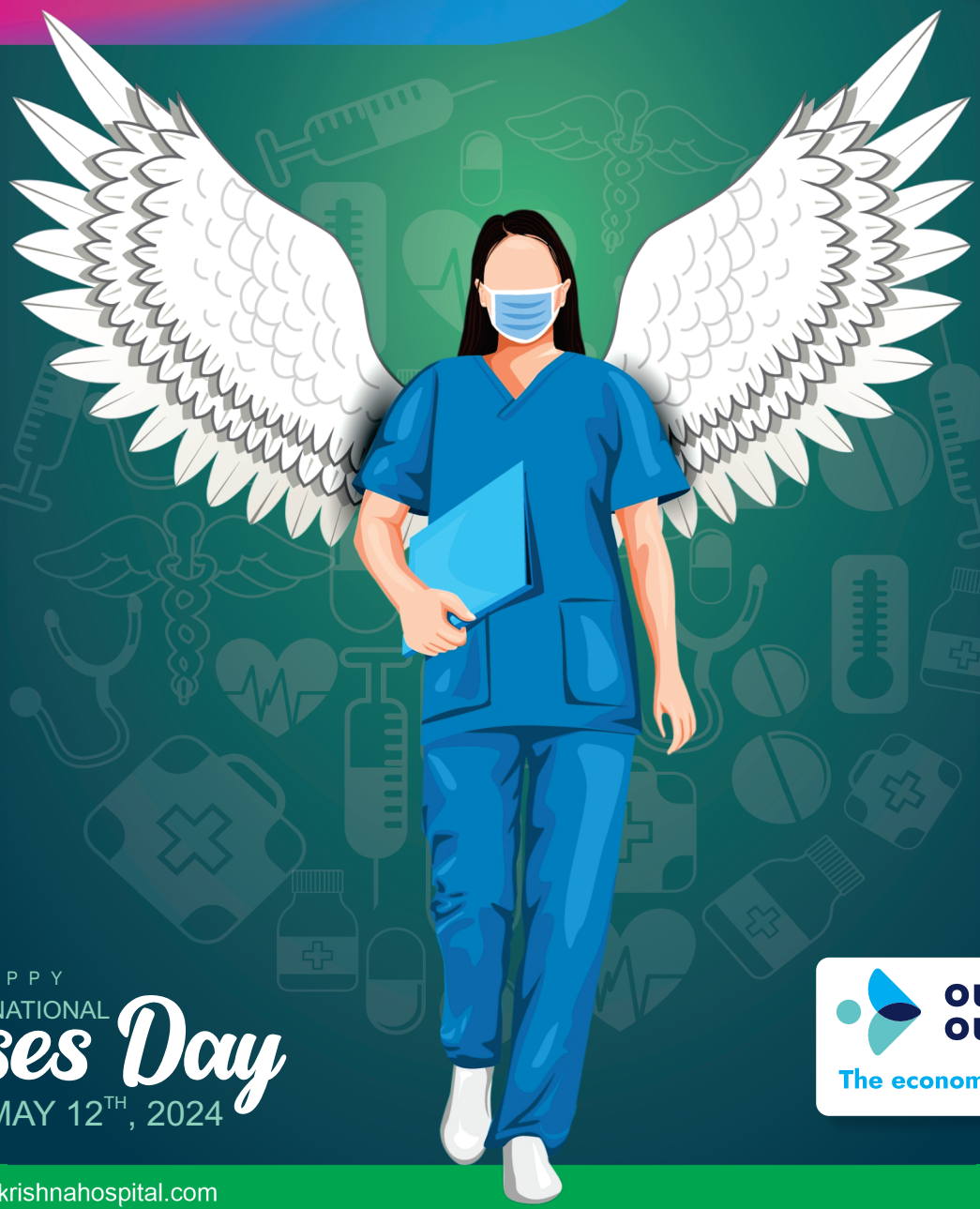
VOLUME 39 | ISSUE 1 | May 2024

Sri Ramakrishna
Hospital (MultiSpeciality)

pulse

Happenings at Sri Ramakrishna...

48 Years of Excellence



HAPPY
INTERNATIONAL
Nurses Day
MAY 12TH, 2024

OUR NURSES.
OUR FUTURE.
The economic power of care

Shri.D.Lakshminarayanaswamy
Managing Trustee

It gives me immense happiness to be a part of this organization and privilege to be the part of the team that constantly strives to provide the best health care services. We work with a vision to provide affordable world-class healthcare services. We believe constant change is important to bring the best out of anything. Similarly technology is the change that act as a foundation to provide best medical services.

I extend my deepest gratitude and appreciation to each and every one of you on this "Nurses Day". **You are a true hero !** Your dedication, compassion, and unwavering commitment to providing exceptional care to our patients are truly commendable.

Especially during the challenging times, your resilience and professionalism have been a constant source of inspiration to all. Your hard work does not go unnoticed, and we are immensely proud to have such a dedicated team of nurses at our hospital.

Dr. S. Rajagopal
Medical Director

Sri Ramakrishna Hospital has always been a forerunner in conducting diverse academic programs alongside its clinical achievements. The emphasis on clinical club meetings, where in the discussion of interesting cases adds an enriching dimension to the professional development of the team.

The specific focus on **Pulmonology, Medical Gastroenterology & Hepatology and Clinical Laboratory** this month demonstrates a commitment to staying updated with medical advancements and addressing a broad spectrum of healthcare needs. This proactive approach not only benefits the medical professionals involved but also enhances the overall quality of patient care.

I express my heartfelt appreciation for the incredible work undertaken by your team everyday and night. Your dedication, compassion, and unwavering commitment to patient care are truly admirable. I am privileged for witnessing the firsthand impact of your hard work and professionalism. Your skills and expertise are the backbone of our healthcare team, and we are grateful for your unwavering dedication, especially during these challenging times. We appreciate your tireless efforts, your unwavering dedication, and your commitment to excellence. **Happy Nurses Day to each and every one of you!**

Editorial Team

Dr.N.Loganathan Pulmonologist	**Dr.S.Prahadeeshwaran** Head - Public Relations	**Mr.Murali Kaliappan** Head - Marketing

Sri Ramakrishna Hospital
LITTLE MIRACLES - 01.04.2024

Sri Ramakrishna Hospital and Rotary Club of Coimbatore Cotton City joined hands and launched an initiative 'Little Miracles', aimed at providing financial aid to premature babies in need of treatment at the Neonatal ICU of Sri Ramakrishna Hospital.

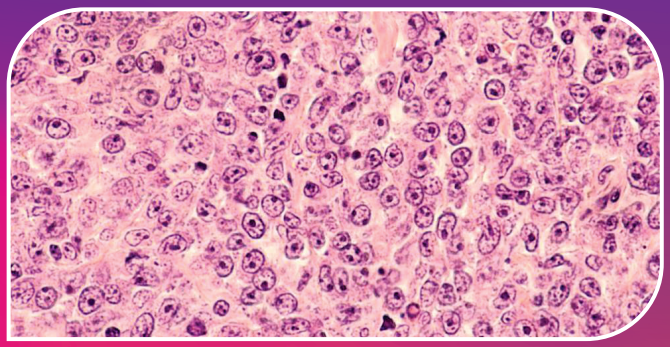
The launch ceremony of this initiative was attended by Shri.D.Lakshminarayanaswamy Managing Trustee - SNR Sons Charitable Trust, Rtn. Chella Raghavendaran DGN DIST 3206, GGR. Rtn. Ajay gupta, President Rtn. Krishna Samant, Rtn. Dr. Neetika Prabu Secretary, Chairman Rtn. Santosh Mundra, Rtn. Pradeep Karnani co- chairman, Rtn. Prassanah Kumar Kothari, Director Community Service, all members, family and friends of Rotary Club of Coimbatore Cotton City.

Through the "Little Miracles" initiative, eligible premature babies in need will receive a substantial sum to cover the expenses associated with their treatment. This collaboration aim to not only save lives but also to alleviate the financial burden on families during their time of need.

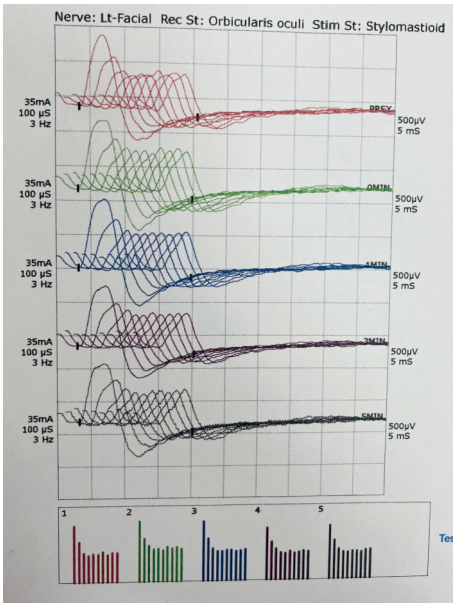
Sri Ramakrishna Hospital - Antimicrobial Stewardship - 04.04.2024

Antimicrobial resistance(AMR) is one of the top global health threat and it is estimated that AMR is responsible for 1.27million global deaths. The misuse of antimicrobials in humans and in animal husbandry, poultry farms are the main drivers in the development of drug resistant pathogens.

In order to create an awareness on appropriate antimicrobial utilization, an academic session was organized in our Hospital on March 29, 2024. Dr. Subramanian Swaminathan, the Vice President of Clinical Infectious Disease Society (CIDS) and Board Member Fungal Infection Study Forum addressed the Senior Consultants, Clinical Pharmacists, Nurses on various aspects of antimicrobial stewardship and Hospital Infection control practices.



Intriguing Interplay: Non-hodgkin's Lymphoma Disguised as Ocular Myasthenia Gravis



A 70 year old male patient who is a diabetic, hypertensive presented with 1 week history of double vision and left sided headache. On Clinical examination left ptosis with preserved pupillary reflex and extra ocular movements,no clinical evidence of long tract signs. Clinical diagnosis of left LMN third cranial nerve palsy was established. Further investigations were carried out as follows

*Ice pack test was positive and repetitive nerve stimulation test showed decremental response in left orbicularis oculi and bilateral nasalis suggestive of post synaptic neuromuscular junction pathology.

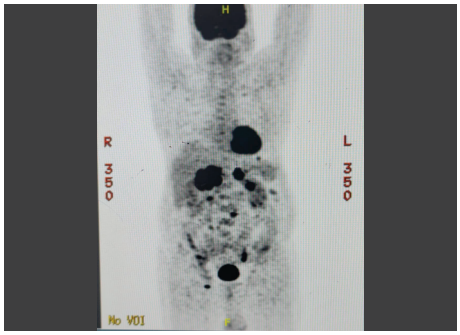
*Anti acetyl choline receptor antibodies were negative.

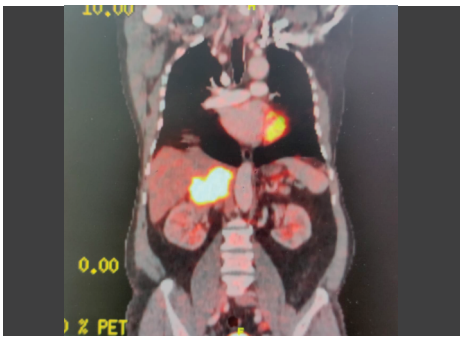
Given the absence of thymoma on the thoracic CT scan and in view of atypical presentation, we aimed at excluding extra thymic malignancy, proceeded with PET CT scan which revealed a hypermetabolic adrenal mass lesion along with multiple enlarged abdominal lymph nodes and pleural deposits.

*CT guided biopsy of the adrenal gland confirmed the presence of Non Hodgkin lymphoma.Immuno histochemistry further identified it as high grade B cell NHL.

Patient was treated with RCHOP regimen consisting of rituximab, cyclophosphamide, doxorubicin, vincristine, prednisolone

Currently patient has completed 3 cycles of chemotherapy.



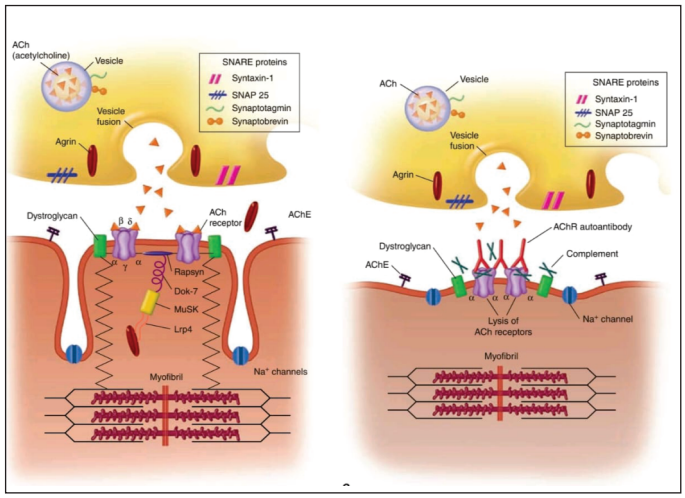


Myasthenia gravis stands as the most prevalent autoimmune disorder affecting the neuromuscular junction. Initially, over half of the patients with generalized myasthenia gravis experience solely ocular symptoms before other body regions become affected.

If generalization does occur, it typically happens within the first year, with up to 90% of patients experiencing it within two years. If a patient with solely ocular myasthenia doesn't progress to generalized symptoms within three years of symptom onset, the likelihood of generalization is low.

Predilection for Extra Ocular Muscles

Extraocular muscles are frequently affected in myasthenia gravis because the twitch fibers within them develop tension more rapidly and have a higher frequency of synaptic firing compared to limb muscles. Moreover, tonic muscle fibers are essential for maintaining gaze in various directions, and they possess fewer acetylcholine receptors, rendering them more vulnerable to receptor loss or damage.



Autoantibodies associated with Myasthenia Gravis Include:

- Acetylcholine receptor (AchR) antibodies, which are positive in 80 to 85% of generalized myasthenia gravis cases and 50% of ocular myasthenia gravis cases
- Muscle-specific kinase (MuSK) antibodies, which are positive in 10 to 20% of all myasthenia gravis cases.
- Low-density lipoprotein receptor-related protein 4 (LRP4) antibodies, which are positive in 5% of myasthenia gravis cases.

The synchronous or asynchronous co- occurence of lymphoma and MG is thought to be driven by shared pathways and genes that foster unchecked lymphocyte proliferation, possibly resulting in both autoimmunity and lymphoma.

This case underscores the uncommon presentation of paraneoplastic ocular myasthenia gravis in a patient with non-Hodgkin lymphoma. Prompt identification and timely intervention have resulted in substantial clinical enhancement.

The above mentioned patient was effectively managed by team of Dr.P.Jambulingam Consultant Physician & HOD, Dr.N.Vedhanayagam Consultant Neurologist, DNB Final year Medical Residents Dr.Preethi and Dr.Padmapriya.

Dr.N.VEDHANAYAGAM
MBBS, DNB in General Medicine, DNB in Neurology
Consultant Neurologist

Dr.P.JAMBULINGAM
MBBS., MD(Gen Medicine)
Consultant Physician & HOD

Approach to a Case of Acute Febrile Illness

Fever accompanies many illnesses and is a valuable marker of disease activity. Infection is a primary concern. Drug reaction, malignancy, vascular thrombo embolism, vasculitis and tissue necrosis are other possibilities but are diagnoses of exclusion. The events preceding fever including exposure to infected materials or vectors of disease should always be ascertained. Physicians should always be aware that elderly patients with chronic liver disease or renal failure and patient taking glucocorticoids or being treated with anti inflammatory drugs or anticytokine therapy may have infection in the absence of fever due to a blunted febrile response. As in all other disciples of medicine, a complete and thorough history is of prime importance in dealing with a possible infectious diseases in any febrile patient. The history is so vital in developing a focused D. D and for guiding the physical examination and also for deciding initial diagnostic tests. Specific complaints relevant to infectious diseases requires particular attention. These include two main points,(1) Exposure history that may identify microorganisms with which the patient may have come in contact. (2) host specific factors that may predispose to development of infection.

History: Presenting symptoms are frequently non-specific. Before the history is elicited and physical examination is performed, an immediate assessment of the patient's general appearance can yield valuable information. History of previous infections and associated microbial sensitivity may be useful in determining the etiological agent. Specifically, history of infection with drug resistant organisms eg. Methicilliin resistant s.aureus, vancomycin resistant enterococcus species, enteric organisms that produce an extended spectrum lactamase or carbanemase which may alter the choice of empirical antibiotics.

Social History: Physicians history taking is most often limited to alcohol and tabacco use in many cases. But a complete social history should often have clues to the underlying illnesses; whether the patient has high risk behaviours (unsafe sexual practices, drug abuse, occupational exposure) can facilitate diagnosis.

Dietary History: History of consumption of raw, under cooked meat can cause shiga toxin producing strains of Escherichia coli, Toxoplasma Gondi infection, S.typhi, listeria monocytogene, M.bovis associated with unpasteurized milk, parasites and enteric bacteria with unpurified water, vibrio species, helminlths and protozoal organisms with raw sea food.

Animal exposure: Animals often serve as vectors of infection diseases. H/o contact with pets at home, visit to zoos or random encounter with animals will be more useful to know the cause of infections.

Travelling history: Both domestic and international travel history is very important. For example, patient with a fever who recently returned from abroad broadens differential diagnosis and may reflect patients exposure to infection with pathogens like mycobacterium tuberculosis or strongyloides stercoralis and what kind of activities and behaviors, the patient engaged during the travel. The type of food, sources of water consumed, fresh water swimming, animal exposure, all will help in understanding the underlying pathogens. History of immunization and history of prophylactic medication are also important as exposure during a patient routine daily living, lack of splenic function, alcoholism with significant liver disease, drug use, HIV infection, diabetes mellitus, organ transplantation, chemotherapy all predispose to different kind of infections. Patient should be questioned about the factor that will help identify a nidus for invasive infection such as recent upper respiratory tract infection, influenza, varicells, prior trauma, disruption of cutaneuos barrier due to laceration, burns, surgery, body piercing or decubitus ulcers. Presence of foreign bodies such as nasal packing after rhinoplasty, tampons or prosthetic joints. Travel contact with pets or other animals that might result in tick or mosquitoes lead to diagnoses that would not the otherwise be considered. Recent dietary intake, medications, social or occupational contact with all individuals, vaccination, recent sexual contacts and menstrual history may yield useful clues. A thorough examination of system should focus on any neurological signs or sensorium alteration, rashes or skin lesions and focal pain and tenderness should be carried out and also should include general examination of respiratory, gastro intenstinal or any genito urinary systems.

Physical examination: Complete physical examination is vital and must be performed with special attention to several areas that are sometimes given scant attention during routine examination. Assessment of patients general appearance, vital signs, skin soft tissue examination and neurological examination are all of particular importance. The patient may appear either anxious, agitated or lethargic and apathetic. Fever is usually present, but elderly patients, immuno compromised individuals(eg. Uremic, cirrhotic) and those who are on cartico steroid medications may not exhibit typical signs of infection because of altered and depressed immune response and may be afebrile despite serious underlying infections. Measurement of blood pressure, heart rate and SPO2 helps to determine the degree of haemodynamic and metabolic compromise. Patients airway must also be assessed to rule out any obstruction due to the invasive oropharyngeal infection. The etiologic diagnosis may be evident after a thorough skin examination. Petechial rashes are typically seen with meningo coccmia, rocky mountain spotted fever cases; erythema is commonly seen in toxic shock syndrome & drug fever. The soft tissue and muscle examination is critical in many infections. Areas of erythema duskiness, tenderness and feverness may indicate underlying necrotizing fasciitis, myonecrosis and myositis. The neurological examination should include a careful assessment of mental status, signs of early encephalopathy. Nuchal rigidity or focal neurological signs should be clearly sought.

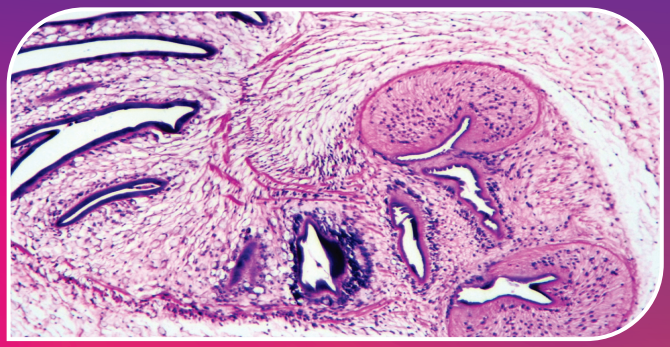
Diagnosis workup: After a quick clinical assessement, diagnostic specimen should be obtained rapidly and antibiotics and supportive therapy begin. Blood cultures, baseline complete blood count with differential count, serum electrolysis, blood urea nitrogen, serum creatinine, plasma glucose and liver function tests should also be carried out at the time of intravenous line placed and before the antibiotics are administered. Blood lactate can concentration should be measured. Three sets of blood cultures should be obtained for patients with possible acute endocarditis; asplenic patients should have a buffy coat examination for bacterimia. Blood smears from patients at risk of severe parasite diseases like malaria, babesiosis must be examined for appropriate diagnosis and quantitation of parasitemia. Patients with possible menginitis should have CSF (CSF drawn before administration of antibiotics) study; focal findings, depressed mental status and pappilloedema on fundus examination should be evaluated by brain imaging studies prior to lumbar puncture, because of risk of cerebral herniation. Antibiotics should be administered before imaging but after blood cultures has been done. If CSF cultures are negative, blood culture will provide diagnosis in 50-70% of cases. Molecular diagnostic techniques like PCR testing for bacterial meninitis pathogens are of increasing importance with rapid diagnosis of the life threatening infection. Cerebral abscesses necessitate immediate CT or MRI as part of an evaluation for surgical intervention. Other diagnostic procedures like wound cultures should not delay the initiation of the treatment for more than minutes. Once emergent evaluation, diagnostic procedures and appropriate surgical consultations whenever necessary are over, other laboratory tests can be done. Appropriate radiological investigations, computed axial tomography, MRI, Urine analysis, ESR and CRP determination and trans- thoracic or transoesophegeal, echo cardiograpy may all prove important.

Treatment: In the acutely ill patient, empirical antibiotic therapy is critical in patients in whom infection is a primary concern as well as the neutropenic and asplenic patients and should be initiated without any delay. Increased prevalence of antibiotic resistance is of serious concern and should always be considered before antibiotics therapy is started. Several of these infections may require urgent surgical attention. Neurological intervention of subdural haemotoma, otolaryngologic surgery for possible mucor mycosis and cardiac surgery for critically ill patients with acute endocarditis are as important as antibiotic therapy. For skin cellulitis like necrotizing fascitis and clostridial myonecrosis, rapid surgical intervention supersedes other diagnositic or therapeutic maneuvers.

Adjunctive treatment may reduce morbidity and mortality rates and include dexamethasone for bacterial meningitis or immunoglobulin for toxic shock syndrome and necrotizing fasctis caused by Group A streptococcus. Adjunctive therapies should be initiated usually within the first hour of treatment; however dexomethasone for bacterial meningitis must be given before or at the time of first dose of antibiotics; Glucorticoids can also be harmful in certain times, resulting in worst outcomes especially when given in the setting of cerebral malaria or viral hepatitis.

Dr.M.RAMASAMY
MBBS., MD(Internal Medicine)

Senior Consultant Physician



Disseminated Cysticercosis: A rare case report

Introduction: Cysticercosis cellulose are the larval forms of the Taenia solium. The definitive and intermediate host are humans and pigs respectively. To develop the disease, the eggs enter into the intestinal lumen through the auto infection or contaminated eatables. Finally the larval forms spread to the distant sites through the blood stream after crossing the intestinal wall leading to the clinical manifestations. Disseminated cysticercosis is an unusual manifestation of this common disease especially in the tropical and sub-tropical regions. Till date, only fewer than 100cases have been reported worldwide so far.Here in we present a case who presented with a relatively asymptomatic sub hyoid lump as a manifestation of disseminated cysticercosis.

Case report: A 33 year old vegetarian woman from rural part of Tamilnadu presented to our department with a 15 day history of lump in the sub hyoid region which had increased in size over last few days. The swelling was otherwise asymptomatic with no specific precipitating or relieving factors. She also revealed recurrent admission to nearby health facility for low grade fever, myalgia and right thigh pain in last few months. A swelling of about 3x2cm was noted in the sub hyoid region in the subcutaneous plane (Figure 1). No other masses were palpable. General and systemic examination was otherwise unremarkable. Investigations revealed haemoglobin of 13g/dl, total counts of 13,850cells/cu.mm with predominant lymphocytosis and eosinophilia; Erythrocyte Sedimentation Rate of 40mm/hr. Inaddition, ECG, urine and other routine biochemical investigations were within normal limits. HIV, HbsAg and HCV screening were negative. The tests for Rheumatoid arthritis factor and antinuclear antibodies were normal.

Ultrasound examination of the sub hyoid region showed a 3.3x2.2cm cystic lesion in the subcutaneous plane and an eccentrically placed echogenic solid nodule with curved structure within it with surrounding inflammatory tissue changes. Findings suggested a possibility of cysticercosis. Furthermore, stool and blood Enzyme Linked Immuno Sorbent Assay (ELISA) were ordered and were normal and positive for Cysticercosis antibody respectively. An excision biopsy of the swelling was done. On gross examination, the specimen showed a firm cyst surrounded by pale fibrous tissue. Cut section showed clear fluid filled cavity with a curved structure attached to the cyst wall. Microscopically, the cyst was surrounded by dense fibrous two layered wall showing lymphocytic infiltration. The tiny nodule contained within the cyst exhibited a coiled parasite within a connective tissue capsule(Figure3). The diagnosis of subcutaneous cysticercosis was made.

Figure:1 Clinical photograph showing a swelling of about 3x2cm in the sub hyoid region in the subcutaneous plane.

Orthopaedic colleague was consulted for thigh pain and Magnetic Resonance Imaging (MRI) was suggested for recurrent pain and low grade fever. MRI of both thigh regions revealed multiple tiny hyper intense lesions with perilesional edema and rim enhancement in T2 weighted images, consistent with cysticercosis lesions. A whole body MRI showed multiple such lesions all over the body (Figure 2).

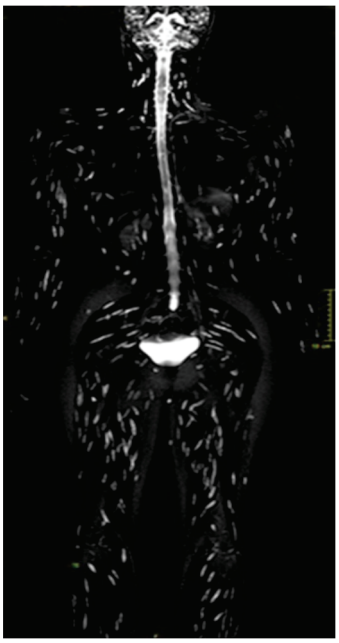


Figure:2 A whole body MRI image showing the typical rice grain likes lesions all over the body-typical 'starrysky' appearance seen in disseminated Cysticercosis.

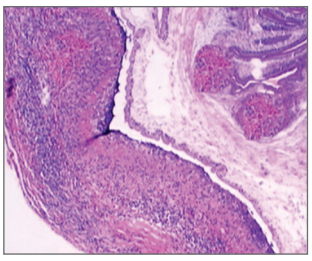


Figure:3 Low power microscopy photograph showing a cross section of cysticerci entrapped in a fibrous capsule and surrounded by dense fibrous two layered wall showing lymphocytic in filtration and granulomatous reaction.

Her family members were screened negative for cysticercosis by means of Stool examination and Blood ELISA for cysticercosis antibody. A multi-disciplinary team planned the treatment for the patient. She was primed with steroids one week prior to the initiation of cysticidal drugs. Later albendazole therapy was initiated at a dose of 15mg/kg for a period of 30days. The patient was observed at the hospital for 5days after initiation of the cysticidal drugs. On follow-up after four months, no new lumps were reported and her myalgia had also improved significantly.

Discussion:

Human cysticercosis is caused by the dissemination of the larval forms of Taenia solium from the intestine via the blood stream to the organs and tissues of the body. The organs most commonly affected are the subcutaneous tissue, skeletal muscle, lung, brain, eye, liver and occasionally the heart. This may involve almost any organ of the body. Widespread dissemination of cysticerci throughout the body was reported as early as 1912 by the British Army medical officers stationed in India. In 1926, Priest described probably the first case of disseminated Cysticercosis in a British soldier who had epileptic seizures, mental dullness, swelling of his muscles and widespread subcutaneous nodules. In 1961, are view of 450 cases of cysticercosis by Dixon and Lips comb reported only one case of dissemination. The clinical features depend on the cyst burden, viability of the cyst, the host reaction and more importantly their location. The syndrome of disseminated cysticercosis is characterized by pseudomuscular hypertrophy(100%), palpable subcutaneous nodules(87%), seizures(78%) and abnormal mentation. Subcutaneous cysticercosis may cause painful or painless subcutaneous nodules.

There is diffuse symmetrical painful or pain less enlargement of all groups of muscles associated with weakness and easy fatigability. Clinically, soft tissue cysticercosis can be misdiagnosed as abscess, lipoma, tuberculous lymphadenitis, epidermoid cyst, pyomyositis, neuroma, sarcoma, neuro fibroma, ganglion, myxoma, or fat necrosis. Although our patient had diffuse cerebral and muscular involvement, there was no significant hypertrophy and she was without associated symptoms except for the swelling in the sub hyoid region and myalgia. Ultrasonography is the most reliable initial diagnostic modality of choice for a soft tissue swelling. Computed Tomography (CT) scans and Magnetic Resonance Imaging (MRI) are useful adjuvants in anatomical localization of the disease. MRI is more sensitive than CT as it identifies live forms, scolex and the response to treatment. Peripheral rim enhancement of the cyst wall is commonly due to reactive edema. Cysts within the muscles are arranged in the direction of the muscle fibers. Within the hyperintense cyst, the scolex is appreciated as a tiny hypointense speck. In our patient the MRI scan had a typical 'starry sky' appearance but did not reveal any calcified foci in muscles. The diagnosis of cysticercosis can be ascertained by fine-needle aspiration cytology (FNAC) or biopsy, which shows the scolex, fragments of the spiral wall and the detached hook lets of Cysticercosis cellulosae. Sometimes, only an inflammatory reaction consisting of large numbers of eosinophils and histiocytes can be seen. Serological tests are used to confirm the diagnosis, especially by detecting antibodies against cysticercosis. Enzyme-linked immunoblots assay is more sensitive and specific than ELISA.

The blood ELISA in our case was positive. Sensitivity of serological tests tends to be substantially lower for patients with a single cyst or calcified cysts and high for patients with multiple cysts (94%).Pharmacological management with the cysticidal drugs praziquantel(10–15mg/kg/dayfor6–21days)and albendazole(15mg/ kg/dayfor30days)help by reducing the parasite burden. These drugs hasten the death of the cysts, which even in the absence of such treatment may occur. It is recommended that all patients with multiple cysts should receive treatment with cysticidal drugs. There is no role for cysticidal drugs in inactive cysticercosis, i.e. calcified cysts, because the parasites are dead. Pharmacological treatment may be associated with severe reactions, which occurs as a consequence from massive release of antigens causing local tissue swelling, generalized anaphylactic reaction and enlargement of cysts. Before starting the cysticidal drugs, priming with corticosteroids decreases the incidence of such complications. Efficacy of treatment should be monitored at regular intervals. The detailed physical examination of the patient cannot be exaggerated, as exemplified in our case, where in a subtle subhyoid swelling led to the detection of a treatable condition like cysticercosis.

Conclusion:

A high degree of suspicion of disseminated cysticercosis must be kept in the list of the differential diagnosis of any solitary long standing soft tissue swelling especially in endemic areas. In addition to the rarity they are also difficult to suspect and diagnose clinically. The investigations need to be tailored to arrive at relevant diagnosis so as to plan the therapy. A multi disciplinary team approach to the treatment offers better results and minimise complications related to treatment. Patients who are on treatment and who have active cysts require periodic follow ups as they remain at risk for serious complications.

Dr.V.SARVESWARAN
MBBS, MS (Gen Surgery), FAIS

Consultant Surgeon & HOD

Flesh Eating Bacteria Syndrome

The term necrotizing fasciitis (NF) describes a group of relatively uncommon, but life-threatening infections of the skin, soft tissues, and muscles, which tend to progress rapidly through the fascial planes, causing gradual destruction of the fascia at a rate reaching 2–3 cm/h.

CASE REPORT

A 52 year old male patient , known Diabetic came with complaints of pain and swelling over the right lower limb with discoloration of skin .On examination patient was pale, hypotensive , tachycardia and tachypnea present . Investigations showed increased WBC COUNT (43.52) , moderate anemia (10.1), and CRP were 34.74 and elevated renal parameters . Arterial Doppler study was taken and it showed no flow in Right Posterior Tibial Artery .Patient started on intravenous antibiotic with aerobic and anaerobic coverage. The patient was posted for wound debridement under Anaesthesia and the necrotizing tissue sent for HPE correlation and the pus sent for culture and sensitivity. HPE REPORT --Skin and subcutis with necrotizing lesion and suppuration in keeping with necrotizing fasciitis, excised/debrided tissue from right leg.

The patient's general condition was not improving and tissues are not viable and patient posted for repeated wound debridement and post operatively patient sent for ICU management in view of hypotension and breathing difficulty and developed cardiorespiratory arrest and reverted .Vac dressing attempted and there was evidence of excessive bleeding from the surgical site because of large raw area, vac deferred and regular dressings were done . Patient's general condition not improved, repeat total count was raised, repeat CRP was elevated, renal output decreased and urea, creatinine were worsening and hence planned for Right above knee amputation.

After obtaining second opinion from vascular surgeon right above knee amputation done. Patient's general condition improved, renal function improved and patient has a raw area over the anterior aspect of above knee stump, skin grafting done after pus culture report.

DISCUSSION

Necrotizing fasciitis, also known as flesh-eating bacteria or flesh-eating disease, is a rare infection of the skin and tissues below it. The condition spreads quickly, with symptoms including blisters, fever, fatigue, and pain, as well as skin changes worse than what one would expect based on the wound's appearance.

Early diagnosis of NF is mandatory. Any delay could prove fatal, given its association with more extensive surgery, higher rates of amputation, and higher mortality rates. Furthermore, if left untreated, the infection could lead to systemic inflammatory response syndrome (SIRS). Bedside tests, imaging tests [CT or magnetic resonance imaging (MRI)], or frozen section biopsy can

be carried out in patients with equivocal clinical findings and a moderate or high risk of NF based on the LRINEC score (>5). The finger test and frozen section biopsy are used as complementary diagnostic modalities in patients with an equivocal diagnosis.

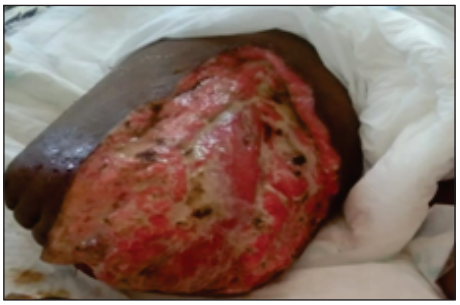
The disease was popularized by the media as “flesh-eating bacteria syndrome” The annual incidence of NF is estimated at 500–1,000 cases annually, and its prevalence globally has been reported to be 0.40 cases per 100,000 population. It is seen to have a predilection for men, with a male-to-female ratio of 3:1; infection of the lower extremities is the most common site of NF (57. 8%).

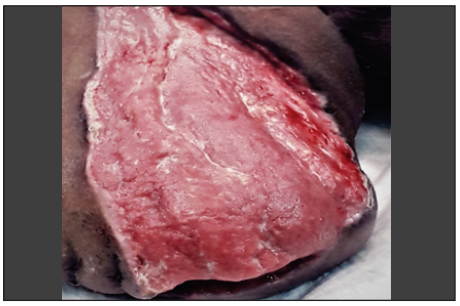
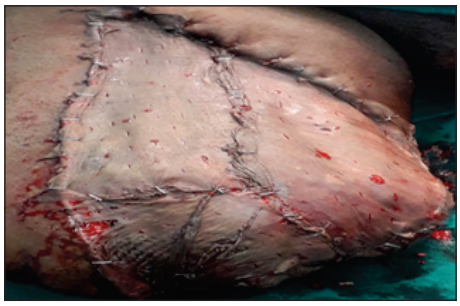
Surgical management

Emergency surgical debridement of the affected tissues is the primary management modality for NF. Surgical debridement, necrosectomy, and fasciotomy are the main aspects of surgical treatment. Surgical debridement should be repeated during the next 24 h or later, depending on the clinical course of the necrotizing infection and vital functions.

The use of a vacuum-assisted wound closing device (VAC) can also be helpful.





Dr.S.SUREES KUMAR
MBBS, DNB. FMAS (General Surgery)

Consultant Surgeon

Successful Split liver transplantation surgery by experts saves 1.5 year old child!

Sri Ramakrishna Hospital has successfully performed one-of-its kind "Split Liver Transplantation" on a 1 1/2 -year old child affected by an inborn condition called Biliary atresia that causes liver failure in children.

This milestone has marked a major achievement in the hospital's commitment to excellence in pediatric care, liver transplantation and service to younger generation. The hospital's highly committed team of Liver transplant surgeons Dr.Anand Bharathan, Dr. Jayabal, Dr. Prakash, Dr. Vikash Moond, Liver anaesthesiologist Dr. Prem Chandar and Paediatric HOD Dr. Siddharth Buddhavarappu, Paediatric and Neonatal Intensive care specialists Dr. Krishna sameera, Dr. Indhiradevi who brought a wealth of experience in this procedure and are supported by state of the art equipments and infrastructure.

In split liver transplantation, a whole liver donated by a brain dead donor was split into two parts, one smaller part for this child (for whom whole liver from an adult will not fit because of large size) and a larger part for another adult patient with liver failure. This way, a single brain dead donor simultaneously saved the life of 2 patients with liver failure, maximising the impact of organ donation.

At first, the child's parents were found to be unfit for donating a part of their livers when initial work up was performed for living donor liver transplantation by liver surgeons of the hospital. The child has now recovered well and has returned to a normal life in his village near Tiruchengode. The transplantation team was congratulated by Thiru. D. Lakshminarayaswamy, Managing Trustee, SNR Sons Charitable Trust, the CEO, Medical Director, Medical Superintendent for their successful completion of the surgery and saving the child's life.

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

For appointments: **0422 - 4500 000 / 3500 000 / 3536 100**

info@sriramakrishnahospital.com
www.sriramakrishnahospital.com