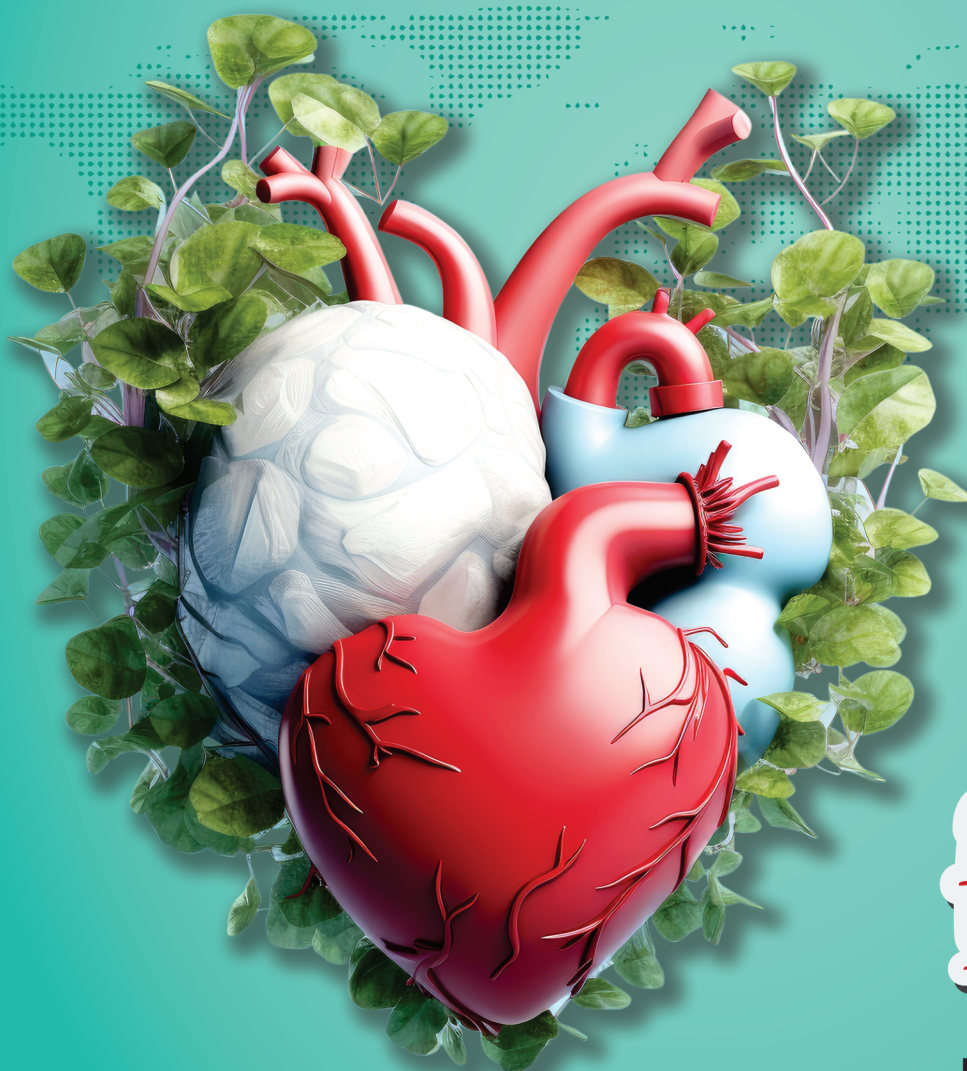




**Sri Ramakrishna**  
Hospital (Multi-Speciality)

# pulse

*Happenings at Sri Ramakrishna...*



World   
**Heart day**

29th September

**USE HE  RT FOR ACTION**



**Shri.D.Lakshminarayanawamy**  
Managing Trustee

I am filled with immense pride and gratitude for the growth and innovation we have achieved together. I am delighted to be a part of the team that has made remarkable progress and achievements over the years. Our commitment to providing exceptional healthcare and serving our community has always been stronger, and I am proud of the strides we have taken together.

As we observe **World Heart Day (September 29)** every year, I take this opportunity to highlight the critical importance of heart health. At Sri Ramakrishna Hospital, we are committed not only to treat heart conditions but also to educate our community on how to prevent them. I encourage everyone to take a moment today to reflect on their heart health. Simple actions like incorporating more physical activity into your daily routine, adopting a balanced diet, avoiding tobacco, and managing stress can make a

significant difference.

On this World Heart Day, let us all pledge to prioritize our heart health and encourage our loved ones to do the same. Together, we can create a healthier, stronger community.



**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 we discuss interesting cases adds an enriching dimension to the professional development of the team.

This month's special focus on **Cardiology, Cardiovascular & Thoracic Surgery and ENT** demonstrates a strong commitment to staying updated with medical advancements and addressing a broad spectrum of healthcare needs, which in turn benefits the medical professionals and also enhances the overall quality of patient care.

As we mark **World Heart Day**, it's an opportune time to reflect on the invaluable role our hearts play in our overall health and the steps we can take to protect them. Cardiovascular disease is a formidable challenge, but with awareness, education, and proactive care, we can overcome.

At Sri Ramakrishna Hospital, our commitment to heart health is unwavering. We are privileged to have a dedicated team of cardiologists, nurses, and allied health professionals who work tirelessly to provide comprehensive, patient-centered care. From preventive screenings to state-of-the-art treatments, we strive to offer the best possible outcomes for every individual who walks through our doors. This year's theme **Use Heart for Action** calls upon each of us to take proactive steps towards a healthier heart. Let's commit to making heart health a priority, not just today, but every day.

## Editorial Team

**Dr.N.Loganathan**  
Pulmonologist

**Dr.S.Prahadeeshwaran**  
Head - Public Relations

**Mr.Murali Kaliappan**  
Head - Marketing



## INAUGURAL CME ON LASER CORONARY ANGIOPLASTY – 10.08.2024



Sri Ramakrishna Hospital has opened its doors for Coimbatore's first "Laser Coronary Angioplasty" to enhance cardiac care in the region. The inaugural Continuing Medical Education (CME) event was held on August 10, 2024 where the Department of Cardiology at Sri Ramakrishna Hospital proudly inaugurated Coimbatore's first state-of-the-art "Laser Coronary Angioplasty"- A true game changer in the field of Cardiology, marking a significant milestone in heart care in Coimbatore.

This CME inaugural event was presided over by Shri. R. Sundar, Joint Managing Trustee, SNR Sons Charitable Trust. Shri. C. V. Ramkumar, Chief Executive Officer, SNR Sons Charitable Trust, Dr. S. Rajagopal, Medical Director, Dr. S. Alagappan, Medical Superintendent, Sri Ramakrishna Hospital and renowned cardiology experts from Department of Cardiology took part in the CME programme. A brief introductory session at the event explained the workflow of the LASER and highlighted its benefits and uses.





## Successful Pregnancy in a Women with Single Ventricle

**Introduction:** Univentricular heart or single ventricle is a rare form of cyanotic Congenital Heart Disease. It accounts for 0.5-1.5% of women with Congenital Heart Disease. Survival of these women to adulthood is rare in uncorrected cases. We report the successful management of pregnancy in a patient with univentricular heart and pulmonary stenosis.

In patients with univentricular heart, systemic and pulmonary circulation originates from the single ventricle where mixing of saturated and unsaturated blood occurs, leading to a varying degree of systemic arterial desaturation and cyanosis. Maladaptation to the hemodynamic changes of pregnancy results in an increased risk of fetal and maternal complications.

Pregnancy is discouraged due to this increased risk of morbidity and mortality as per the modified WHO classification. The maternal complications which occur include Pre-eclampsia, embolism,

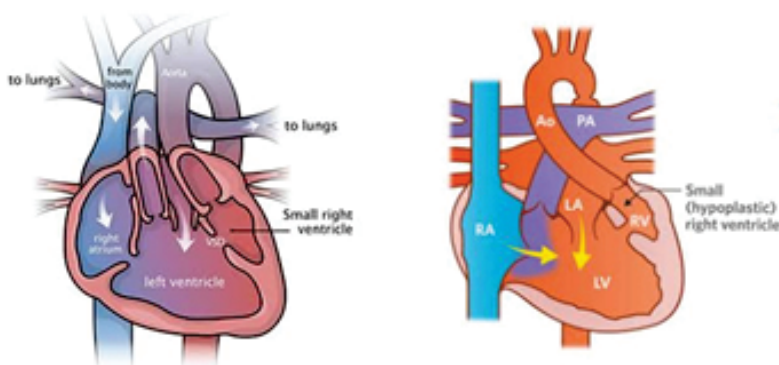
arrhythmia, pulmonary embolism and thrombosis. Fetal complications include miscarriage, preterm labour, low birth weight, fetal growth restriction and fetal cardiac anomalies.

These women require pre pregnancy counseling and if become pregnant requires a multidisciplinary team based approach with obstetrician, cardiologist, anaesthetist, and neonatologist in the management of labour and delivery to optimise the outcome.

**Case Report:** This is the report about the case of successful pregnancy in a 26 year old woman with univentricular heart and pulmonary stenosis.

She was diagnosed with single ventricle - Double Inlet Left Ventricle with Rudimentary Right Ventricle and Pulmonary Stenosis in childhood at around 9 years of age. She underwent Total Cavo Pulmonary Connection by Modified Fenestrated Fontan Procedure at 10 years of age at Sri Ramakrishna Hospital. She was on regular follow-up with the cardiologist at Sri Ramakrishna Hospital since then and was on cardiac drugs for 4 to 5 years post surgery. Her O<sub>2</sub> saturation used to be between 88-94% and she remained asymptomatic.

Her first visit to the AN clinic of our hospital was at 8 weeks of amenorrhea and a single intrauterine pregnancy with positive fetal heart





beat was confirmed with transvaginal ultrasound. Both she and her husband were counselled in detail about the risks of her pregnancy.

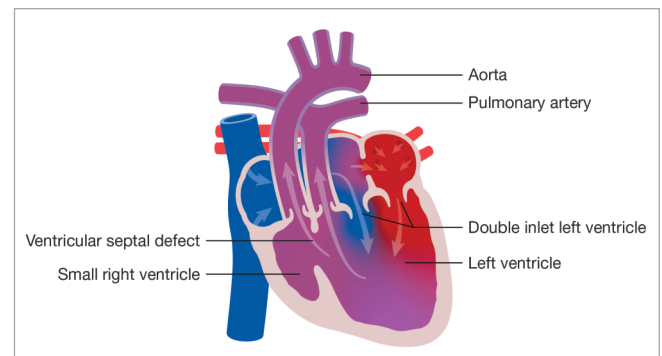
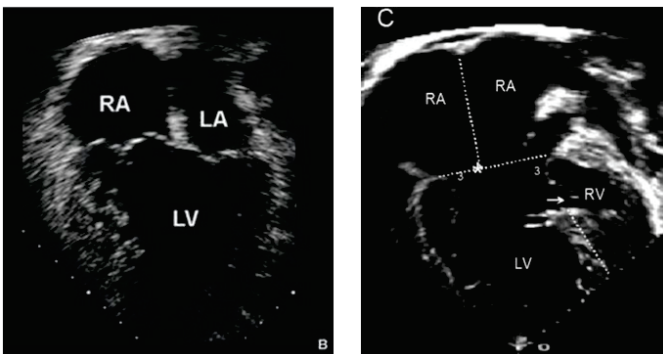
She had regular obstetric care combined with cardiological assessment since confirmation. At 14 weeks of gestation she developed hypertension and was started on Labetalol and later Nifedipine was added at 30 weeks of gestation. Routine follow-up ultrasound scans were done and found to be normal. Her antenatal ECHO showed Left ventricle Ejection Fraction - 60%. Sinus Rhythm. Single Ventricle (DILV) SLL(left sided subaortic, hypoplastic right ventricle- [L loop ventricle] and L-transposition of great arteries) ventricular Septal Defect with Pulmonary Stenosis. No obstruction to superior vena cava and inferior vena cava flow. No congestive heart failure. Because of fluctuating blood pressure, she was admitted to the hospital at 29 weeks and at 34 weeks for fetomaternal surveillance.

Because of uncontrolled hypertension and fetal growth restriction, it was decided to terminate the pregnancy by elective cesarean section. She

delivered an alive preterm female baby of weight 2.045 kg by Cesarean section under Epidural anaesthesia at 35 weeks of gestation. Apgar score was 8/10, 9/10 for the baby.

She had an uneventful recovery and was discharged home with a single dose of antihypertensive per day as per cardiologist's advice .

**Discussion:** The term "single ventricle" is generally used to describe any congenital heart defect with one functioning ventricle. Double Inlet Left Ventricle is one of them. In this condition, most frequently left ventricle will be dilated with rudimentary right ventricle although vice versa can also occur. With advancement in medical care more women with single ventricle are surviving to reproductive age. Despite these advances, women with a single ventricle are at increased risk of maternal & fetal complications. Therefore, careful multidisciplinary management is necessary for a good maternal and fetal outcome. Thanks to the multidisciplinary team in our hospital we were able to send her home without any complications.

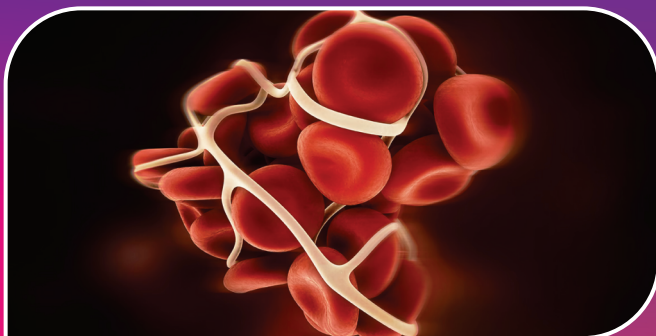


**Dr.LALITHA.R**

MBBS, DGO.,

Consultant Obstetrician & Gynaecologist - HOD





## Rare manifestations in Anti phospholipid syndrome - beyond thrombosis and pregnancy loss

**Background:** Pregnancy per se is a state of immunosuppression and hypercoagulability. When associated with Autoimmune conditions, we encounter life threatening situations.

Mrs S, 38 years old, G 5 P4 L0 A0 Admitted with H/o 2 MA with severe headache and difficulty in speech since 1 day, sudden onset, no H/o vomiting, convulsions, syncope or bleeding per vaginum. She is a known case of Anti

Phospholipid syndrome diagnosed after recurrent pregnancy loss and on treatment. Undergone Aortic valve replacement in 2012 at our institute for Aortic stenosis and on anticoagulants. She has periodical follow up with Cardiologist and Prosthetic valve functioning well.

She was taking treatment for migraine on and off. She had 2 Intra Uterine Fetal Demises, Medical abortion at 5 months amenorrhoea for severe PIH, and one neonatal loss [gross preterm]. She has undergone 3 vaginal deliveries and one caesarean section and no living child.

Present pregnancy was confirmed at 6 weeks as intrauterine and viable. She was on Folic acid, Ecosprin and oral anti coagulant. She was switched over to LMWH with the concurrent consultation with Rheumatologist and Cardiologist.

### Laboratory values at booking

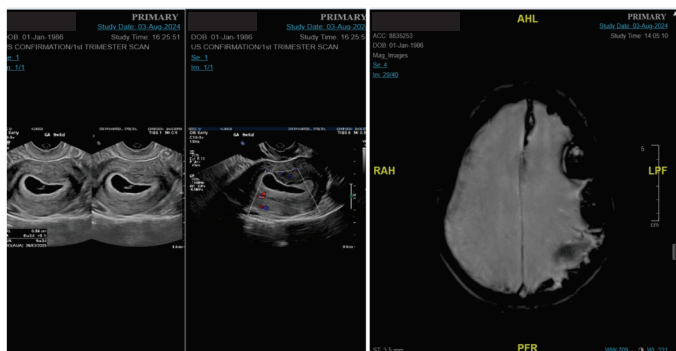
LUPUS Anti coagulant - DRVVT	222.50 s	Cardiolipin Antibody Ig M	16.84 = mpl
Patient Plasma : PNP1 : 1 Mix value	137.90 s	Cardiolipin Antibody Ig G	>150 gpl
Screen ratio	6.23	Cardiolipin Antibody Ig A	11.91 apl
Mix rate	3.86 s	CBC	normal
B2 Glycoprotein Ig G	>150 SGU	S.Creatinine	normal
B2 Glycoprotein Ig M	5.44 SMU		
B2 Glycoprotein Ig A	15 SAU		

On admission, Patient conscious, afebrile well oriented, vision normal and no other neurological deficit other than phonation difficulty. Systemic examination normal. Investigations revealed deranged coagulation parameters, anemia with thrombocytopenia.

Haemoglobin	8.4 gm%	<b>MRI Brain</b> Acute on Chronic Subdural Haemorrhage in Left Cerebral convexity, anterior Falx –mass effect, mild midline shift Chronic Micro bleeds	
Platelet count	33,000/cc		
APTT	69.7 secs		
PT	13.3 secs		
INR	0.86		
Electrolytes	normal	<b>USG Abdomen and Pelvis</b>	Upper abdomen normal Pelvis - <b>Failed Intrauterine gestation</b>
LFT	normal		
Creatinine	1.3mg/dl		



Multi disciplinary team of Obstetrician, Neurologist, Neuro surgeon, Haematologist and Cardiologist involved in the management of Patient. Surgical intervention of SDH and Missed miscarriage was planned. Patient and family members counselled regarding the risk factors involved during surgery and Anaesthesia and the guarded prognosis. Measures taken to improve the coagulation parameters by blood components transfusion since her general condition was stable.



Preoperative Imaging

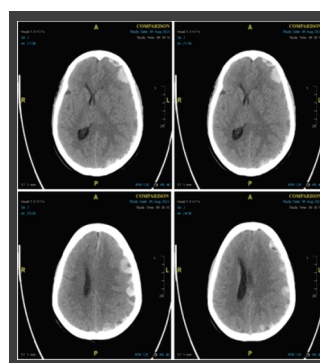
Under General Anaesthesia, Craniectomy with subdural haematoma evacuation done. Clots impinging on the cerebral surface removed. Diffuse oozing tackled meticulously. Bone not replaced. Skin flap closed with drain. In lithotomy position Suction evacuation to empty the products of conception undertaken. There was difficulty in visualizing the cervix and explored after careful dissection. Under USG Guidance Products of conception removed and uterine cavity empty with no undue bleeding PV. POC sent for HPE Patient withstood the surgery reasonably well. Patient received 10 units of FFP, 6 units of Platelets, 2 units of PRBC and one unit of Single donor platelet. Immediate post operative period patient had one episode of convulsions and managed efficiently, subsequently recovered smoothly.

Follow up CT Scan brain on 2 occasions - Post operative D1, D3 normal and drain removed. Slowly regaining her speech with stable vitals and no other neurological deficit. Physiotherapy ,oral fluids and antibiotics continued. HPE confirmed the products of conception Patient discharged on 7th postoperative day.

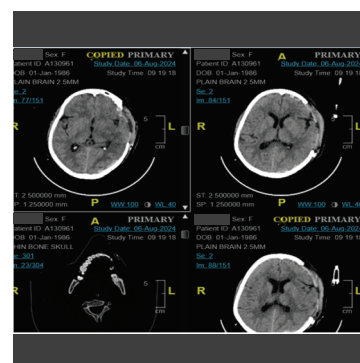
**Discussion:** Antiphospholipid syndrome[APS] still represents an important treatable cause of pregnancy morbidity. Known for its systemic arterial and venous thrombotic manifestations. There exist a complexity and heterogeneity of the mechanisms beyond the poor obstetric outcome in APS. Rarely, APS can manifest in the form of hemorrhage and

we encountered Subdural haematoma in pregnancy which is an infrequent manifestation. Our patient had gone through all bitter experiences on account of APS mentioned in Domain 4- Obstetric of ACR/EULAR clinical criteria [2023]: Prefetal death, Fetal death, Preeclampsia with severe features, central nervous system dysfunction, placental insufficiency with severe features.

With the multidisciplinary team work we were able to treat the uncommon manifestation successfully. Embarking on pregnancy in future is a critical thought process.



Preoperative Imaging  
MRI brain



Preoperative Imaging

Table 1. Summary of the 2023 ACR/EULAR APS classification criteria.

Clinical Criteria
Domain 1—Macrovascular: venous thromboembolism
Domain 2—Macrovascular: arterial thrombosis
Domain 3—Microvascular
Suspected: Livedo racemosa, Livedoid vasculopathy lesions, Antiphospholipid antibody (aPL) nephropathy, Pulmonary hemorrhage
Established: Livedoid vasculopathy, aPL nephropathy, Pulmonary hemorrhage, Myocardial disease, Adrenal hemorrhage or microthrombosis
Domain 4—Obstetric: Prefetal death, Fetal death, Preeclampsia with severe features, Central nervous system dysfunction, Placental insufficiency with severe features
Domain 5—Cardiac valve: Valve thickening, Valve vegetation,
Domain 6—Haematology: Thrombocytopenia,
Laboratory Criteria
Domain 7—aPL test by coagulation-based functional assay
Domain 8—aPL test by solid phase-based assay

## Acknowledgements to

**Dr.Vedhanayagam** [Neurologist],

**Dr.Murali** [Neurosurgeon],

**Dr.Balaji** [Cardiologist]

**Dr.Muthukumar** [Anaesthetist],

**Dr.Sridhar Gopal** [Haematologist],

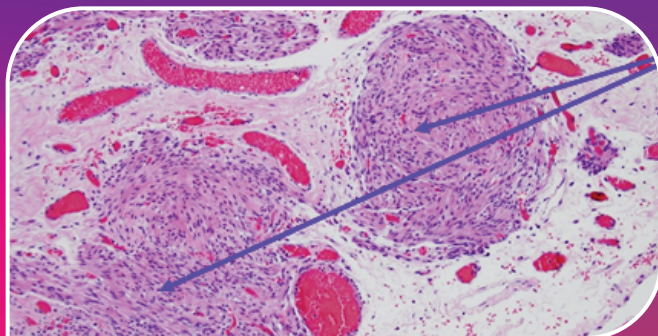
**Dr.Nagendran** [Rheumatologist]

**Dr.BANUMATHY.M**

MBBS, DGO, DNB, FICOG

Consultant Obstetrician & Gynaecologist. HOD (Academic)

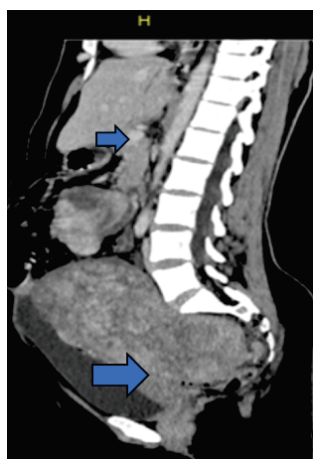




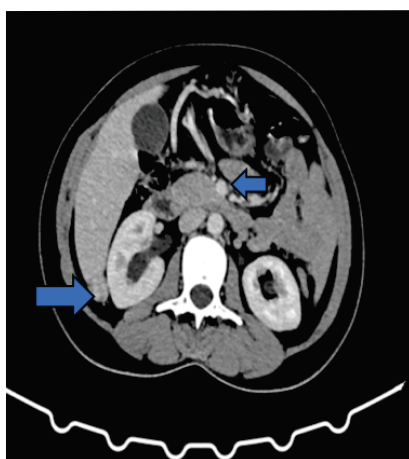
## Disseminated Peritoneal Leiomyomatosis

**Introduction:** Disseminated peritoneal leiomyomatosis is a rare benign Smooth muscle tumor proliferating along the sub peritoneal and peritoneal surface. The actual incidence of DPL might be underestimated, considering its asymptomatic nature. The pathogenesis of the disease remains unknown, but iatrogenic implantation, hormonal effects, heredity, and peritoneal mesenchymal stem cell metaplasia has been implied. We present a case of DPL intervened in our center.

**Case Report:** A 38-Year-old women with P1L1, has come with the complaints of abdominal discomfort and increased abdominal size since 1 month. She had regular cycles with history of laparoscopic myomectomy elsewhere 8 year back and also reports a history of morcellation during the surgery.



CT Scan shows large heterogenous enhancing lesion in the right adnexa



Small heterogenous nodule seen along the Morison pouch and along the greater omentum

Clinical examination revealed a firm uterine mass of 20 weeks size. Per vaginal examination showed the uterus to be of 20-week size with restricted mobility. A firm mass, separate from the uterus was felt through bilateral fornix.

All laboratory investigations were within normal limits.

CT abdomen showed large heterogenous enhancing lesion in the Right adnexa likely broad ligament fibroid.



Large heterogenous mass displacing the uterus to the left

Heterogenic lesion in mesentery along the surface of segment VI of liver and left subphrenic region likely disseminated peritoneal leiomyomatosis, and mild hydroureteronephrosis due to pressure effect.

Post-contrast imaging also showed similar finding with a Parasitic fibroid in mesenteric plane of size (7.1x6.8 cm)

The imaging findings were suggestive of uterine leiomyoma with coexisting disseminated peritoneal leiomyomatosis. The patient underwent **total abdominal hysterectomy, bilateralsalpingo-oophorectomy and removal of peritoneal leiomyomata.**



### Intraoperatively

- Uterus - 14 weeks size with multiple subserosal and intramural fibroid
- Parasitic fibroid of size 15 x 12 cm is seen involving the seromuscular layer of sigmoid colon
- Fibroid of size 10x10cm seen encased within greater omentum and
- Ectopic fibroid of size 2x3cm seen in the Morison pouch

Histopathological examination of the specimens was performed after surgery showed a tumour composed of interlacing bundles and whorls of benign spindle cells with focal areas of hyalinization, Multiple extrauterine lesions showed a whorled pattern of smooth muscle bundles separated from each other by vascularized connective tissue and no pleomorphism **Suggestive of benign leiomyomatous nodules with myxoid change in stroma**

**Discussion:** Leiomyoma are smooth muscle tumours that are common to the uterus, but uterine smooth muscle tumour with unusual growth pattern are rare and include 3 primary neoplasms: intravenous leiomyomatosis (IVL), benign metastasizing leiomyoma (BML) and disseminated peritoneal leiomyomatosis

The etiology of DPL remains controversial and includes two main theories: iatrogenic theory and hormone theory. The iatrogenic theory hypothesizes that DPL is caused by the iatrogenic spread of myoma because of morcellation during myomectomy. DPL takes an average of 39–132 months to present after initial laparoscopic morcellation. It is estimated that the overall incidence of DPL after laparoscopic uncontained morcellation was 0.12–0.95%[3].

During unconfined morcellation, small leiomyoma fragments and microscopic deposits, are easily dispersed and lost within the peritoneal cavity which in later life gets converted into DPL.

DPL occurs mainly in the reproductive-aged females, and in some cases they are found after the use of oral contraceptives and hormonal replacement therapy, or during pregnancy and in the presence of an estrogen-secreting tumour.

Most of the patients with DPL are asymptomatic. Others usually present with non-specific symptoms such as abnormal, heavy uterine bleeding and lower abdominal pain or discomfort. Less common presentations include increased frequency of micturition, mass per abdomen and symptoms of obstructive uropathy.

Imaging studies delineate the presence of intrauterine leiomyoma as well as the extent and location of peritoneal deposits. Ultrasonography and CT scan in patients with DPL show multiple, solid and complex soft tissue masses that are usually large and similar in morphology to uterine leiomyoma. MRI features include multiple masses with hypointense signal similar to that of skeletal and smooth muscles on T1 and T2 weighted images, which show variable post-contrast enhancement. Positron emission tomography is therefore a problem-solving tool in differentiating DPL from malignant peritoneal disease, which classically shows avid FDG uptake.

Because of the rapid recovery and minimal trauma, laparotomy should be the first choice for surgical diagnosis and treatment. For patients with who desires fertility, focal resection is feasible, and aromatase inhibitors or gonadotropin-releasing hormone agonists are used post-operatively. For patients without fertility requirements, resecting the entire uterus, bilateral appendages, and the abdominal mass is feasible, and resecting the greater omentum is performed if necessary.

**Conclusion:** DPL should be considered as a differential diagnosis of any intra-abdominal masses in patients with a history of myomectomy. Care should be taken during laparoscopic extraction of myomas with in-bag morcellation, mandatory to avoid iatrogenic recurrence. Transvaginal morcellation through a posterior colpotomy incision has also been described following laparoscopic myomectomy and may be a valuable alternative to traditional morcellation methods.

### Dr.KANMANI.M

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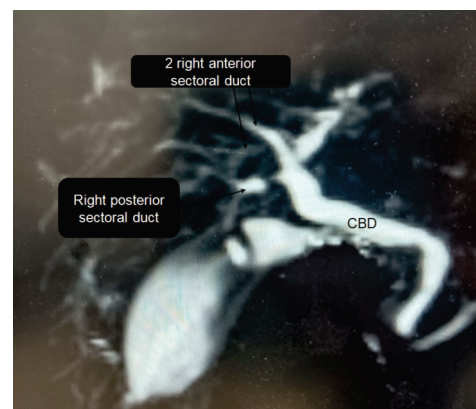
## Difficult Living Donor Liver Transplantations under TNCMHIS

Liver transplantation is the only curative treatment in decompensated chronic liver disease. Living donor liver transplantation (LDLT) has evolved significantly over the past few years enhancing the donor safety and reducing the waitlist mortality and unpredictability associated with deceased donor liver transplantation (DDLT). Our team performs liver transplantation (LDLT and DDLT) regularly and is one of the well experienced and trained team of this region. We share two difficult living donor liver transplantation performed recently at our hospital under TNCM health insurance scheme.

**Case 1:** A 55-year-old male was evaluated and diagnosed with Acute on chronic liver failure (ACLF) since March 2024. He had decompensation in the form of jaundice, ascites and hepatorenal syndrome. He had rising trend of serum bilirubin (16.3 mg/dL) despite medical management. His MELD-Na score at the time of admission was 36. He was assessed and counselled for liver transplant. Since it was the index presentation, the family were initially apprehensive regarding liver transplant surgery, but after counselling and discussing all other options, went ahead with the surgery. Considering his worsening liver functions and long waiting list in his blood group (o+), he was planned for LDLT. His elder son was evaluated and found fit to donate. He was the only donor in the family. The donor had a future liver remnant of 33.5% and CT estimated liver volume of 813 gm. The donor had type 3A biliary anatomy (figure 1) and there were three bile ducts left to reconstruct.

The difficulties encountered in this operation were

- Sick recipient (ACLF)
- Borderline graft weight (606 g), Graft recipient weight ratio (GRWR): 0.70
- Low future liver remnant in donor (33.5%)
- Multiple bile ducts (three)



**Figure 1**

The donor operation was done very diligently and had uneventful course in intra-operative and post-operative period. There were two right anterior sectoral ducts and were measuring 1mm and 2 mm in diameter and were 2mm away from each other.

The right posterior sectoral duct was 3mm in diameter. In a sick ACLF recipient, it was very challenging to use a borderline weight graft with three bile duct reconstruction.

After implantation of the graft with cold and warm ischemia kept to minimum, the three bile ducts were reconstructed to native bile ducts D4, caudate and RPSD branches. Both the donor and recipient recovered well after the operation without any post-operative complications.

The donor was discharged on POD 9 and the recipient was discharged to home on POD 17. He is on regular follow up (3 months) with decreasing requirement of immunosuppressants.

This case highlights 2 important aspects:

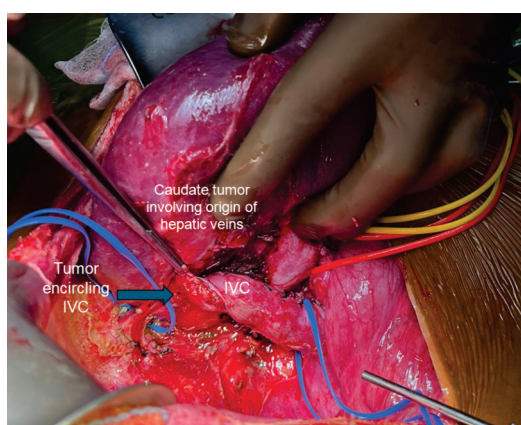


- Alternatives to the surgery were plasmapheresis and continued medical care, including ICU care which is a financial burden itself, costing almost equivalent to the transplant surgery and even if the patient recovers from that episodes of acute exacerbation, he will need regular monitoring and blood investigations, and such episode are bound to recur in majority. In contrast, transplant surgery gave him a one-time curative option, with no aggressive long term follow up. Three months post-surgery, he is on minimal immunosuppression and having a normal life.
- In many of the transplant centers in our city this case may be rejected for living donor transplant considering the difficulties highlighted above and the patient may be asked to wait on the DDLT waiting list. With the abundance of experience our team possesses in managing such challenging cases the surgery was performed with no complications and a smooth recovery for both the donor and recipient

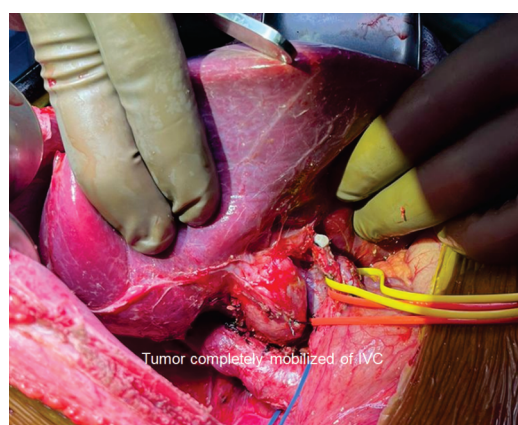
**Case 2:** A 10-year-old boy was diagnosed with hepatoblastoma (unresectable, PRETEXT IV) and was initiated on neoadjuvant chemotherapy with cisplatin and doxorubicin elsewhere. He received 6 cycles of chemotherapy and then referred to us for surgical resection. The lesion was present in caudate lobe and caudate process. There was no option of resecting the tumor safely as it involved the origin of all the 3 hepatic veins and caused significant involvement of the IVC and

portal bifurcation. He was then planned for liver donor liver transplantation under TNCMCHIS scheme. PET CT and CECT abdomen did not show any extrahepatic disease. His mother came forward for donation and she was found to be fit. As the left liver had 3 arteries to reconstruct, we decided to use the right liver which weighed around 386 gm and should be adequate for a 30 kg child. In view of IVC involvement all arrangements were made to replace the IVC with a graft and implant the new liver into the graft. But during surgery we were able to mobilize the tumor off IVC as it was only compressing rather than infiltrating the IVC. (figure 2 and 3) The right liver was implanted uneventfully and there were no intraoperative complications. Post-operatively the child had a good recovery barring small duration of postoperative ileus. The histopathology showed a complete resection of the lesion. Now the child is managed with standard immunosuppressive therapy and followed up.

Neoadjuvant treatment followed by surgical removal is the standard of care in treatment of hepatoblastoma at present. Resection and liver transplant both offers similar long-term outcome in children with hepatoblastoma and the only negative predictive factor is incomplete resection. Liver transplant was chosen in the current child as there was no option to achieve a R0 resection due to the anatomical reason mentioned above. We took all the measure to avoid tumor rupture during surgery and ensure the completeness of resection.



**Figure 2**



**Figure 3**

### Department of HPB, GI Surgery and Liver Transplantation

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PDF (Liver Transplantation)  
Consultant Surgeon

# Sri Ramakrishna Hospital

## WORLD ORGAN DONATION DAY - 13.08.2024



Sri Ramakrishna Hospital marked “World Organ Donation Day” by hosting an enlightening awareness session on August 13, 2024 presided over by Shri C. V. Ramkumar, CEO, SNR Sons Charitable Trust; Dr. S. Rajagopal, Medical Director, Sri Ramakrishna Hospital; Dr. S. Alagappan, Medical Superintendent, Sri Ramakrishna Hospital.

The event was attended by over 150 students of Sri Ramakrishna Educational Institutions. The event highlighted the importance of organ donation in saving lives and improving the quality of life for recipients.

The students of Sri Ramakrishna Hospital Institute of Allied Health Science performed an awareness street play for the community to help spread awareness on organ donation and encourage volunteers. An awareness talk was led by esteemed medical professionals, Dr. Chezhiyan, Consultant Nephrologist & HOD, Dr. Madhu Shankar, Consultant Nephrologist; and Dr. Vikas Moond, Consultant Surgeon - Liver Transplantation, HPB and GI Surgery, who shared their expertise on the critical need for organ donation, its impact on quality of life, and the challenges faced in increasing awareness and the role of medical practitioners in promoting organ donation by bridging the gap.



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