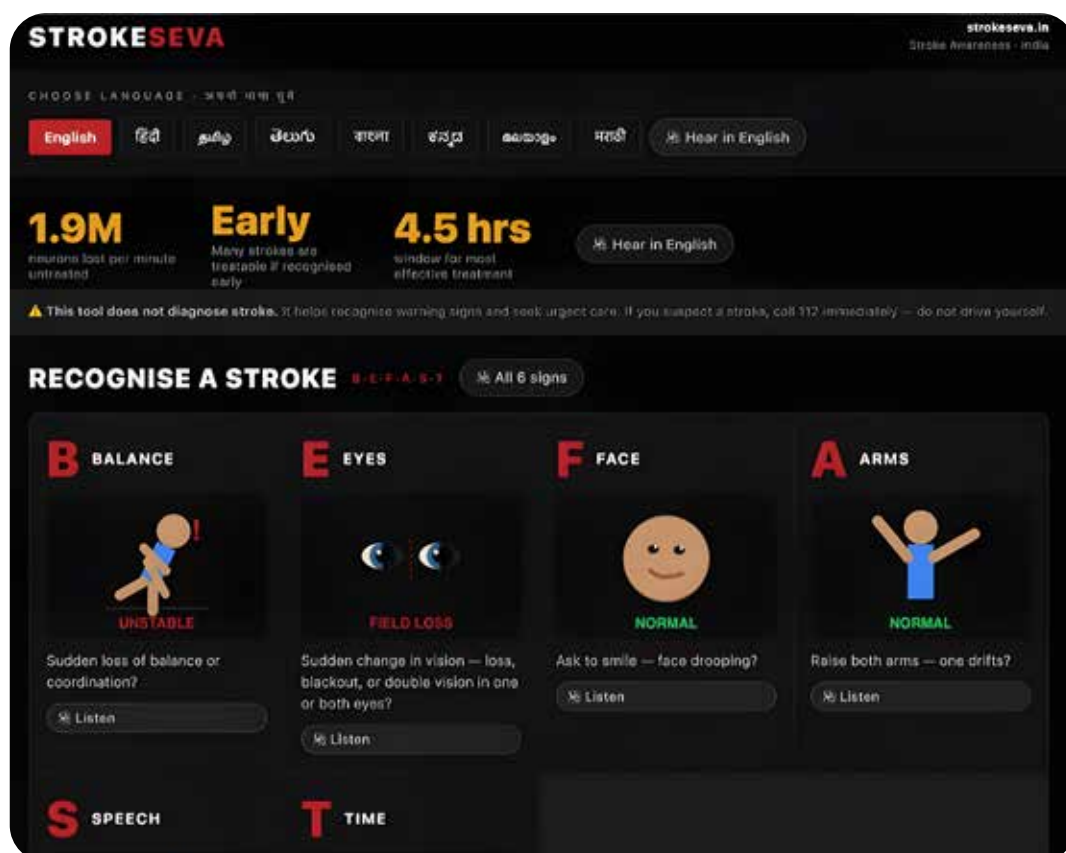
As we reflect on the success and immense educational value of these four engaging sessions, the YNRF is looking forward to an ambitious future. We are thrilled to announce that our academic activities will soon be shifting to our new interactive platform, Communa. This transition marks the beginning of an expansive new chapter for our forum. Utilizing this enhanced digital infrastructure, our core vision is to forge deeper, sustained collaborations with prominent international organizations, including the World Federation of Neuroradiological Societies (WFNRS). By expanding our global footprint and elevating our educational offerings, we are ushering in truly exciting times ahead for the entire ISNR community.

Dr. Shriram Varadharajan. Convenor, YNRF

Dr. Sabha Ahmed (Neuroimaging & Interventional Radiology, NIMHANS) has built and launched StrokeSeva, a free, multilingual stroke-awareness Progressive Web App available at strokeseva.in. Designed to close the language and access gap in stroke education, the app delivers the BE-FAST warning-sign framework through animations and audio narration in eight Indian languages, works fully offline, and guides users through emergency action steps in real time.

The Inspiration Behind StrokeSeva

The idea took shape after too many cases that ended the same way — patients who reached hospital well past the point where treatment could help. Families would often say the same thing: they hadn't realised what they were seeing were signs of a stroke. StrokeSeva was built to close that gap — helping people recognise the warning signs, know what to do in the moment, and understand why every minute before hospital arrival matters, because the first step in saving brain tissue often happens long before a patient reaches the angiography suite.



Key Features

- Free, multilingual Progressive Web App
- BE-FAST warning-sign framework with animations and audio narration
- Available in eight Indian languages
- Works fully offline
- Real-time emergency action guidance
- Accessible at strokeseva.in

Critical Stroke Statistics

- 1.9M strokes per minute worldwide
- Early intervention is key — most effective treatment window is 4.5 hours
- Recognition of warning signs is the crucial first step in saving lives

Access StrokeSeva

Visit strokeseva.in or scan the QR code to access the app and learn the BE-FAST recognition framework in your language.





National ISNR conference 2026, was hosted by PGIMER, Chandigarh at the prestigious Hotel Hyatt Regency in the vibrant city of Chandigarh from 27th to 29th March, it was a truly remarkable and dynamic gathering that set new benchmarks in academic excellence. With an impressive turnout of over 550 enthusiastic participants, the event showcased the expertise of 120+ eminent national faculty and 20+ distinguished international speakers. The scientific program was diverse and impactful.

Key Statistics

550+
Participants

120+
National Faculties

20+
International Faculties

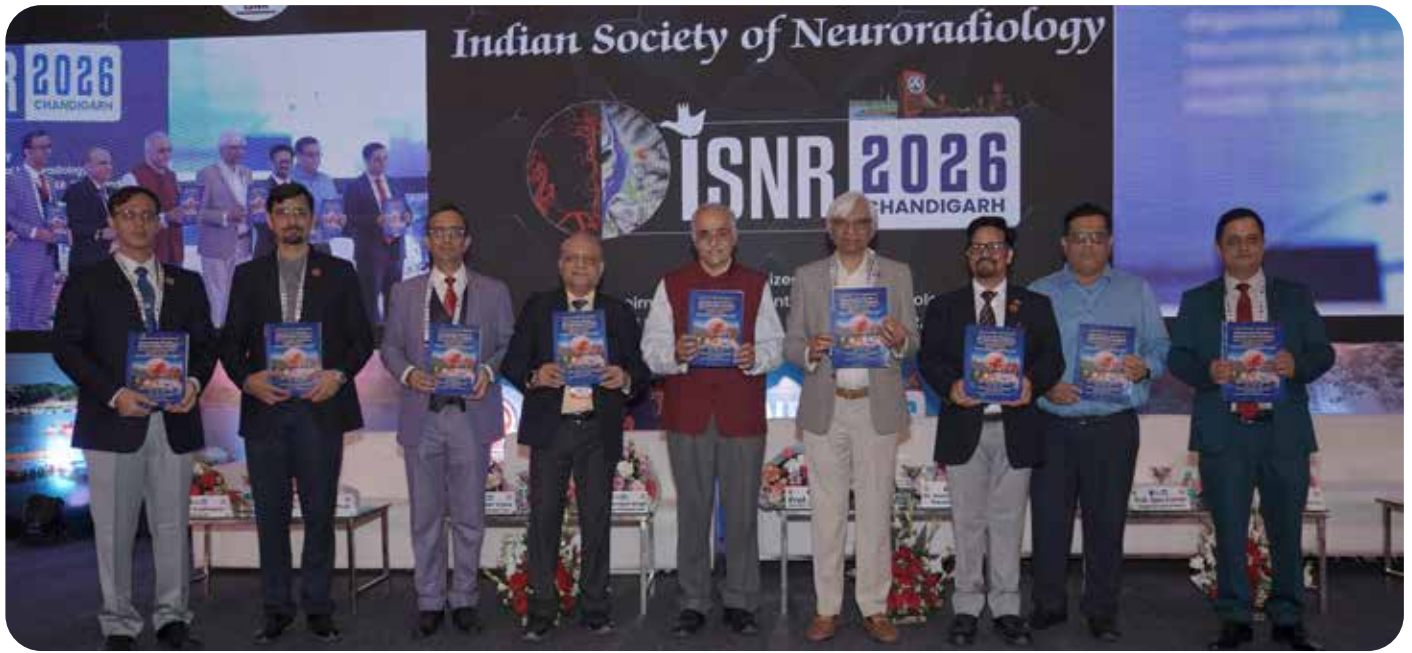
12
CME Credit Hours (Max ever)

Conference Highlights

- Cutting-edge lectures and hands-on workshops
- Basic Life Support workshop by anaesthesia faculties
- Art Gallery showcasing creative expression
- Launch of public education book on brain and vascular disorders and neuro-intervention awareness
- International-standard working lunches with no tea breaks to maximize academic time
- Record-breaking 12 CME credit hours

Closing Statement

ISNR 2026 emerged as an inspiring, innovative, and unforgettable milestone in the field of neuro-intervention.



ISNR Gold Medal – The Society's Highest Honour

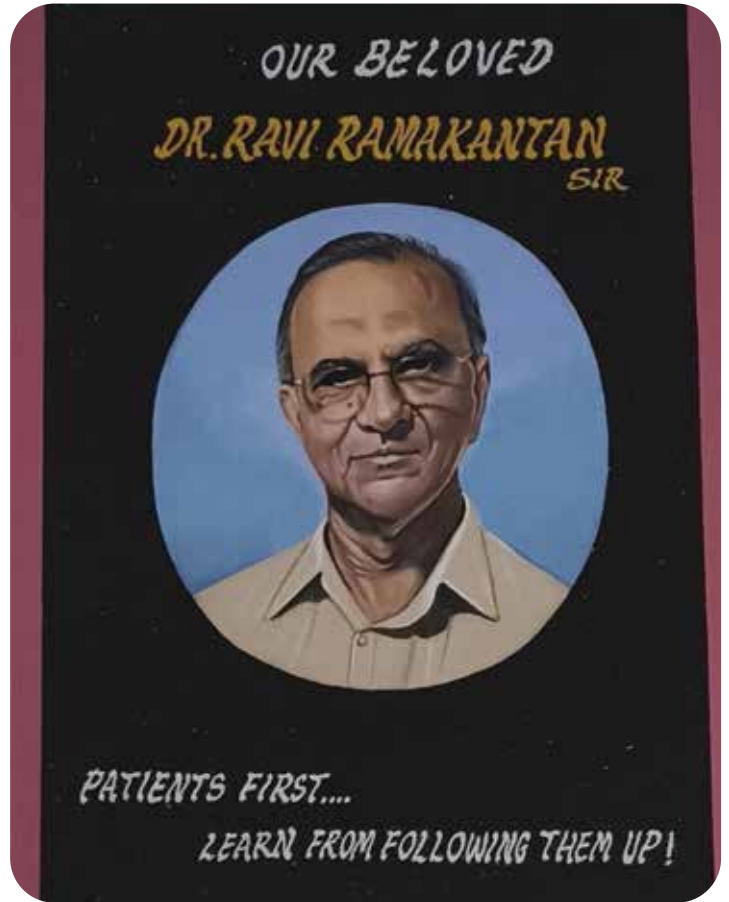


The ISNR Gold Medal, the highest honour of the society, was recently announced at the ISNR National Conference in Chandigarh. To date, it has been presented to two legends and pioneers of Indian neuroradiology. On 11th July 2026, the medal was presented to Prof. V. R. K. Rao at SCTIMST, Trivandrum, and on 18th July 2026, to Prof. Ravi Ramakantan at KEM Hospital, Mumbai. The awards were conferred by ISNR President Dr. Mathew Cherian and Secretary Dr. Navin Mulimani. Both ceremonies were attended by many stalwarts of the field, several of whom have been mentored by these distinguished awardees. This recognition highlights their extraordinary contributions and enduring influence on the growth of neuroradiology in India.

Prof. Dr. V.R.K. Rao



Prof. Dr. Ravi Ramakanthan



About the Award

The ISNR Gold Medal recognises exceptional contributions to neuroradiology in India through clinical excellence, research, service, and mentorship. As the society's highest honour, it celebrates those who have shaped the discipline and inspired generations of neuroradiologists.

ISNR Gold Medal commemorating the society's highest honour for excellence in neuroradiology.

ISNR Mid-Term CME 2026 - Lucknow

Theme: Brain Vascular Malformation of Childhood

The ISNR Mid-Term CME 2026 will be held in Lucknow with the theme "Brain Vascular Malformation of Childhood." Organized by the Indian Society of Neuroradiology (ISNR), the event promises a rich academic program featuring expert lectures, interactive case discussions, oral paper presentations, and e-poster sessions.

Key Scientific Highlights

- Pediatric neuroradiology
- Stroke imaging
- Neurointervention workshops with hands-on training
- Specialized workshops on stroke management, carotid stenting, and endovascular aneurysm treatment

Important Dates

- Abstract Submission Deadline: 20 August 2026 (for oral papers and e-posters in neuroimaging or neurointervention)
- Early Bird Registration: Until 15 August 2026
- Open for: Residents, Delegates, Faculty, and Trade Members

Organizing Committee

- Dr. Vivek Singh – Organizing President
- Dr. Sarfraz Ahmed – Organizing Secretary
- Dr. Dewansh Mishra – Treasurer



ISNR Mid-Term CME - Bhubaneswar

Venue & Dates: AllMS Bhubaneswar, 24th and 25th October 2026

The academic program will be led under the guidance of the organizing committee, ensuring a well-structured and enriching event.

Organizing Committee

- Dr. Suprava Naik – Organizing President
- Dr. Manoj Kumar Nayak – Organizing Secretary
- Dr. T. Seetam Kumar – Organizing Secretary

Celebrating Creative Expression in Neuroradiology

Beyond the intricate world of clinical challenges of complex neuro-intervention procedures and diagnostic imaging, the ISNR community harbors a vibrant pool of creative talent. Our "Art Corner" initiative serves as a unique platform to showcase the artistic endeavors and diverse forms of expression from our members, offering a refreshing perspective on the human element within a highly technical field.

Artist: Dr. Swatee Halbe

A tree stands as the axis of harmony, its branches alive with green vitality while radiant birds encircle it in quiet companionship. Each bird, adorned in vivid patterns, becomes a symbol of diversity woven into unity. The artwork whispers of balance between nature and spirit, where color and form transcend mere decoration to evoke a meditation on coexistence, beauty, and the timeless rhythm of life.

Inspiration

Inspired by an image available on internet and an event of a friend's generous donation to his school to rebuild the school in its new campus. He infused life in the school which gave him footing in life.





Indian Society of
Neuroradiology

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Indian Society of
Neuroradiology
ISNR

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2

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3

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Society notices, first-hand

**Events & webinars**
Register in a tap

**Case & topic discussion**
Diagnostic and intervention

**Newsletter & greetings**
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