



Sri Ramakrishna
Hospital (Multi-Speciality)

pulse

Happenings at Sri Ramakrishna...



World

diabetes day





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 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.

The Children remind us of their boundless potential, creativity, and innocence. As caretakers of their future, it is our responsibility to nurture their dreams by providing a safe, healthy, and supportive environment. As a healthcare institution, we are committed to the growth and holistic development of every child, emphasizing preventive care and healthy lifestyle choices from an early age.

On this World Diabetes Day at Sri Ramakrishna Hospital we together raise an awareness about on diabetes that affects millions of people worldwide. We recognize the need to empower individuals and families with the knowledge of the available and resources to prevent, manage diabetes beginning with understanding its risks, especially in the face of rising cases among younger generations. By observing this day we promote healthy lifestyles, including balanced nutrition, regular physical activity, and routine medical check-ups.



Dr.S.Rajagopal
Medical Director

Sri Ramakrishna Hospital has consistently been at the forefront in conducting diverse academic programs, complementing its clinical achievements. The focus on Clinical Club meetings, where we engage in discussions on intriguing cases, significantly enriches the professional development of our team.

This month's spotlight on **Diabetology & Endocrinology, Neonatology and Radiology & Imaging Services** reflects our strong commitment to staying abreast of medical advancements and addressing a wide range of healthcare needs, ultimately benefitting both our medical professionals and the overall quality of patient care.

On the occasion of **Children's Day (November 14)** and **World Prematurity Day (November 17)**, we celebrate the resilience and potential of every child. It is a reminder of our responsibility to nurture their growth and ensure they have access to the best healthcare right from the beginning. For premature babies, this responsibility is even greater. These little fighters often face significant challenges in their early days, and it is our duty to provide a special care, attention, and love that they need to thrive. Our Neonatal Intensive Care Unit (NICU) is dedicated to this mission, offering cutting-edge support to help them to overcome the hurdles of prematurity.

On **World Diabetes Day (November 14)**, we take an opportunity to highlight the importance of diabetes awareness, prevention, and management. Diabetes remains a significant health challenge, affecting millions of people worldwide, and its impact is growing. Early diagnosis allows for better management and can prevent serious complications such as heart disease, kidney problems, and vision impairment. Our hospital is committed to delivering comprehensive care to help individuals manage their condition effectively and prevent complications.

Editorial Team

Dr.N.Loganathan
Pulmonologist

Dr.S.Prahadeeshwaran
Head - Public Relations

Mr.Murali Kaliappan
Head - Marketing

Unique Digital Pledge Campaign Launch to promote Breast Cancer Awareness- 01.10.2024

Sri Ramakrishna Hospital – Sri Ramakrishna Institute of Oncology & Research(SRIOR) observed World Breast Cancer Awareness Month on October 01, 2024.

As part of the observance, SRIOR launched a unique digital pledge campaign to promote breast cancer awareness through website available in both Tamil and English aligned with WHO's theme for World Breast Cancer Awareness "No one should face Breast Cancer alone"



Dr. Guhan, Director , Consultant Medical Oncologist – SRIOR welcomed the gathering and emphasised the importance of raising awareness about breast cancer in the current scenario.

The digital campaign was officially launched in the presence of Mr. R. Sundar, Joint Managing Trustee, SNR Sons Charitable Trust and Chief Guest Ms. Swathy Rohit, Chief Operating Officer, SNR Sons Charitable Trust, in the presence of Mr. C.V. Ramkumar, Chief Executive Officer, SNR Sons Charitable Trust, Dr. S. Rajagopal, Medical Director – Sri Ramakrishna Hospital, Dr. S. Alagappan, Medical Superintendent - Sri Ramakrishna Hospital.

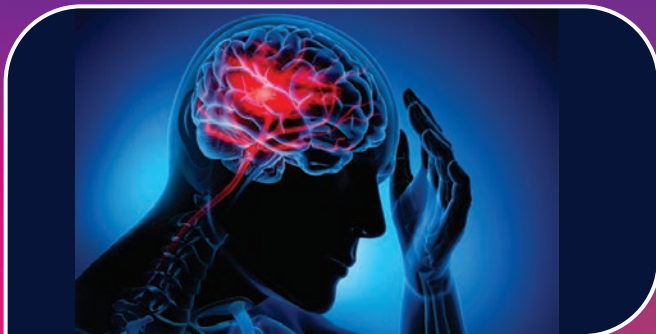
The event was concluded with vote of thanks, delivered by Dr. Karthikesh, Consultant Surgical Oncologist – SRIOR.

As part of the Pink October initiative, SRIOR offered free breast cancer screenings and mammograms throughout October on all working days.

PHYSICIAN ASSISTANTS DAY – 23.10.2024



Sri Ramakrishna Hospital on October 23,2024 observed Physician Assistants Day. Prof. Dr. Jambulingam, General Physician and HOD was the Chief Guest and delivered a speech on the theme "We make a Difference". SNR Sons Charitable Trust CEO Shri C V Ramkumar, Medical Director Dr. S.Rajagopal, Medical Superintendent Dr.S. Alagappan, Human Resources Manager Mr. Vijayakumar graced their presence and felicitated Physician Assistants. At the end, a short video on A day in the life of PA's was screened.



Comprehensive Stroke Care

Stroke is the 2nd leading cause of death and 1st leading cause of physical disability worldwide. About 1,85,000 strokes occur every year in India with nearly 1 stroke every 40 seconds and 1 stroke death every 4 minutes.

Nihilism on stroke treatment is long gone, now replaced by the exciting proven treatment options, by these options we can reverse ischemia and bring back functions to patients who are otherwise destined to death.

To achieve this, early identification of stroke symptoms and starting the definite treatment of thrombolysis is a must. Window period of thrombolysis is 4 ½ hours. If you can diagnose the stroke and lyse the patient within this window period outcome is good. Early clots are mostly RBC rich red clots soft and easily permeable to the lytics. Overtime, clots become fibrin rich hard and less permeable that's why we always insist upon early thrombolysis. If you thrombolysed out of this window period two things might happen

- May not be beneficial to the patients
- May end up with reperfusion injury

What is reperfusion injury?

You are putting back blood supply to the brain tissue which was ischemic for some time (Hypoxic and anoxic), this may cause tissue injury by ensuing inflammation and oxidative damage. This may cause hemorrhage in the ischemic tissue.

BE-FAST is the acronym developed to identify early stroke symptoms

- B - Balance - losing balance
- E - Eye signs - Blurring etc.
- F - Face droop
- A - Arm drift
- S - Slurred speech
- T - Time to act/treatment

Soon after suspecting stroke, you send the patient for imaging, by plain CT/MRI Stroke protocol whichever is available nearby.

After confirming the diagnosis, you start the treatment by IVT - Intravenous thrombolysis within the golden hour.

After the IV, Thrombolysis if worsening of symptoms and if you suspect LVO - Large Vessel Occlusion (ICA, M1-MCA, BA) send the patient for thrombectomy and it is called bridging thrombectomy.

If you are getting the patient out of window period, late presenting stroke, stroke of unknown time of onset or wake-up strokes, you do the imaging fast and if you suspect LVO - Large vessel occlusion can be taken for direct thrombectomy, angioplasty and Stenting if required.

If the patient is not improving after thrombolysis & thrombectomy and progressive worsening of neurological status and increased brain edema, we may send the patient for neurosurgical opinion and surgical decompression which saves life of the patient.

All these facilities are available at our SRI RAMAKRISHNA HOSPITAL under one roof, our hospital accredited for Advanced Stroke Centre by QAI (Quality accreditation Institute, New Delhi) where the patient gets comprehensive stroke care. We thank our Managing trustee, CEO, Medical director, Medical superintendent, Quality control department, Managerial staff and all others involved in stroke programme for helping us to get this accreditation.

Dr.ASOKAN.K

MD, DM (Neuro), FCCP

HOD & Chief Neurologist



Sri Ramakrishna Hospital

EXTERNAL MOCK DRILL @ COIMBATORE RAILWAY STATION - 10.10.2024

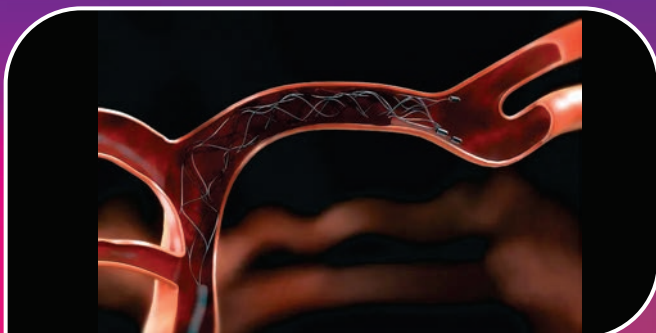
Sri Ramakrishna Hospital in association with Southern Railway – Salem Division, conducted an “External Disaster Mock-Drill” on October 10th at Coimbatore Railway Station. This mock drill had twenty eight passengers and two loco pilots involved in a train accident that caused the disaster. This mock-drill was designed to help the staff and hospital to stay alert and be prepared in handling mass casualties by conducting an efficient triage process. This mock drill highlighted the concept of “Golden Hour” which is crucial in saving lives during an emergency situation, where the care is provided within the first hour of impact.



The entire mock-drill was recorded. At the end, Chief Executive Officer Shri C. V. Ramkumar, Medical Director Dr. S. Rajagopal, Medical Superintendent Dr. S. Alagappan, Emergency Medicine Consultants Dr. Manjunath and Dr. Parthiban briefed the media personnel about the disaster through mock drill. Deputy Commissioner of Police Dr. Stalin IPS, visited the triage area along with his team. Officers and staff Coimbatore Railway Station, Railway Protection Force took part in the mock drill.

The Emergency Medicine Consultant Dr. Lavanya and team provided CPR Training where the Salem Divisional Railway Manager Mr. Pankanj Kumar Sinha took part in the session along with other Railway department personnel.





"Together We Can Overcome Stroke"

Stroke is one of the major morbidities in people aged more than 60 years. But nowadays stroke strikes even the young people due to our life style changes.

Case study: One of our recent stroke patient who was presented to us within the time window for whom we were able to do thrombolysis and mechanical thrombectomy with Basilar artery stenting and could save him. Posterior circulation strokes are themselves very dangerous and life threatening. We are presenting this patient who came with posterior circulation stroke with basilar artery occlusion. But due to the early presentation we could save his limbs and life.

Mr.B ,49 years old was admitted with c/o right upper limb and lower limb weakness associated with slurring of speech on 18/9/24 from 9am.

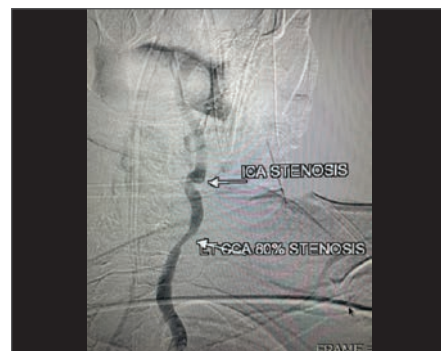
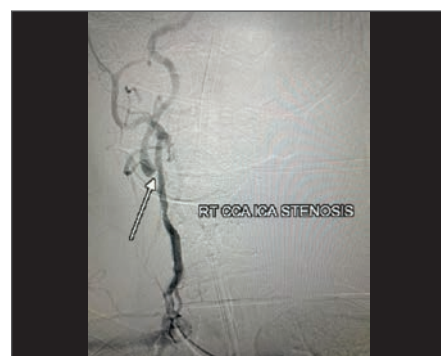
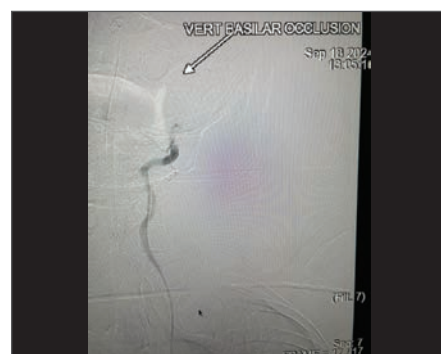
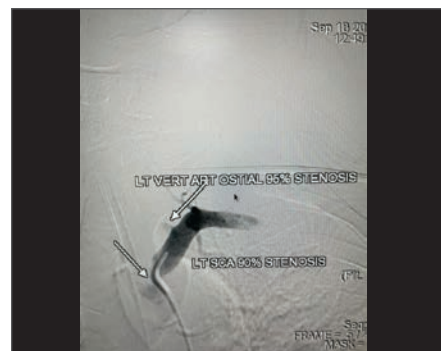
On arrival patient was conscious oriented with stable vitals and his NIHSS score was 6. Stroke protocol was initiated and MRI Brain was done which showed bilateral cerebellar hemisphere and left hemipons infarct with complete left basilar artery occlusion.

Risks and benefits of Thrombolysis were explained. And was proceeded with thrombolysis. Since there was complete occlusion of the basilar artery, need for thrombectomy was also explained. In the meantime NIHSS worsened further to 16. Hence the patients condition was again explained to the patients attenders for thrombectomy and thrombectomy was done immediately

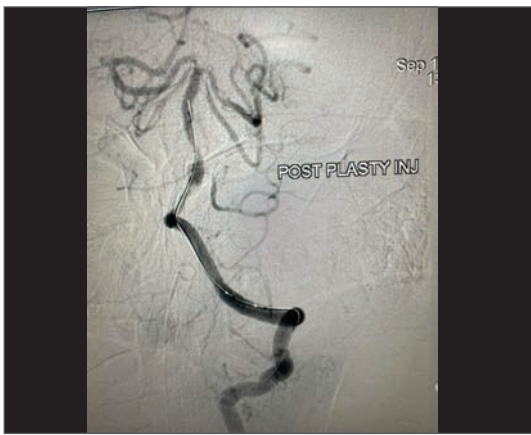
Dr.P.MUTHURAJAN - Consultant in Neuro & Vascular Interventional Radiologist opinion was obtained for Thrombectomy and thrombectomy and stenting was done.

Through right CFA access, right innominate artery injection showed diffuse disease of right CCA with 50-60% stenosis and 90% stenosis of right ICA

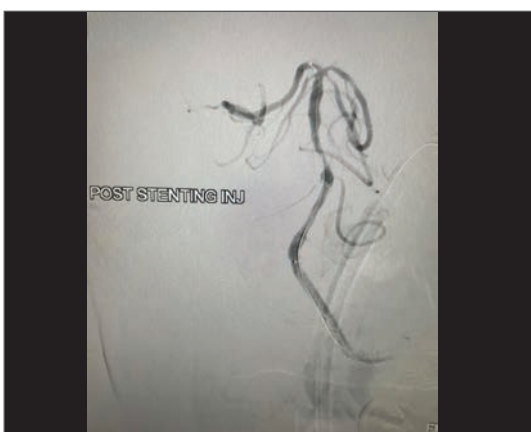
origin. Right vertebral artery was ending in PICA. V4 segment was occluded. Right PICA ostial 90 % stenosis was seen. Left CCA injection showed 70 to 80% stenosis of CCA and proximal ICA.



Left subclavian artery ostial 80% stenosis seen. Left vertebral ostial 90% stenosis with sluggish flow and stasis in vertebral artery with occlusion of left V4 segment and basilar artery seen. Cerebase sheath was placed in left V2 segment vertebral artery and red aspiration catheter was navigated to distal vertebral artery. The vertebrobasilar occlusion was crossed with microcatheter, guided wire and embrotrap was placed. Post aspiration thrombectomy injection showed 95% stenosis of proximal basilar artery. The stenosis was dilated and 2mm PTA balloon.



Postplasty check injection after 15 minutes showed, thrombus formation with reocclusion. Hence repeat thrombectomy was performed and stenosis was stented with 2.2x18mm resolute onyx balloon expandable stent.

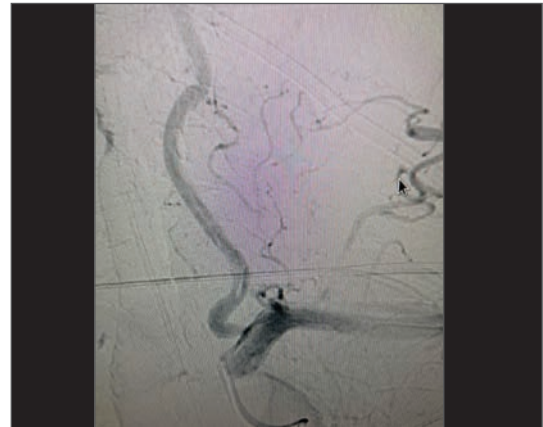


Post stenting injection showed good forward flow in left vertebrobasilar and bilateral PICA. Left vertebral artery ostium was dilated with 4 mm PTA balloon. Post

procedure cone beam CT showed contrast staining in lower pontine infarct region. No hemorrhage.

Patient improved well and was discharged home on 8th day.

I conclude by saying that TIME IS BRAIN. And early intervention in stroke can save patients limbs and life and allow them to have a good life even after stroke.



"TOGETHER WE CAN OVERCOME STROKE".

Dr. ARUNADEVI.K

MBBS, DNB Medicine, DM Neurology

Consultant Neurologist





Intravenous Thrombolysis for Acute Stroke in CKD Patient - A Case report

Highlights

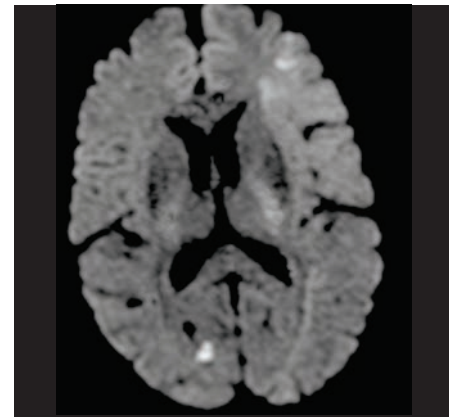
- *The management of CKD patients who suffer from stroke poses a challenge to our professionals*
- *Renal failure is not the contraindication for acute stroke thrombolysis in eligible cases*

Abstract: We present a case of a 61-year old female, a known case of HT, DM, CAD and CKD (3.8mg/dl) not on dialysis who suffered from an acute ischemic stroke was given Intravenous thrombolysis.

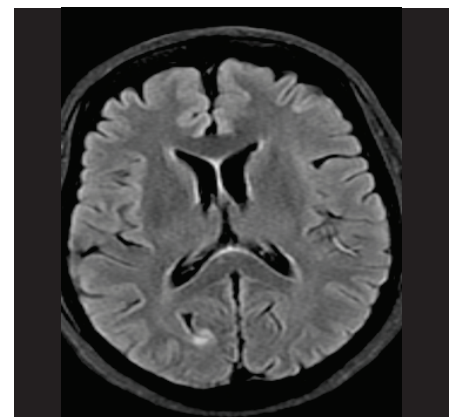
Introduction: IV tenecteplase is administered in ischemic stroke patients who are eligible for thrombolysis. There is no contraindication in the administration of IV tenecteplase in patients with CKD. Administering IV tenecteplase in CKD cases poses a risk and challenges if they cause bleeding complication.

Case report: A 61-year old female, known hypertensive, diabetic, dyslipidemic, CAD and CKD presented with a history acute aphasia and right hemiplegia of 4.2 hours of window. Her NIHSS score was 6/42 on arrival. Basic blood investigations along with aPTT was done through ChemDX method. Immediate MRI diffusion image showed acute infarct in left frontal, perisylvian areas with corresponding ADC hypointensities, additional small embolic lacunar right parieto occipital infarct. FLAIR image had no signal (ie, mismatch between DWI and FLAIR was noted). So we came to the conclusion, that there is large area of penumbra which need to be taken care immediately. MR-angiography showed significant stenosis and reduction in the left M1 segment of the Middle Cerebral Artery (Fig. 1b). As a PTT was normal, Hence thrombolysed with IV TNK-15 mg as a bolus (0.25 mg/kg body weight)

Immediately after IV TNK, the patient's right upper limb weakness resolved and patient started talking with an NIHSS of 2. Hence, clinically we came to the conclusion of successful clot lysis.



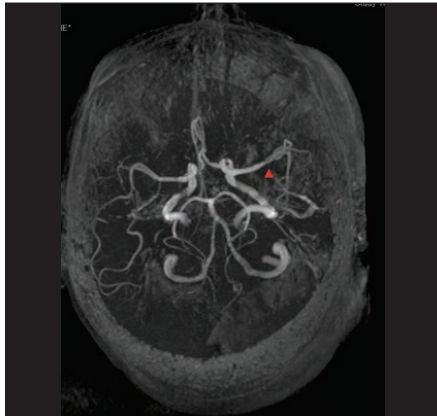
DWI-Acute left frontal infarct, subcortical infarcts and small right parietal embolic infarct.



FLAIR-Normal



MRA angiography shows atherosclerotic intracranial arteries with significant stenosis at the M1 segment of the MCA.



Post TNK angio showing near normal flow in distal MCA

ECHO showed Large Left ventricular apical clot. Repeat MRI plain after TNK was done one hour later, to check for the angiographic evidence of clot lysis. MRA showed near complete reversal of MCA flow (TICI 3). Post thrombolysis, she is being managed by clopidogrel and apixaban as secondary prophylaxis along with other risk factor control. Patient is still having mild dysarthria and subtle right upper extremity drift (NIHSS of 2) but independent for her daily routines.

Discussion: Renal failure is a potent risk factor for stroke. The risk of stroke is 5-30 times higher in patients with chronic kidney disease (CKD), especially on dialysis. Case fatality rates are also higher reaching almost 90%.

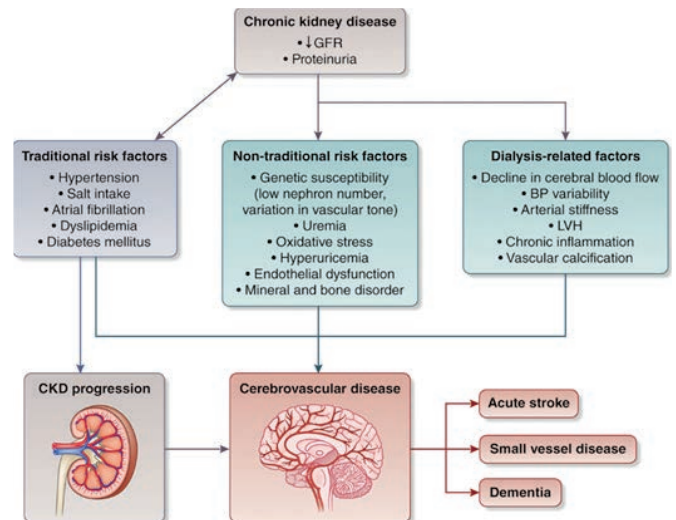
Prevalence of CKD: Affects as many as 9.1% of the global population.

Increased Stroke incidence: The overall incidence of stroke in CKD patients is more than twice that in individuals with normal kidney function.

Relationship with eGFR: There is an inverse linear relationship between estimated glomerular filtration rate (eGFR) and stroke risk.

Risk increases by 7% per 10 mL/min/1.73 m² decrease in eGFR.

Role of Proteinuria: Presence of proteinuria independently confers a 2-fold higher risk of stroke compared to its absence



Possible mechanisms that explains acute ischemic events in CKD is IV thrombolysis – A patient with CKD or who is dialysis- dependent should be treated with thrombolytic therapy provided that the aPTT is normal and that there is no other contraindication present. Dose modification for renal function is not recommended.

Especially in those with multiple comorbidities. This reported case had significant stenosis in the left M1 segment of the middle cerebral artery which would make thrombolysis a better option as we did here ,even though the patient is on dialysis(not in our case), the aggressiveness in stroke management remains a priority because stroke is reversible in time.

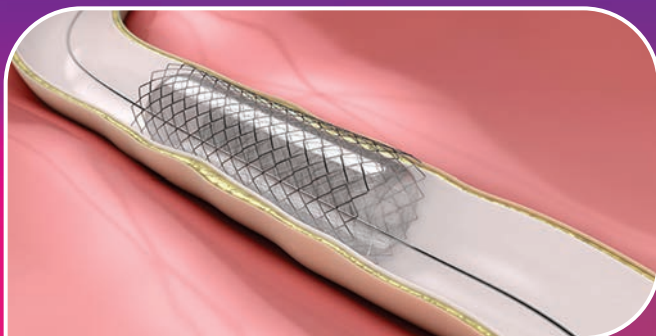
Conclusion: IV-TNK is indicated for acute ischemic stroke in patients with ESRD/HD. It should not be withheld based solely on ESRD/HD status.

Dr. VEDHANAYAGAM.N

MBBS, DNB in General Medicine, DNB in Neurology

Consultant Neurologist





Being decisive can often lead to better outcomes-carotid Artery Stenting

Introduction:

Acute stroke in emergency patients can be either due to ischemia or hemorrhagic cause. Among the ischemic stroke patients cerebral arterial occlusion can be due to cardiovascular embolus or insitu atherosclerotic stenosis with occlusion due to plaque rupture. Identifying the asymptomatic carotid artery stenosis and elective carotid artery stenting will prevent the occurrence of catastrophic major stroke.

Case Report:

75year old gentleman was admitted with right side limb weakness , giddiness and completely recovered after 2hrs. His MRI showed acute lacunar infarct in corona radiata with non occlusive internal carotid artery thrombus. CT cerebral angio revealed 99% atherosclerotic stenosis of proximal internal carotid artery with long segment internal carotid artery thrombus extending to cervical and petrous segment causing 90% narrowing.

Clinically patient was conscious ,speech was normal and no limb weakness.

Intervene or Observe?

Since patient had no neurological deficit, it was decided to manage with low molecular weight heparin ,antiplatelets and close observation for any worsening of neurological status.

Next day morning patient suddenly developed aphasia with limb weakness(2/5).MRI stroke protocol showed occlusion of middle cerebral artery and internal carotid artery.

Mechanical Thrombectomy and Carotid Artery Stenting

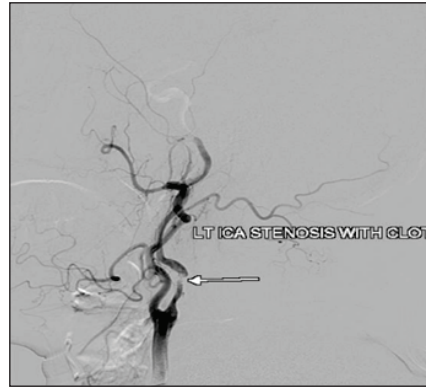
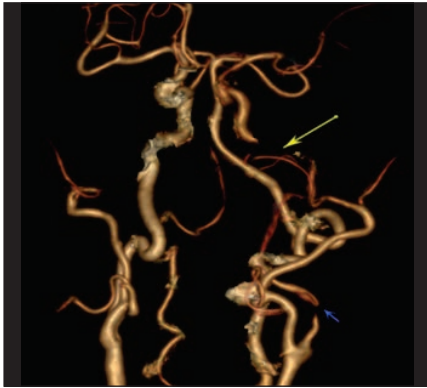
DSA carotid angio revealed 99% stenosis of internal carotid artery with detached internal carotid artery thrombus occluding the left middle cerebral artery M2M3 segments. Left carotid artery angioplasty followed by retrieval of left middle cerebral artery clot and finally left carotid artery stenting was done. TIC13 flow was achieved.

At the time of discharge patient completely recovered with no neurological deficit.

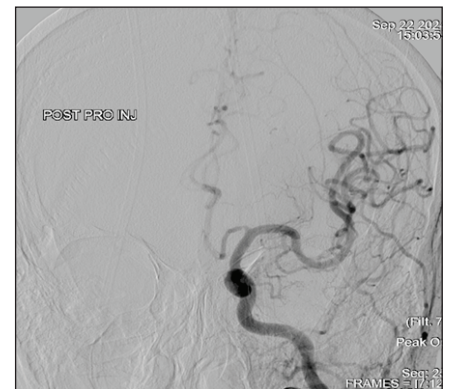
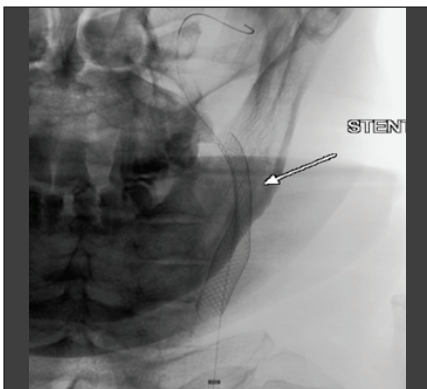
Take Home Message

Asymptomatic patients with >70% stenosis of carotid artery and patients with TIA or minor stroke with >60% stenosis of carotid artery needs carotid artery stenting to prevent major stroke occurrence. Elective carotid artery stenting will not only prevent stroke disability but also the financial burden of the patients.





1. ICA STENOSIS AND THROMBUS



Dr.MUTHURAJAN.P

DMRD, DNB, FNVIR.,

Consultant Neuro and Vascular Interventional Radiologist



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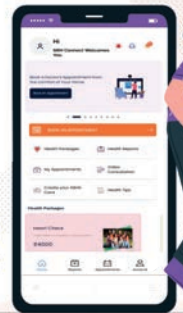
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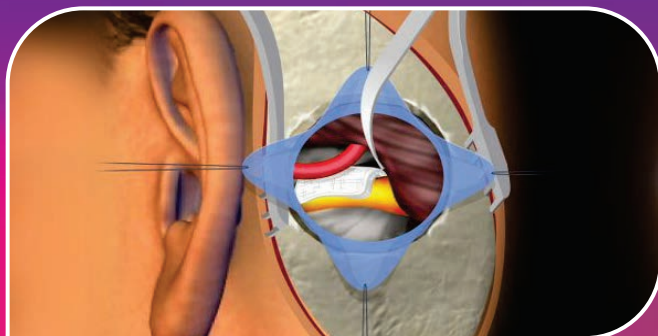


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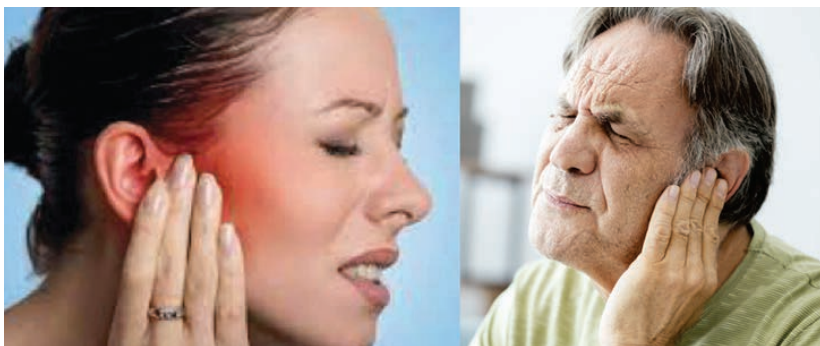
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Awake Mvd for Trigeminal Neuralgia

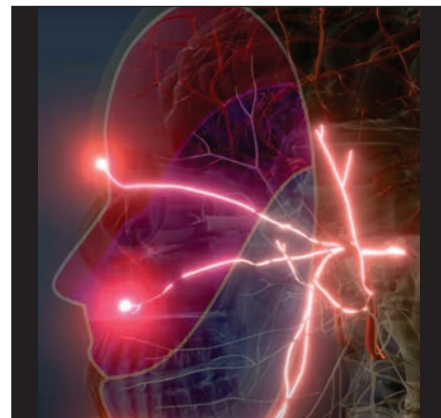
Most excruciating lightning like pain in the face with a rewarding and long-lasting solution by Micro Vascular Decompression (MVD).

Trigeminal Neralgia: Lightning pain involving Trigeminal neuralgia (TN or TGN), also called Fothergill disease, tic douloureux, trifacial neuralgia, or suicide disease, is a disorder that affects the trigeminal nerve, the nerve responsible for sensation in the face and motor functions such as biting and chewing. It is a severe form of neuropathic pain. Lightning pain involving Trigeminal neuralgia (TN or TGN), also called Fothergill disease, tic douloureux, trifacial neuralgia, or suicide disease, is a disorder that affects the trigeminal nerve, the nerve responsible for sensation in the face and motor functions such as biting and chewing. It is a severe form of neuropathic pain. Lightning pain involving Trigeminal neuralgia (TN or TGN), also called Fothergill disease, tic douloureux, trifacial neuralgia, or suicide disease, is a disorder that affects the trigeminal nerve, the nerve responsible for sensation in the face and motor functions such as biting and chewing. It is a severe form of neuropathic pain.



The typical form results in episodes of severe, sudden, shock-like pain in one side of the face that lasts for seconds to a few minutes. Groups of these episodes can occur over a few hours. The atypical form results in a constant burning pain that is less severe. Episodes may be triggered by any touch to the face like even swallowing fluid or food, brushing or even a airflow from fan or breeze at trigger points in the course of any or all of the

three division of the nerve in the face and mouth without crossing the midline or behind the ear, occipital region. It is regarded as one of the most painful disorders known to medicine, and often results in depression and many have even attempted suicide.



Available Treatment options

The most common cause attributed being nerve compression from one or more blood vessels, but exact cause in cases is unknown. It is believed due to loss of the myelin of the trigeminal nerve from various reasons as the nerve exits the brain stem like multiple sclerosis, stroke, or trauma. Less common causes include a tumor or arteriovenous malformation. Diagnosis is typically based on the symptoms, after ruling out other possible causes such as postherpetic neuralgia, tumor in the region of CP angle or along the course of nerve and primary intrinsic pathologies of brainstem.

Treatment options

• Medical Management

In initial phase after confirming the diagnosis its wise to treat them always with standard drugs like carbamazepine, oxcarbazepine, gabapentin from lower dose up to its maximum permissible limits with monitoring of its side effects, and drug interactions. The most common side effect being drowsiness and restricted lifestyle due to the same.

• Non Surgical Interventions Includes

- Balloon compression of the gasserian ganglion
- RF ablation of the roots close to gasserian ganglion
- Glycerol ablation of or root ablation with absolute alcohol
- Botox treatment at gasserian ganglion
- Stereotactic Radio surgical gasserian ganglion ablation

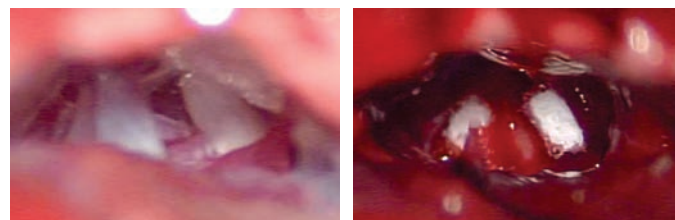


Most of these ablative procedures are ideal for persons with confirmed etiology diagnosed due to non-vascular loop causes except for tumor which is relieved with resection of the tumor as well ideal for persons who are medically unfit for the surgical intervention under GA. However, although these ablative procedures often provide successful short-term relief, the long-term results can be disappointing, with reported success rates of 40% to 50%. Additionally, they are more likely to cause facial numbness, especially the bothersome kind. The major limiting factor being these procedures require repetitive interventions as regeneration of the nerve reinstates the pain mainly in whom the vascular loop is the causative agent for the pain.

• Surgical Intervention

Under General Anesthesia in the posterior aspect of the ear in the retro mastoid region a miniature craniotomy helps in exposing the cerebello-pontine fissure under microscope or endoscope guidance to expose the trigeminal nerve from its root entry zone into the brainstem up to the gasserian ganglion. Usually, AICA OR SCA branches or venous vascular channel compression either alone or in combination could be identified which is rerouted and the root is decompressed and held apart with the help of inert Teflon sponge to relieve the trigeminal pain. This is a non-destructive and long-lasting pain relieve procedure which aids the patients to lead the normal life without pain and medication for the same.

Immediate pain relief occurred in 90.6% of patients with a recurrence rate of 10% after 3.5 ± 4.6 years in various studies. The most common causative factors being Most of the surgical failures developed within 2



years after the initial MVD. Annual recurrence after an initial MVD is about 2%. The most common cause being inadequate decompression, under recognition of the 2nd offending vessel, slip of the Teflon patch, Teflon granuloma etc.,

• Awake Mvd For Trigeminal Neuralgia

Awake craniotomy is a well-established procedure that has been employed widely for glioma resection and functional procedures which require neurological monitoring of eloquent cortical and subcortical. Awake procedures have also been used for similar purposes in cerebrovascular surgery, specifically for carotid endarterectomy.

Multiple case reports describing the use of awake craniotomy for aneurysms have also been presented in the literature, including three cases of distal vessel occlusion for mycotic aneurysm clipping an ophthalmic artery aneurysm with intraoperative visual testing, trapping a giant fusiform middle cerebral artery aneurysm, and anterior choroidal artery aneurysm clipping.

In our institute we have been performing awake craniotomy protocol mainly for the resection of gliomas and other lesions in eloquent areas with the help of IONM, clinical psychologist, anaesthesia teams help for eloquent areas functional monitoring per operatively.

The option of performing MVD under awake anaesthesia protocol ("awake" MVD) was used here to assess whether intraoperative pain evaluation can identify and mitigate insufficient decompression of the trigeminal nerve, improving surgical outcomes. Additionally, "awake" MVD could expand procedure indications for those with comorbidities that would prohibit general endotracheal anaesthesia but will achieve the result of pain free quality of life.

Awake MVD was performed under monitored anaesthesia care. Spontaneous respirations were maintained throughout the procedure with dexmedetomidine and fentanyl infusions IV dexamethasone dose. A scalp block with 0.5% bupivacaine, 2% xylocaine, was performed to anesthetize the appropriate scalp region.

All interpretations of the electrophysiological monitoring results were made by a specially trained clinical psychologist or with the help of Anaesthetist, Junior Consultant in the operating room.

From a positioning standpoint, the patients were placed in a supine position with a large roll below the ipsilateral shoulder and chest area, which allowed the turning of the head toward the contralateral side by 70-80 degrees. The patients were checked for comfort in the proposed position prior to administration of intravenous sedation.

A standard small postauricular incision was made using image guidance to localize the transverse and sigmoid sinuses. Retro mastoid apt size craniotomy performed, dural incision and reflection taken towards the venous sinus, under microscope or endoscopic guidance cerebello medullary cisternal CSF released to relax cerebellum for dynamic retraction. CP cistern explored, arachnoids dissected to identify superior petrosal vein and protection with gel foam 5th cranial nerve delineated from root entry zone till the tentorium where nerve enters Meckel's cave. Vascular loop of arterial and venous nature compressing the root released re-routed and Teflon sponge of apt size placed circumferentially to decompress the nerve.

As part of awake MVD, pain relief prior to and following decompression was assessed intraoperatively. Once CN V was exposed, dexmedetomidine and remifentanyl drips were halted, and the patient was brought into a fully awake stage for pain assessment. Intraoperative awake pain relief testing was conducted in two steps:

- Elicitation of facial pain using specific patient - reported trigger prior to CN V decompression to establish baseline pain severity, and
- Attempted elicitation of pain using the same triggers after CN V decompression to establish relief of pain

Awake surgery gives excellent relaxed pulsatile brain with dynamic retraction requirements, with limited movements from the patient if the procedure duration is prolonged, is the additional risk. The pain relief was observed instantaneously in these patients after dissection and in 2 patient the pain relief was inadequate aiding us to search for second vessel conflict which was identified and dissected out decompressing the nerve achieving complete pain relief.

Since 2016 at Sri Ramakrishna Hospital, we have done about 59 microvascular decompressions for trigeminal neuralgia of which 35 patients consented for the procedure in awake protocol and 24 patients under general Anaesthesia. All patients had complete relief of pain post op.

Three patients in awake group had partial relief of pain intraoperatively leading to search for other offending vessel where in two of them had another arterial loop compressing were detected, and one patient had a venous channel as the offender. Complete relief was achieved post decompression of those loops.

Five patients had minimal numbness in the trigeminal distribution for about 5 days and recovered completely two of them were from awake group mostly they are attributed to neurapraxia due to dissection. One patient had cerebellar small haemorrhage due to venous ooze control but recovered completely without any new deficits. One patient had minimal wound dehiscence post op and none had any mortality in both the groups. None of these patients required resurgery or additional procedure so far for the trigeminal pain.

Of these patients only 2 patients had very minimal recurrence of the pain, and they were from general anaesthesia group. Both of them did improve with once-a-day carbamazepine medication but not on regular basis.

Performing microvascular decompression in awake craniotomy protocol helps the surgeons to achieve complete decompression and have at par or superior results than the general anaesthesia group. However, the data sampling is small in number may need more validation with higher data. Needless to say microvascular decompression is the optimal procedure with long term results either in awake or general anaesthesia mode for these persons having this severe pain and are refractory to medical managements and superior to all other modalities for being a non-destructive procedure of the trigeminal nerve or ganglion.

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PINK OCTOBER @ POLICE TRAINING SCHOOL, COIMBATORE - 26.10.2024

The Police Training School, Coimbatore observed Breast Cancer Awareness month by organizing CELEBRATING PINK OCTOBER 2024. Dr. S. Bhargavi, Consultant Surgical Oncologist, SRIOR - Sri Ramakrishna Hospital was invited as the Chief Guest along with Mr. Balakrishnan IPS, Commissioner of Police Coimbatore City. Women Police Officers, family members of other officers took part in the event. Diet Counselling were provided to the participants by Dietician from Sri Ramakrishna Hospital.



Department of Diagnostics - CAHOTECH 2024 - 26.10.2024

CAHOTECH Hospital Innovation/ Early Adoption of Technology award program had been organized by Consortium of Accredited Health Care Organization (CAHO) on 26th October 2024 at J.N. Tata Memorial Hall, IISc Medical School Foundation, Bangalore. Nominations were invited from various healthcare sectors to recognize their work towards hospital innovation & early adoption of technology.



Juries from CAHO and IISc Medical School Foundation analyzed each nomination and selected few categories out of seventy five nominees. Our Laboratory has won the prestigious "Automation of Laboratory Practices Award in the Early Adoption of Technology" on CAHOTECH 2024 held at IISc Medical School Foundation, Bangalore for their dedication and services towards advanced automation technology. Dr. Vijay Agarwal, President- CAHO, Dr. Lallu Joseph, Secretary General- CAHO Associate GS & Quality Manager, CMC Vellore, and Dr. Uma Nambiar, CEO, Bagchi Parthasarthy Hospital, Indian Institute of Science delivered the esteemed award to Mr. R. Dorairaj, Administrative Director- Diagnostics & Dr. P. Suseela, Director & Consultant Biochemist, Quality Director- Laboratory, Sri Ramakrishna Hospital.

360° Health Care



Sri Ramakrishna Hospital
(Multi-Speciality)

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