VOLUME 19 | ISSUE 1 | SEPTEMBER 2022

Sri Ramakrishna
Hospital (MultiSpeciality)

pulse

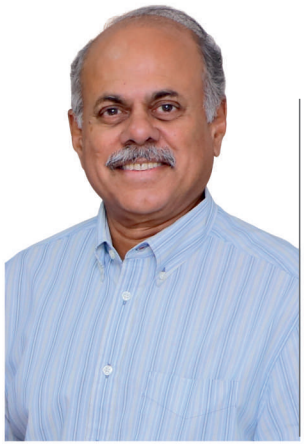
Happenings at Sri Ramakrishna...

47 Years of Excellence

breastfeeding

- Provides much needed nutrition
- Protects against disease
- Healthy brain development, high IQ
- Lowers risk of allergies and infections diarrhea, asthma, diabetes & obesity, etc.

WORLD BREASTFEEDING week



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 equipments to give them the best. The core purpose of healthcare is to provide dedicated service for the well - being of humanity. Mother's milk bank was established in our hospital. It assists several mothers who are unable to feed their children for various reasons. The program has been running for a year. In a grand manner, first anniversary of this great programme was celebrated with our hospital staff members in our Hospital.Donation of organs is vital, and we consider it extremely important. We have been successfully doing it for years.We increased awareness and ensured that people recognised the importance of organ donation.

Dr P Sukumaran
Dean / Medical Director

Sri Ramakrishna hospital has been a forerunner in conducting various academic programmes apart from regular clinical achievements. With increasing number of covid patients, it is always the rule of the land to adhere to the COVID appropriate behavior by wearing face masks, hand hygiene practices and sufficient interpersonal distancing to avoid spread of the disease again. Protect yourself and others as you follow these measures. We had interesting webinars, this month on Minimally Invasive valve replacements – Leading destination in Tamilnadu and Management of supraventricular tachyarrhythmia – An Electrophysiologist's perspective .

Editorial Team

Dr P Sukumaran
Dean / Medical Director

Dr N Loganathan
Pulmonologist

Dr S Prahadeeshwaran
Head - Public Relations

Mr Murali Kaliappan
Head - Marketing

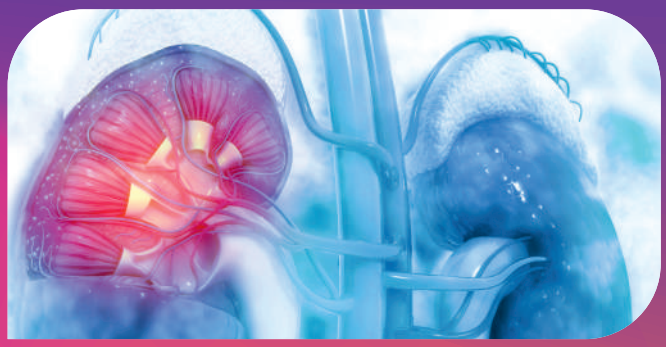
1st Anniversary Celebrations of Nectar of Life a Human Milk Bank at Sri Ramakrishna Hospital in association with Rotary Club of Coimbatore Cotton City, Rotary Club of Coimbatore

Rotary Club of Coimbatore Cotton City had started one of its kind private mother's milk bank in south Tamil Nadu at Sri Ramakrishna Hospital in August 2021 under the banner of Rotary International to provide mother's milk to infants. This deprived milk bank celebrated its 1st anniversary on 22.08.22 at Sri Ramakrishna Hospital Coimbatore. Mothers milk offers the best immunization to babies, but many a times due to extreme situations lot of babies do not get mothers milk and in such situation Breast Milk Bank comes handy. A breast milk bank collects breast milk donated by lactating mothers, pasteurizes it for the removal of bacteria and viruses and then deep freezes it for storage before dispensation to infants in need. Mothers can either donate milk at the hospital or express it in the convenience of their homes and store it in their refrigerators which is later collected by our nectar bees or the milk collectors. Our bank has been collecting milk from places like Tirupur, Pondicherry, Pollachi, Karamadai other than Coimbatore.

All these milk collectors are volunteers who are businessmen, doctors, housewives who believe in this social cause. The milk bank has collected 400078 ml of milk and donated 297769 ml of milk free of cost to benefit 250 infants across Tamil Nadu in a span of just one year To mark the anniversary celebration and meet the increasing demands for storage Rotary Club of Coimbatore Cotton City donated a vertical deep freezer with storage bottles and disposable bags to the milk bank. The mothers who had donated milk over the past one year were given personalized mementoes to honour their donation and efforts for this Nobel cause. The recipient mothers and donor mothers also shared their experience.

Celebrations were conducted in the presence of Shri R.Sundar, Joint Managing Trustee, SNR Sons Charitable Trust, District Governor Rtn. S.Rajmohan Nair, Rt.R.Madhav Chandaran District Trainer RI Dist 3201, Mr C.V.Ramkumar CEO, SNR Sons Charitable Trust and Dr.P.Sukumaran, Dean and Medical Director of Sri Ramakrishna Hospital.

The celebration ceremony was attended by the District officials of Rotary District 3201 organising team of Rotary Club of Coimbatore Cotton City comprising of Rtn.Dr.Neetika Prabu, Chairperson, Rtn.Rakesh Kumar Ranka GGR Co- Chairperson, Rtn. Ajay Kumar Gupta,IPP, Rtn. Nirov Sheth, President, Rtn.Krishna Samanth, Secretary and the members of Coimbatore Parenting Network and Achintaya Milk Donation Drive.



Acute Kidney Injury in Pregnancy [P-AKI]

Introduction :

Pregnancy has been viewed as a pleasant and joyful experience in woman's life. In fact it is a stress test for her and impending dangers can crop up at any point of time during pregnancy and postpartum. Here we report a successful management of a parturient with Acute kidney injury.

Back ground :

In India incidence of pregnancy related Acute Kidney Injury is 3.7% in 2000's. Mortality in mothers due to pregnancy related AKI is 6.4%. Prognosis is unpredictable and is still a significant cause of maternal morbidity and mortality in developing countries. Hence it is important to focus on the prevention, early diagnosis and prompt management.

Case report:

Mrs X , 23 year old Primigravida at 30 weeeks of gestation, booked and immunized elsewhere reported in our emergency room at early hours with hypovolemic shock and breathlessness, suspected to have Dengue fever. She is married for 2 years and conceived after Ovulation induction .First and second trimesters were uneventful and screening tests were normal. She had fever, severe abdominal pain, continuous vomiting, haematemesis, malena , purpuric rashes for last 3 days.

Clinically she was severely anaemic, icteric , dehydrated, tachycardic, hypotensive with SpO2 98% in room air. Uterus corresponding to 30 weeks gestation, relaxed and good fetal heart sounds was heard. No vaginal discharge, temperature 1000 F and no other focus of sepsis identified. Patient was admitted in HDU. Steroid coverage started for fetal lung maturity. Relevant investigations were done. Patient was started on Piperacillin-Tazobactam. IV Fuids were started at 80ml/hr. Patient had temperature spikes on and off..

Initial evaluation revealed Haemoglobin of 6.6 gm%, leucocytosis, thrombocytopenia raised bilirubin levels, hypoproteinemia elevated renal parameters, metabolic acidosis and oliguria. Echo revealed LVEF 60%, PH with mild to moderate TR and tachycardia. Peripheral smear showed bicytopenia, macrocytic hypochromic RBCs and thrombocytopenia.

Dehydration was corrected, packed cell transfusion with correction of acidosis was done. Dengue test proved negative but Urine output was 200 ml for 12 hours

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Initial values :

Provisional diagnosis of Viral Haemorrhagic fever with multi organ insult with acute kidney injury made. Counselling was done with family members regarding the status and prognosis by multi disciplinary team of Obstetrician, Nephrologist, Physician, Haematologist Intensivist Anaesthetists and Neonatoloist. In order to treat AKI robustly emergency LSCS done under general anaesthesia and delivered an alive preterm female .baby weighing 1.33 kg, with good APGAR and the baby was handed over to Neonatologist. Peroperatively steps taken to prevent postpartum haemorrhage. The mother was on ventilator support for 36 hours and Haemodialysis was initiated soon

after surgery.

Supportive measures with broad spectrum antibiotics , blood components , close vigilance on parameters and periodic haemodialysis undertaken .Patient received 3 cycles of haemodialysis , 8 units of platelets ,4 units of PRBC and 4 units of FFP.Renal function started improving 6 days after admission. Patient discharged on 12 th postoperative day in good condition. Baby on minimal support in NICU

Parameters:

	4/07/22	5/07/22	6/07/22	7/07/22	8/07/22	9/07/22	11/07/22	12/07/22	13/07/22
TOTAL COUNT	13.18	17.90	14.50	20.02	24.43	24.19	25.19		21.96
HB	6.6	6.2	6.8	9.2	8.5	8.4	8.9		8.6
PLATELET	20,000	81,000	1,25,000	1,40,000	1,83,000	2,98,000	4,58,000		5 lakh
UREA	157↑	168↑	151↑	102↑	127↑	75↑	109↑	111↑	100↑
CREATININE	6.1↑	7↑	5.8↑	4.4↑	6.1↑	3.9↑	4.2↑	3.2↑	2.1↑
POTASSIUM	3.8	3.9	3.5	3.2↓	2.7↓	3↓	3.1↓	3.3↓	3.7↓

Urine output:

Day1	2	3	4	5	6	7	8	9	10
240ml	250ml	540ml	530ml	545ml	840ml	990ml	1810ml	2500ml	2520ml

Discussion:

Diagnostic definition of AKI during pregnancy is not uniform owing to physiological adaptations in pregnancy.

Patients with AKI exhibit features of multi organ insult and a heterogenous syndrome. The causative factors can be pregnancy specific conditions namely preeclampsia/HELLP syndrome, acute fatty liver of pregnancy and thrombotic microangiopathies and septicaemia.. The management in these cases is prompt delivery of fetus, vigorous volume resuscitation, suitable antibiotics, correction of electrolyte imbalance, and haemodialysis as required, which helps in speedy recovery.

With the multidisciplinary team in our institution we were able to manage our patient who landed in acute kidney injury owing to Viral haemorrhagic fever and good perinatal outcome could be achieved. Patient is doing well on follow up and counselling given regarding future care.

Key message:

Diagnostic criteria of AKI in pregnancy :

Raising the values of serum creatinine by 0.3 mg/dl (26.5 µmol/l) within 48 hours
or increase in serum creatinine to 1.5 times baseline, which is known or presumed to have occurred within the prior 7 days

Dr.M.Banumathy
MBBS, DGO, DNB, FICOG

Consultant Obstetrician & Gynaecologist. HOD (Academic)

Vaginal Anomalies – Varied Presentations and vaginoplasty

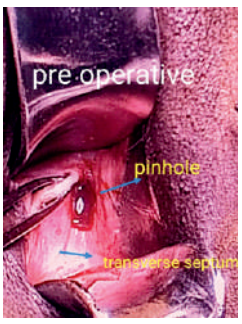
CASE 1: Restenosed Transverse Vaginal Septum

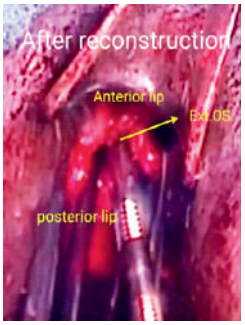
A 33 old nulligravida on infertility treatment planned for IVF elsewhere has been referred to vaginoplasty. History of scanty flow during menstrual cycle. No history of cyclical abdominal pain. She had regular cycles of 3-5 days . Married since 6 years, but at, 16 years she was found to have vaginal septum and surgery was done, details are not available. Two months back, she underwent laparoscopy for primary infertility and found to have bilateral hematosalpinx with adhesionds and bilateral salpingectomy done outside.

On per abdominal examination, abdomen was soft , no mass palpable. On per speculum examination transverse vaginal septum with pinhole opening was seen at 1 o'clock position through which minimal bleeding seen. MRI Pelvis showed mild narrowing in external os with collection in endocervical canal. Patient was referred to our hospital for reconstruction of vaginal and cervix for the purpose of IVF treatment. Under GA,Patient was catherised. On per speculum examination – blind pouch 3 cm from perineum seen. Pinhole opening at 1 O'clock position, on insertion of dilators through the opening, minimal organized clots came out. By keeping the dilator in position through the pinhole opening, transverse incision was made on the fibrous tissue and 15ml of collected blood drained. Fibrous vaginal wall excised, cervix made out and it was patulous due to distension of endocervical canal. Septal wall sutured with respective to vaginal wall all around. Haemostasis achieved. Foleys catheter inserted through the internal os , fixed to ensure draining from uterus and cervix. Cervix was visualized all around and Vaginal pack kept. Urine clear at the end of the procedure. On post operative day2, pack removed, no bleeding per vagina. Vagina dilated with vaginal dilators and same taught to the patient for daily dilatation. Patient reviewed twice weekly for 3 weeks and ensured opening of vaginal and cervix. The incidence of Transverse Vaginal Septum is between 1/2100 and 1/7200. It results from either incomplete canalization of the vaginal plate or failure of the paramesonephric ducts to meet the urogenital sinus. The successful management of Transverse Vaginal Septum is not only the surgical reconstruction of vagina but also in preventing the post operative vaginal restenosis and proper follow-up. The patient recovered well and was advised the use of dilator on daily basis for 1 month followed by regular intercourse. On follow-up patient had normal menstrual cycle and had a properly healed vagina with 7 cm length, cervix was seen healthy. Patient was on regular follow-up and conceived through IVF conception. She underwent abdominal cerclage in view of short cervix at 12 weeks. Currently she is 20 weeks of gestational age.

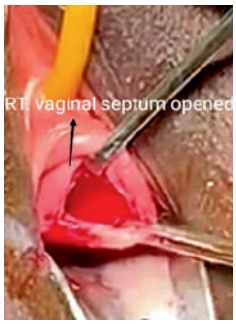
Case 2: OHVIRA

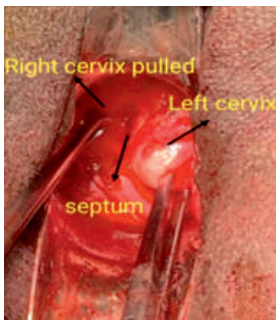
A 22 years old unmarried was admitted with c/o Continuous abdominal pain for 1 week. Her menarche is at 12 yrs,Irregular cycles for past 3 months P/A : Soft, L/E : External genitalia normal,P/V : Introitus admits 1 F (left hemivagina connected to left cervix),Blind obstructed right hemivagina upto





1.5 cm from introitus.





USG abdomen showed Right kidney not visualized. Uterus diadelphus , E/O 10.5x4.5 cms sized thick walled hemorrhagic cystic foci in vaginal cavity – hematocolpos. Diagnosis of OHVIRA made and proceeded for Vaginoplasty. Under GA, On examination- Bulge in right hemivagina noted compressing the left patent hemivagina and left cervix. Right cervix not visualised. A transverse incision made in the right transverse vaginal septum 30ml of pus with blood let out. Right cervix visualised with difficulty due to longstanding obstruction and the septum over cervix. Then the septum on the right side excised with cautery and vaginal wall reconstructed. The two cervices were felt on either side of the septum communicating to the 2 uterine horns. At the end of procedure there was single vagina with 2 cervices, communicating to 2 uterine horns. Vaginal pack and further vaginal dilatation ensured till healing to prevent restenosis.

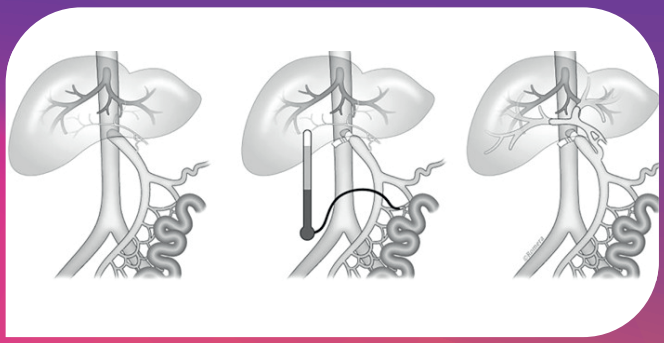
CASE :3 VAGINAL AGENESIS IN MRKH SYNDROME

Anterior Peritoneal reflection from Mullerian band.

A 29yrs old unmarried female presented with primary amenorrhea with normal development secondary sexual characters and external genitalia. Local examination showed normal vulva, urethral meatus and vagina appears as a dimple. MRI pelvis confirms type1MRKH syndrome with bilateral. Laparoscopic Davydov procedure (peritoneal pull through technique) was planned. Under GA, Intraoperative findings: Uterus and bilateral fallopian tube- absent, Mullerian band /rectovesicular band seen, uterine buds seen on both lateral pelvic walls. Bilateral larged ovaries with multifollicular cysts. Peritoneal releasing incisions were made from the round ligament on both sides and bladder dissected down. Posterior peritoneum is mobilized by cutting the peritoneum close to rectovesical band posteriorly and dissected caudally. Vaginal pouch is created by using two sets of vaginal dilators over the dimple and the median raphe. Further dissection proceeded till the apex of vagina. Haemostasis achieved by using 3-0 chromic catgut and vaginal pouch easily admitted 2 fingers. Apex of vagina is opened. First, the posterior vaginal wall is formed by pulling the posterior peritoneum through vagina and is sutured to the vestibule of vagina. Then the rectovesicular band is divided towards the left end, for free mobilization and to get large peritoneal flap, it is used to cover the anterior and lateral walls of vagina and the same sutured to the respective future vaginal walls. Both utricles were mobilized and two layers of purse-string sutures were taken with 1 PDS to incorporate bilateral uterine buds, anterior peritoneum, and rectal fat posterior. At the end of procedure, vaginal length was 8cm and 2 fingers width. Vaginal mould was kept and removed after 48hrs .Vaginal dilators with lubrication used for further dilatation and maintenance. She was reviewed periodically. After 3 months, speculum examination was done Vagina was pale pink, more pallor towards the apex. Final vaginal length was 7.5cm and easily admitted 2 fingers. Vaginal smear taken after 3 months suggestive of metaplasia of peritoneal epithelium to vaginal epithelial cells (superficial and intermediate cells).

Neovagina - 3 months after surgery.

Dr.M.Kanmani
MBBS, MD, DNB(OG), Fellowship in Endogynecology,
Diploma in UROGYNECOLOGY, D.MAS
Consultant Obstetrician & Gynaecologist, Urogynecologist



Caval partition for large type II Abernethy malformation

Introduction

Congenital portocaval shunts drain the portal blood directly into systemic circulation bypassing the liver was described first by Abernethy in 1793. Clinical problems are either due to hepatic encephalopathy to portal flow bypassing the liver resulting in hyperammonemia or pulmonary hypertension to direct venous return from digestive organs to right heart. End to side porto-caval shunts are called type I and side to side porto-caval shunts as type II. Variations where mesenteric veins or splenic vein (portal component) drain into inferior venacava or renal veins (systemic component) exist. Most of the type II shunts could be closed by interventional pediatric cardiologists using endovascular device closure. We treated a child with very large Abernethy malformation that was not amenable to device closure.

The clinical problem

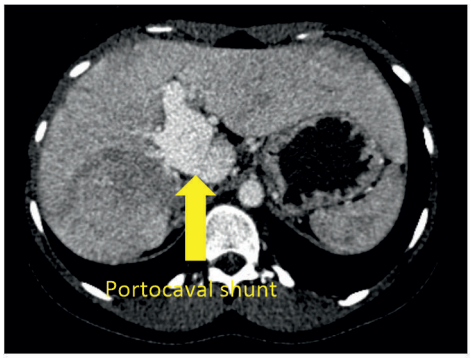
A 17-year-old child presented to Dr. Devaprasath, our pediatric cardiologist with recurrent cough and lower respiratory tract infection. Though symptoms were present for several years and multiple evaluations had been performed, no clear diagnosis was arrived earlier. Echocardiogram showed severe pulmonary hypertension (RVSP of 76 mm Hg) and absence of congenital cardiac anomalies. Contrast CT scan of chest and abdomen revealed a 3.5 cm wide type II Abernethy malformation. Inferior venacava was grossly dilated (diameter- 4 cm. normal around 18 mm). No endovascular device was available in the country for minimal access interventional closure of this large Abernethy malformation. She was referred to our team for surgical closure that would help relieve pulmonary hypertension.

Evaluation

Liver and renal function tests were within normal limits. Blood counts were normal. Pulmonary hypertension was a concern for general anaesthesia, but was considered acceptable as the procedure would make it better.

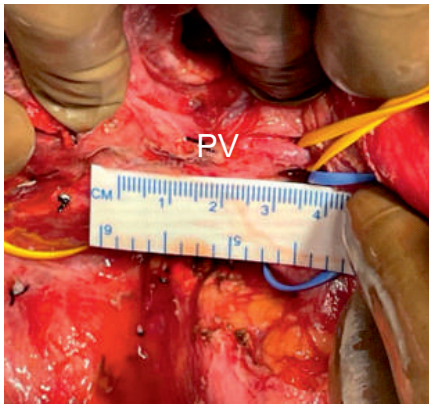
The operation and intraoperative surprises

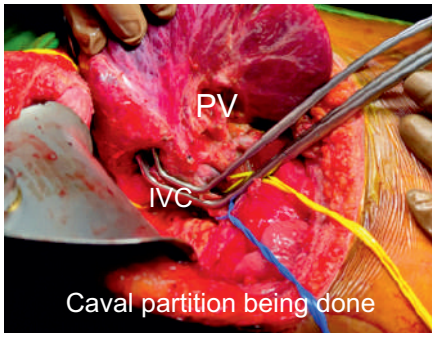
At operation, when we mobilized the right triangular ligament and divided a phrenic artery branch to segment 7 of liver, we noticed segmental hepatic ischemia due to absence of portal flow. Normally, such peripheral arterial supply to liver does not exist and in view of dual supply to liver from portal vein, ligation of peripheral arteries does not cause hepatic ischemia. But, access to retrohepatic inferior venacava certainly required this step to be performed. Shunt was carefully isolated and on test clamping it, portal pressure increased from a baseline of 9 mm Hg to 26 mm Hg.

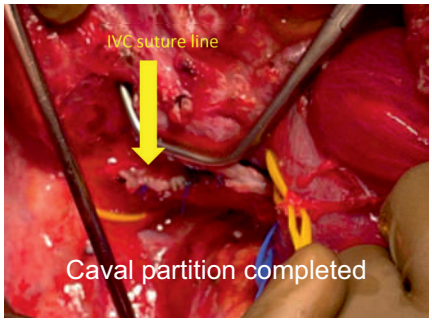


The ensuing portal hypertension was unacceptable. Hence, we preserved an 8 mm width of the congenital shunt and suture closed the rest of the shunt by splitting the inferior venacava by a technique called "caval

partition. By this technique, part of the wall of inferior venacava becomes the wall of the portal vein, thus preventing narrowing of the portal vein after shunt closure. Inferior venacava will not be narrowed as already its diameter was about 4 cm. Portal pressure After the partial preservation of shunt was 12 mm Hg.







Postoperative course

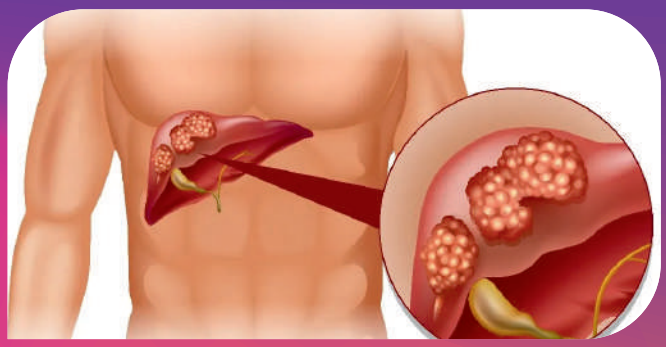
The child was extubated immediately after the procedure and did not require any ICU stay, even after such a complex procedure. She developed fever, transaminitis and high INR in the immediate postoperative period. Peak INR was 4.3 and peak aspartate and alanine transaminase were 2419 and 1573 U/L respectively on postoperative day (POD) 2. This was managed with liver supportive measures and broad-spectrum antibiotics. Peak bilirubin was 1.6 mg/dl on POD 3. She was discharged after 10 days. Follow up CT scan of the abdomen showed that the left-out portion of shunt has closed spontaneously. No features of portal hypertension.

Conclusion

Successful treatment of this child with a large Abernethy malformation, a complex congenital porto-caval shunt is testimony to the complexity of hepato-biliary-pancreatic surgery work that our hospital is competent of doing Our multi-specialty care, in this case was provided by pediatric cardiology led by Dr. Devaprasath and our anaesthesia team led by Dr. Prabha Udayakumar.

Dr. Jayapal R
MS (PGIMER), MCh (GI Surgery & Liver Transplantation-AIIMS, Delhi)

Consultant Surgeon, HPB, GI Surgery and Liver Transplantation



Liver Resection for Liver Cancer in extremes of ages

Introduction

Major liver resections, often considered complex are routine operations in our center. Good outcomes are routinely obtained in close to 97-98% patients who undergo these operations. There are unique challenges when performing liver resections in young children and old people. We describe 2 patients in age groups who underwent successful liver resections in our practice and explain the nuances in their management.

Patient 1

An 84-year-old gentleman approached to us in July 2018 with upper abdominal discomfort for 1 month. There were no other symptoms. He was on regular treatment for diabetes mellitus and systemic hypertension for 40 years. He regularly walked for 2 kilometers per day. Ultrasound scan of the abdomen showed a 15 x 10 cm mixed echoic liver lesion in segment 2 and 3 of liver. CECT scan of abdomen showed definitive radiologic features of a solitary hepatocellular carcinoma (HCC) in a non-cirrhotic liver. There was no involvement of hepatic vasculature or biliary tree and there was no metastatic disease. Liver function tests, blood counts and renal function were within the normal limits. Serum alpha-fetoprotein, tumour marker for hepatocellular carcinoma was 0.9 ng/ml (40% of HCCs may not secrete this tumour marker). Cardiac stress tests showed that he did not have inducible myocardial ischemia. He underwent open left lateral sectionectomy of liver in July 2018. He was extubated on table. Epidural analgesia was given in the perioperative period for pain control. He was ambulated from postoperative day (POD) 1 and was on regular diet by POD 2. Wound was healed by primary intention and he was discharged home on POD 6. Histopathologic examination confirmed hepatocellular carcinoma. But he did not receive any adjuvant therapy. He remains active and disease free till this day.

Patient 2

A 1-month-old child was referred to us by the neonatology team following diagnosis of a liver mass. Child's mother noticed a mass in the upper abdomen 1 week before presentation. Ultrasound scan of abdomen showed a large mass originating from the right lobe of liver. Serum alpha-fetoprotein was elevated (45000 ng/ml), its's higher than acceptable range for his age. CECT scan of the abdomen done in the refered hospital, showed a large mass in the inferior aspect of right lobe of liver, predominantly involving segments 5, 6, 7 and caudate process of the liver. Biopsy of the lesion suggested hepatoblastoma. Cardiac evaluation did not suggest any anomaly. Child underwent right hepatectomy successfully by our team along with senior pediatric surgeon, Dr. Rajamani. Our neonatal intensive care team led by Dr. Siddharth and Dr. Suja Mariam actively participated with our highly experienced anaesthesiology team

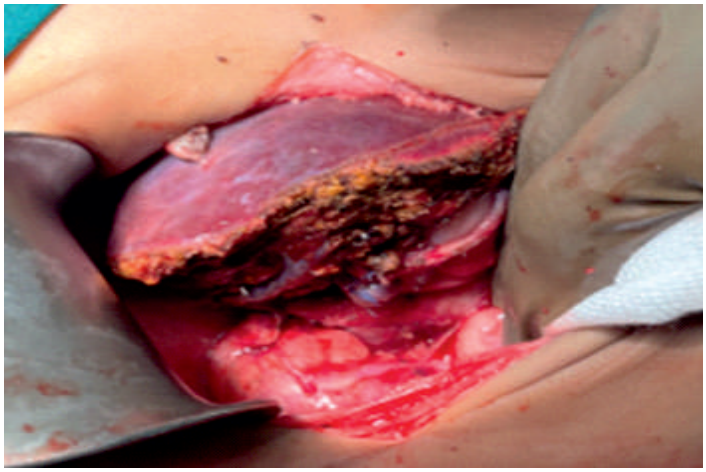


Fig. 1- The surgeon's finger is so large compared to 1 month old child's abdominal cavity

led by Dr. Prabha Udayakumar to keep the child stable and safe through a 2-hour operation. Postoperative period was uneventful and histopathology confirmed hepatoblastoma and resection margins were negative for cancer.

Conclusion- What made these operations safe and affordable?

Our hospital has been very successful in bringing together highly experienced teams of liver surgeons, Neonatologists/Pediatricians and Anaesthesiology/ICU services and has a highly dedicated nursing service. We have the fulltime service of a highly competent interventional radiologist and a dedicated diagnostic radiology service. This environment makes major liver resections in any age group very safe in our hospital and the above examples serve as testimonies. Our results in liver resection are comparable to any of the best hospitals across the world. Safe surgeons working in an appropriate environment in our highly cost-conscious hospital make these procedures highly affordable for patients.

Dr. Prakash N Krishnasamy
MS (Gen Surgery), MCh (SGE), Fellowship in Transplantation (UK)

Consultant Surgeon, HPB, GI Surgery and Liver Transplantation

Beyond the pains...

We as species started walking upright as an evolutionary solution. This requires a small fixed bony pelvis and a large brain which translates as head is too big to fit that small pelvis in the process of child birth. Human birth is a feat involving intricate sequence of events.

With the effect of hormones, the mother's pelvis enlarges, the joints stretch and loosen adding an inch of space to the foetus to let go through the bony passage. The uterus, a sealed pouch starts acting (contracting) at the end of ten months pushing the baby into the pelvis and outside the soft tissue. The cervix made up of muscle and connective tissue softens and stretches gradually allowing the baby to be born. At ten centimetres of cervical dilatation the baby is head slips into the narrowest part of the bony pelvis and then into the vagina and delivered from the mother's womb.

The pelvis is usually wider from side to side than front to back so as to accommodate the widest portion of the baby head .At the climax the mother has a mounting urge to push .The head comes out , then the shoulders and a suddenly breathing ,wailing child is born ,.The umbilical cord is cut ,the placenta separates from the uterine lining with a slight tug on the cord and a push from the mother it is expelled out .The uterus contracts into a clenched ball of muscle ,closing off its bleeding sinuses – the expanded veins in the uterine wall .The mother breasts immediately let down with colostrum the first milk and the new born can latch to feed .

That's if all goes well. At almost any step the process can go wrong. For many years child birth remains a common cause of death for young women and infants.

The placenta can tear or separate or a portion can remain stuck in the uterus after delivery and then bleed torrentially. The uterus may not contract after delivery that makes it bleeding until the mother dies of blood loss. Sometime uterus ruptures during labour. Infection can set in. Thanks to Semmelweis who taught the concept of hand washing and reduced puerperal sepsis.

Obstruction of labour: This is the basic problem. The baby may be big, mother's pelvis may be small. The baby can present as a breech or the head can come out but the shoulders get stuck behind the pubic bone of the mother's pelvis.

Princess Charolette of Wales, King George IV s daughter spent four days in labour and died from haemorrhagic shock.

Three quarters of a century later,

child birth medicine obstetrics has made child birth safer. Child birth is also becoming surgical. There can be overwhelming indications for this. Sceptics have noted caesarean delivery is convenient for obstetric schedules. Obstetrician have fear of mal practice and public rage when baby gets asphyxiated. Doctors in other fields always look weird at their obstetric colleagues. The child birth is a physiological process. Top medical students are not attracted as there is little science or fascination unlike in coronary stents, mechanical joints and artificial ventilators.

Child birth is a natural process. We are seeing the wane of art of child birth.
The skill to bring a child in trouble safely through a vaginal delivery however inconsistent and unevenly distributed has been nurtured over centuries. The mother's pain, blood loss, length of recovery and positive birth experience is accountable. We aim for everyone to do better as child birth is unforgettable memory in ones life .

Dr. Saradha Jaganathan
MD, DNB,FNB

Consultant Obstetrician and Gynecologist

Academics - Sri Ramakrishna Hospital, Coimbatore

August 2022

September 2022

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 offers 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 previously conducted 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.

Welcome on Board

Dr.Arun Gangadhar
DNB (Resp.Med)., MNAMS.,
IDCCM (Critical Care)., EDARM., (Europe)
Consultant Pulmonologist

- Post graduation in Respiratory Medicine from the reputed Ganga Ram Institute of Post graduate Medical Education and Research (GRIPMER), New Delhi.
- Trained in several interventional procedures by renowned experts in the field and has acquired the skills to perform basic and advanced bronchoscopical procedures like flexible bronchoscopy, transbronchial & endobronchial lung biopsy, endobronchial ultrasound (Linear & Radial), thoracoscopy, foreign body extraction, and interventions such as airway stent placements.
- Adept and proficient in the management of critically sick patients & patients requiring Extra Corporeal Membrane Oxygenation (ECMO). He has done post doctoral fellowship in critical care (IDCCM) & later fellowship in ECMO from GRIPMER, N.Delhi.
- Active member of various academic societies like European respiratory society, Indian society of critical care medicine & Indian chest society.

Dr.R.Vickram Vignesh
MD, DM(Cardio), PDF (EP)
Consultant Cardiologist and Electrophysiologist

- MD (Internal Medicine) from Madras Medical college.
- Completed his DM Cardiology from GB Pant Hospital (MAMC) - Delhi University.
- Post doctoral fellowship training in Cardiac Electrophysiology and Heart failure.
- Expertise include 3-D Electrophysiological study and Radiofrequency ablation of SVT, VT, and Implantation of pacemakers, ICDs and CRT -D/P.

Dr.MAHESH PALANIVELU
MBBS, DO, DNB
Opthalmologist

- MBBS from IRT Perundurai Medical College.
- D.O from MMC (Regional Institute of Ophthalmology and Government Ophthalmic Hospital).
- DNB from Aravind Eye Hospital, Coimbatore.
- Worked as junior doctor in MV eye hospital and Shalom Thomas eye hospital.
- Has experience in management of ocular trauma diabetic retinopathy and Glaucoma.
- General Ophthalmologist with good experience in Small incision cataract surgery, phacoemulsification and anterior segment surgeries.

Dr.APARNA S VIDYA
MBBS., MD., DNB (DVL)., FRGUHS
Consultant Dermatologist

- Md dermatology University gold medalist.
- Expertise in neonatal and pediatric dermatoses, cosmetic dermatology and dermatosurgical procedures along with clinical dermatology.

Welcome on Board

Dr. R. SABARINATHAN
MBBS, DNB(General Medicine), DM(Gastroenterology), FAGIE(Fellowship in Advanced Gastrointestinal Endoscopy)
Consultant Gastroenterologist & Hepatologist

- DNB (General Medicine) in Meenakshi Mission Hospital Research Centre, Madurai.
- DM (Medical Gastroenterology) in Madras Medical College.
- Fellowship in Advanced GI Endoscopy in Medindia Hospital, Chennai.
- Well trained in basic to advanced endoscopic procedures including ERCP.
- Special interests: Evaluation and Management of Basic to Complex Gastrointestinal, Hepatobiliary and Pancreatic diseases.

Dr R Jayapal
M.S., MCH (G.I. Surg & Liver Transplantation, AIIMS, New Delhi)
Surgical Gastroenterologist

- Post graduate surgical training from the prestigious PGIMER, Chandigarh.
- MCH in G.I.Surgery and Liver Transplantation from the internationally acclaimed AIIMS, New Dehi.
- Special interest, vast knowledge and experience in complex liver, pancreas and biliary surgery.
- Trained in advanced laparoscopic surgeries, and bariatric surgery.

Dr. PRAKASH KRISHNASAMY
MS., MCH (Surgical Gastroenterology)., Fellowship in Transplant Surgery (UK) FMAS
Surgical Gastroenterologist

- Post graduate and Superspeciality (surgical gastroenterology) training at nationally acclaimed Amirta Institute of Medical Sciences (AIMS), Kochi.
- Transplant surgery fellowship at Internationally renowned Addenbrooke's - Cambridge University Hospital, UK.
- Medical Scientist training in HPB & colorectal surgery at Samsung Medical Center, Seoul ,South Korea.
- Colorectal surgery specialist doctor at York Teaching Hospital,UK.
- Expertise in complex Liver,Gall bladder,pancreas,hernia, colon and advanced laparoscopic gastro intestinal surgeries.

Dr. Chitra Jayakumar
MBBS., DCP(Ire), MRC Psyc (UK)
Consultant Psychiatrist

- Completed her membership exam (MRC Psych, UK) from Royal college of Psychiatrists in her very first attempt.
- Did her Diploma in clinical psychiatry (DCP) in Ireland.
- Experienced in various psychiatric subspecialities like general adult psychiatry, old age psychiatry including dementia care, learning disabilities and trained in dealing with psychiatric emergencies.

Sri Ramakrishna Hospital's organized awareness campaigns on Donating Mother's Milk and Breastfeeding

Sri Ramakrishna Hospital, with the Rotary Club of Coimbatore Cotton City association and NSS Volunteers from Sri Ramakrishna College of Arts and Science along with Nectar of Life (Mother's Milk Bank), organized a Walkathon on 6th August 2022, at Sri Saradhambal Temple, Race Course, Coimbatore at 7:00 AM to mark the Breastfeeding Awareness month.

This Walkathon-2022 was flagged off by Dr. G. S. Sameeran, District Collector, Coimbatore, in the presence of R. Sundar, Joint Managing Trustee, Rtn. Adv. AKS. N. Sundaravadivelu, Rtn. R. Mylsamy, Rtn. Sumit Kumar Prasad, Rtn, Rakesh Kumar Ranka, Rtn. Nirov Seth, Rtn. Dr. Neethika Prabu and Rtn. Krishna T. Sampath,Mr.C.V.Ramkumar- CEO SNR Sons Charitable Trust, Dr.P.Sukumaran - Dean and Medical Director, Dr.B.L.Shivakumar - Principal, Sri Ramakrishna College of Arts and Science.

Breast Feeding Awareness Stall at SRH

WORLD BREASTFEEDING week

Sri Ramakrishna Hospital
(Multi-Speciality)
395, Sarojini Naidu Road, Siddhapudur, Coimbatore

0422 4500000 | info@sriramakrishnahospital.com | www.sriramakrishnahospital.com