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Sri Ramakrishna
Hospital (MultiSpeciality)

pulse

Happenings at Sri Ramakrishna...

46 Years of Excellence

2022 Awards

Best Hospital in Kongu Region

D Lakshminarayanaswamy
Managing Trustee

"It is an honour for me to lead this great organization and a privilege to be a part of an exceptional team of people who are passionate about providing the best care for patients."

We stand committed in constantly raising the bar to deliver best-in-class healthcare. We recognise the vital role that technology plays in delivering superior healthcare services and endeavor to be at the forefront in procuring the best of equipment to serve better for our patients.

Sri Ramakrishna Hospital is now joined hands with Neuro Equilibrium for advanced neuro treatments like Vertigo and balance disorders. We are proud to receive the "Best Hospital Award" in Kongu Region for the year 2022 organized by the News18 Tamil Nadu Television "Maruthuva Viruthugal 2022".

Dr P Sukumaran
Dean / Medical Director

Sri Ramakrishna hospital has been a forerunner in conducting various academic programmes apart from regular clinical achievements. Our hospital in March 2022, hosted a webinar on "Diabetes, Hypertension & Kidneys and Recent Advances in Kidney Stone Management" on the occasion of World Kidney Day. Our hospital also conducted a corporate webinar on Kidney Disease - Not Rare, and What a Common man should know about Kidney Stones and Enlarged - prostate for industries and old age homes.

Sri Ramakrishna Hospital has been awarded as the Best Hospital in Kongu Region

The "Best Hospital" in Kongu Region for the year 2022 was awarded to SRH. The award was presented by Hon'ble Thiru. M. Subramaniam - Minister for Health and Family Welfare Department (Tamil Nadu) to our Joint Managing Trustee, Thiru. R.Sundar, along with our CEO Mr.C.V.Ramkumar at “Maruthuva Viruthugal 2022” - an exclusive healthcare award ceremony, organized by News18-Tamil Nadu at Hyatt Regency, Chennai on 24.03.2022

e GFR - Easy and Accurate Way of Assessing Renal Function

The most important function of the kidney is to excrete nitrogenous waste material like Urea and Creatinine. In renal failure there is a fall in Glomerular Filtration Rate (GFR) hence the level of urea and creatinine increases.

There are many different methods to calculate the fall in GFR. Inulin clearance, though gold standard, it cannot be performed in clinical practice. Radio isotope studies like DTPA renal scan also cannot be performed routinely due to high cost, non availability and exposure to radioactive material.

Traditionally Renal function is being assessed testing by Blood urea and Serum creatinine. In Mr. body Blood urea is normally produced by liver from protein and from diet or endogenous breakdown. They are freely filtered at glomerulus, but about 50% of them are reabsorbed in tubules. So their level varies in liver disorders, dehydration and hypercatabolic state apart from renal failure.

Serum creatinine is produced by the muscles, freely filtered at glomerulus and practically neither absorbed nor secreted in tubules. Hence, it is a better marker than blood urea, but their level varies with age, sex, muscle mass (Body Weight) and race of the individual. So the normal value varies from individual to individual and many times more than 50% of the renal function is lost before serum creatinine raises above normal range.

Better method to assess GFR will be the urinary creatinine clearance, which needs 24 hour collection of urine and may not be practical.

To have a better understanding of the patient's renal function, we use Cockroft and Goult formula.

CrCl(Male) = ([140-age] x weight in kg / (Serum creatinine x 72)

With this formula we can assess the renal function in a better way. It can be done at bed side even without using a calculator: It gives you a rough idea of renal function though not very accurate.

To overcome all these problem, now a days, we use e GFR (Estimated Glomerular Filtration Rate): These formulas are derived by using software with a lot of inputs from various studies. First one to come into use was MDRD formula. Now a days, we use CKD – EPI formula (Chronic Kidney Disease–Epidemiology study -2009).

e GFRcr = 142 x min(Scr/K, 1)A x max(Scr/K, 1)-1.200 x 0.9938Age x 1.012 [if female]

Here, you need a software where you have to feed the age and sex of the patient and you will get the GFR in ml/min. Many apps are available which can also be downloaded in your mobile phone. Most of the labs give the Serum creatinine reports along with e GFR value. With the knowledge of e GFR, you can classify CKD into 5 stages.

This method is useful only in stable chronic kidney disease. In acute kidney injury the decline in GFR is much more severe than indicated by serum creatinine level.

STAGE of CKD	e GFR result	What it means
Stage- 1	90 or higher	-Mild kidney damage -Kidneys work as well as normal
Stage-2	60-89	-Mild Kidney damage -Kidneys still work well
Stage 3a	45-59	-Mild to moderate kidney damage -Kidneys don't work as well as they should
Stage 3b	30-44	-Moderate to severe damage -Kidneys don't work as well as they should
Stage 4	15-29	-Severe kidney damage -Kidneys are close to not working at all
Stage 5	Less than 15	-Most severe kidney damage -Kidneys are very close to not working of have stopped working (failed)

USEFULNESS

1. To know the severity of CKD.
2. To identify the people in early stage of renal failure before a radio contrast study or before planning an elective surgery.
3. To modify the dosage or to avoid certain drugs in patients with renal impairment.

Dr. N. Chezhiyan
MBBS., MD., DM (Nephrology)

Consultant Nephrologist & HOD

Advanced Dialysis unit with updated version of state-of-the-art machines

The Department of Nephrology at Sri Ramakrishna Hospital work with top nephrologist in Coimbatore, treating patients for more than 4 decades. The first haemodialysis unit was installed here way back in 1980. This was also the year we performed our first kidney transplant.

Holmium Laser - The Safest tool in Pregnant females with uretric stones

1. Background

Urolithiasis in pregnancy is a major health concern and is one of the common causes for non-obstetrical abdominal pain and lower the way for subsequent hospital admission in pregnant women. Stone formation during pregnancy is predisposed by urinary tract dilatation due to ureteric obstruction by gravid uterus, smooth muscle relaxant effect of progesterone and infection .

Physiological hydronephrosis can occur in up to 90% on the right side and 67% on the left side in pregnancy.In pregnancy, stones are mostly composed of calcium phosphate and more commonly located in ureter rather than renal pelvis. This is due to the migration of renal stones into the ureter which is favored by physiological dilatation of the collecting system.

Management of ureteric stone during pregnancy is crucial because of the potential risks it causes to the mother and fetus . The main threats are preterm labor with delivery and premature rupture of membranes.

2. Materials and methods:

9 pregnant patients with ureteric colic were included .
(Jan 2018 to Jan 2022)

Trimester	I	II	III
No.of patients	2	6	1

Size of Uteric Stone	No.of patients
<4 mm	2
4 to 6 mm	3
>6 mm	4

Complication	No.of patients
Urosepsis	2
Elevated Creatinine	3
Pain not responding to medical management	4

Management	No.of patients
Medical expulsive therapy	2
Only DJ stenting	2
Lithotripsy with DJ stenting	5
Percutaneous Nephrostomy	0

Obstetric Complications	No.of patients
Premature Labour	0
Premature membrane rupture	0

Trimester	Stent Material
I, II	Silicon
III	Polyurethane

Lithotripter energy source	No. of Patients
Holmium Laser	5
Pneumatic Lithotripsy	0
ESWL	0

3. Diagnostic evaluation:

Ultrasonography(USG):Abdominal USG is considered as a first-line imaging technique in cases of suspected ureteric calculi during pregnancy.

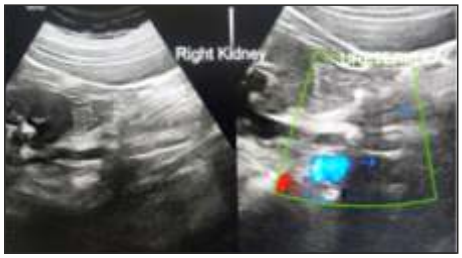
Obstetric Medical Problems	No. of Patients
Pre eclampsia	2
Gestational Diabetes	1

X Ray, IVU, CT Scan all are contra indicated during pregnancy.

It is difficult to differentiate hydronephrosis due to obstructing stone from the physiological hydronephrosis of pregnancy.To improve USG imaging characteristics, a number of adjunct measurements have been utilized,

1.Transvaginal USG:

Transvaginal US assists in the detection of distal ureteral calculi obstruction and differentiates it from physiological hydronephrosis of pregnancy.



The presence of hydroureter distal to the iliac vessels indicates obstruction as compared to physiological hydronephrosis of pregnancy.

2.Doppler USG with resistive index (RI):

- The intrarenal RI does not increase by the physiological hydronephrosis during pregnancy.
- An elevated RI (> 0.70)has been suggested as a marker of obstruction.

3. Urinary jets:

Magnetic resonance urography (MRU):

MRU using T2-weighted "water" images is useful to identify the urinary system and ureters; it can differentiate dilatation due to physiological effects from dilatation related to calculi. For detection of small stones, a high-resolution, thin-slice, highly T2-weighted fast spin echo (FSE) sequence of MRU is helpful.

Medical Therapy	Drug of choice
Uretric colic	Paracetamol (No NSAIDs)
Vomiting	Ondansetron
Sepsis	Cephalosporins

Management overview:

Relieving Colicky pain:

Since NSAID are contra indicated in pregnancy we prefer using intravenous paracetamol one gram dose for pain relief.

We avoided anti spasmodics as there are studies to show that they may induce membrane rupture. Opiods were avoided in all patients.

If the patients doesn't respond to paracetamol in spite of 48 hours medical management ,intervention will be planned.

Medical expulsive therapy (MET):

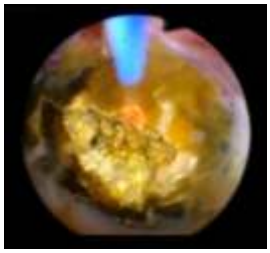
Indication: Stone less than 4 mm with no complications

The alpha blockers and calcium channel blockers are classified as Category B drugs in pregnancy and are often used without any adverse effects.

We used Tamsulosin 0.4 mg in two patients and both passed out stone spontaneously.

Indications for intervention:

1. Failure of conservative treatment
2. Unresolved symptoms
3.Progressive hydronephrosis,
4. Urinary tract infection
5. Sepsis
6. Obstruction of a solitary kidney
7. Bilateral obstruction
8. Progressive renal impairment



Ureteroscopic stone removal (URS) and Double J stenting :

URS is known to be safe and effective option in pregnancy since long time .Whenever patient was not fit for surgery we did urteroscopy and DJ stenting under local anaesthesia. When patient is in second trimester and fit for spinal anaesthesia we did a proper lithotripsy cleared stones completely followed by DJ stenting. If it is first trimester or early second trimester we placed a silicon stent which can stay upto 8 months safely inside. When patient underwent intervention during late second trimester or third trimester we left in a polyurethane stent which need to be removed within 3 months.Regarding energy source we used Holmium laser which is proven to be safe to the fetus with no teratogenic effects.Laser energy was kept to minimum (6 Joules) and stone clearance was achieved in almost all cases.(5 cases).Though pneumatic lithoclast was found to be safe it was avoided since we had better option in the form of laser.

Intra operative strategy:

1.Obstetrician during procedure. (Safety standby)
2.Radiologist during procedure to look for stent postion and to monitor fetal heart using USG.

Conclusion:

During pregnancy, ureteric stone is a diagnostic and therapeutic challenge. It increases the morbidity for mother and fetus by increasing the risk of obstetric complications.Ultimately, a multi-disciplinary approach involving experienced urologists, obstetricians, neonatologists, radiologists and anesthesiologists is critical in maximizing safe outcomes for mother and child.

Acknowledgement:
Department of Obstetrics and Gynecology,
Department of Radiology,
Department of Anaesthesiology.

Dr. S.Ganesh Prasad
MBBS., MS., Mch., MRCS

Consultant Urologist

Lithotripsy laser SHPINX® JR

The Sphinx jr. Holmium laser is the latest development for laser fragmentation and laser dusting of urinary stones.

Outstanding features of the Sphinx jr. Holmium laser are efficient stone dusting, high stone fragmentation rate at 18 kW pulse peak power, noiseless operation (Whisper technologytm), intuitive touch screen, real time pulse display, optional single or double pedal footswitch.

Besides rigid and flexible laser lithotripsy the Sphinx jr. is excellent for PCNL, strictures, incisions, bladder tumours, condylomas and tissue ablation.

Thrombocytopenia Associated Retinopathy

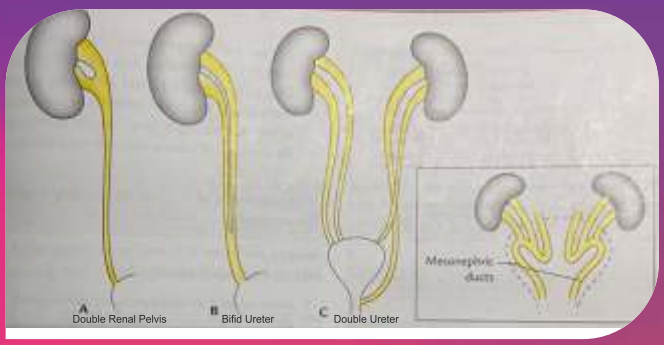
A 32yr old male was referred from the medicine ward for ophthalmology opinion for sudden decrease of vision in both eyes for the past 2 days. He was already undergoing treatment in the medical ward for idiopathic thrombocytopenic purpura. Patient was apparently normal before 3 days and he was not taking any drugs for other illness. Routine blood investigations revealed thrombocytopenia and anemia for which multiple blood and platelet transfusions were done. On examination in the ophthalmology department, his visual acuity was counting fingers close to face in both eyes. Intraocular pressures were normal in both eyes. Anterior segment in both eyes were normal, pupils were 3mm, equal, round, regular and reacting to light briskly. Dilated fundus examination revealed multiple superficial and deep retinal hemorrhages and Roth spots in the posterior pole and large pre-retinal sub hyaloid hemorrhage over the macula in both eyes which explained the loss of vision. There were no vessel abnormalities or exudates to suggest diabetic or hypertensive retinopathy. Also his blood pressure and blood glucose levels were within normal limits. Hence a diagnosis of thrombocytopenia associated retinopathy was made and he was referred for Nd:Yag laser hyaloidotomy to clear the hemorrhage over macula. Patient was lost for follow-up.

Ophthalmic manifestations of thrombocytopenia are rarely encountered, and thrombocytopenia manifesting with decreased visual acuity secondary to retinal hemorrhage has been previously reported only in very few cases. Idiopathic thrombocytopenic purpura can rarely result in significant morbidity or even mortality from bleeding complications. Other ophthalmic manifestations associated with thrombocytopenia include vitreous hemorrhage associated with intracranial bleeding in a Terson type phenomenon, hemorrhage within the optic tract, nonarteritic anterior ischemic optic neuropathy, and subconjunctival hemorrhage. Thrombocytopenia alone, even severe (a platelet count <50 000), is rarely sufficient to cause significant retinal hemorrhage. However, thrombocytopenia combined with anemia is a known risk factor, and retinal hemorrhages in association with thrombocytopenia have only been reported to occur with concurrent anemia.

Retinal hemorrhages are often an indication of an underlying blood dyscrasia, and their presence, in the absence of a known etiology, warrants evaluation. In addition to the ophthalmic examination, a thorough medical history, review of systems, and physical assessment of the skin and mucosal surfaces may aid the physician in assessing the urgency of hematologic evaluation. Patients exhibiting significant abnormalities may warrant urgent evaluation to initiate potentially life-saving interventions.

Dr. Mahesh Palanivelu
MBBS, DO, DNB

Opthalmologist



Management of Vesicoureteric Reflux (VUR)

INTRODUCTION:

Up to 8% of febrile infections in infants and children are due to urinary tract infection (UTI). Vesicoureteral Reflux (VUR) occurs in 1% - 2 % of all newborns, but it is found in 25%to 40% of children after their first UTI. VUR facilitates ascent of bacteria from bladder to the kidney. VUR associated with severe reflux nephropathy may result in hypertension, proteinuria, renal tubular acidosis and chronic renal insufficiency. Here we discuss at out two patients of two different presentations of VUR and their surgical management. First patient was having double ureter on one side which is relatively uncommon condition. Ureter develops from ureteric bud which arises as a diverticulum from the mesonephric (Wolfian) duct. Double ureter occurs due to division of the ureteric bud,

CASE 1:

DUPLEX SYSTEM LEFT SIDE WITH VESICO URETERIC REFLUX

- **COMMON SHEATH URETERIC REIMPLANTATION**

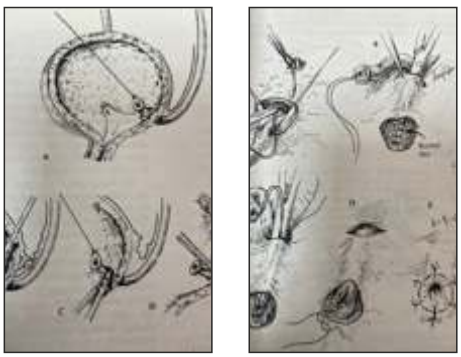
6 and half year old girl child presented to department of pediatrics with history of recurrent UTI and diagnosed to have right grade II and left grade III VUR with duplex system on the left side at the age of one and half years. Since then she was on long term low dose antibiotics. Currently she was treated for acute UTI and treated by Dr.Devaparsad (Pediatrician, SRH) and referred the patient to us. On evaluation with MCU, it revealed complete resolution of reflux on the right side and Grade IV reflux into both the ureters on the left side. USG-Abdomen showed mild splenomegaly, reduced size of left kidney with contracted lower pole. No hydronephrosis. Floating sediments in urinary bladder. DMSA renal scan showed normal functioning right kidney, less functioning left kidney. CT-Abdomen (Plain and contrast) showed Left kidney is a duplex moiety. The upper pole and lower poles excrete via the upper and lower ureters. The left kidney lower pole is contracted. No hydronephrosis in the upper and lower poles. Ureters not dilated. Left kidney lower pole shows reduced contrast excretion. Left lower ureter not fully opacified with contrast. Patient was taken up for left common sheath ureteric reimplantation. Politano – Leadbetter repair was done. Stents were kept in both ureters on the left side. Patient are doing well with no UTI for the past 6 months on regular follow up

MCU IN YEAR 2014 (AGE 1 ½ YEARS)

MCU IN YEAR 2021 (AGE 6 ½ YEARS)

POST OP 2 DJ STENTS

Politano – Leadbetter repair



CASE 2:
MEGAURETER WITH VUR ON THE LEFT SIDE

- **LEFT URETERIC REIMPLANTATION**

24 Years female, came with complaints of left loin pain for 1 year. USG abdomen and pelvis showed left mild hydro uretero nephrosis ?cause to rule out vesicoureteric reflux. CT abdomen and pelvis with contrast revealed left moderate hydro uretero nephrosis. Left ureter is dilated predominantly the distal ureter. The distal most segment of ureter dose to vesicoureteric junction shows a short segment narrowing for a length of 8mm. Distal ureter shows alternate expansion and collapse. Left ureteric jet is mildly sluggish (USG correlation)- probably refluxing primary mega ureter. MCU was done Left grade IV VUR with narrow terminal ureter and Normal bladder capacity. With diagnosis of megaureter with reflux on the left side patient was taken up for open left ureteric reimplantation and the same was done by Politano – Leadbetter method. Patient is on regular follow up and symptom free.

PRINCIPALS OF MANAGEMNET OF VUR:
MEDICAL MANAGEMENT:

- Spontaneous resolution is very common and facilitated by correction of bladder bowel dysfunction (BBD)
- Higher grade of reflux less likely resolve spontaneously especially in older children
- Sterile reflux less likely to cause renal damage hence prevention of UTI is more important
- Prophylactic antibiotic is beneficial especially in patients with high grade VUR, recurrent febrile UTI or BBD

SURGICAL MANAGEMENT:
INDICATIONS:

- Breakthrough UTI or Pyelonephritis while the patient on antibiotics
- Failure to resolve higher grades of VUR

SURGICAL OPTIONS:

- Open ureteric reimplantation intravesical or extravesical approach
- Robotic assisted laparoscopic ureteral reimplantation

Endoscopic subureteric injection of bulking agents has success rate of 70%

TAKE HOME MESSAGE:
VUR has to be ruled out and treated in any child with recurrent UTI to prevent silent kidney damage. Patient with low grade reflux usually resolve with long term antibiotics and correction of bladder bowel dysfunction. Patient with high grade reflux usually will end up in surgery. It is not uncommon for VUR to present in adults.

Dr. P.Kathamuthu
MBBS., DNB., DNB., MRCS

Consultant Urologist

Dr. R. Palaniswamy
MBBS, MS, M.Ch(Urology)

Consultant Urologist

Integrated Brain & Mind Care
buddhi CLINIC

The Dull Mr. H

Thirty-two summers ago, H was born, the second of two children in an agricultural business family. With a disabled girl child (later diagnosed as Turner's syndrome) being the first born, the parents were overjoyed to have what appeared to be a healthy boy. Over time, when H did not achieve developmental milestones and made limited progress in school, the parents realised he had a developmental disability. He required special educational support and some rehabilitation care as he grew up, which his family provided as best as they could, based on local available services. A slow learner who could not progress beyond the tenth standard, H had no significant temperamental peculiarities, managed his self care and largely led an idyllic life. While friendly, he was largely isolated from his peer group, spent most of his time with his extended family and had a limited sphere of activities with which he was satisfied. His religious instruction served to provide him with some community connect. Indeed, as he approached 30 summers, his parents were considering settling H down, as the family had the affluence and will to support him.

It was at this time that H began to change. He became dull and withdrawn, had trouble with everyday memory and problem solving , started to exhibit aggressive, out of control behaviour, had crying spells, would laugh and talk to himself periodically, was sleeping poorly and suffered with chronic gastritis. As the complaints continued unfettered, his parents brought him to Buddhi Clinic, seeking our help, having been strongly recommended by another parent.

At Buddhi Clinic, H underwent a multidisciplinary assessment with the treating team. He was found in the Physical Disability evaluation to have an atypical limping gait, with shortening of the right lower limb and fixed flexion deformity of the right knee (15-20*). On examination SLR was 70* with spasm in both hamstrings; he had fair co-ordination, balance, gait and proprioception. On psychometry there was an anxious affect and mood lability with poor scores on physical and social domains and average scores on psychological and environmental domains of the World Health Organisation Quality of Life Schedule (WHOQoL)-

In addition on the Clinical Interview Schedule (Revised) he had significant symptom scores in fatigue, concentration, sleep problems, worry about physical health and depression indicating a common mental disorder. On the Addenbrooke Cognitive Examination (done as a measure of multidomain cognitive function) he had the following scores: Attention-11/18; Memory 13/26; Fluency 8/14; Language 21/26; Visual-spatial 8/16 Total: 61/100, indicating multi-domain cognitive impairment. On caregiver interview (mother) about client behaviour using the Neuropsychiatric Inventory (NPI), significant scores on sleep and night-time behaviour, disinhibition, anxiety and dysphoria (indicating significant caregiver rated behavioural and psychological symptoms). He also underwent holistic revaluation with our Ayurveda physician who diagnosed unpredictable thought (Vichara) and forgetfulness (Smrithi).

Medical Summary:
Neurodevelopmental disability with new onset behavioural, sleep

and psychosomatic dysfunction. The EEG shows non-specific changes but no clear cut epileptiform of encephalopathic dysfunction (borderline record)
Bio-psycho-social construct:
Bio: Developmental disability confers risk of neuropsychiatric symptoms
Psycho: Parental dependence, pressure of impending life change
Social: Peer comparisons, concerns about adequacy and ability to assume responsible roles in the future

MedicalTreatment:
Oxcarbazepine (as a thymoleptic agent) and Olanzapine-Fluoxetine combination for agitated mood state with vitamin and mineral supplements

Rehabilitation:
H underwent our multimodal care process at Buddhi Clinic receiving:
- Behaviour Therapy, Supportive Counselling & Family Therapy from the psychologist
- Neurodevelopmental therapy with focus on affected knee and gait
- Shiroabhyangam (for psychosomatic symptoms), mud therapy (for digestive symptoms) & reflexology (for relaxation and sleep) as part of holistic care

Outcome:
In 3 weeks he improved significantly with regard to his neurobehavioural symptoms. He became more communicative, emotionally stable and responsive, confident in his conduct and interactions with improved sleep, appetite and biological functions. His activities of daily life and health related quality of life started to improve. The repeat NPI evaluation showed persistent depression & anxiety. His predominant concerns were about his marriage and the future. He was discharged from active therapy and returned to his home town.

Subsequent Progress:
He returned to Buddhi Clinic after 2 months, for a five-day booster program of therapy and demonstrated continued progress. With reducing doses of medication he has remained well for 6 months, until his last follow up. He has started taking part in the chores of the house, assists his mother with cooking and other daily tasks; accompanies his father to his work where he lends a helping hand. His mood is stable, he is confident and interacts well with his family members. The family have started considering helping him "settle down into marriage" once again and have been advised to take an empathetic and transparent approach in their search, which we are confident they will.

Lessons Learnt:
People with mental disability have a prone-ness to neurobehavioural symptoms and these could reveal themselves at any time in their lives. The biological vulnerability is in the disruption of brain circuits that have lead to NDD in the first place. Psychosocial factors include aspirations not being met, concerns about the future and unwitting pressure from caregivers in this regard. Mr. H's story reveals these various elements; fortunately, his disability is limited, his family have adequate resources to assist him and his response to our care paradigm was swift. His story tell us that a comprehensive approach to clinical care, supported by a loving and caring family environment has the potential to help people achieve a good outcome.

Economic Development and Kidney Diseases

TIME TO RE-PRIORITIZE

Post globalization, particularly in the last 3 decades, there has been tremendous economic growth all over the world. Economic development has been very robust not only in high income countries, but also in mid & low income countries with sequentially increasing GDP(Gross domestic product). Paralleling increase in literacy rates, the number of doctors per 1000 population has increased significantly, particularly in mid & low income countries. Health care spending has increased as a percentage of total expenditure. But out-of pocket spending in seen in low & mid income countries, whereas people living in high income countries are covered with insurance. On the disease front, what was once known as "disease of plenty/elite", life style disease like Diabetes mellitus, Hypertension, Obesity is now prevalent across all strata of society and among all age groups.

The prevalence of Chronic Kidney diseases, between 14-40%, is on the rise. Approximately 1/3rd of US population is expected to have CKD secondary to diabetes & hypertension. Mortality, morbidity, Disability adjusted life years(DALY) secondary to CKD in steadily increasing, with CKD being the 12th leading cause of death. And this paradox of increase in disease prevalence despite increasing health care spending is because major chunk of spending goes in treating kidney diseases with very meagre allocation towards prevention.

When one has to spend money from pocket on a monthly basis for chronic dieases like CKD, it causes huge burden on the family. Not only the household income reduces because of loss of work, expenditure also increases due to medications & procedures. This results in foregoing medications or discontinuing dialysis treatments.

This calls for re-prioritization of our spending with more allocation towards prevention of kidney diseases than treating them, particularly in low & mid income countries where out-of pocket spending is more. More focus should be on prevention(diet, life-style changes, periodic check ups), cost-effective strategies (RAS inhibitors, control of sugar/blood pressure), counselling & proper preparation for dialysis, transplantation where possible, comprehensive conservative care for frail & elderly. With coronavirus pandemic disrupting the advances in health care & savings, government & health agencies should design a system to direct funds to appropriate causes & limit out-of pocket expenses. Being healthy is more of a journey than a destination & the journey is prolonged like a marathon unlike a sprint.

Dr. G. Madhu Shankar
MD, DM(Nephro) (AIIMS),
SCH(ASH), Clinical Fellowship (Toronto)
Consultant Nephrologist

Academic - Sri Ramakrishna Hospital, Coimbatore

March 2022

April 2022

Tune in to Safe Healthcare

Organizing a webinar authorizes you as a healthcare professional to share your knowledge and expertise from your experience in the healthcare field to a large audience.

Sri Ramakrishna Hospital offer free healthcare webinars 2022 led by industry experts from our healthcare space. Check into our website in the academics section, where you can find the upcoming healthcare webinars and the completed webinars for healthcare professionals.

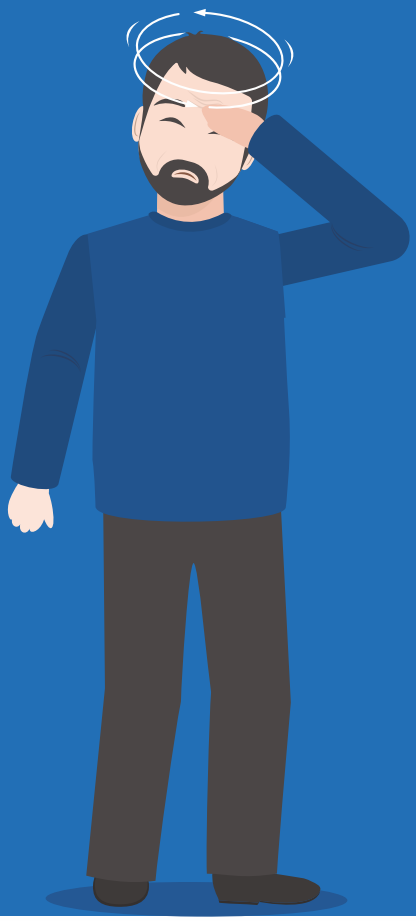
You'll also get the opportunity to participate in a Q&A session when you tune in to the live webinars.

Neuro Equilibrium®

Sri Ramakrishna Hospital opens its doors for Advanced Vertigo Treatment with Neuro Equilibrium in Coimbatore

Sri Ramakrishna Hospital, in collaboration with NeuroEquilibrium, launched Coimbatore's first super-speciality dizziness and vertigo diagnosis and treatment center on 4th March 2022. This center will house cutting edge vertigo diagnostic systems and provide specialized rehabilitation therapies for patients affected by balance disorders.

This specialized vertigo clinic utilizes advanced diagnostic equipment to diagnose and treat all causes of dizziness and balance disorders with customized medical treatment and vestibular rehabilitation after diagnosing the underlying cause of vertigo and balance disorders to ensure better outcomes.



6 Crore Indians have Vertigo

Do you suffer from?

- VERTIGO
- SPINNING SPELLS
- UNSTEADINESS
- RECURRENT FALLS
- FEAR OF FALLING
- IMBALANCE
- HEADACHES WITH DIZZINESS
- DIFFICULTY IN FOCUSSING DURING HEAD MOVEMENT

GET DIAGNOSED TODAY

One or more of these symptoms could mean you have a Balance Disorder

World's First Chain of Vertigo, Dizziness & Balance Disorder Clinics

Sri Ramakrishna Hospital (Multi-Speciality)

395, Sarojini Naidu Road, Siddhapudur, Coimbatore

SNR SONS TRUST

NABH ACCREDITED PATIENT SAFETY & QUALITY OF CARE

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