ORIGINAL ARTICLE

Association between Serum Uric Acid Levels and Stroke Severity in Acute Ischemic Stroke: A Cross-Sectional Study

Santosh Prasad Shah[1], Dayanand Prasad Sah[2], Bhusan Kumar Subedi[3], Ganga Ram Khatri[2], Himani Poudyal[2], Muneshwar Sah[4], Basanta Kumar Bastola[2], Prabin Gaire[5]

[1] Department of Internal Medicine, Topa PHC, Tilathi Koiladi, Saptari, Nepal
[2] Department of Internal Medicine, Nepal Armed Police Force Hospital, Balambu, Kathmandu, Nepal
[3] Department of Internal Medicine, Bhaktapur Hospital, Bhaktapur, Nepal
[4] Department of Internal Medicine, Koshi Hospital, Biratnagar, Nepal
[5] Department of Pathology, Bheri Hospital, Bheri, Nepal

Corresponding Author:
Dr. Dayanand Prasad Sah
Department of Internal Medicine
Nepal Armed Police Force Hospital
Balambu, Kathmandu, Nepal
Email: dayanandsahdps@gmail.com

Article History:
Received date: July 20, 2025
Revised date: January 16, 2026
Accepted date: June 28, 2026
Published date: August 01, 2026

Online Access

DOI: 10.64772/mjapfn.2.2.13

Abstract

Introduction: Ischemic stroke represents a significant global health burden. Studies have suggested a potential link between serum uric acid levels and stroke risk through mechanisms such as oxidative stress and inflammation. This study aimed to evaluate the association between serum uric acid levels and severity of acute ischemic stroke.

Methods: A hospital based cross-sectional study was conducted in a tertiary care hospital from November 2020 to October 2021, after ethical approval (Reference no:1317/2078/79). The study included adults with acute ischemic stroke confirmed by neuroimaging within 7 days of presentation. The study excluded patients with hemorrhagic stroke, malignancies, those receiving chemotherapy, recent surgery or trauma and medications affecting serum uric acid level. Purposive sampling technique was used for data collection. Serum uric acid levels and National Institutes of Health Stroke Scale scores were calculated to assess stroke severity. Statistical Package for Social Sciences version 25.0 was used for analysis. Descriptive statistics were used to present the data. The association between serum uric acid levels and stroke severity was assessed using Pearson's correlation coefficient and p value <0.05 was considered significant.

Results: Out of 95 patients, 53 (55.79%) were males and 42 (44.21%) females. The mean serum uric acid was 5.18±1.48 mg/dl. Among them, 82 (86.31%) patients had serum uric acid level <6.8 mg/dl. Pearson correlation coefficient was used to assess the association between serum uric acid level and NIHSS score. There was no statistically significant correlation between the two variables ($r = 0.066$, $p = 0.525$, $n = 95$).

Conclusions: This study found no statistically significant association between serum uric acid levels and ischemic stroke severity.

Keywords: *ischemic stroke; national institutes of health stroke scale; serum uric acid; stroke severity.*

How to cite (Vancouver Style)
Shah SP, Sah DP, Subedi BK, Khatri GR, Poudyal H, et.al. Association between Serum Uric Acid Levels and Stroke Severity in Acute Ischemic Stroke: A Cross-Sectional Study. Med J APF Nepal. 2026;2(2):34-41.

Introduction

Acute ischemic stroke (AIS) is defined as the sudden onset of neurological deficits due to insufficient blood flow to the brain, leading to significant morbidity and mortality world-wide.[1,2] While established risk factors such as hypertension, diabetes, and hyperlipidemia play a critical role in stroke pathogenesis, emerging research has proposed an association between serum uric acid (SUA) levels and stroke risk.[3]

SUA, end product of purine metabolism, traditionally considered a waste product, is a clinical indicator of various metabolic disorders such as metabolic syndrome, hypertension, gout, cardiovascular disease and its role as an antioxidant has only recently gained recognition.[4,5] Some studies indicate that SUA may have pro-oxidant or antioxidant properties and may exert neuroprotective effects.[6] In contrast, some studies showed high prevalence of hyperuricemia in ischemic stroke patients, indicating possible role of uric acid as a risk factor of ischemic stroke.[7]

Although some research supports the notion that high SUA levels may predispose individuals to stroke, others suggest a protective effect.[8,9] Given this conflicting evidence, this study aimed to evaluate the association between serum uric acid levels and severity of acute ischemic stroke.

Methods

This cross-sectional study was performed in Bir Hospital, National Academy of Medical Sciences (NAMS) for a period of 1 year (November 2020 to October 2021) after IRB approval of the institution (Reference no:1317/2078/79). The study population were the patients diagnosed with Acute Ischemic Stroke (AIS) admitted in the medicine unit. The sample size was calculated as follows:

$n=(Z^2xpxq)/e^2$ where,

n= Required sample size

Z= Statistics for level of confidence (for 95% level of significance, Z= 1.96)

p= Prevalence of increased SUA in stroke cases (47.3%)[10]

e=Precision or maximum tolerable error

n=1.962x0.473 (1-0.473)/0.12 =95.76

Purposive sampling technique was used. The inclusion criteria were patients of either sex above the age of 18 years with acute ischemic stroke within 7 days of presentation (gait abnormalities, speech abnormalities, facial deviation, paralysis etc) and confirmed by neuroimaging (CT, CT Angiography, MRI). The study excluded patients with hemorrhagic stroke, known malignancies, chemotherapy, recent surgery, trauma, or drugs affecting SUA level. The data were collected using structured proforma and informed written consent was taken from all the patients. The data collection tool comprised socio-demographic variables, co-morbidities like hypertension, diabetes mellitus etc. as well as serum uric acid level and NIHSS score at the time of admission. For all the patients modified National Institutes of Health stroke scale were calculated to access the severity of stroke and severity categorization; there are altogether 11 variables and total score of 42 and according to the score it is categorized as minor, moderate and severe stroke.[11]

Table 1: National Institute of Health Stroke Scale (NIHSS).

SN	Definition	
1.	1a. Level of consciousness	0= Alert, keenly responsive 1= Not alert, but arousable by minor stimulation 2= Not alert, arousable by repeated stimulation 4= Unresponsive or responds only with reflex
	1b. LOC questions (Ask patients the month and her/his name)	0= Answers two questions correctly 1= Answers one question correctly 2= Answers neither question correctly
	1c. LOC commands (Ask patient to open/close eyes and form and release fist)	0= Performs both tasks correctly 1= Performs one task correctly 2= Performs neither task correctly
2	Best gaze (only horizontal eye movements)	0= Normal 1= Partial gaze palsy 2= Forced deviation
3	Visual field testing	0= No visual loss 1= Partial hemianopia 2= Complete hemianopia 3= Bilateral hemianopia

4	Facial paresis (Ask patient to show teeth, raise eyebrows and close eyes tightly)	0= Normal symmetric movement 1= Minor Paralysis 2= Partial paralysis 3= Complete paralysis of one or both sides
5	5a. Motor Function Arm (Right) 5b. Motor Function Arm (Left)	0= No drift 1= Drift 2= Some efforts against gravity 3= No efforts against gravity; limbs fall 4= No movement
6	6a. Motor Function Leg (Right) 6b. Motor Function Leg (Left)	0= No drift 1= Drift 2= Some efforts against gravity 3= No efforts against gravity; limbs fall 4= No movement
7	Limb Ataxia	0= Absent 1= Present in one limb 2= Present in both limbs
8	Sensory (Use pinprick to test arms, legs, trunk and face- compare side to side)	0= Normal, no sensory loss 1= Mild to moderate sensory loss 2= Severe to total sensory loss
9	Best Language (Ask patient to describe Picture, name items, read sentences)	0= No aphasia, normal 1= Mild to moderate aphasia 2= Severe aphasia 3= Mute, global aphasia
10	Dysarthria (Ask patients to read several words)	0= Normal 1= Mild to moderate dysarthria 2= Severe dysarthria
11	Extinction and inattention (Formerly neglect) (Use Visual or sensory double stimulation)	0= No abnormality 1= Visual, tactile, auditory, spatial or personal inattention 2= Profound hemi-inattention or extinction
Total score= 0-42		
National Institute of Health (NIH) Stroke Score		**Stroke severity**
0		No stroke symptoms
1-4		Minor stroke
5-15		Moderate stroke
16-20		Moderate to severe stroke
21-42		Severe stroke

Though the purposive sampling technique made sure that clinically relevant cases were included, selection bias could be introduced because the sample might not accurately reflect the larger stroke population. This may limit the findings' generalizability and compromise their external validity.

Collected data were entered and analyzed using Statistical Package for Social Sciences version 25.0. Analyzed data were presented in the form of tables as mean ± standard deviation for continuous variables and as numbers and percentages for categorical variables. The relationship between uric acid levels and stroke severity, as measured by the National Institutes of Health Stroke Scale (NIHSS), were assessed using Pearson's correlation coefficient. The p-value of less than 0.05 was considered significant.

Results

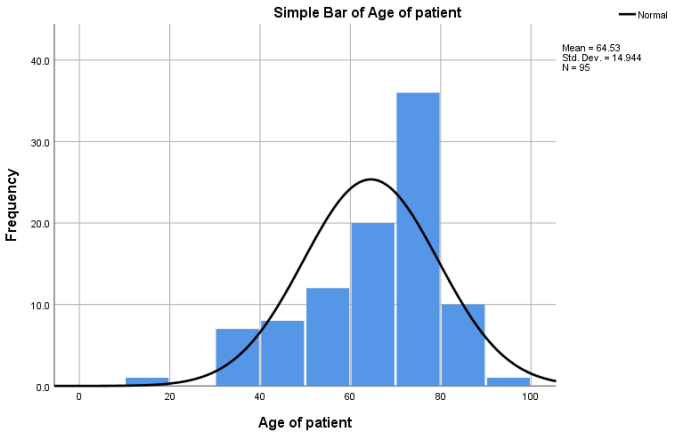

Figure 1: Age Distribution of the Patients with Ischemic Stroke

In this study, the ages range broadly, with most patients clustered between 50 and 80 years old. The mean age of patients with ischemic stroke was found 64.53 years; suggesting the majority of patients in this study are older adults.

Table 2: Characteristics of Patients with Ischemic Stroke (n=95).

Characteristics of Patients		n (%)
Sex	Male	53 (55.79)
	Female	42 (44.21)
Smoking	No	34 (35.79)
	Yes	61 (64.21)
Alcohol intake	No	61 (64.21)
	Yes	34 (35.79)
Diabetes	No	67 (70.52)
	Yes	28 (29.48)
Hypertension	No	43 (45.26)
	Yes	52 (54.74)
Past history of CVD	No	90 (94.74)
	Yes	5 (5.26)
Past history of CAD	No	88 (92.63)
	Yes	7 (7.37)

Out of 95 patients, 53 (55.79%) were males and 42 (44.21%) females. The risk factors of ischemic stroke, smoking 61 (64.21%) ranked the highest followed hypertension 52 (54.74%).

Table 3: Serum uric acid level in patients of Ischemic stroke (n=95).

Uric acid level	Sex	n(%)
<6.8	Male	46(48.42)
	Female	36(37.89)
>=6.8	Male	7(7.37)
	Female	6(6.32)

The mean serum uric acid was 5.18±1.48 mg/dl. Among the total patients, 82 (86.31%) patients had serum uric acid level <6.8 mg/dl. Similarly, 13 (3.69%) patients had serum uric acid level ≥6.8 mg/dl.

Table 4: Serum Uric Acid Level and Severity of Stroke (n=95).

NIHSS grade	Serum Uric Acid Level	
	<6.8	≥6.8
	n(%)	n(%)
mild	1(33.30)	2(66.70)
moderate	77(90.60)	8(9.40)
moderate to severe	-	2(100)
severe	4(80)	1(20)

Among patients with serum uric acid value < 6.8 mg/dl, 1 (33.30%) patient had mild stroke, 77 (90.60%) patients had moderate stroke followed by 4 (80%) severe stroke (Table 4).

Pearson correlation coefficient was used to assess the association between serum uric acid level and NIHSS score. There was no statistically significant correlation between the two variables ($r = 0.066$, $p = 0.525$, $n = 95$).

Discussion

The findings of this study provide insightful perspectives on the demographic and clinical characteristics of patients who presented with ischemic stroke, particularly focusing on age, gender distribution, risk factors and serum uric acid levels.

In this study, the mean age of patients with ischemic stroke was 64.53 years which is similar to the study done in China by Zhang et al. and Yang et al. that showed mean age, 64.6 years, 65.6years respectively.[12,13] However, this value is lesser than that resulted in the study conducted by Arevalo Lorido et al. and Chamorro et al., which showed mean age as 72.4 years and 72.7 years respectively. Such variation may be due to geographical and environmental variation.[14,15] The predominance of elderly patients, specifically those aged 71-80 years aligns with existing literature that highlights age as a significant risk factor for stroke.[16] Aging is the most robust non-modifiable risk factor for incident stroke, which doubles every 10 years after age 55 years.[17]

The study found that males (53) were more affected with ischemic stroke than females (42). Similar male preponderance (52-59%) was seen in other studies.[3,18,19] In contrast, females (54%) were seen more affected than males (45%) in another study.[20] Furthermore the higher incidence of ischemic stroke in males compared to females is corroborated by previous studies, which have inconsistently shown that men are at a greater risk for stroke at younger ages, although this risk converges as both genders age.[21,22] Likewise, in the study there were found the patients with ischemic stroke had smoking behavior

(64%), hypertension (55%), excessive alcohol consumption pattern (36%), diabetes (30%), past Coronary Artery Disease (CAD) history (7.4%), and past Cerebrovascular Disease (CVD) (5.3%). Similar results were found in other studies done in Kohalpur Teaching Hospital and Nepal Medical College Teaching Hospital.[23,24] The predominance of moderate-grade ischemic stroke (85 patients) in our cohort reflects similar trends observed in clinical settings where the severity of stroke correlates with modifiable risks factors such as hypertension, smoking, diabetes.25 Similarly, the high prevalence of hypertension (54%) in our cohort underscores its well-documented role in the pathophysiology of ischemic strokes.[26]

The study found a mean serum uric acid of 5.18±1.48 mg/dl, similar to previous studies done in 2017 and 2013 with 4.98±1.54mg/dl and 5.30±1.64mg/dl respectively but lower with the study (12.36±3.86 mg/dl) done in 2006.[3,27,28]

This study revealed a statistically non significant association between serum uric acid level and NIHSS (p= 0.525) which is similar to one of the previous studies (0.69). However, the study result is contrary to some previous studies that suggested a link between uric acid levels and stroke severity.[29] Likewise, another study found that appropriate uric acid levels in ischemic stroke patients improve outcomes, but can be harmful when too high or low.[30]

This finding indicates that in our samples, serum uric acid may not have a direct impact on stroke severity, which is a noteworthy conclusion. This discrepancy may stem from differences in study populations, sample sizes or methodological variations across research.

In summary, the study sheds light on the demographics and prevalent risk factors associated with ischemic stroke in our cohort, highlighting the importance of tailored intervention strategies for at risk populations. Further research, ideally involving larger samples and diverse populations is warranted to deepen our understanding of the relationship between nature of stroke risk factors.

As this was a single-center study, the findings should be interpreted with caution and may not be generalizable to the broader population. The sample size was calculated using a prevalence formula rather than a formula for assessing the association between serum uric acid levels and stroke severity. Therefore, the study may have been underpowered or overpowered for detecting the observed association, and the findings should be interpreted with caution.

Conclusions

This study found no statistically significant association between serum uric acid levels and ischemic stroke severity as assessed by the National Institutes of Health Stroke Scale (NIHSS) in this cohort of 95 ischemic stroke patients. The predominance of moderate-severity strokes and the low proportion of patients with elevated serum uric acid levels limits the analytic capacity. Though serum uric acid has been proposed as a potential biomarker of oxidative stress in ischemic stroke, definitive conclusions regarding the prognostic utility of serum uric acid in ischemic stroke cannot be drawn from this study alone.

Source of Funding: None

Acknowledgment: None

Conflict of Interest:

The author declares no competing interest. Dr. Himani Poudyal is currently serving as Editor in MJAPFN. She was not involved in the editorial review or decision making for this manuscript.

Author's Contribution and ORCID iDs

Dr. Santosh Prasad Shah: Conceptualization, Methodology, Data Curation, Formal Analysis, Writing

: https://orcid.org/0009-0009-9822-0506

Dr. Dayanand Prasad Sah: Data Curation, Literature Review, Formal Analysis.

: https://orcid.org/0009-0000-4094-4979

Dr. Bhusan Kumar Subedi: Data Curation, Formal analysis, Writing

: https://orcid.org/0009-0004-9192-4117

Dr. Ganga Ram Khatri: Literature review, Formal analysis, Writing

: https://orcid.org/0009-0009-6171-2806

Dr. Himani Poudyal: Literature review, Data analysis, Writing

: https://orcid.org/0009-0002-6486-3502

Dr. Muneshwar Sah: Data Curation and Formal Analysis

: https://orcid.org/0009-0007-4789-133X

Dr. Basanta kumar Bastola: Formal Analysis, Writing

: https://orcid.org/0009-0007-7902-8805

Dr. Prabin Gaire: Formal Analysis, Writing

: https://orcid.org/0000-0002-6368-2198

References

1. Jameson JL, editor. Harrison's principles of internal medicine. Twentieth edition. New York: McGraw-Hill Education; 2018.
2. Pyakurel M, Bhattarai S, Joshi B, Koju RP, Shrestha A. Burden of Stroke in Nepal: Findings from Global Burden of Disease Dataset 2017. Kathmandu Univ Med J. 2021. (CVDs) Special Issue 75(3):11–7. PMID: 35526132
3. Falsetti L, Capeci W, Tarquinio N, Viticchi G, Silvestrini M, Catozzo V, et al. Serum uric acid, kidney function and acute ischemic stroke outcomes in elderly patients: a single-cohort, perspective study. Neurol Int. 2017 Mar; 9(1): 6929. DOI: 10.4081/ni.2017.6920
4. Maiuolo J, Oppedisano F, Gratteri S, Muscoli C, Mollace V. Regulation of uric acid metabolism and excretion. International journal of cardiology. 2016 Jun 15;213:8-14. DOI: 10.1016/j.ijcard.2015.08.109
5. Pasalic D, Marinkovic N & Feher-Turkovic L. Uric acid as one of the important factors in multifactorial disorders--facts and controversies. Biochem Med (Zagreb). 2012;22(1):63-75. DOI: 10.11613/bm.2012.007
6. Glantzounis GK, Tsimoyiannis EC, Kappas AM, Galaris DA. Uric acid and oxidative stress. Current pharmaceutical design. 2005 Dec 1; 11(32):4145-51. DOI: 10.2174/138161205774913255
7. DomínguezZambrano E, PedrazaChaverri J, LópezSantos AL, MedinaCampos ON, CruzRivera C, BuenoHernández F, EspinosaCuevas A. Association between serum uric acid levels, nutritional and antioxidant status in patients on hemodialysis. Nutrients. 2020;12(9):2600. DOI: 10.3390/nu12092600
8. Li M, Hou W, Zhang X, et al. Hyperuricemia and risk of stroke: a systematic review and meta-analysis of prospective studies. Atherosclerosis 2014;232:265-70. DOI: 10.1016/j.atherosclerosis.2013.11.051
9. Wang YF, Li JX, Sun XS, Lai R, Sheng WL. High serum uric acid levels are a protective factor against unfavourable neurological functional outcome in patients with ischaemic stroke. Journal of International Medical Research. 2018 May;46(5):1826-38. DOI: 10.1177/0300060517752996
10. Mehrpour M, Khuzan M, Najimi N, Motamed MR, Fereshtehnejad SM. Serum uric acid level in acute stroke patients. Medical journal of the Islamic Republic of Iran. 2012 May;26(2):66. PMID: 23483825
11. Kwah LK, Diong J. National institutes of health stroke scale (NIHSS). Journal of physiotherapy. 2014 Mar 1;60(1):61. DOI: 10.1016/j.jphys.2013.12.012
12. Zhang X, Huang ZC, Lu TS, You SJ, Cao YJ, Liu CF. Prognostic Significance of Uric Acid Levels in Ischemic Stroke Patients. Neurotox Res. 2016 Jan;29(1):10–20. DOI: 10.1007/s12640-015-9561-9
13. Yang XL, Kim Y, Kim TJ, Jung S, Kim CK, Lee SH. Association of serum uric acid and cardioembolic stroke in patients with acute ischemic stroke. J Neurol Sci. 2016 Nov;370:57–62. DOI: 10.1016/j.jns.2016.09.019
14. Arévalo-Lorido JC, Carretero-Gómez J, Robles Pérez-Monteoliva NR. Association between serum uric acid and carotid disease in patients with atherosclerotic acute ischemic stroke. Vascular. 2018;27(1):19-26. DOI: 10.1177/1708538118797551
15. Chamorro A, Obach V, Cervera A, Revilla M, Deulofeu R, Aponte JH. Prognostic significance of uric acid serum concentration in patients with acute ischemic stroke. Stroke. 2002 Apr;33(4):1048-52. DOI: 10.1161/hs0402.105927
16. Hossain MA, Ahmed M, Mahbubul I, et al. Age-specific incidence and patterns od stroke in Bangladesh: a community - based study. Ann Neurosci. 2018;25(2):55-60. DOI: 10.1016/j.puhe.2018.03.024
17. Fernández-Gajardo R, Matamala JM, Gutiérrez R, Lozano P, Cortés-Fuentes IA, Sotomayor CG, et al. Relationship between infarct size and serum uric acid levels during the acute phase of stroke. Mongin AA, editor. PLOS ONE. 2019 Jul 11;14(7):e0219402. DOI: 10.1371/journal.pone.0219402
18. Wang Z, Lin Y, Liu Y, Chen Y, Wang B, Li C, et al. Serum Uric Acid Levels and Outcomes After Acute Ischemic Stroke. Mol Neurobiol. 2016 Apr;53(3):1753–9. DOI: 10.1007/s12035-015-9134-1
19. Chamorro A, Obach V, Cervera A, Revilla M, Deulofeu R, Aponte JH. Prognostic significance of uric acid serum concentration in patients with acute ischemic stroke. Stroke. 2002 Apr 1;33(4):1048-52. DOI: 10.1161/hs0402.105927

20. Padda J, Khalid K, Padda S, Boddeti NL, Malhi BS, Nepal R, et al. Hyperuricemia and its association with Ischemic Stroke. Cureus. 2021 Sep;13(9):e18172.
DOI: 10.7759/cureus.18172

21. Arboix A, Martinez-Espinosa S. Gender Differences in stroke epidemiology. Adv Cardiovasc Dis. 2009;2 (2)292-302.

22. Feigin VL, Lawes CM, Bennett DA, et al. Worldwide stroke incidence and early case fatality reported in 56 population-based studies: a systematic review. Stroke. 2009; 40(10);200-205.
DOI: 10.1016/S1474-4422(09)70025-0

23. Wu H, Jia Q, Liu G, Liu L, Pu Y, Zhao X, et al. Decreased uric acid levels correlate with poor outcomes in acute ischemic stroke patients, but not in cerebral hemorrhage patients. J Stroke Cerebrovasc Dis. 2014 Mar;23(3):469–75.
DOI: 10.1016/j.jstrokecerebrovasdis.2013.04.007

24. Patil TB, Pasari AS, Sargar KM, Shegokar VE, Bansod YV, Patil MB. Serum uric acid levels in acute ischemic stroke: a study of 100 patients. Journal of Neurology Research. 2011 Dec 25;1(5):193-200.
DOI: 10.4021/jnr71w

25. Appelros P, Stegmayr B, Terent A. Sex differences in stroke epidemiology: a systematic review. Stroke. 2009; 40(4):1080-1088.
DOI: 10.1161/STROKEAHA.108.540781

26. O'Donnell MJ, Xavier D, Liu L, et al. Risk fsctors for ischemic stroke. N Engl J Med. 2010; 363(24):2462-2473.
DOI: 10.1016/S0140-6736(10)60834-3

27. Chiquete E, Ruiz-Sandoval JL, Murillo-Bonilla LM, Arauz A, Orozco-Valera DR, Ochoa-Guzmán A, & et al. Serum uric acid and outcome after acute ischemic stroke: Premier study. Cerebrovasc Dis. 2013;35(2):168–74.
DOI: 10.1159/000346603

28. Hozawa A, Folsom AR, Ibrahim H, Javier Nieto F, Rosamond WD & Shahar E. Serum uric acid and risk of ischemic stroke: The ARIC Study. Atherosclerosis. 2006 Aug;187(2):401–7.
DOI: 10.1016/j.atherosclerosis.2005.09.020

29. Bansal S, Purohit M, Bansal M, et al. The relationship between uric acid level and severity in patients with ischemic stroke J Stroke Cerebrovasc Dis. 2017;26(11):2527-2532.
DOI: 10.1155/2020/2310307

30. Miedema I, Uyttenboogaart M, Koch M, Kremer B, de Keyser J & Luijckx GJ. Lack of association between serum uric acid levels and outcome in acute ischemic stroke. J Neurol Sci. 2012 Aug;319(1–2):51–5.
DOI: 10.1016/j.jns.2012.05.019

Bios

Dr. Santosh Prasad Shah is an MD in Internal Medicine and works as a Consultant Physician at District Hospital Sunsari, Nepal. His clinical interests include internal medicine, diabetes mellitus, hypertension, infectious diseases, and evidence-based patient care. He is actively involved in clinical practice and has a keen interest in medical education and clinical research.

Email: drsantosh15019@gmail.com

Dr. Dayanand Prasad Sah is currently a DM Endocrinology resident at Chitwan Medical College, Bharatpur, Nepal. He has a strong clinical and academic interest in Diabetes, Thyroid disorders, metabolic disorders, and clinical research.

Email: dayanandsahdps@gmail.com

Dr. Bhusan Kumar Subedi is a Consultant Physician and Internal Medicine specialist at Bhaktapur Hospital, Nepal. He completed his MD in Internal Medicine from the National Academy of Medical Sciences, Kathmandu. His clinical and research interests include infectious diseases, diabetes, emergency medicine, and antimicrobial stewardship.

Email: bhusansubedi410@gmail.com

Dr. Ganga Ram Khatri is an MD in Internal Medicine and works as a Consultant Physician at the Nepal Armed Police Force Hospital. His clinical interests include internal medicine, hypertension, neurology, infectious diseases, and evidence-based patient care.

Email: drgrkhatri@gmail.com

Dr. Himani Poudyal is an MD in Internal Medicine and serves as a Consultant Physician at the Nepal Armed Police Force Hospital. Her clinical expertise encompasses the comprehensive management of adult medical conditions, with particular interests in internal medicine, endocrinology, rheumatology, neurology, infectious diseases, and preventive healthcare. She is committed to delivering evidence-based, patient-centered care and is actively engaged in medical education, continuous professional development, and clinical research to advance healthcare quality and outcomes.

Email: drpoudyalhimani@gmail.com

Dr. Muneshwar Sah is an MD in Internal Medicine and works as a Consultant Physician at Koshi Hospital, Nepal. His clinical interests include internal medicine, diabetes mellitus, hypertension, infectious diseases, and evidence-based patient care. He is actively involved in clinical practice and has a keen interest in medical education and clinical research.

Email: drmun2020@gmail.com

Dr. Basanta Kumar Bastola is a consultant Physician of Nepal APF Hospital Nepal. He has completed MD Internal Medicine from Pokhara Academy of Health Sciences. His clinical and research interest includes endocrinology, particularly thyroid disorders, rheumatology and neurology.

Email: basanta2922@gmail.com

Dr. Prabin Gaire is a Consultant Pathologist at Bheri Hospital, Nepal. He completed his MD in Pathology from the Institute of Medicine, Tribhuvan University, Kathmandu. His clinical and research interests include histopathology, cytopathology, hematopathology, and diagnostic pathology.

Email: pgairr@gmail.com