

Happenings at Sri Ramakrishna...







Wings & Stethoscopes: Healers of Hope





Shri.D.Lakshminarayanaswamy Managing Trustee

It gives me immense happiness to be a part of this organization and also I feel privileged be a part of the team that constantly strives to provide the best of healthcare services.

On this **Doctors' Day**, I extend **my warmest wishes and heartfelt gratitude to each one of you**. Your dedication, compassion, and tireless efforts a source of great strength to our Hospital. You bring hope and healing to countless lives, often going above and beyond the call of duty. Your commitment to excellence in patient care, your resilience in the face of challenges, and your unwavering pursuit of medical advancements are truly inspiring.

We recognize the many sacrifices you make, often putting the needs of others before your own. Your ability to provide comfort, your skill in diagnosing and treating illnesses, and your commitment to ongoing education and improvement are what make our hospital a beacon of hope and healing.

We Thank you for your relentless dedication and for making a difference every day. May you continue to inspire, heal, and lead with the same passion and integrity that defines you !



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 special focus on **IVF**, **Paediatrics & Paediatric Endocrinology** 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.

July 1st is celebrated as **Doctor's Day** for honoring doctors and I am filled with immense pride and gratitude as I extend my wishes to each one of you. As Medical Director, it is an honor to lead and work with an extraordinary team of dedicated professionals. Your contributions to the field of medicine, through research, teaching, and patient care, are invaluable. You work seamlessly with nurses, technicians, administrative staff, and all members of our healthcare team to ensure the best possible care for our patients. **Wishing you a very Happy Doctors' Day!**

Editorial Team

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

WORLD BLOOD DONOR DAY - 14.06.2024

Sri Ramakrishr

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World Blood Donor Day is celebrated on 14th June, which serves as a global platform to thank volunteers for their unpaid blood donation, thus saving multiple lives around the globe and to raise awareness about the need for blood donations.

To mark this day Sri Ramakrishna Hospital organized a successful blood donation drive which was inaugurated by Thiru. D. Lakshminarayanasamy, Managing Trustee, SNR Sons Charitable Trust, Thiru. C. V. Ramkumar, Chief Executive Officer, Dr. S. Rajagopal, Medical Director, Dr. S. Alagappan, Medical Superintendent where students volunteers, staffs of Sri Ramakrishna Educational Institutions and Sri Ramakrishna Hospital, donated over 100 units of blood. Also, to encourage the blood donation in the community, Sri Ramakrishna Hospital introduced "Blood Donor card", a privilege card to the donors for availing treatment facilities at a discounted rate in the hospital.



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Airway Puzzle: Cracking the Code of Complexity Sebaceous Cyst Scalp – Is Airway Management Difficult?

Case Report: A sebaceous cyst is an epidermal cyst often found on the hairy areas of the body such as the scalp, trunk, and face. Though a sebaceous cyst is commonly encountered in practice, its presentation as a large sebaceous cyst over the scalp is rare. Preoperative assessment revealed potential airway management challenges due to the large cyst, causing difficulty in mask ventilation, endotracheal intubation and patient positioning. Therefore, alternate positioning and intubation methods must be sought, highlighting the importance of interdisciplinary collaboration and meticulous planning in ensuring successful anaesthesia delivery for this complex case.

We were presented with a 64-year-old female with complaints of large parietooccipital scalp swelling for the past 23 years which was slow-growing and didn't affect the patient's day-to-day activities. Patient was posted for surgical removal due to cosmetic concerns of the family.

The patient didn't undergo any surgeries previously and had no medical illness. CT brain was done which showed very large cystic lesion of size 30.1cms (CC) *18.9cms (AP) * 22.3cms (Transverse) in right parieto-occipital region with



Fig 1: Large Sebaceous Cyst



Fig 2: Restricted Neck Extension

mild thinning of parietal bone- probably sebaceous cyst with no evidence of any bony involvement. On pre-anaesthetic evaluation ,general and systemic examination were within normal limits.

Airway examination: Modified Mallampati Score- III, Neck movements- extension restricted because of the swelling, mouth o p e n i n g - a d m i t s t h r e e fingers, ThyroMentalDistance-6cm. All these indicate difficult airway and a plan of action as depicted below was drawn and the same was explained to the patient and family and consent obtained.



On the day of surgery, reassessment was done in the preoperative holding area. Patient was premedicated with i.v. Midazolam, ondansetron and glycopyrolate. Airway preparation with 4% xylocaine nebulisation was done. After shifting the patient to the Operation theatre, ASA standard monitors were attached, 2 large-bore IV cannulas were secured, and an invasive arterial line was placed in the right radial artery.

Positioning: The patient was positioned with shoulders at the edge of the main table with a smaller table, one foot shorter than the main table, placed adjacent to support the swelling, such that the swelling was hanging from the edge of the main table with the head resting on the smaller table.

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Adequate padding was provided, and a pillow was placed under the shoulder, ensuring the swelling rested comfortably on the smaller table, with 1 assistant holding the swelling while facing the performing anaesthetist. (as seen in fig 3).



Fig 3

Preoxygenation was done with 100% oxygen for 3 minutes. Inj. Fentanyl and Inj. Propofol was given till the patient lost consciousness but maintaining spontaneous respiration. Trial video laryngoscopy was done with C-MAC D BLADE, which showed POGO – 50% (percentage of glottic opening). Since the check laryngoscopy was satisfactory, we planned to proceed with intubation with muscle relaxant.

Intubation was attempted with a video laryngoscope under suxamethonium muscle relaxation, but on first attempt only the epiglottis was visualized and the vocal cords was not visible. Hence, we resumed mask ventilation which was adequate, during which positioning was corrected. With 1 assistant holding the swelling in position, 2nd attempt of intubation was attempted with a video laryngoscope and external laryngeal manoeuvre, vocal cords were visualized and successful intubation done with ETT 7.0mm and patient connected to ventilator.

Anaesthesia was maintained with oxygen/ air/ sevoflurane, with intermittent bolus dose of Inj. Atracurium IV and IV fluid with RL. The patient was turned to prone position, taking care of the ETT with 1 assistant and, 2 assistants holding the swelling even during the surgical procedure until decompression of the swelling was done. Around 8.5 litres of hemorrhagic fluid removed from the cyst, excision of excess skin done, flap raised and sutured. The patient was hemodynamically stable throughout the intraoperative period. After the completion of the procedure, patient turned to supine position, extubated on table and postoperative period was uneventful.





Fig 4 Prone Position





Fig 6 Post procedure in recovery area

Fig 7 CMAC D BLADE

Difficult intubation due to patient positioning is a common challenge.

The size and site of the tumour had made the airway management complex. Appropriate planning, and execution of the plan makes even difficult situations easier. In this scenario, careful positioning of the patient and with availability of video laryngoscope (Fig 7 D BLADE CMAC), we were able to tide over the crisis and avoided awake intubation and tracheostomy /cricothyrotomy. This avoided the added stress to the patient of awake fibreoptic intubation and the challenges involved in maintaining the airway in prone position with FONA.

To conclude, proper multidisciplinary approach, with clear strategy for both anticipated and unanticipated difficult airway will give a successful outcome.



Dr. PRABHA UDAYAKUMAR MD (Anaesthesiology)

Consultant Anaesthesiologist & HOD

Dr.A.RAMYA PARAMESWARI MBBS, DA, DNB (Anaesthesiology)

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Navigating Anesthetic Challenges in Pregnant Woman With Single Ventricle For LSCS

Congenital heart disease is one of the most common congenital disorders. Single ventricle physiology is a term used to describe the group of congenital heart defects with single functioning ventricle where mixing of oxygenated and deoxygenated blood takes place and single ventricle has to pump blood to both pulmonary and systemic circulation. With advancement of cardiology and surgical procedures palliation is possible with Modified Fontan surgery where total cavopulmonary circulation is achieved by bypassing the right atrium. These patient present with anaesthetic challenges when they attain adulthood and present for non-cardiac surgeries.

Patients with Modified Fontan circulation have a challenging and delicate physiology. Pregnancy has a great impact on cardiovascular system of these patients. With increased demands

Modified Fontan Procedure



of cardiac output in pregnant patients with single ventricle adequate pumping of blood to lungs is compromised and hence unable to augment the cardiac output.

A 26 year old primigravida who underwent Modified Fontan procedure for Double inlet left ventricle at the age of 12 year on regular follow up during pregnancy was referred to PAC with signs of severe pregnancy induced hypertension at 35 weeks of gestation. She was treated with Tablet labetalol 100mg thrice daily and Tablet Nicardipine 30mg twice daily and had received 2 doses of steroids prophylactically at 33 weeks of gestation. Her heart rate -88 bpm ,Blood pressure-160/100, Room air saturation of 88%,Cardiovascular system examination -both heart sounds heard ,systolic murmur heard. Preoperative 2d echo-Ejection fraction of 60% single ventricle, total cavopulmonary circulation, Situs levocardia, ventricular septal defect with pulmonary stenosis.

Patient was posted for elective Caesarean section at 36 weeks. Patient evaluated preoperatively and counseled regarding anesthetic management and risks associated with anesthesia and surgery. Multidisciplinary team involving obstetrician, cardiologist, anaesthetist and pediatrician were alerted regarding patient status since she could be taken on an emergency basis too. On the morning of surgery patient presented in the ward with mild uterine contractions and increase in blood pressure of 180/110mm Hg, with no signs of imminent eclampsia. A team of Obstetrician ,Anesthetist and Pediatrician were ready and patient was immediately taken up for Caesarean section.

Wide bore intravenous cannula was sited and fluid ringer lactate was on flow at 75 ml/hr. Patient was premedicated with injection Ondansetron 4 mg intravenously and shifted inside the operation theatre and ASA standard monitors were attached. Right radial artery was cannulated under aseptic precautions and transduced for continuous intra arterial blood pressure monitoring.

Epidural catheter placed in L1-L2 space, Inj fentanyl 25 mcg given intrathecally in L3-L4 space. Incremental doses of lignocaine 2% and bupivacaine 0.5% was given to attain sensory level of T6 with minimal hemodynamic changes. After 8 mins of epidural activation adequate level achieved and incision taken, vitals remained stable throughout the procedure, patient had no complaints. A healthy female baby of 2.045kg was delivered with Apgar of 8/10,9/10. After delayed cord clamping inj oxytocin 10 units given in 100ml Normal saline over 5 mins, another 10 units in 500 ringer lactate for maintanence. Uterus well contracted, hemostasis achieved, wound closed and procedure lasted for 45 minutes. Total blood loss was 500ml, Urine output of 300ml, 600ml of intravenous fluid was given. Patient shifted to post operative ward for observation, arterial BP monitored for 24 hr, epidural top up given as and when required. Epidural catheter taken out

after 36 hr of procedure as patient was comfortable and pain free. Patient's blood pressure stabilised within 24 hr of surgery. Patient was discharged on post op day 4 after reviewing with cardiologist and medications changed to T. labetalol 100mg twice daily and T.Nicardipine 30mg once daily.

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Complications encountered in pregnant patients with Fontann circulation are arrhythmias, heart failure, myocardial infarction, bleeding and fetal complications like miscarriage, prematurity, intrauterine growth retardation ,small for gestational age. Anesthetic challenges involves maintaining preload without increasing the load on pulmonary circulation. Since the left ventricle is the only functioning ventricle ,one should be vigilant about chances of myocardial infarction. Anesthesia can alter the preload and after load and can compromise the cardiac output. Hence choice of anesthesia is pivotal in this case. Titrated doses of epidural anesthesia maintains preload and afterload and thereby myocardial perfusion and maternal blood pressure. This in turn maintains placental perfusion and fetal circulation. Addition of intrathecal Fentanyl provides intense sensory block without hemodynamic compromise.

Early anaesthetic referral and multidisciplinary team management with good communication is the key in reducing these complications. A team involving obstetrician, cardiologist, an aesthetist and pediatrician who are well aware of the patient condition can successfully manage these patients and improve the maternal and neonatal outcomes.



Dr. RESHMA B H MBBS, MD, DNB (Anesthesiology)

Senior Registrar

Dr. PRABHU CHINNASWAMY MBBS, DA, F.C.A.R.C.S.I (U.K.)



Consultant Anaesthesiologist





Unchartered Territory: Conquering the Challenges of Airway Management Tracheal Stenting : A Unique Anaesthetic Challenge

Tracheal stents are tracheobronchial prosthesis, that are used to relieve airway obstruction and maintain airway patency, or to prevent tracheal soiling due to aspiration from a tracheo oesophageal fistula. Airway management in a patient undergoing tracheal stenting poses a significant challenge to the anaesthesia team, as this involves sharing the airway with the pulmonologist. This is compounded by the challenge of maintaining airway patency, adequate oxygenation and ventilation with a compromised airway due to the patient's disease pathology. The stimulus from the bronchoscopy along with an already reactive airway can lead to life threatening hypoxia due to bronchospasm or complete loss of airway.

Here we present a case of a 65 yr old gentleman with a tracheo oesophageal fistula(TOF), secondary to Carcinoma hypopharynx, posted for a flexible bronchoscope guided tracheal stenting. The patient had a large opening in the trachea, connecting with the oesophagus posteriorly. Patient was a chronic smoker, with history of COPD. He also had a productive cough with copious secretions, probably due to micro aspirations from the fistula. Patient was also a known case of IHD, with an EF of 30-35%, which posed a greater risk for cardiac events during the procedure.

ANAESTHETIC MANAGEMENT: Anaesthetic management in airway procedures are particularly challenging as it involves sharing the airway with the pulmonology team, limting our access for oxygenation and ventilation.

Anaesthetic management for this patient was further complicated by his underlying COPD and decreased pulmonary reserve secondary to micro aspirations from the TOF. His decreased cardiac reserve secondary to IHD with low EF, exposes the patient to major on-table coronary events due to sympathetic stimulation or hypoxia. General anaesthesia with an established airway with an endotracheal tube would be the ideal option to maintain adequate oxygenation. However controlled ventilation will lead to gastric insufflation thereby increasing the risk of aspiration through the TOF and diaphragmatic splinting. An ETT will also reduce the working space available to successfully place a stent.

Conscious sedation with airway topicalisation can greatly reduce the sympathetic stimulus during airway procedures, while maintain patency, in an awake patient. Hence after careful planning and discussion with our pulmonologist, we decided to go ahead with this approach as our plan A.

The patient was thoroughly evaluated and counseled prior to the procedure as patient cooperation is paramount. The patient was premedicated with inj. Glycopyrrolate to reduce the secretions during the procedure. Continuous invasive intra arterial monitoring to ensure stable hemodynamics.

AIRWAY TOPICALISATION: This method involves anesthetising the oral and nasopharyngeal airway upto the vocal cords to allow for procedures like awake fibreoptic intubation and bronchoscopic procedures.

The patient's nasopharynx and orophaynx was anesthetised with 10% lignocaine spray and nebulization with 4%lignocaine to anesthetise the lower aiways.This greatly reduces the sympathetic stimulus and coughing during the procedure.

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CONSCIOUS SEDATION: Conscious sedation is defined as a depressed level of consciousness, during which a patient is able to maintain airway reflexes with spontaneous respiration, and is able to obey commands. It provides adequate anxiolysis along with analgesia, thereby reducing hemodynamic changes from sympathetic response that occurs during airway manipulation. The drugs we used during this procedure were fentanyl, which is a short acting opioid, and dexmedetomidine, which is an alpha2 agonist. The drugs were titrated to effect in subanaesthetic doses to provide a comfortable and cooperative patient and hence ease of performing the bronchoscopy and stenting in a sedated patient.

OXYGENATION: Oxygenation was maintained through a nasal airway, connected to the anaesthesia workstation to maximise oxygen delivery to lower airways as hypoxia could prove to have catastrophic consequences and result in abandoning the procedure.



Large Tracheo **Oesophageal Fistula**



Bronchoscopic Guided Tracheal Stent Deployment



Proximal End of Stent Checked Post Procedure

PROCEDURE: The procedure involved placing a self expanding stent under bronchoscopic guidance which spanned across the fistula. Stent placement was checked by fluoroscopy. The procedure was performed successfully by the pulmonology team with minimal disturbances in hemodynamics and no cardio respiratory complications.

Anaesthetic challenge: As mentioned earlier, this procedure involves sharing the airway with the pulmonologist. This with the lack of a definitive airway to oxygenate and ventilate the patient, poses a high risk of desaturation during the procedure due to bronchospasm and laryngospasm. This can lead to severe cardio respiratory compromise, and eventually result in abandoning the procedure along with increased morbidity in case of emergency intubation and ventilation.

In our patient, the background of ischemic heart disease with LV dysfunction, exposes the patient to very risk of MACE, in the event of sympathetic stimulation during airway manipulation. Airway topicalisation greatly reduced the hemodynamic changes during the procedure.

When working on an unsecured airway, it is preferable to have the patient awake enough to maintain their own airway. Hence adequate anxiolysis with preprocedural counselling, vigilant monitoring will greatly reduce the stress on the patient and the anaesthesia and pulmonology team.

Overall, careful planning and team work made this high risk procedure in a high risk patient at a NORA site a success.



Dr. PREETI VIJAY KUMAR MBBS., DA., DNB

Junior Consultant Anaesthesiology

Dr. PREETHI. A MBBS., MD.,





Diffuse Large B Cell Lymphoma (DLBCL) Relapsing as Primary Cardiac Lymphoma - A Rare Case Report

Case Report: Mr.A, a 56 years gentleman, initially presented with difficulty in breathing with Dyspnoea on Exertion (DOE) - NYHA –II. He also had fever associated with night sweats, loss of weight and loss of appetite ('B' Symptoms) for 2 months in the year 2022. On examination, he had multiple cervicallymph nodes and decreased air entry in the left side of lung, tachypnoeic (RR-30/ min) with desaturation in room air (Sp 02- 85%), tachycardia (PR- 123/min). Routine blood investigations were done which showed elevated leukocytes WBC- 30,020 with Lymphocytosis 58%, with Mild anemia-Hb-11.2 gm%, elevated LDH- 542 U/L. Other blood investigations were unremarkable. CT Thorax was taken which showed Pleural effusion on left side with multiplemediastinal, cervical and retroperitoneal lymphnodes.

As he was symptomatic for pleural effusion, he underwent Pleurocentesis with ICD(Intercostal drain) insertion. Pleural fluid analysis suggested **Exudative pleural effusion.** Infective aetiology work up (Bacterial, TB, Fungal cultures, Gene XPERT) was negative. He underwent Right cervical lymph node excisional biopsy for Histopathological diagnosis which revealed High grade Non Hogkin's Lymphoma – Diffuse Large B cell Lymphoma (DLBCL). FDG PET-CT–showed Hypermetabolic lymph nodes on both sides of diaphragm, Hypermetabolic Lesions in liver and spleen with Hypermetabolic marrow in axial and appendicular skeleton suggested as **Ann ArborStage IV disease**.

He received standard chemotherapy R-CHOP (Rituximab, Cyclophosphamide, Doxorubicin, Vincristine, Prednisolone) based regimen. Considering his age and general condition at presentation, higher intensive regimen like R-DA-EPOCH (Dose adjusted Etoposide, Doxorubicin in each cycle) was not given. He completed 6 cycles of chemotherapy without any major infective/ noninfective complications. Post chemotherapy PET-CT in 2023 showed complete metabolic response with disease in Remission (CRI). He was on regular followup for almost a year without any complaints. In March 2024, he presented with dyspnea on exertion NYHA II for 2 weeks which was insidious onset and gradually progressive without any chest pain or palpitations. He did not have any typical 'B' symptoms nor other cardiac symptoms. He did not have any lymphadenopathy or otherwise unremarkable on examination. He was sent for cardiac evaluation to rule out ischemic cardiac event, if any. Initially cardiologist had suspected probable LV dysfunction. Hence Echocardiogram was done. Echocardiogram revealed normal LV systolic function (EF – 65%), no regional wall motion abnormality, no diastolic dysfunction but surprise with a mass in right atrium and right ventricle (Fig-1) abutting the tricuspid valve. He also underwent TEE (Trans Esophageal Echocardiogram), which confirmed the mass (Fig-2).



Fig 1 – Subcostal view showing mass in Right Ventricle



Fig 2 – TEE – Four chamber Mid Esophageal View showed mass in Right Atrium and Right Ventricle

Once mass was demonstrated in transthoracic and transesophageal echocardiogram, other imaging modalities were done. CT Thorax was done followed by FDG PET-CT. CT Thorax again delineated the mass in Right atrium and Right Ventricle (Fig.3). PET-CT revealed increased uptake in Right atrium and right ventricle abutting the tricuspid valve (Fig. 4,5). It also revealed there was no metabolically active disease elsewhere in the body.

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Fig.3 - CT Thorax showing mass in Right Atrium and Right Ventricle



Fig.4,5 - PET CT showing increased uptake in Right Atrium and Right Ventricle

As he was a treated case of Diffuse Large B Cell Lymphoma (DLBCL), relapse of NHL was suspected but there was no metabolically active disease elsewhere in the body. Relapse needed to be proved histologically with tissue for immunochemistry. Hence cardiac biopsy was planned. Initially he was planned for surgical resection or imaging guided percutaneous biopsy by interventional radiologist but due to high risk involved of the above procedure it was not preferred. He underwent **Transfemoral intravenous catheter Cardiac biopsy** without any major complications.



Fig.6,7 - Cardiac biopsy in Right Atrium done under TEE guidanc Multiple biopsy samples of mass were obtained and sent for analysis. Histological analysis of samples revealed fragments of neoplasm. Immunohistochemistry revealed it to be consistent with Non Hodgkin's Lymphoma - DLBCL. Results of the biopsy of mass are delineated below. (Table 1)



Dr. SRIDHAR GOPAL

MD, Fellowship in Clinical Haematology

Consultant Haemto-Oncologist & Physician

Cardiac Biopsy	
7 fragments of tan soft tissue 0.1 cm to 0.2 cm	
Composed of intermediate to large sized cells having scant eosinophilic cytoplasm	
Immunohistochemistry	
CD 20 – Strong – Positive	
CD 3 – Negative	
Ki6 – Strong – 70% at hotspots	
Impression	
High grade B cell Non Hodgkin's Lymphoma, consistent with relapse in a treated case of DLBCL	

Hence he was diagnosed as **DLBCL- Relapse with Primary Cardiac Lymphoma.** He was started on R-ICE Regimen -Rituximab, Ifosfamide, carboplatin and Etoposide, as per relapse protocol. He is planned for 3 cycles of R-ICE regimen followed by Autologous Stem Cell Transplant.

Discussion: There is no lymphoid tissue present in the heart, thus, it is rarely involved in lymphomas originating from the lymphatic hematopoietic system. Lymphomas originating from the heart (or only affecting the heart) are called primary cardiac lymphomas. This type of lymphoma is extremely rare, accounting for less than 1% of all extra-nodal lymphomas and an even lower percentage of all lymphomas. Previous studies reported that the tumour can spread to the pericardium and myocardium during the course of the disease, which is called secondary cardiac lymphoma, in 9% to 24% of patients with lymphoma. In cardiac lymphoma (primary and secondary) involving different parts of the heart, the clinical manifestations can include chest tightness, suffocation, cardiac insufficiency, pericardial effusion, and arrhythmia. However, the occurrence of solid heart tumors is rare. Because most lymphomas involving the heart are secondary, the cardiac presentations are easily hidden by the symptoms of other organs, and thus, the condition is easily missed or misdiagnosed. Tissue is mandatory for histopathological diagnosis but involves very high risk. Once diagnosis is made, treatment almost always requires Intensive chemotherapy followed by Hematopoietic Stem Cell Transplant(HSCT) with a curative intent.

> Dr. S.BALAJI MRCP (UK), FICC.,



Senior Consultant Cardiologist



Dear Sir / Madam,

Warm Greetings from Sri Ramakrishna Hospital, Coimbatore.

Thank you for your eternal support to Sri Ramakrishna Hospital. It is our privilege and honour to connect with you, and great pleasure to bring to your kind notice that, We have developed a new mobile app named Dolphin Referral Management System(SRH-DRMS) which helps to track and service our referral patients electronically between you, patients and Sri Ramakrishna hospital.

The mobile app helps to Go Green and to avoid errors as well. Our marketing field force and the respective video product manual are designed, which helps you to enroll smoothly and patient referrals.

Request you to download the mobile app **SRH-DRMS** from the following links

Google Play Store Link for Android: https://play.google.com/store/apps /details?id=com.drms.prod&pcamp aignid=web_share





App Store Link for iOS: https://apps.apple.com/in/app/srh -drms/id6466620577

We assure you the best of our services. In case of any queries, please feel free to contact me.

Murali Kaliappan, Head - Marketing | 96003 90333





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