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Sri Ramakrishna
Hospital (MultiSpeciality)

# pulse

*Happenings at Sri Ramakrishna...*

48 Years of Excellence

## WORLD Heart Day

USE ♥ FOR EVERY ♥

**D Lakshminarayanaswamy**
Managing Trustee

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 the best treatment for patients.

Every year the World Heart Day is observed on 29th September in order to spread awareness among public on the importance of keeping the heart healthy and safe from any CardioVascular Disease (CVD).

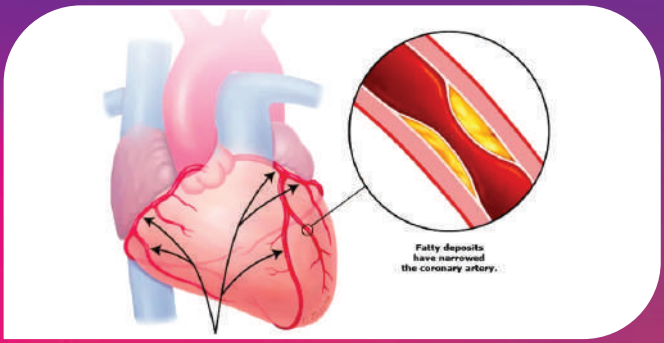
The theme of the day for this year is 'Use Heart For Every Heart'. It aims to highlight the power of digital health to improve awareness, management and prevention of CVD globally.

**Dr. S. Rajagopal**
Medical Director

Sri Ramakrishna Hospital is not just providing a healthcare facility to the public, it is a place of hope, compassion, and healing. At the heart of our clinical setup, we are fortunate to have a team of highly skilled and dedicated doctors, specialists, and healthcare professionals. On the occasion of World Heart Day 29th September 2023, Sri Ramakrishna Hospital has flagged off the largest cardiology exhibition that is scheduled from 29-09-2023 to 01-10-2023 at Smt Velumani Ammal Auditorium (Sri Ramakrishna Hospital Campus) from 9 am to 7.30 pm.

This innovative event promises to be an exceptional gathering of medical professionals, experts, various aspects of human heart technology used to treat heart and enthusiasts, showcasing the latest advancements in the field of cardiology.

In the month of October, we are planning to conduct Webinar on the topics Mechanical Thrombectomy in Basilar Artery Occlusion and one more topic Surgery for Stroke.




# Anomalous Origin of Coronary Arteries

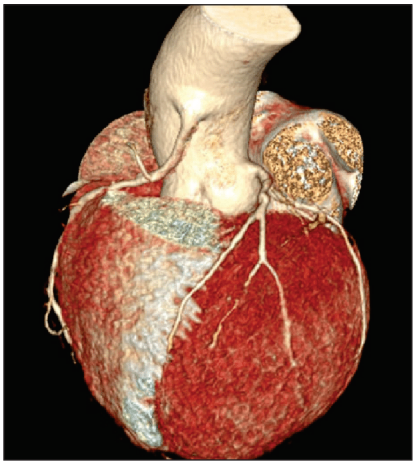
Coronary artery anomalies are observed in approximately 5% of the coronary angiograms performed in any cardiac catheterization laboratory. The observed coronary anomalies include anomalies in origin, course , associated intrinsic defects and their termination.

We present two cases where the right coronary artery arises from the ascending aorta, just above the right coronary sinus, one as an isolated anomaly and the other with left coronary artery arising from right coronary artery.

The right coronary artery, after its origin courses vertically downwards, and reaches the right atrio ventricular groove. The coronry orifice is usually slit like in this anomaly and atherosclerosis is a common feature.

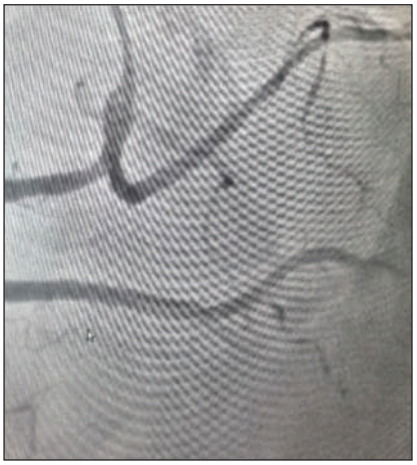
There could be technical difficulties in engaging this artery during coronary angiography or PTCA using regular RCA catheters.

Multi purpose catheter is very helpful in engaging this anomalous artery.



**RCA arising from ascending aorta**

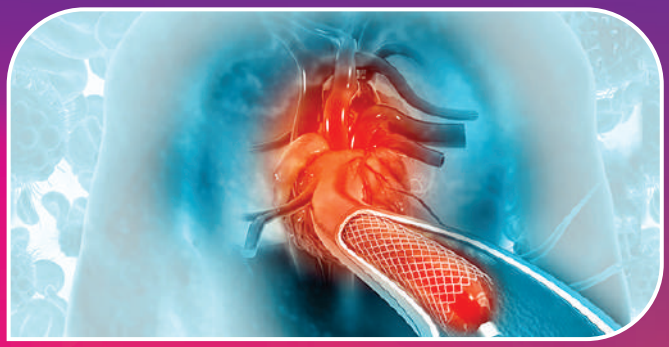
**RCA arising from ascending aorta with signicant proximal stenosis**



**RCA arising from ascending aorta with LCA arising from RCA (single coronary artery)**

**Dr.S.MANOHARAN**
MD.,(General Medicine)., DM (Cardiology)

Consultant Cardiologist & HOD



# Advancements in Interventional Cardiology: Pioneering Techniques and Technologies

**Introduction**
Interventional cardiology has made remarkable strides in recent years, revolutionizing the diagnosis and treatment of cardiovascular diseases. As one of the most dynamic fields in medicine, interventional cardiology constantly evolves, introducing innovative techniques and cutting-edge technologies that enhance patient outcomes and improve quality of life. In this article, we will explore some of the newer developments in interventional cardiology that are shaping the future of cardiovascular care.

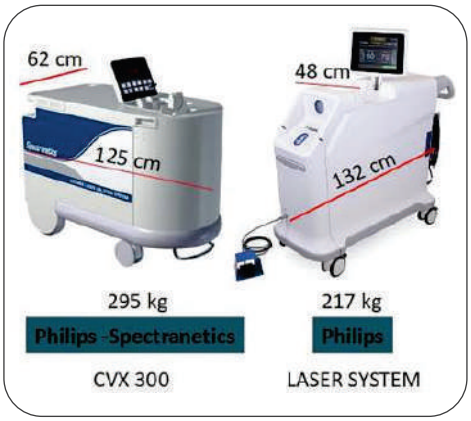
**Primary angioplasty**
Primary angioplasty is now offered 24 X 7 for all acute MI patients and timely reperfussion has revolutionised and shortened acute MI treatment.

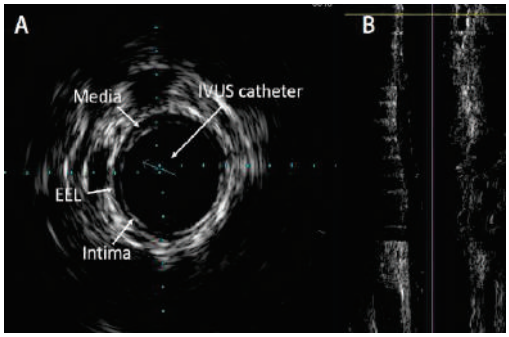
**Transcatheter Aortic Valve Replacement (TAVR)**
Transcatheter aortic valve replacement, or TAVR, has emerged as a game-changer in the treatment of aortic stenosis, a condition characterized by the narrowing of the aortic valve. This minimally invasive procedure allows the replacement of the damaged valve without the need for open-heart surgery. TAVR has become increasingly popular due to its reduced recovery time, lower risk of complications, and improved patient outcomes, especially among high-risk or elderly patients who may not be suitable candidates for traditional surgery.

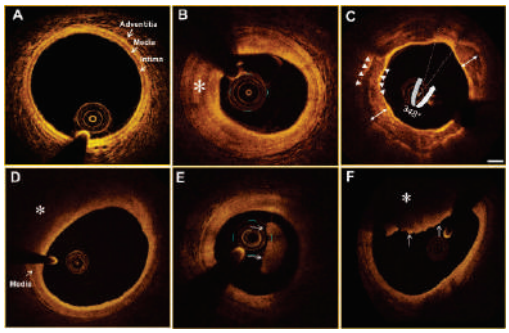
**Stent Technology**
Traditional metal stents have been a standard treatment for coronary artery disease for decades. Stent struts have become thinner and drug and polymer technologies have evolved making stent delivery in complex lesions easier. Bioresorbable stents provide mechanical support to the artery during the healing process and then disappear, allowing the vessel to return to its natural state. However this technology has setbacks and has not reached prime time use.

**Robot-Assisted Intervention**
Robot-assisted interventions have gained traction in interventional cardiology. These systems provide greater precision and control during procedures, enhancing the safety and accuracy of interventions. Robotic platforms allow cardiologists to perform complex procedures with smaller incisions, reducing patient discomfort and speeding up recovery times. Furthermore, they reduce radiation to operators.

**Fractional Flow Reserve (FFR) and Instantaneous Wave-Free Ratio (iFR)**
Fractional Flow Reserve (FFR) and Instantaneous Wave-Free Ratio (iFR) are advanced physiological measurement techniques used to assess the severity of coronary artery blockages. These technologies help cardiologists determine the need for stenting or intervention more accurately. By measuring blood pressure changes across a narrowed segment of an artery, FFR and iFR provide real-time data on blood flow, assisting in the decision-making process and reducing unnecessary interventions.






**Advanced Imaging Modalities**

In recent years, interventional cardiology has benefited significantly from advancements in imaging technologies. High-resolution intravascular ultrasound (IVUS) and optical coherence tomography (OCT) have become indispensable tools for visualizing coronary arteries during procedures. These technologies provide cardiologists with detailed, real-time images, enabling precise placement of stents and thorough assessment of arterial health.

**Cardiac resynchronisation therapy & EP interventions**

This field has evolved significantly and 3D mapping and other EP ablations have become simpler. CRT implantation helps a lot of heart failure patients.

**Laser assisted interventions**

Use of laser has evolved and is now available for variety of applications; Laser can be used to vaporise thrombus during primary angioplasty and has a role in stent restenosis interventions. It is also useful for pacemaker lead retrievals.

**Drug-Coated Balloons**

Drug-coated balloons are another innovative intervention in the fight against coronary artery disease. These balloons, when inflated at the site of a narrowed artery, deliver a drug to prevent restenosis and promote healing. They offer a less invasive alternative to traditional stenting, particularly in cases where stent placement may be challenging.

**Artificial Intelligence (AI) and Machine Learning**

Artificial intelligence and machine learning are rapidly being integrated into interventional cardiology. These technologies help cardiologists analyze large datasets, predict patient outcomes, and optimize treatment strategies. AI-driven algorithms can assist in diagnosing heart conditions, personalizing treatment plans, and even predicting adverse events, ultimately improving patient care and outcomes.

**Cardiac Transplantation**

Transplantation is one modality that has also seen great advances and patients are now living longer after heart transplants when all other modalities of treatment have been exhausted. ECMO & Left ventricular assist devices have also become handy in selected patients waiting for transplant.

**Conclusion**

Interventional cardiology continues to evolve, with newer developments offering improved patient outcomes, reduced risks, and enhanced precision in diagnosing and treating cardiovascular diseases. From TAVR to bioresorbable stents, robot-assisted interventions, advanced imaging, physiological measurements, and the integration of AI and telemedicine, the field is at the forefront of medical innovation. As technology continues to advance, interventional cardiologists are better equipped than ever to provide timely and effective care, ultimately improving the quality of life for patients with heart conditions. These developments represent a promising future for interventional cardiology, where innovation and patient-centered care go hand in hand. Cardiology department at Sri Ramakrishna hospital has 4 state of art Cath labs. Facilities include Rotablation, IVUS, OCT, FFR , 3D mapping and EP lab . A laser has also being installed and this will be the first facility in Tamilnadu after Chennai. Primary angioplasty is done 24 x 7 for all acute MI patients at our centre.

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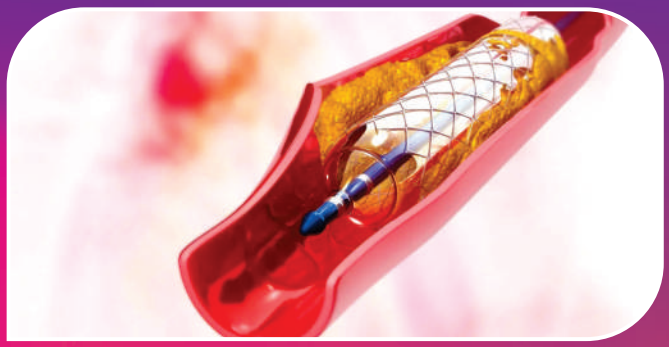
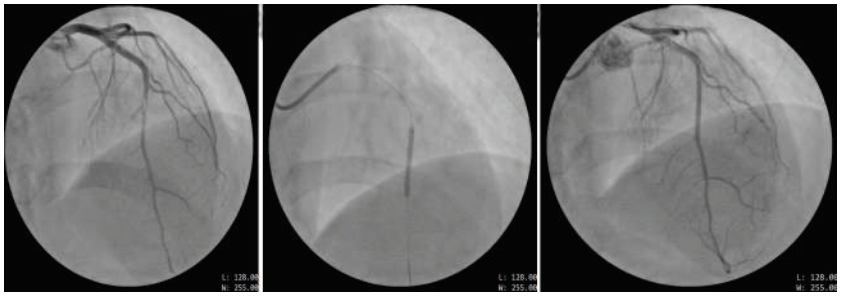
MRCP (UK), FICC.,
Senior Consultant Cardiologist



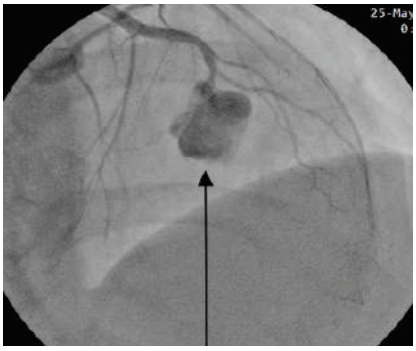
# An Interesting Case of Stent Failure

**Case Report**

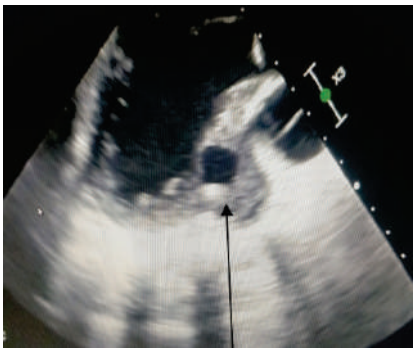
30 years Old, Male, Had anterior wall MI, CAG was done which revealed Single vessel disease and underwent PTCA (DES) – LAD on 13/3/2023.



- Immediately after PTCA he got discharged against medical advice without proper perioperative antibiotic coverage.
- Now admitted with complaints of recurrent high grade fever for 15days. ECG - F/S/O old anterior wall MI. Echo showed Moderate LV systolic function (EF-45%). CAG showed ISR with Aneurysm in LAD stent site.
- Median sternotomy, Pericardial adhesions released. While releasing the pericardium around the aneurysm gush of pus came out - C/S sent.
- Aorta Bi-caval cannulation, Aorta cross clamped, Antegrade root plegia. LAD aneurysm dissected out clots evacuated.

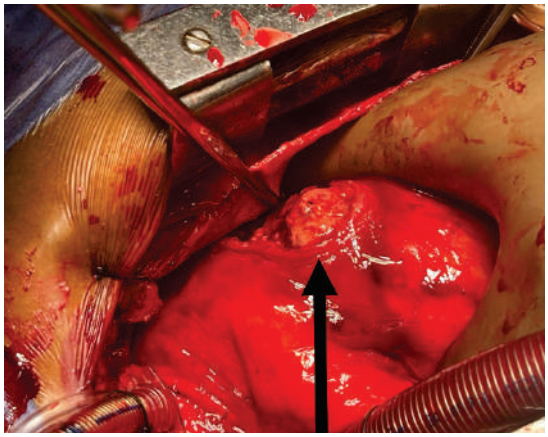


**Aneurysm in Previously stented LAD**

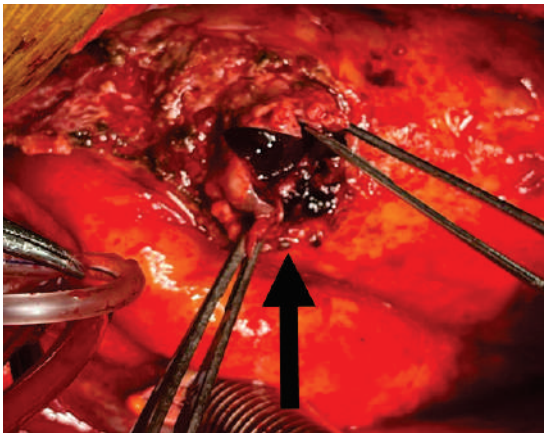


**TEE showed collection anterior to Left ventricle within the LAD Stent**

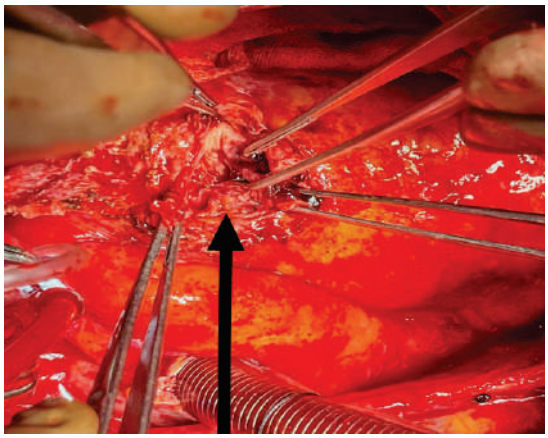
- LAD orifices sutured with pledgetted 4-0 prolene. Cavity cleaned well hemostasis achieved.
- Post operative period was uneventful. His cultures were sterile.He is having EF of 45 % and doing well in his follow-up periods.
- Take home message: Strict adherence to Peri-procedure antibiotics.Aggressive surgical management when medical management fails.



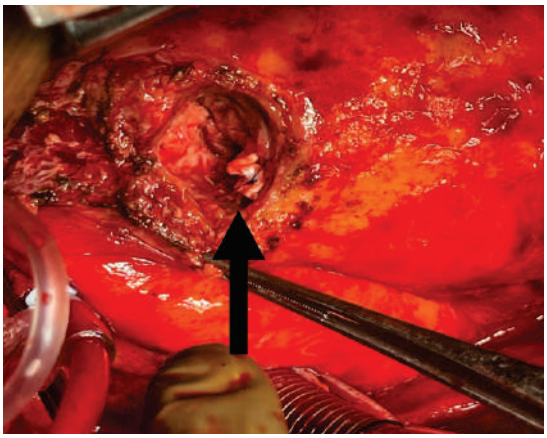
Aneurysm seen



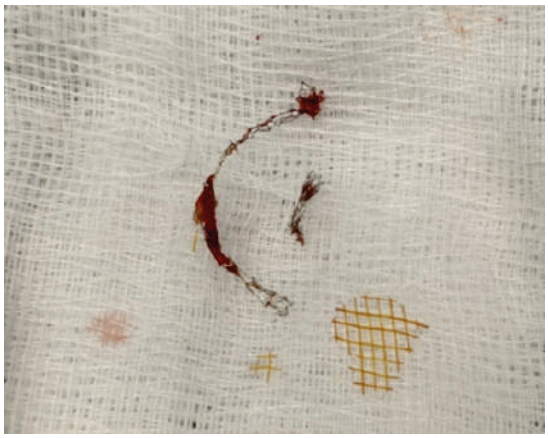
Aneurysm opened clots evacuated



Stent seen protruding



Stent removed and LAD orifice closed.



Excised stent

No residual collection seen

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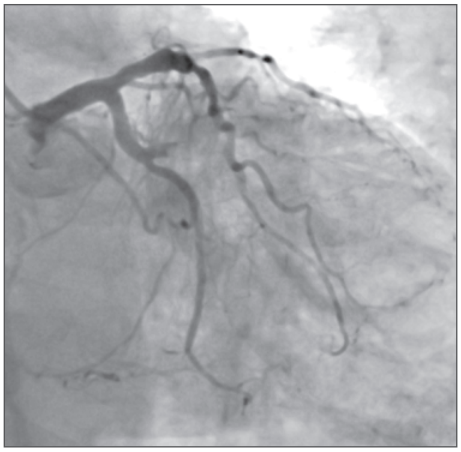
# Unmasking the Cardiac Wolf in Sheep's Clothing: A Suspected 'Gastritis' Case

We present an intriguing case that underscores the significance of maintaining a high index of suspicion and considering repeat cardiac evaluation in patients presenting with ischemic symptoms, even if prior assessments show normal results. In this report, we discuss the case of a 70-year-old male who underwent urological surgery and subsequently experienced epigastric and retrosternal pain, highlighting the need for timely intervention.

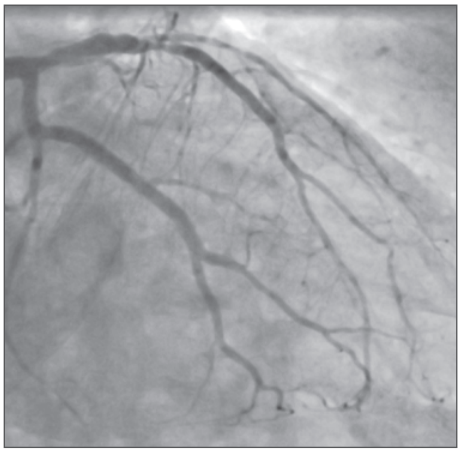
The patient initially sought care at an outside hospital, where he underwent cardiac evaluation, including an electrocardiogram (ECG) and echocardiogram (Echo), both of which turned to be normal findings. With this seemingly reassuring cardiac assessment, he was deemed fit for his planned urological surgery. However, a few days following his discharge, the patient's symptoms persisted, leading him to believe he was suffering from gastritis, given his recent cardiac evaluation and clearance.

In his quest for an alternative approach to address his discomfort, the patient sought consultation at a local Gastroenterology clinic. Dissatisfied with the clinic's environment, he declined an endoscopy and, instead, sought the opinion of Dr. Rajamani MS, McH, who wisely recommended further cardiac evaluation, despite the patient's prior cardiac assessment.

Upon presentation to our clinic, the patient's ECG revealed a startling finding: an Acute Inferior wall myocardial infarction (MI). Subsequent coronary angiography confirmed triple vessel disease, with complete occlusion of both the left circumflex artery (LCX) and right coronary artery (RCA), necessitating immediate primary percutaneous transluminal coronary angioplasty (PTCA)



**LCX Before PTCA**

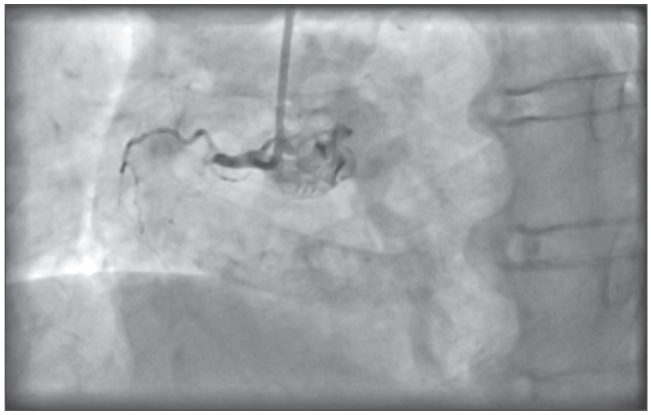


**LCX After PTCA**

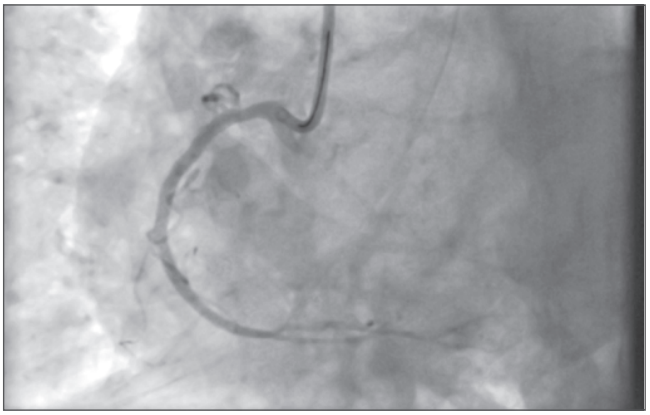
procedures on the LCX and RCA. PTCA of the left anterior descending artery (LAD) was performed subsequently.

This case serves as a poignant reminder of the importance of not solely relying on a patient's previous cardiac evaluation, especially in the presence of ongoing or new ischemic symptoms.

The seemingly normal preoperative ECG and Echo results did not rule out the possibility of underlying coronary artery disease. In this instance, a timely repeat ECG proved pivotal in uncovering a



RCA Before PTCA



RCA After PTCA

potentially life-threatening condition, ultimately leading to prompt intervention and a more favorable outcome for the patient.

In conclusion, we emphasize that clinicians should maintain a vigilant approach to patients presenting with ischemic symptoms, regardless of prior cardiac evaluations. This case underscores the critical role of repeat ECG assessments in the diagnostic workup, as it can reveal evolving cardiac conditions that may have been missed during initial evaluations. Early detection and intervention can make a substantial difference in patient outcomes.

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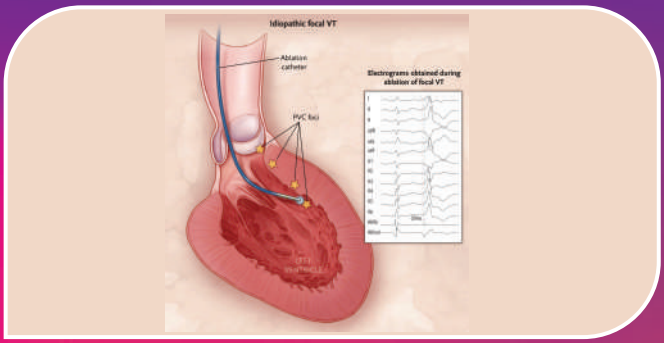
Senior Consultant Cardiologist

## CT - Coronary Angiogram




# RADIOFREQUENCY ABLATION (RFA) OF VENTRICULAR TACHYCARDIA (VT) IN A YOUNG PATIENT

**Case Presentation**

A 24-year-old female presented with palpitation followed by presyncope. Her pulse rate was 200 per minute and blood pressure was 90/70 mmHg. Her 12-lead ECG showed monomorphic VT with LBBB morphology (Figure 1). She was DC cardioverted in the ER. Following cardioversion, her baseline showed normal sinus rhythm without any ischemic changes.

Her labs were normal. Her echocardiogram showed normally functioning heart. She underwent cardiac MRI to look for any inflammatory or infiltrative cause. Cardiac MRI did not reveal any abnormality. She was diagnosed as a case of Monomorphic VT arising from outflow tract of the ventricle based on ECG morphology.

**Electrophysiological study and radiofrequency ablation of LVOT VT**

The patient was taken up for electrophysiology procedure. The right groin was infiltrated with 1% Lidocaine and accessed using a modified Seldinger technique and three venous sheaths (7, 7 & 6 French) were introduced into the right femoral vein under ultrasound guidance. Using similar technique, one 7 French sheath was introduced into the right femoral artery.

A decapolar electrophysiology catheter was placed in the coronary sinus. The mapping and ablation catheter was used to record a His bundle electrogram and was then placed in the right ventricle. A comprehensive EP study was performed, including: pacing and recording in the right atrium, right ventricle, and His bundle recording. Attempted induction of VT was performed using ventricular burst and extrastimulus pacing. Sustained ventricular arrhythmias were noted. Using a combination of pace mapping and activation mapping, the right ventricle was initially mapped. Later, left ventricular outflow tract was mapped.

The origin of the VT was mapped with electroanatomic (Ensite) and catheter mapping to the aortomitral continuity region of left ventricular outflow tract. (Figure 2 and 3) Radiofrequency energy with maximum power of 30 W and temperature of 50 degrees centigrade was applied to this region using an open irrigated 3.5 mm ablation catheter. Following ablation, VT was unable to be reinduced.

All antiarrhythmic drugs were stopped and there was no further episodes of VT during one year follow-up period.

**Highlights:**

Catheter ablation has emerged as the primary treatment of idiopathic VT and an additional tool for reducing VT burden in ischemic and scar VT.

Catheter ablation offers cure rates of over 90% and is the treat¬ment of choice for significantly symptomatic patients.

**FIGURE 1**
**Twelve Lead ECG Showing Monomorphic Ventricular Tachycardia (VT)**

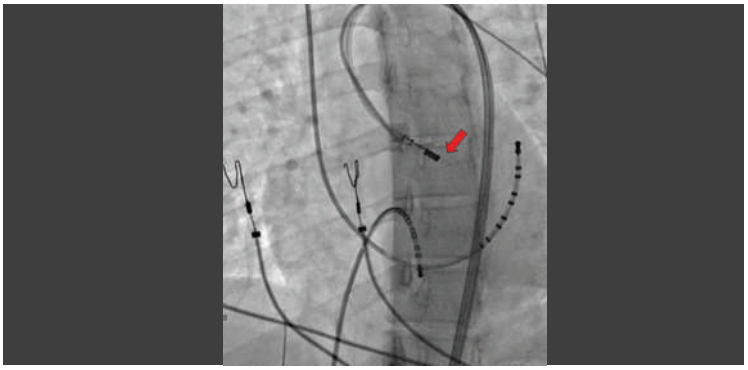


**FIGURE 2**
**Fluoroscopic Image of Radiofrequency Ablation Catheter (arrow) Below The Left Coronary Cusp In Left Ventricular Outflow Tract**

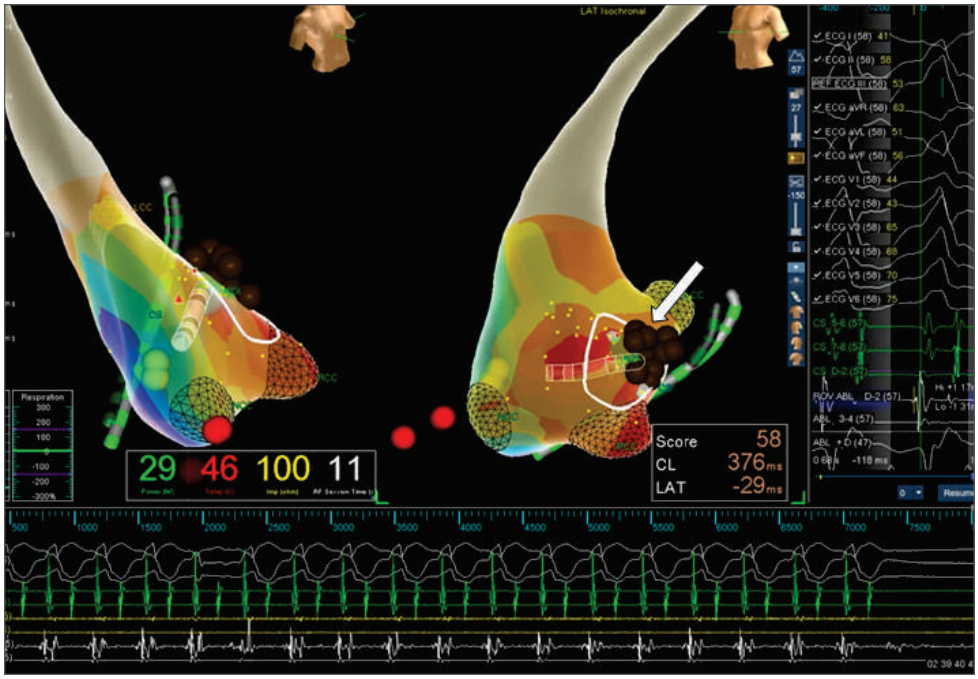



**Figure 3**
**3d – Electroanatomical Map of Left Ventricle and Successful Site Of Ablation (arrow) (below Left Coronary Cusp)**

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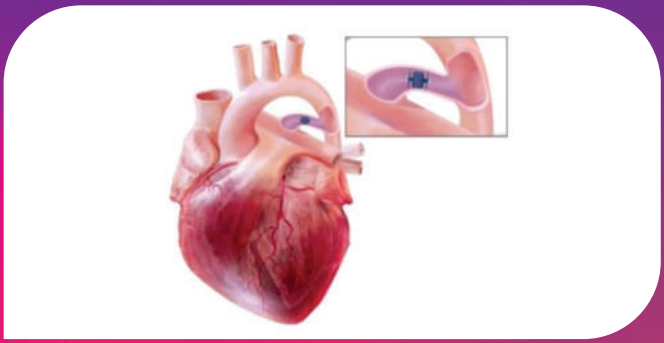
Consultant Cardiologist & Electrophysiologist



## Minimally Invasive KEY HOLE -PDA DEVICE Closure with PICCOLO device in PRETERM BABIES : CASE REPORT -Advancements and Outcomes

**CASE 1:** A premature female baby was born to a 22 years primigravida mother by LSCS at 31 weeks conceived through in vitro fertilization with GESTATIONAL DIABETES AND PREEGNANCY INDUCED HYPERTENSION with a birth weight of 1700 g in an outside hospital . Baby was under B-CPAP support for three weeks and was on caffeine maintanence in view of apnea of prematurity. Post natal ECHO was done in view of continuous murmur and persistent symptons of CCF showed large PDA and was started on medical management (Paracetamol). Despite three course of Paracetamol (Each course for 5 days), PDA failed to close and was referred to SRH

Baby was in room air at admission with mild respiratory distress. ECHO done here revealed large 3.5 X 4 mm diameter and 7mm length haemodynamically significant PDA, LA LV dilated with moderate PAH and good biventricular function.

PRETERM PDA DEVICE CLOSURE was done on 17.11.2022

Post procedure, baby had features of BPD changes , was treated with short course dexamethasone and nebulised bronchodilators. Baby's respiratory effort and neurological status improved and baby was extubated on POD 4 Repeat 2D echo showed closure of PDA with device in position, good cardiac function with good flows in pulmonary artery, aorta and no tricuspid regurgitation. Discharge weight was 2.9kg.

**CASE 2:** A Premature female baby was born to a primigravida mother at 27 weeks with a birth weight of 1100 g in an outside hospital. Baby had respiratory distress with hyaline membrane disease for which baby was given 1 dose of surfactant, required continuous positive airway support and received caffeine in view of apnea of prematurity. Baby was under intensive care support for 23 days. She was referred to us at 3 months of age in view of congestive heart failure . CT pulmonary angiogram done showed Large Patent Ductus Arteriosus (PDA) 1cm in length and 4.5mm in diameter.

On admission she was in congestive cardiac failure weight with the 3kg ,was started on oxygen and anti failure medications. PRETERM PDA DEVICE CLOSURE was done on 05.09.2023.

Feeding resumed after 6 hours and was well tolerated. The baby began gaining weight and received routine preterm care as per unit policy. Neurological examination indicated age-appropriate development. She was discharged after 2 days, with a closure of PDA confirmed by a follow-up 2D echo, good cardiac function, and a discharge weight of 3.1 kilograms.

**PROCEDURE:** Intervention was done under general anesthesia and mechanical ventilation support. The procedure involved cannulating the right femoral vein under ultrasound guidance and inserting a 4F radial sheath. The PDA was crossed using a Runthrough PTCA wire and 4F RCA catheter from the venous end. A 4F AMPLATZER Torqvue LP catheter was threaded through the right femoral vein, inferior vena cava, right atrium, right ventricle, pulmonary artery, and into the descending aorta. The 5 X 4 mm AMPLATZER Piccolo occluder IN CASE 1 AND The 5 X 2 mm AMPLATZER Piccolo occlude IN CASE 2 was implanted under echocardiographic and fluoroscopic guidance, ensuring no obstruction to the pulmonary artery or descending thoracic aorta

**DISCUSSION:** The Piccolo Occluder is the first commercially available device for use in premature infants ≥700 g in India. Significant procedural complications can occur, especially with smaller babies despite the excellent outcomes in various studies. Potential adverse events that may occur during or after placing this device

include air embolism, apnea, arrhythmia, hypertension, allergic dye reaction, valvular regurgitation, vascular access site device embolization, hematoma, partial obstruction of aorta, partial obstruction of pulmonary artery, pericardial effusion, name some.

While most pediatric interventional cardiologists are familiar with the technique of percutaneous transcatheter PDA closure, in case of babies weighing ≤1 kg, several procedural modifications may be required to achieve success and reduce complication rates. In extremely low birth weight babies attention must be paid for necessary accommodations during transportation from and to neonatal intensive care unit (NICU), ventilator support during the procedure, pain management during the procedure, maintenance of euthermia and backup for blood products. Currently the contraindications for the usage of this occluder device are weight <700 gm at time of the procedure, age <3 days at time of procedure, coarctation of the aorta, left pulmonary artery stenosis, cardiac output that is dependent on right to left shunt through the PDA due to pulmonary hypertension, intra-cardiac thrombus that may interfere with the implant procedure, active infection requiring treatment at the time of implant, PDA length smaller than 3 mm, PDA diameter that is greater than 4 mm at the narrowest portion. At present, there is no consensus on the ideal timing for PDA closure in premature infants. Transcatheter PDA closure for ELBW and premature infants is a new therapy that could shift the treatment paradigm. Further studies are necessary to continue to answer important questions of which PDAs require closure and when to close the hsPDA in premature infants.

**CONCLUSION:** Percutaneous device closure of haemodynamically significant PDA in extremely low birth weight babies is challenging. Many administrative and procedural alterations may be required during the procedure. Piccolo device is the first FDA approved device for such small babies.

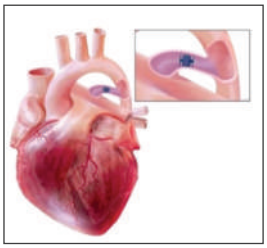


**FIG 1 animation showing piccolo device intraductally**

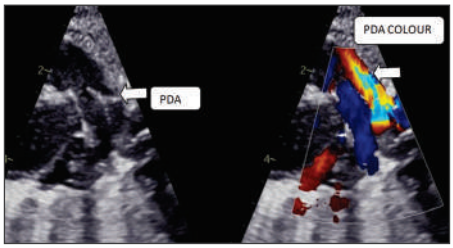



**Fig 2 echo showing tubular PDA with2D and colour doppler**

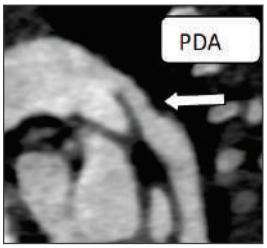



**Fig 3 CT still picture showing tubular PDA**

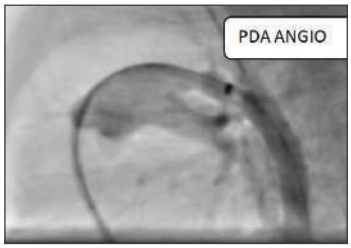



**Fig 4 Angiogram still picture showing tubular PDA**

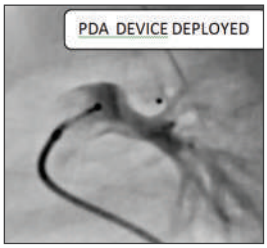



**Fig 5 angiogram still picture showing piccolo device occluging PDA**

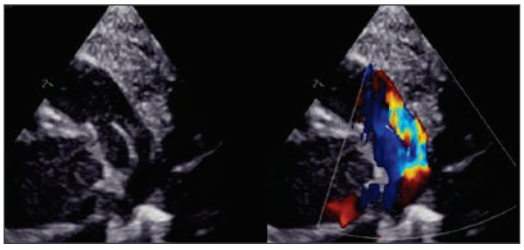


**Fig 6PRE PDA DEVICE ECHO**

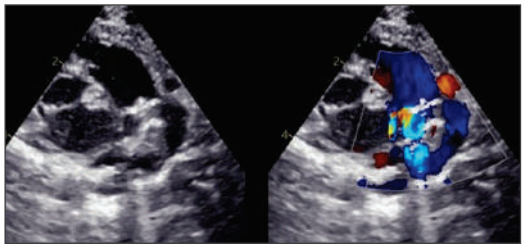


**Fig 7 POSTPDA DEVICE ECHO**

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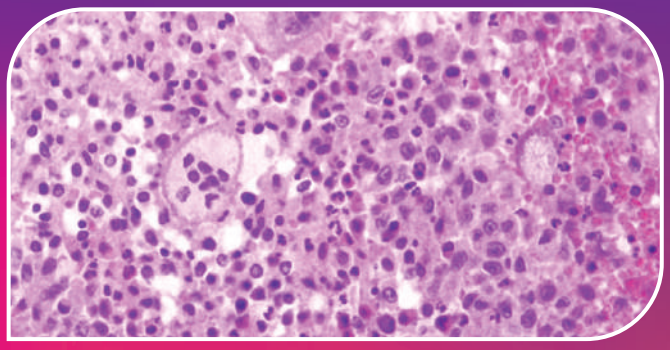
MD (Paediatrics), FNB (Paediatrics Cardiology).,

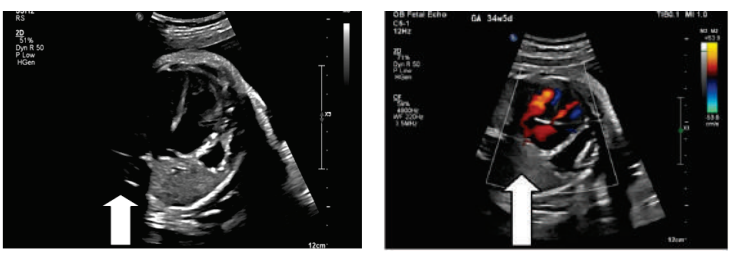
Consultant Interventional Paediatric Cardiologist



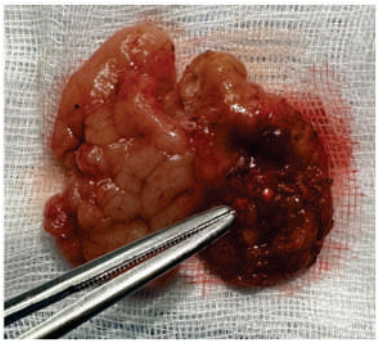
# A Rare Case Of Thymic Langerhans Cell Histiocytosis in Neonate: A Case Report

**Introduction:** Langerhans Cell Histiocytosis (LCH) is a complex systemic disorder characterized by an abnormal proliferation of Langerhans cells, generally organized in granulomas. The estimated prevalence is between 1 and 2 per 100,000 population. The organs most frequently involved are the bone, the skin, the pituitary gland, the lung and, less commonly, the hematopoietic system, the liver and the central nervous system. Thymus involvement is rare. LCH typically occurs in children as part of a multifocal, multisystem process. Only few reports of isolated tumours involving the thymus have been published in adults, either in association with coexistent myasthenia gravis, low grade leiomyosarcoma or multilocular thymic cyst. In the literature, we found only a single case of a child who presented an isolated thymic LCH, mimicking lymphoma . Here, we report a case of isolated Langerhans cell histiocytosis of the thymus in a neonate with non-specific symptoms. We excised the thymic mass successfully.

**Case Report:** A 12 days old baby which was delivered by LSCS in our hospital was evaluated in NICU for anterior mediastinal mass which was diagnosed antenatally. A few vesicular skin lesions were present over the chest and trunk which spontaneously resolved over time. Echo showed PDA, small ASD with good biventricular function. USG chest done which showed Right paracardiac mediastinal cyst. MRI chest done showed anterior Mediastinal mass involving thymus on right side with calcifications and fat components possibly teratoma with bilateral lung nodules suspicious of metastatic disease. Planned for surgical excision.



**Fetal echo showing anterior mediastinal mass**

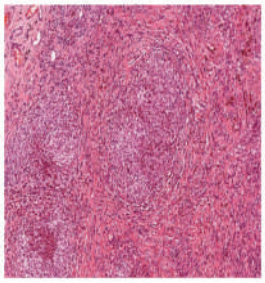


**Excised Mass along with thymus showing calcification spots**

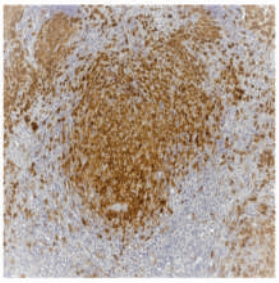
After informed consent, baby was taken up for surgery. There was 2.5x2.5 cm cystic lesion in Right lobe of thymus with specks of calcification seen in the thymic lobe. Total Excision of the mass with Thymectomy was done on 13/03/2023. In the immediate post operative period, baby was doing well and extubated on POD 2. The Wound healed well and she was discharged on 19/03/2023. HPE reported as Mature cystic teratoma with Langerhans cell histiocytosis.

**Discussion:** Because of its rarity, LCH remains poorly understood. The disease was first described in 1953 by Lichtenstein under the term "histiocytosis X". This entity encompassed a group of rare syndromes of unknown aetiology such as eosinophilic granuloma, Letterer-Siwe disease or Hand-Schuller-Christian disease. In 1987, because of the presence in the tumour of Langerhans cells, a sub group of dendritic histiocytes initially described by Paul Langerhans in 1868, the name was changed to "Langerhans cell histiocytosis".

The disease pattern, i.e. whether LCH is localized or occurs as part of a multisystem process, is known to be a marker of severity. In patients with high risk multisystem disease, the most effective treatment strategy involves a



Langerhans cell histiocytosis, H/E 10x. Infiltrate of medium-size cells with epithelioid features displaying irregular and grooved nuclear membrane, vesicular chromatin, prominent nucleoli, surrounded by lymphocytes and eosinophils.



Langerhans cell histiocytosis, Cd1a stain.

combination of chemotherapy and steroids to limit the risk of complications and improve outcome. By extension, this treatment tends to be also applied in patients with lower risk, localized LCH. Reports of LCH within the thymus are less frequent than within the bone, the skin or the endocrine system. Although thymic lesions are commonly reported in the setting of multisystem disease, isolated forms are rare. Indeed, in a series of 14 LCH patients with thymic involvement, either at presentation or during the course of the disease, reported by Junewick and Fitzgerald, 7 had multisystem involvement, 1 had unisystem but multifocal involvement and 6 had isolated unifocal disease. Several studies have described thymic LCH as an enlargement of the mediastinum due to increased thymic volume. The thymus is enlarged, with lobulated/nodular contours and heterogeneous ultrasound pattern, and possibly contains liquid cysts and/or calcifications. As demonstrated here, the presentation of the disease is highly variable, which makes diagnosis extremely challenging. Because of the diagnostic difficulties, it is hypothesized that the incidence of LCH may be underestimated, as for instance in very young children with typical thymic enlargement associated or not with non-specific episodes of fever and bronchial or pulmonary infection. The incidental discovery of a thymic LCH in young adult patients with myasthenia gravis is also in favour of this hypothesis. Based on these observations, the actual contribution of chemotherapy to the treatment of patients with localized LCH may appear questionable. These patients are likely to have a good response to treatment. The skin rash is the most common presentation like our patient had. In children, the rash may be misdiagnosed for other common skin lesions and it will not respond to typical treatment. The rash of LCH ranges from a single lesion to widespread involvement. Characteristics include scaly papules, nodules, or plaques and can resemble seborrheic dermatitis. One may distinguish LCH by the presence of petechiae, bloody crusting, or firmly indurated nodules. Pulmonary lesions occur in 20% of patients, and lymph node involvement in 30%. As such, the patient may present with pulmonary symptoms or lymphadenopathy. Hepatosplenomegaly may be present as well. Bony involvement occurs in about 78% of patients. Pituitary involvement also seen in few cases. Biopsy of the involved site (usually skin) is required to confirm the diagnosis. Lesions will stain positive for S-100 and CD-1a. When the diagnosis is confirmed, workup for systemic involvement should include a skeletal survey, abdominal ultrasound, complete blood count (with bone marrow biopsy if indication of bone marrow involvement). Treatment varies greatly depending on the involved organs. If the disease is isolated, observation alone may be appropriate. Surgical removal of an isolated area is also a treatment option. Isolated skin lesions may resolve on their own, Chemotherapy and radiation may be used for more systemic involved cases. Our patient had isolated thymus involvement. Pre operatively we managed the baby as isolated anterior mediastinal cystic mass probably as teratoma. Total excision of the mass was done. Postoperative histopathoogy was reported as Mature cystic teratoma with Langerhans cell histiocytosis.

**Conclusion**: LCH with thymic involvement is a rare but well described disease. Typically, patients with unifocal tumours have a good prognosis and respond well to chemotherapy, although one may question the appropriateness of treating these patients who may well recover spontaneously. The incidence of LCH is probably underestimated because diagnosis is hampered by the lack of specific clinical presentation and poor knowledge of radiological manifestations of the disease. An early diagnosis and proper treatment can achieve good outcome in such children. Our child is well now and is asymptomatic.

**Dr. S.VIJAY SADASIVAM**
MS, MCH, (CTVS), DNB

Consultant Paediatric Cardiothoracic Surgeon

# World Heart Day Exhibition at Sri Ramakrishna Hospital

Sri Ramakrishna Hospital inaugurated the largest cardiology exhibition as a part of World Heart Day 2023. This exhibition was inaugurated by Kranthikumar Pati, Collector; Dr. A Nirmala , Dean Of Coimbatore Medical College Hospital; Shri D. Lakshminarayanaswamy, Managing Trustee (SNR Trust); Shri C. V. Ramkumar, CEO (Sri Ramakrishna Hospital); Dr. S. Rajagopal, Medical Director (Sri Ramakrishna Hospital) and Dr. S. Alagappan, Medical Superintendent (Sri Ramakrishna Hospital), at Velumani Ammal Auditorium (Sri Ramakrishna Hospital Campus) from 9 am to 4 pm.

Sri Ramakrishna Hospital has flagged off the largest cardiology exhibition that is scheduled from 29-09-2023 to 01-10-2023 at Smt Velumani Ammal Auditorium (Sri Ramakrishna Hospital Campus) from 9 am to 4 pm. This innovative event promises to be an exceptional gathering of medical professionals, experts,various aspects of human heart technology used to treat heart and enthusiasts, showcasing the latest advancements in the field of cardiology. Attendees will have an unique opportunity to gain insights into functioning of human heart, cutting-edge technologies, breakthrough treatments, and innovative solutions that are revolutionizing the world of heart care. The inaugural event was graced by Sri Kranthikumar Pati, Collector; Dr. A Nirmala , Dean Of Coimbatore Medical College Hospital; Shri D. Lakshminarayanaswamy, Managing Trustee (SNR Trust); Shri C. V. Ramkumar, CEO (Sri Ramakrishna Hospital); Dr. S. Rajagopal, Medical Director (Sri Ramakrishna Hospital) and Dr. S. Alagappan, Medical Superintendent (Sri Ramakrishna Hospital).

ஒருங்கிணைந்த

# மகப்பேறியல் மற்றும் மகளிர் மருத்துவம்

## தாய்மையின் சுதந்திரம்

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# World Pharmacist Day at Sri Ramakrishna Hospital

World Pharmacist Day 2023 was celebrated by the Hospital organized by Department of Clinical Pharmacy and Pharmacy on 26th September 2023 at 9:00 AM, in SRH Auditorium. The Chief Guest of the function was Dr. S. Sri Ram, Head of Department - Pharmacy Practice. The programme was started with a prayer song and Dr.S.Alagappan, Medical Superintendent welcomed the gathering. The key note address on the Pharmacist theme " Pharmacist Strengthening the Health System " was delivered by our chief Guest Dr. S. Sri Ram who emphasized on bringing the Pharmacy profession into lime light and reflected the importance of Pharmacist in Clinical setting, Industrial and Community. He also highlighted the importance of patient education in Hospitals by the Pharmacists. A book was released by the Clinical Pharmacy Department entitling "Clinical Pharmacy a Break Through in Health Care" which focuses on role of clinical Pharmacists in Hospital Setting.

## Upcoming Events

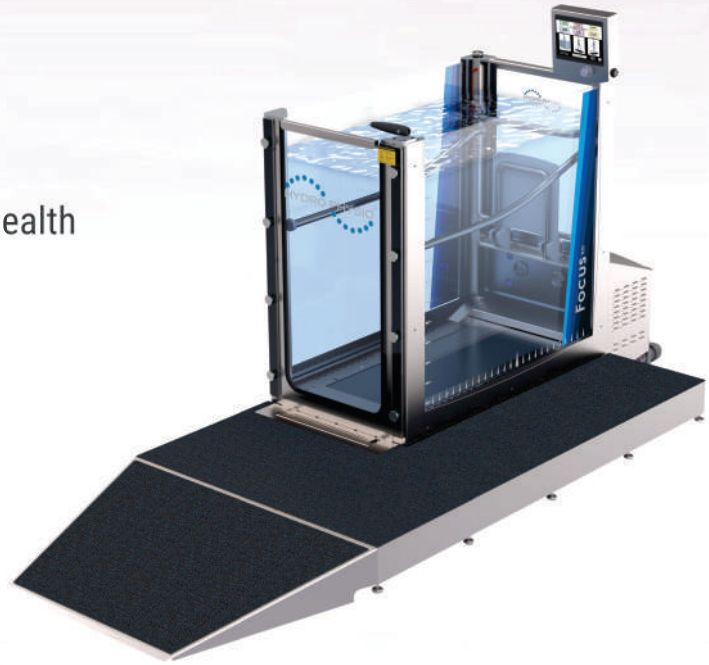
# Academics - Sri Ramakrishna Hospital, Coimbatore


SRH Academics continuously extends its focus to the entire Doctors' Community. We are organizing webinars on the 3rd of every month at 4:00pm.

1st time in TAMILNADU

# Aquatic Treadmill

Aquatic Treadmill is a advanced equipment, first to be launched in Tamilnadu in the field of physiotherapy. It is the advanced exercise treatment offered as a part of hydrotherapy. Aquatic treadmill work by wearing a suitable equipment(conveyor belt) in a pool so that the patient can perform exercise opposed to the force of the water under the guidance of the therapist.



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- Builds strength and fitness
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- Enhance Relaxation

## Population

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- Balance deficits
- Perceptual / Spatial problems
- Cerebral palsy
- Spinal cord Injury
- Rheumatogical Condition[Arthritis]
- Ligament Injury in Lower Limb [sprain]
- Strain [Muscle Tear]
- Sport fitness & endurance
- Pre & Post pregnancy conditions


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