



Sir Ganga Ram Hospital

newsletter

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Symposium on 'Extracorporeal therapies in ICU'



From left to right: Dr S.C. Sharma, Dr Ajay Swaroop, Dr D.S. Rana, Dr B.K. Rao, Dr Anil Gurnani, Dr A.K. Bballa

The concept of extracorporeal therapy was introduced about 100 years ago while investigating devices for renal replacement therapies (RRT). Gradually, with the development in science and technology, extracorporeal devices for supporting other organ systems such as lungs, heart, liver, etc. were also developed. Besides organ support, extracorporeal therapies such as plasmapheresis and adsorptive filters are also used for modulating the disease process in patients with severe disease.

Patients admitted with critical illness in the intensive care unit (ICU) often develop multiple organ failure due to humoral and cellular interactions between organs (organ crosstalk), necessitating the need for multiple extracorporeal organ support. Several devices have been developed that are capable of providing multiple organ support; for example, extracorporeal carbon dioxide removal (ECCO2R) and adsorption filters are often combined with continuous renal replacement therapies (CRRT).

The Institute of Critical Care Medicine, SGRH organized a one-day symposium on 'Extracorporeal therapies in the ICU' in association with the Department of Nephrology on 29 July 2023 under the aegis of the Society of Critical Care Medicine Delhi-Noida Branch (SCCM), ECMO Society of India (ESOI) and the Ganga Ram Institute of Postgraduate Medical Education and Research (GRIPMER). The main objectives of the symposium were to increase awareness and knowledge about the potential uses of various types of extracorporeal organ support and current applications of extracorporeal therapies in modulating various disease processes such as severe sepsis, autoimmune disorders, acute liver failure, etc. Prominent faculty members from critical care medicine and nephrology delivered didactic lectures on plasma

exchange, adsorption therapies, ECCO2R and various modes of RRT. An entire session was dedicated to various aspects of CRRT such as principles and modes of CRRT, prescription, initiation, maintenance/ troubleshooting, anticoagulation, and complications weaning from CRRT. A panel discussion on various aspects of an ICU extracorporeal therapy programme was also organized. The most important point of the panel discussion was how to deliver multiple extracorporeal organ support; for example, how to combine CRRT with ECMO or ECCO2R or adsorption therapies effectively. In the afternoon, a workshop was organized which included four workstations for hands-on experience. Technical teams from Baxter & Fresenius Company participated in the workshop along with their CRRT machines, filters, circuits, replacement, and dialysate fluids. Workshop faculty members were from Critical Care Medicine. The workstations were as follows: (1) Machine, equipment, and fluids for RRT; (2) Prolonged intermittent replacement therapy, intermittent haemodialysis, slow continuous ultrafiltration; (3) CRRT: priming, initiation, troubleshooting, anticoagulation, quality indicators; (4) Non-renal extracorporeal therapies: ECCO2R, plasmapheresis, and various adsorption filters for sepsis, toxins, etc.

The symposium highlighted the need for a multidisciplinary approach with institution-based extracorporeal therapy protocols, training programmes, and dedicated teams of clinicians, technicians and nursing staff for the care of patients receiving extracorporeal therapies.

Compiled by
Dr Rahul Kumar, Consultant
Institute of Critical Care Medicine

7th Sialendoscopy Workshop



The 7th SGRH Sialendoscopy Workshop, held on 8–9 July 2023, marked another milestone in the field of sialendoscopy, bringing together experts, practitioners, and enthusiasts to exchange knowledge, innovations and experiences. Hosted by the prestigious SGRH in New Delhi, India, this two-day event showcased the latest advancements in the diagnosis and treatment of salivary gland disorders through sialendoscopy.

Sialendoscopy, a minimally invasive procedure used to diagnose and treat various salivary gland conditions like salivary stones, salivary strictures and systemic conditions such as Sjogren syndrome, has rapidly evolved over the years. The SGRH Sialendoscopy Workshop series has been at the forefront of this evolution, facilitating the dissemination of knowledge and fostering collaboration among professionals in the field.

The workshop drew a diverse and global audience, featuring participants from various countries. This international representation enhanced the richness of discussions and the sharing of best practices.

Attendees had the opportunity to participate in practical workshops, honing their skills and gaining a deeper understanding of sialendoscopy techniques. These hands-on sessions were a favourite among participants, offering invaluable experience for both beginners and experienced practitioners. Hands-on sessions included set up of the sialendoscope, practising endoscopy on 3D printed anatomical models and use of Holmium Laser to break down large stones within simulated conditions.

The faculty included Dr Varun Rai (SGRH), Dr P.P. Singh (Delhi), Dr Milind Navalakhe (Mumbai) and Dr Bini Faisal (Kochi). Twelve cases were operated upon as part of live surgery, which was enthusiastically received by the audience. Interspersed between the surgeries, academic lectures were taken by host faculty comprising Dr Neeraj Jain (Rheumatology), Dr Samarjit Ghumman (Radiology), Dr Manish Munjal (ENT) and Dr Raghav Seth (Interventional Radiology).



SGRH is the first private hospital in North India to offer the branch of sialendoscopy for minimal access treatment for obstructive salivary gland diseases. Over the years, the sialendoscopy branch led by Dr Varun Rai has successfully treated more than 800 such cases, further establishing the hospital as one of the highest volume centres in the entire country.

Compiled by Dr Jatin Verma, Department of ENT

Condolence Letter



The members of the Board of Trustees, Board of Management (BOM), Consultants and Employees of Sir Ganga Ram Hospital express their deep sorrow at the sad demise of Dr Indrani Ganguli.

The BOM and its members, in remembering her significant contribution to Sir Ganga Ram Hospital, BOM and the Institute of Obstetrics and Gynaecology want to share deep sorrow and a feeling of loss with the family members and friends of Late Dr Indrani Ganguli.

Dr Indrani Ganguli was a fine human being and a good surgeon with vision. She was a passionate person to achieve her goals who set an example of hard work, honesty, integrity and transparency. She was a great friend of her colleagues both senior and junior.

We convey our heartfelt condolences to all the members of the bereaved family and pray to the Almighty God to rest her soul in peace.

Dr D.S. Rana
Chairman, Sir Ganga Ram Trust Society

Dr Ajay Swaroop
Chairman, Board of Management

Hyperreactio luteinalis in pregnancy

Introduction

Hyperreactio luteinalis (HL), a rare benign condition of pregnancy, is typically seen in 3rd trimester. It is triggered by very high endogenous or exogenous β -hCG stimulation. It is characterized by gross cystic enlargement of ovaries. The ovaries show a significant enlargement. Bilateral theca lutein cysts are seen in females with molar pregnancy (50%), trophoblastic disease (10%–22%) and chorioamnionitis (10%). It is also seen in pregnancies with large placenta (multiple pregnancy, Rh sensitization) and PCOD (increased sensitivity of stroma to β -hCG). Other associations are – diabetes mellitus (DM) and ovulation induction.¹ Genetic predisposition: abnormal sensitivity of the hCG receptor due to a gene mutation can lead to HL in a spontaneous singleton pregnancy. High levels of hCG are seen (multiple pregnancy, molar pregnancy, chorio or hydrops).² HCG is involved in: cytotrophoblastic differentiation, propagation of angiogenesis of uterine vessels, fetal growth and organ formation. Abnormally raised levels of β -hCG lead to congenital anomalies 3.5%, pre-eclampsia 19%, IUGR 32% and abnormal genital development.³

The case

A 34-year-old, booked patient G2A1 with 35 weeks pregnancy came to the gynaecology OPD with complaints of pain abdomen. Her previous menstrual cycles were regular and the pregnancy was dating on ultrasound. She had a history of a missed abortion 3 years back and she was trying to conceive after that and taken multiple cycles of ovulation induction drugs and underwent 3–4 cycles of IUI and the last cycle was 1 year back, and this pregnancy was a spontaneous conception. She was found to have PCOD during her infertility workup. In this pregnancy, 1st trimester screen was low risk. She gave a history of hoarseness of voice, hirsutism and new onset acne during the second trimester. Fig. 1 shows her routine USG at 34 weeks.

Fused placenta was seen in the anterior upper segment, liquor

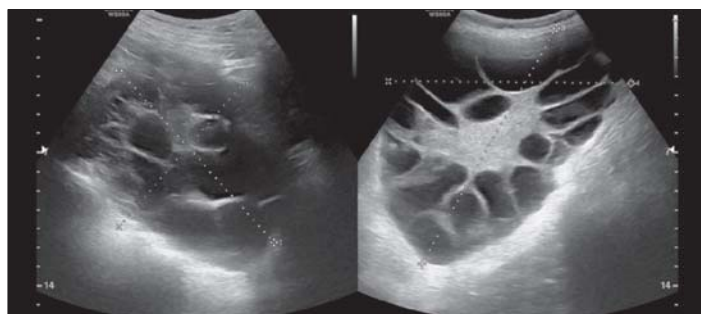


Fig. 1. DCDA twins live fetus at 34 weeks POG

was adequate, there was no GCA and doppler flow was normal. Note was made of bilateral enlarged ovaries, right ovary 12×7 cm, left ovary 14×6.9 cm. Both ovaries showed multiple enlarged thin-walled cysts, largest measuring 4.5×3.8 cm in the left ovary. Also both ovaries showed more than 10 locules with thick septa and anechoic cyst fluid. The cyst wall was regular. On colour doppler, vascularity was raised in both ovaries suggestive of ovarian hyperstimulation syndrome (colour score: 3).

At 35 weeks, she was admitted with labour pains and underwent LSCS in view of forecoming breech and delivered twins, a male and a female baby of weight 2.110 kg and 2.115 kg, respectively.

Intraoperatively, bilateral ovaries were found grossly enlarged with multiple cyst suggestive of hyperreactio luteinalis. A decision was made to preserve the ovaries and manage them conservatively.

Total testosterone: 1972 [POD 3] and 46.8 [POD 42] normal 14–76 ng/ml. She was followed up with serial ultrasound scans during her postoperative period, which showed a gradual decrease in the size of bilateral ovaries and subsequently her hoarseness of voice, hirsutism and acne also improved.

Discussion

A study published in 2015, conducted the largest review to date of HL in the English literature drawing on cases from PubMed between 1993 and 2014. This yielded 58 pregnancies. Of these, 81% were singleton (93.1% spontaneously conceived) with 66.7% occurring in primiparous women; 93% of patients showed spontaneous conception; maternal virilization and fetal virilization were seen in 29% and 3.5% of cases, respectively.⁴ The associated comorbidities were PCOS 6.9%, hypothyroid 3.4% and hyperthyroid 8.6%. The adverse events found were pre-eclampsia 19% and GDM 5%. 36% of patients underwent surgery due to acute complications and due to suspicion of malignancy (76% of cases). Fetal anomalies were seen in 3.4% of cases, preterm deliveries in 37% of cases and

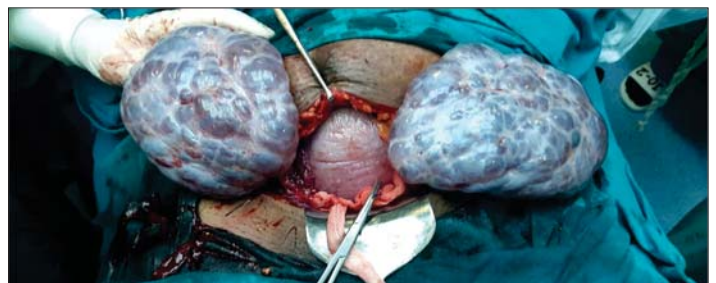


Fig. 2. DHEA: S 63 SHBG: 78.5 [POD 9] and 63.6 [POD 43]
Normal 11.70–137.20

FGR in 31% of cases. The mode of delivery was 50% vaginal deliveries and 50% LSCS. The sex distribution was: female 70% and male 26%. Early pregnancy loss was seen in 4% of cases.

Symptoms of hyperemesis gravidarum or hyperthyroidism have been reported and are usually not related to hyperreactio luteinalis but are provoked by the underlying problem that is causing high levels of β -hCG (trophoblastic disease, multiple pregnancy). The prognosis of this benign condition is good and in the postpartum period theca lutein cysts usually regress spontaneously.⁵

Virilization due to hyperandrogenism can occur in as many as 25% of affected patients. Maternal virilization is seen in 30.5% cases in the form of hirsutism, acne, temporal balding, clitoromegaly and deepening of voice. Female fetal virilization occurs if hyperandrogenism occurs between 7 and 12 weeks POG, it leads to labioscrotal fusion and clitoral hypertrophy.⁶

It is important to differentiate between hyperreactio luteinalis and OHSS (ovarian hyperstimulation syndrome) as they both differ in management but have similar ultrasound presentation. Hyperreactio luteinalis is mainly seen with molar pregnancy, PCOS and DM. It is generally seen in 2nd and 3rd trimester, has less acute indolent clinical course and maternal virilization is common.

OHSS is however exclusively associated with ovulation induction, in the luteal phase. It is seen in early 1st trimester. It is associated with significant fluid and electrolyte imbalances, ascites, hypovolemia and thrombosis. Enhanced knowledge of the characteristics and evolution of HL and the availability of reliable ultrasound should allow clinicians to make the diagnosis with confidence and avoid unnecessary surgical treatment. Surgical intervention should be reserved for acute complications (i.e. rupture of cysts, ovarian torsion and haemorrhage).⁷

Diagnosis

USG diagnosis

(1) large bilateral ovarian masses, (2) spoke wheel appearance, (3) thin-walled small theca lutein cysts, (4) large number of locules with thick walls, and (5) solid tissue.

HPE

- hypertrophy and luteinization of granuloma and theca interna layer

Inhibition of lactation

About 30–35-day delay in lactation noted; testosterone level of approximately 300 ng/dl or less is required for successful milk production.⁸

Postpartum

High maternal levels of both β -hCG and testosterone, as in HL, have been associated. Maternal virilization is rare; with delayed lactation. Early involvement of a lactation consultant and nipple stimulation

strategies are essential components of the postpartum management of these patients. Our patient had transient delay in lactation and low milk supply.

Conclusion

Patients presenting after the first trimester of pregnancy with bilateral multicystic ovaries with a 'spoke wheel' appearance on sonogram, hyperandrogenism, abnormally elevated β -hCG or symptoms consistent with elevated β -hCG should prompt a possible diagnosis of HL.

An understanding of the natural history of this condition and targeting conservative management is paramount in minimizing unnecessary iatrogenic harm to patients. Close monitoring with ultrasound examinations antepartum and postpartum to ensure return to normal ovarian architecture is recommended.

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Case Report 2

Resection of a carinal tumour

Introduction

Carinal resection and reconstruction is a complex and aggressive surgical procedure performed for carinal and trachea–bronchial tumours. They should be performed by highly experienced thoracic surgeons with perfect coordination between the surgeon and the anaesthetist for intraoperative airway management. Proper selection of patients can improve long-term survival and minimize postoperative complications. We present a case of carinal tumour and its surgical management.

The Case

A 36-year-old man presented with audible wheeze in the right side of the chest with streaky haemoptysis for the past 2 months. Physical examination was unremarkable except wheeze was audible on auscultation. Chest X-ray showed a bulky right hilum. CT thorax showed a mass at the carinal level just at the opening of the right main bronchus, partially obliterating the lumen (Fig. 1). Bronchoscopy showed a lobulated mass involving the carina and opening of right main bronchus (Fig. 2). Bronchoscopic biopsy from the mass showed adenoid cystic carcinoma. PET-CT showed an FDG-avid lesion at the carina with the right main bronchus extension with no mediastinal lymph node activity and no metabolic activity at any other sites.

The patient was planned for resection and anastomosis. Laboratory tests were unremarkable. PFT showed good lung function.

The patient was intubated with a single lumen 8F endotracheal tube and kept above the mass. Median sternotomy was done. The aorta, SVC, brachiocephalic vein and the right pulmonary artery dissected, looped and retracted. The lower end of the trachea, right main bronchus was also looped (Fig. 3). The lower end of the trachea just above mass was divided circumferentially along with

division of the left and right main bronchus. Cross-table ventilation was done through the right main bronchus. The lower end of the trachea was then anastomosed with the proximal end of the left main bronchus using vicryl 3-0 in continuous fashion (Fig. 4). The endotracheal tube was then passed through the trachea into the left main bronchus. A window was then created over the lower end of the trachea above anastomosis, which was done between the lower trachea and the proximal right bronchus in the end-to-side fashion using vicryl 3-0 in a continuous layer (Fig. 5). The endotracheal tube was pulled back to the lower part of the trachea and the leak test was performed. Haemostasis was achieved, drains placed in the mediastinum and the right pleural cavity and sternotomy closed with sternal wires. Guardian stitches were applied.

Postoperatively, the patient's recovery was uneventful and he could be discharged on postoperative day 5. Biopsy showed adenoid cystic carcinoma with negative margins, lymph nodes (level 7 and 2) were negative. The patient was followed up for 3 years with no recurrence.

Discussion

Neoplasms involving the carina and/or proximal main bronchus without systemic or lymphatic metastases are uncommon and usually present in advanced stages.¹ The surgical options include carinal resection and reconstruction or sleeve pneumonectomy. Carinal resection and reconstruction is mainly indicated for centrally located, low-grade and small tumours of the carina not extending to the main bronchi. The most common indication for a sleeve pneumonectomy is a tumour involving the origin of the main bronchus or extension into the lower trachea. The choice of sleeve pneumonectomy or carinal resection depends mainly on the surgeon's preference and experience and also radiological features.

Lung parenchyma must be preserved as much as possible if



Fig. 1. Preoperative CT thorax showing mass at the level of carina



Fig. 2. Bronchoscopic view of carinal tumour

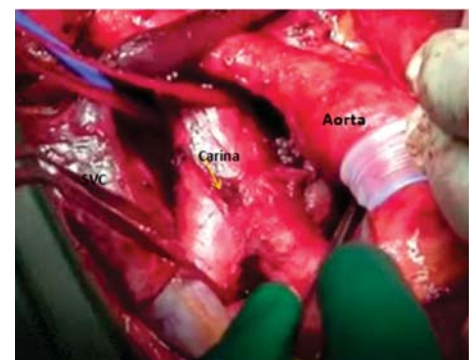


Fig. 3. Intraoperative view of carina in relation to great vessels

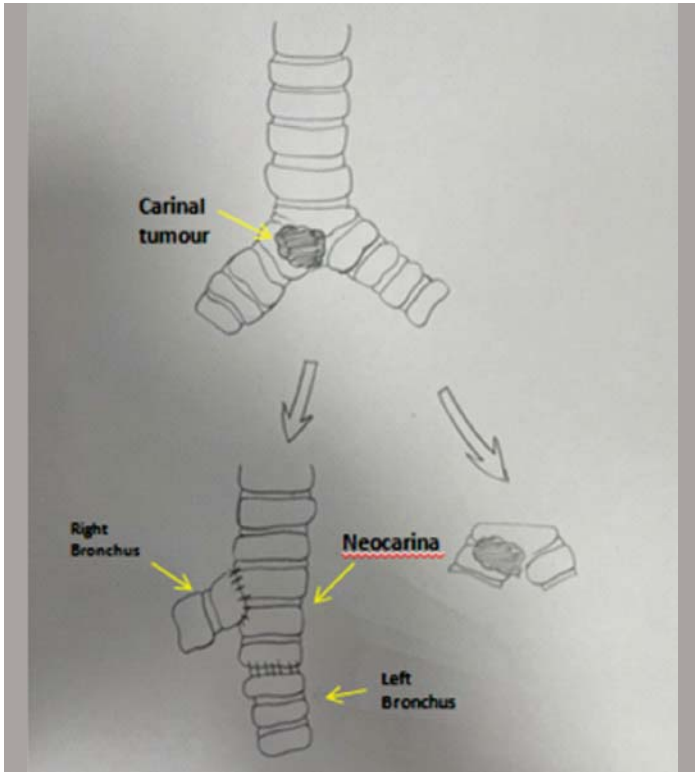


Fig. 4. Schematic diagram showing intraoperative plan of carinal resection and anastomosis

oncologically acceptable and anatomically possible. Various methods for carinal reconstruction have been reported, including: the double-barrel method; end-to-end left main bronchus with trachea and end-to-side right bronchus intermedius to trachea; end-to-end left main bronchus with trachea and end-to-side right bronchus intermedius to the left main bronchus; and end-to-end right main bronchus with trachea and end-to-side left main bronchus to the right main bronchus.² In our case, the left main bronchus was anastomosed to the trachea and right main bronchial end-to-side of the trachea. It is important to reduce tension on the anastomotic site and maintain sufficient blood flow. The release manoeuvres (e.g. inferior pulmonary ligament release, inferior U-shaped hilar release, pericardiophrenic release) are mandatory.

There are various approaches for carinal resection and reconstruction. We performed Median sternotomy in this case, however it can also be approached via right thoracotomy through 4th or 5th intercostal space, clamshell or hemiclammshell. The left thoracotomy approach is difficult due to the left-sided aortic arch.

Maintaining ventilation is an important step in this surgery. A perfect coordination between the surgeon and the anaesthetist is required.

The mortality rate following carina resection and reconstruction ranges between 3% and 20% with an overall morbidity rate of 11% to 50%.¹ Anastomotic complications vary from granulation tissue, necrosis, mucosal sloughing, micro-fistula to life-threatening

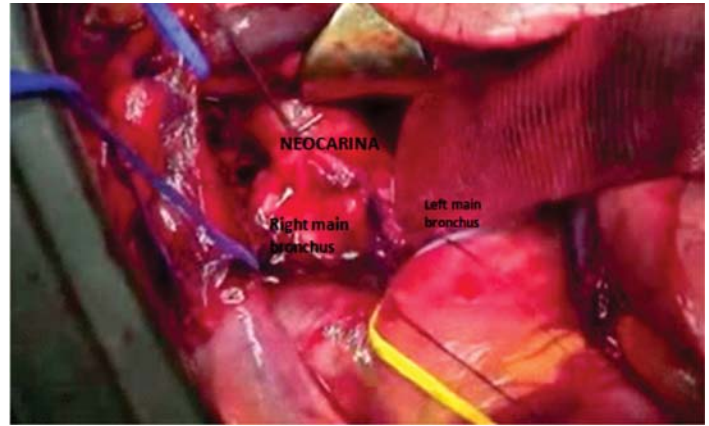


Fig. 5 Intraoperative view after formation of neo carina

dehiscence of the anastomosis. Preoperative radiotherapy is an important risk factor for anastomotic dehiscence and formation of bronchopleural fistula. Sleeve pneumonectomy is also associated with such complications with acute respiratory distress syndrome (ARDS), which is a life-threatening complication in up to 20% of cases. Ventilator-induced injury and fluid overload during surgery are also referred as the risk factors. Airway resection limited to 4 cm, avoidance of bronchial devascularization, precise anastomotic suture technique and careful handling of tissues are key factors in preventing anastomotic problems.³

Conclusion

Resection and reconstruction of carinal tumours requires a highly specialized team of thoracic surgeons, anaesthetists and operative staff because of the complex nature of the procedure. Careful patient selection, operative planning, and execution of the procedure is required for optimal results.

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HOSPITAL NEWS



Dr D.S. Rana, Chairman, Sir Ganga Ram Hospital Trust Society and Chairman, Institute of Renal Sciences and Dr A.K. Bhalla, Joint Secretary-cum-Treasurer, Board of Management, SGRH and Chairman, Department of Nephrology were honoured with the 'Doyens of Nephrology' award for their immense contribution and pioneering work in haemodialysis, peritoneal dialysis and vascular access at the International Society of Hemodialysis Conference held at Mumbai on 7 July 2023. In the photo above, Professor Kumud Gupta, Paediatric Nephrologist, Mumbai is giving award to Dr Rana and Dr Bhalla.



Dr Shyam Aggarwal, Senior Consultant, Department of Medical Oncology, SGRH received The Economic Times Award for the 'Inspiring Oncologist of India' from Deputy Chairman Rajya Sabha, Shri Harivansh Narayan Singh on 1 July 2023. Dr Shyam Aggarwal also received the 'Super Achiever' award at the 3rd Dr Advani Legendary Oncology Series meeting in Mumbai on 16 July 2023.

Professor Jayashree Sood, Chairperson, Institute of Anaesthesiology, Pain and Perioperative Medicine, and Honorary Secretary, Board of Management, SGRH was felicitated as an outstanding senior teacher in Anaesthesia by the national and Delhi state branch of the Indian Society of Anaesthesiologists at the annual conference of the Delhi state chapter on 2 September 2023.

Ultrasound-guided Regional Anaesthesia Workshop

The Institute of Anaesthesiology, Pain and Perioperative Medicine (IAPPM), under the guidance of Dr Jayashree Sood, Chairperson, IAPPM and Honorary Secretary, Board of Management, SGRH; Dr Anil Jain, Co-Chairman, IAPPM; Dr Pradeep Jain, Vice-Chairman and Director, Pain Medicine, IAPPM; and Dr Bimla Sharma, Vice-Chairperson, IAPPM and Chairperson, Department of Palliative Medicine have conducted one of its kind 'Ultrasound-guided Nerve Block' training programme in India and abroad. A series of 15 online webinars preceded the 2 days of extensive Ultrasound-guided Regional Anaesthesia workshop held on 15–16 July 2023.

The workshop was inaugurated by Dr D.S. Rana, Chairman, Sir Ganga Ram Hospital Trust Society; Dr Ajay Swaroop, Chairman, Board of Management, SGRH; and Dr Anil Bhalla, Joint Secretary-cum-Treasurer, Board of Management, SGRH. Stalwarts of anaesthesia from various prestigious hospitals were present to conduct the course. It was attended by over 90 faculty and 200 delegates from across the country. The workshop included masterclasses from experts, live demonstration of blocks from OT on patients and hands-on practice on volunteers. The 'Indian Diploma in Regional Anaesthesia (IDRA)' exit examination was conducted at the end of workshop. The programme aims to spread awareness about 'Pain-free hospital' and 'Opioid-free postoperative period'.



Dr Pankaj Garg, Senior Consultant, Department of Neonatology, Institute of Child Health, SGRH was awarded the 'Vishisht Chikitsak Award' by the Indian Academy of Pediatrics (LAP), during the LAP North Delhi Annual day celebration on 30 July 2023.

A CME on 'Challenges during Congenital Cardiac Intervention' was organized by the Department of Paediatric Cardiac Sciences, SGRH on 5 August 2023.

Dr Rajeev B. Abuja, Senior Consultant, Department of Plastic Surgery, SGRH; Dr Pankaj Garg, Senior Consultant, Institute of Child Health, SGRH; Dr Sandeep Aggarwal, Senior Consultant, Institute of Vascular Surgery, SGRH; and Dr Saurabh Taneja, Consultant, Department of Critical Care Medicine, SGRH were awarded the 'Vishisht Chikitsa Ratan Award' on the occasion of Doctors Day by the Delhi Medical Association on 1 July 2023.

The Economic Times felicitated Sir Ganga Ram Hospital as one of the 'Best Healthcare Brand of Year 2023'.

Dr Harsba Jaubari, Senior Consultant and Chairperson, Department of Renal Transplant was conferred the 'Lifetime Achievement Award' by Dr Mansukh Mandaviya, Honourable Minister of Health and Family Welfare, Government of India on 3 August 2023 on the occasion of the 13th Indian Organ Donation Day 2023.

Dr C.S. Agarwal, Senior Consultant and Chairman, Department of Neurology, SGRH was awarded the 'Legends of India Award' at the Economic Times Doctors Day Conclave on 30 June 2023.

World Breastfeeding Week from 1 to 7 August was celebrated by the Department of Neonatology, Institute of Child Health, SGRH on 2 August 2023.

9th DAAS (Dermatology And Allied Specialties) Summit

On 28–30 July 2023, the 9th DAAS (Dermatology And Allied Specialties) Summit was organized with the theme 'Practic(s) Dermatology Sans Doubt' in an attempt to make learning easier and interesting. The DAAS Summit focused on multidisciplinary learning and brought together top researchers and professionals from the fields of dermatology, immunology, rheumatology, microbiology, internal medicine, intensive care, endocrinology, gynaecology, paediatrics, plastic surgery and many more.

Several faculty members from SGRH such as Dr Ambrish Satvik, Ruma Satvik, Dr Manu Gupta, Dr Neeraj Jain, Dr Anubhav Gupta, Dr Rajeev Mehta, Dr Soumya Tandon, Dr Manish Malik, Dr Atul Gogia and others participated and enlightened the dermatology fraternity regarding their specialty while treating clinical dermatology cases. Over the past 9 years, the DAAS Summit has exalted its name for being a conference where dermatologists get to learn from various medical and surgical specialists and treat their cases more comprehensively and effectively. Faculty from SGRH helped dermatologists from all across the world in treating their patients in a better manner by engaging in keynote speeches, panel discussions and workshops



with the idea that the road to knowledge is via people, conversations, connections and relationships.

Observing and learning from the experts was a very gratifying experience for the delegates and also for the faculty who seek pleasure from spreading their knowledge and experience to the keen learners.

The Rheumatology and Arthritis Foundation (RAAF) under the patronage of Dr Ved Chaturvedi, Senior Consultant, Department of Rheumatology, SGRH and President of RAAF hosted the Ankylosing Spondylitis assembly on 13 August 2023. The meeting was inaugurated by Dr D.S. Rana, Chairman, Sir Ganga Ram Hospital Trust Society. The assembly was attended by

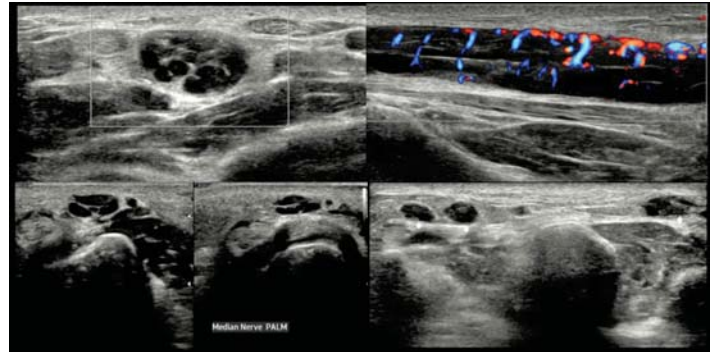
leading rheumatologists from across the country including Dr Lalit Duggal, Chairman, Department of Rheumatology, SGRH and Dr Neeraj Jain, Senior Consultant, Department of Rheumatology, SGRH. The attendees shared insights into the latest advancements, innovative techniques, and therapeutic approaches in the management of ankylosing spondylitis.

Images

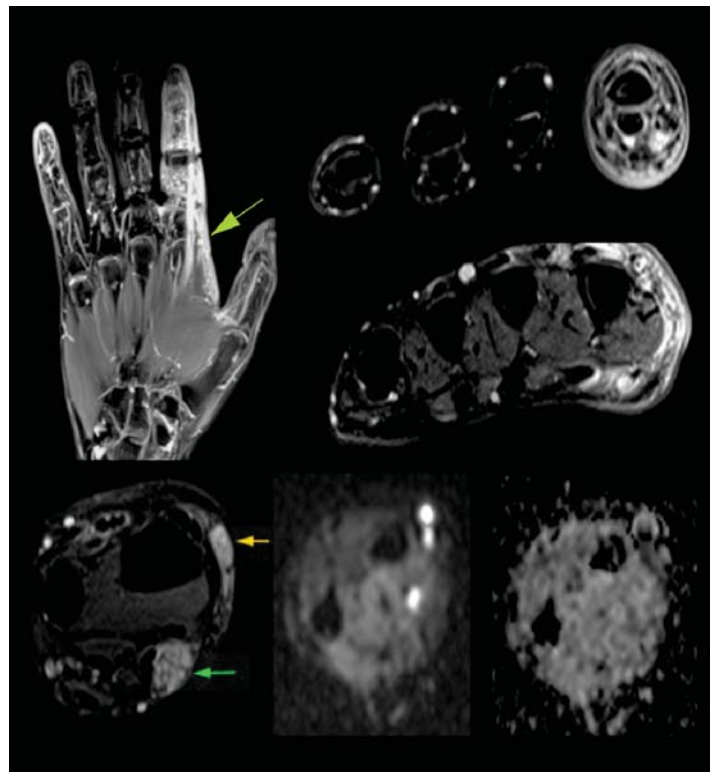


CT coronary angiography of a 45-year-old man who presented with sudden onset pain. CAC=0. VR, 3D globe and curved MPR images reveal critical (99%) stenosis mid LAD (CAD-RADS 4a).

A 24-year-old man presented with soft tissue swelling in the right thumb and index finger with associated parasthesia.



On ultrasonography, there was enlargement of the entire median nerve with thickened fascicles seen associated with increased internal vascularity. Thickening of digital branches of the median nerve was also noted.



Long segment thickening of the median nerve, distally extending till digital branches of the thumb and index finger (more on radial aspect), which is a hyperintense signal on PDFS, TIRM and with true diffusion restriction.

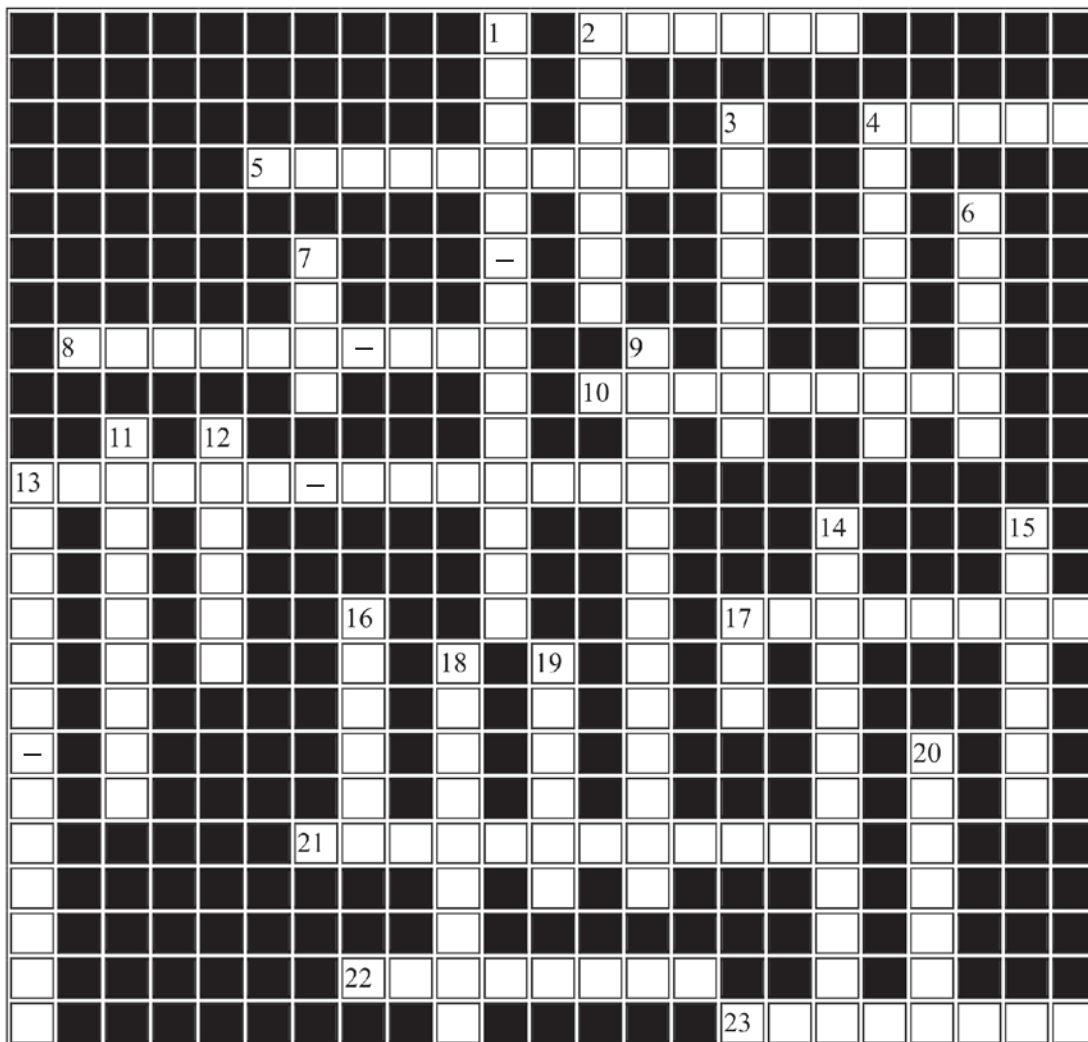
On skin biopsy, findings were suggestive of 'Borderline tuberculoid leprosy'.

Contributed by Department of MRI & Ultrasound



The Arunachal Pradesh government has inked a tripartite memorandum of understanding (MoU) with Sir Ganga Ram Hospital and Religare Enterprises Ltd to strengthen the tertiary healthcare services of the state. According to the MoU, the state government will work with SGRH and aided by Religare, for strengthening tertiary care health services of the state. The technical advisory support would cover various areas of the healthcare ecosystem including the work on addressing the skill gap in specialized branches of medical care. The initiative would involve establishing a Centre of Excellence for renal sciences at the Tomo Riba Institute of Health and Medical Sciences (TRIHMS), the first medical college in the state.

Newsletter Crossword



Across

2. A sign where percussion over a nerve elicits a tingling sensation (6)
4. Fast and rapid prefix (5)
5. Baby born in a plastic-like wrap (9)
8. Toe is bent at the middle joint, used for hitting things (6-3)
10. This agent comes and tells the uterus – 'Please slow down your efforts' (9)
13. Strong feeling of fear or worry, term coined by cartoonist Billy Dibeck (6-7)
17. In final stages people arriving at the airport (8)
21. Fearing pleasure (12)
22. A sauce for salads, used to cover and protect a wound (8)
23. An embrocation with oil for rubbing to relieve pain (8)

Down

1. This law states that the genetic variation in a population will remain constant from one generation to the next in the absence of disturbing factors (5-8)
2. Syndrome due to changes in the gene CACNA1C characterized by

cardiac, arrhythmia, syndactyly, autism and intermittent hypoglycaemia (7)

3. A gene in two or more species that has evolved from a common ancestor (8)
4. A syndrome of repetitive blinking or clearing of throat (8)
6. Baby breaking the rules and coming out feet first (6)
7. Central part of an organism or fruit (4)
9. Cause of egg smelling foul breath (13)
11. An agent that disturbs the development of fetus or embryo (9)
12. Uterus that tilts towards the back (6)
13. Painful disability where big toe is bent laterally overlapping the second toe (6-6)
14. A female trying to develop male traits (12)
15. Wall thickness more than 2.5 mm indicates outlet obstruction (7)
16. A curse when the CNS fails to control breathing while asleep (6)
17. An identification mark of a small outgrowth (3)
18. Feeling pain (9)
19. A drink specially of medicine, poison or some magic beverage (6)
20. An ineffective medicine produced by an unqualified person to bring about some social or political reform (7)

Created by Dr P.K. Pruthi, Director, Institute of Child Health

Pearls of Wisdom

What is worth doing, Is worth doing well.

*Dr Samiran Nundy, Emeritus Consultant
Institute of Surgical Gastroenterology, GI and HPB Onco-Surgery and Liver Transplantation*

NEW ENTRANTS

Dr Bhawani Shekhar *Obstetrics and Gynaecology Associate Consultant (Ad hoc) 17.07.2023*
Dr Ajay Aggarwal *Endocrinology Senior Consultant 17.07.2023*
Dr Purvi Khandelwal *Obstetrics and Gynaecology Associate Consultant 20.07.2023*
Dr Bhavdeep Kaur *Paediatric Cardiac Anaesthesia Associate Consultant 01.09.2023*
Dr Anivita Aggarwal *Medicine Associate Consultant (Ad hoc) 01.09.2023*

PROMOTIONS

Dr Manish Kumar Sharma *Cardiology Senior Consultant 07.07.2023*
Dr Abhijit Singh Pahwa *Anaesthesia Senior Consultant 25.08.2023*
Dr Ashwin Marwaha *Anaesthesia Senior Consultant 25.08.2023*
Dr Ajay Sirohi *Anaesthesia Senior Consultant 25.08.2023*
Dr Akhil Kumar *Anaesthesia Senior Consultant 25.08.2023*
Dr Mridul Aggarwal *Paediatric Cardiac Anaesthesia Senior Consultant 25.08.2023*
Dr Karan Rai *Dental Surgery Consultant 25.08.2023*
Dr Devika Duggal *Dental Surgery Consultant 25.08.2023*

CROSSWORD ANSWERS

ACROSS: 2. Tinels 4. Tachy 5. Collodion 8. Hammer-toe 10. Tocolytic 13. Heebie-Jeebies 17. Terminal
21. Hedonophobia 22. Dressing 23. Liniment

DOWN: 1. Hardy-Weinberg 2. Timothy 3. Ortholog 4. Tourette 6. Breech 7. Core 9. Tonsilloliths 11. Teratogen
12. Tipped 13. Hallus-Valgus 14. Virilization 15. Bladder 16. Ondine 17. Tag 18. Douloureux 19. Potion 20. Nostrum

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