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Sri Ramakrishna
Hospital (Multi-Speciality)

pulse

Happenings at Sri Ramakrishna...

49 Years of Excellence

HAPPY NEW YEAR

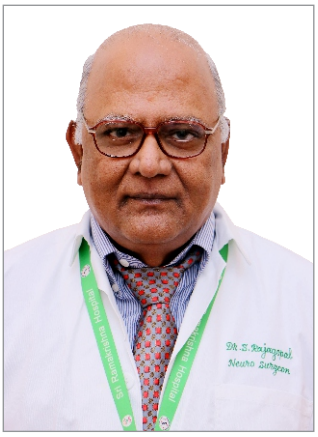
Shri.R.Sundar
Managing Trustee

As we step into a brand-new year 2025, I extend my heartfelt wishes to each one of you for a prosperous and fulfilling year ahead. The past year has been a testament to our dedication, resilience, and commitment to delivering exceptional healthcare to our patients and the community we serve.

We have achieved numerous milestones together—advancing medical care, introducing innovative technologies, and fostering an environment of compassion and healing. These accomplishments reflect the collective spirit and hard work of our doctors, nurses, support staff, and administrative team.

As we welcome this new chapter, let us reaffirm our commitment to excellence. This year, we aim to enhance patient care, focus on continuous learning, and strengthen our efforts to make quality healthcare accessible to all.

Wishing you and your families a year filled with good health, happiness, and success.



Dr.S.Rajagopal
Medical Director

As the New Year begins, I want to take a moment to reflect on the incredible strides we made together in the past year and to express my deepest gratitude to your unwavering commitment to excellence in healthcare.

The dedication of our doctors, nurses, technicians, and administrative staff has been the cornerstone of our hospital's success. Your hard work and compassion have not only saved lives but have also brought comfort and hope to countless families. Let us step into this new chapter with renewed enthusiasm, staying true to our shared mission of making a meaningful difference in the lives of our patients and the community.

Wishing you all a year filled with good health, personal growth, and professional success. May we continue to work together as one team, united by our passion for healing and excellence.

SRI RAMAKRISHNA HOSPITAL

has been awarded

BEST MULTI-SPECIALITY HOSPITAL

in KONGU REGION

by

NEWS 18 தமிழ்நாடு

Award presented by

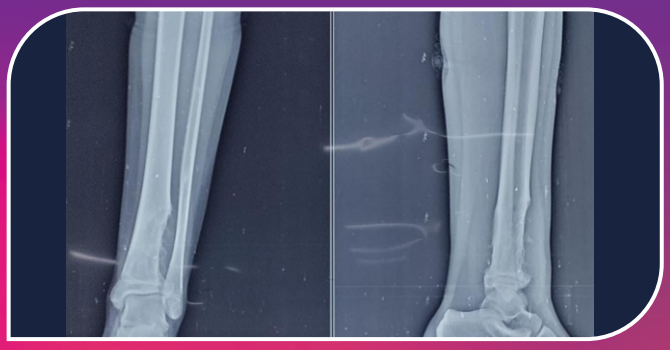
Honourable.Ma.SUBRAMANIAN

Minister for Health and Family Welfare,
Government of Tamil Nadu

to

Mr.R.SUNDAR

Managing Trustee
SNR Sons Charitable Trust



Distal Tibia Ewings Sarcoma-Reconstruction Challenges in Limb Salvage Surgery

Distal tibia is an uncommon locations for primary malignant tumours. considering the tumour location, many reconstruction challenges are expected.

Limb salvage in extremity tumors is now established as an oncologically safe option without compromising long-term survival and functional outcome. En bloc tumour resection followed by extra corporeal radiation theraphy and reimplantation is a biological reconstruction option in diaphyseal Ewing's sarcomas.

Patient and Observation

A 11 year old girl presented with complaints of pain and swelling of distal leg, with difficulty in walking for 1 month. Radiograph and mri showed features of distal tibia-ewing sarcoma. USG guided trucut biopsy-suggestive of ewings sarcoma. This case was discussed in Tumour board (Dr.P.Guhan - Medical Oncologist, Dr.K.Karthikesh - Surgical Oncologist, Dr.S.Bhargavi - Surgical Oncologist, Dr.T. Karthika - Radiation Oncologist, Dr.N.Krishna Priya - Radiation Oncologist, Dr. Vivek Jayaraj - Radiation Oncologist, Dr. T. Sethumadhavan - Oncopathologist) Dr.R.Gokula Krishnan - Orthopedic Surgeon, Dr.S.Mohan - Orthopaedic Surgeon planned for neoadjuvant chemotheraphy and limb salvage surgery after repeat MRI, followed by post op chemotheraphy .

Patient was positioned in supine posture, incision was placed anteromedially. meticulous dissection done to preserve the neurovascular structures and adequate clearence margins with intraop frozen section study.

Tumour bone dissected and exposed to radiation of 50 GY. After that irradiated bone placed, ankle arthrodeisis done with tibiotalocalcaneal nail and corresponding screws, malleolar reconstruction done using native fibula graft, primary closure done with available soft tissue and skin.

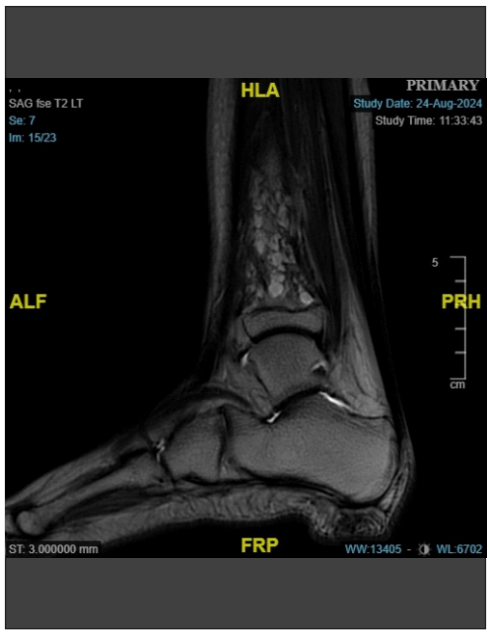
Post OP chemotheraphy started after suture removal.

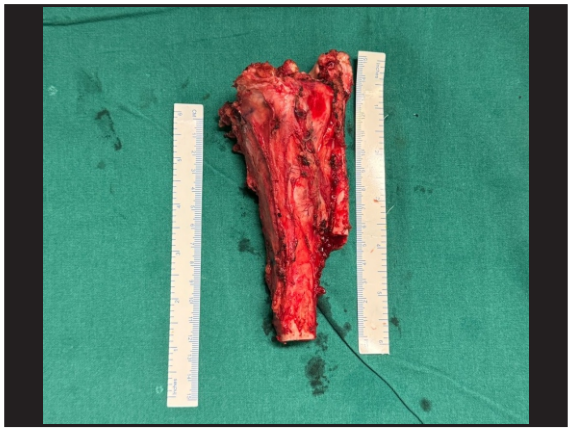
Postoperative rehabilitation allowed immediate mobilization without loading operated limb.

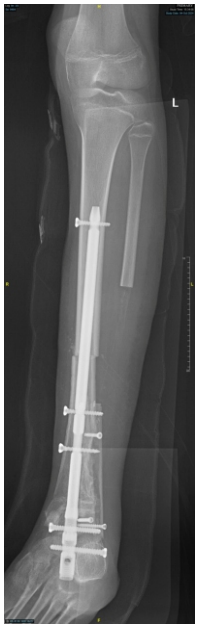
Extracorporeal irradiation is a useful, convenient technique for limb salvage in diaphyseal Ewing's sarcomas when there is reasonable residual bone stock.

It is oncologically safe and has good functional results. A radiation dose of 50 Gy for sterilizing the bone ensures adequate tumor kill, while minimizing the deleterious effects on the biomechanical and biological properties of the bone.

The use of appropriate implants for adequate internal fixation and supplementary bone grafting at the index surgery may help reduce the need for subsequent additional interventions to achieve union. The limitations of this procedure are that it is not applicable in tumor bones that are structurally weak and in bones with pathological fractures.

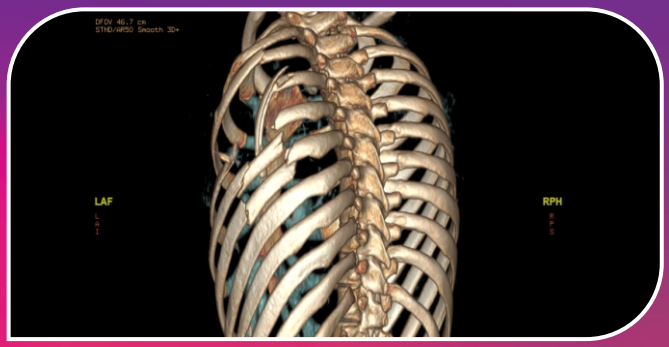






Dr. R. GOKULA KRISHNAN
MBBS., D.ORTHO., MCh. Orth.

Consultant Orthopedic Surgeon



FLAIL CHEST INJURY

Back Ground: Flail chest is a dangerous injury, that can occur after thoracic injury. It means a segment of chest wall moving in paradoxical pattern with rest of the rib cage due to fracture of 3 or more consecutive ribs at 2 or more different places. This injury is caused by injuries of anterior or lateral thorax, or sternal fractures and injury of multiple costochondral joints.

Case Description: 19 year old male college student , presented with history of Left chest injury and difficulty in breathing, head injury to emergency room. His Pulse rate was 72/min, BP – 116/78 mmHg, Oxygen Saturation of 96%, Respiratory System examination revealed diminished air entry on left chest with diminished volume of heart sounds. His GCS was E3V5M5 – 13/15. He had abrasion on left anterolateral chest wall with tenderness over left 3,4,5,6 ribs over anterolateral aspect, midaxillary line and posterior aspect over subscapular area. Left shoulder movements of flexion, abduction, rotations were painful. There was no focal neurodeficit. CT scan of chest revealed hemothorax with tension pneumothorax, left lung contusion, segmental fracture in left 3rd, 4th , 5th and 6th rib comminution and internally displaced fracture of 4th rib , with similar internally displaced 5th and 6th ribs. There was also a large 6x3 mm deficit noted in lateral chest wall involving the pleura and intercostal muscles at left 3-4 intercostal space. The other findings were pneumomediastenum and interstitial emphysema. CT scan of cervical spine revealed air pockets in left retropharyngeal space extending into bilateral parapharyngeal space and left posterior triangle of neck. Immediately after diagnosing, the patient was managed by multidisciplinary approach involving cardiothoracic surgeon, neurosurgeon and pulmonologist. On left 5th intercostal space, intercostal drainage tube was inserted. Then his general condition was stabilized in ICU. Since his respiratory function deteriorated on the following day with asynchronous movement of left chest wall, he was planned for early open reduction and internal fixation of fractured left ribs. After 48 hours of injury, he underwent left high lateral thoracotomy & multiple comminuted rib fracture compressing a partially collapsed lung parenchyma were noted in thoracic cavity. Chest wall stabilization with AO SYNTHES Plate by fixing the left 4th, 5th and 6th ribs on lateral aspect was done. The patient was extubated following the surgery. His respiratory function recovered well during the postoperative period. on 6th postoperative day his chest tube was removed. He was discharged On 8th postoperative day with good general condition and stable vital signs with total stay of 11 days in hospital.

Discussion: Flail chest constitutes 10-15% of rib fractures. The mortality can reach upto 40% with additional extrathoracic serious injuries. Flail chest movements are caused by the paradoxical movement characterized by an inward compression of fractured segment on inspiration and an onward shift of flail chest with or without pneumothorax preventing the expansion of ipsilateral lung. This results in change of intrapleural pressure gradient, reduced venous return and cardiac output, hypotension, syncope, and sudden cardiac death may occur.

Massive hemothorax or pulmonary contusion is the underlying cause of early mortality in flail chest, whereas ARDS is often the cause of late mortality. 75% of flail chest patients managed medically require mechanical ventilator therapy and should be continued till the end of paradoxical movement.

Aim of surgery is to elevate the compressed segment, fix and stabilize the defect. The indications of surgery are uncontrollable progressive respiratory failure with aggressive medical management, large flail chest covering the anterior and the lateral portion of the chest wall, failure to terminate the ventilator treatment, thoracotomy being performed for any other indication, severe pulmonary contusion in elderly patient. For better outcome, after stablizing the general condition of the patient, surgery is indicated within the first 36 to 48 hours.

In our case, flail chest injury was converted to simple rib fracture by early fixation with plate, thus avoiding mechanical ventilation and length of stay in ICU resulting in good outcome.

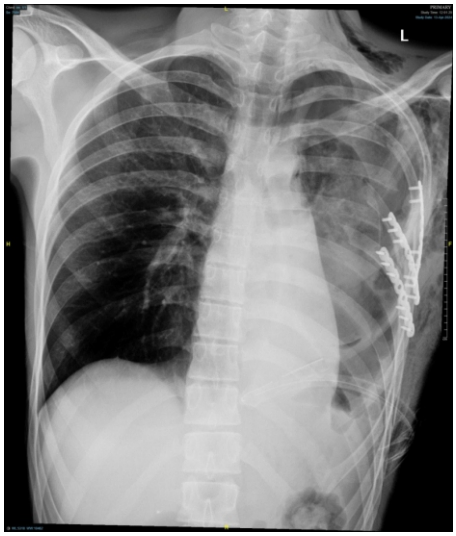


Fig:1 - Early post OP X-ray showing decreased aeration in left lung

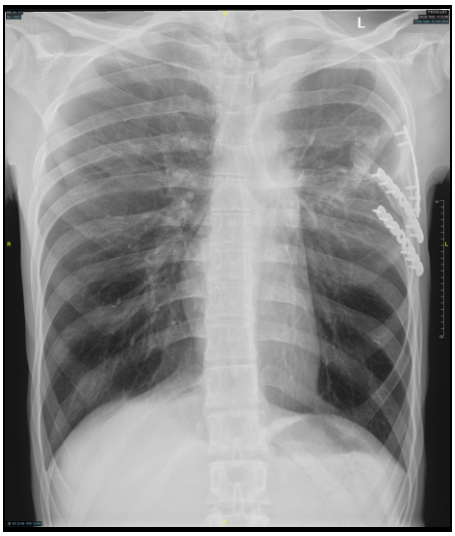
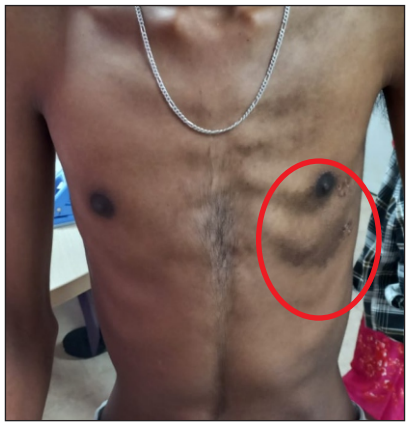


Fig:2 - 6 months post OP X-ray showing good aeration in left lung

Fig:4

Fig: 5

Fig: 6



Marked areas in images showing reconstructed chest wall

Dr. N. KANNIAPPAN
MBBS, D.Ortho.,M.S.(Ortho),
Fellowship in Spine Surgery (Germany)

Consultant Orthopedic and Spine Surgeon

Saddle Nose Deformity

Saddle Nose Deformity

Saddle Nose is a condition characterized by the collapse of the nasal bridge resulting in the loss of nasal height. This condition resembles the shape of a saddle. The depressed nasal bridge may involve bony or cartilaginous components or both.

Causes

Saddle nose deformity occurs due to the Injury of the nose causing depressed #s, excessive removal of septum during nasal surgery, destruction of septal cartilage by haematoma or abscess, infections like leprosy, tuberculosis, syphilis.

Granulomatous disorders, relapsing polychondritis may also leads to this deformity.

Treatment

Augumentation Rhinoplasty is the treatment of choice

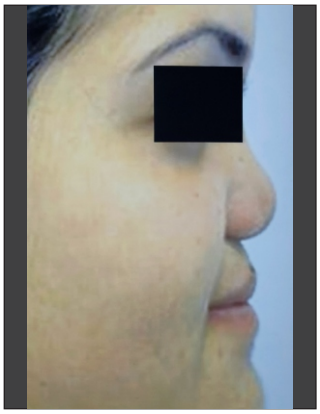
The depressed nasal bridge is filled with

Cartilage ---nasal septum or conchal cartilage
Bone cancellous bone from iliac crest

Synthetic implants silicon or Teflon

Case reports

The female patients presented with Saddle nose deformity and augumentation rhinoplasty was done by taking bone graft From iliac crest.



Pre OP - 1

Pre OP - 2

Post OP - 1

Post OP - 2

Dr. N. THIRUGNANAM
MS, MCh (Plastic Surgery)

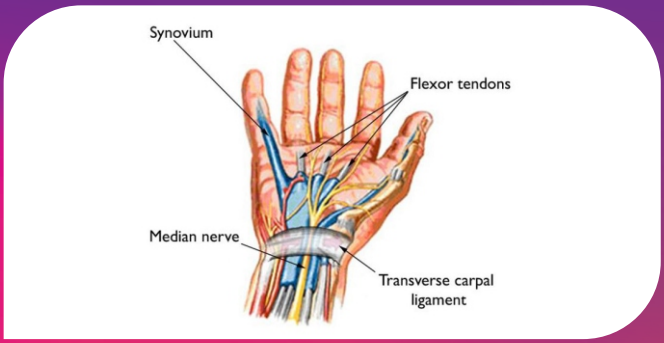
Visiting Consultant Plastic Surgeon

SRI RAMAKRISHNA HOSPITAL
"EXCELLENCE IN FAST-GROWING HOSPITAL (SOUTH)"

Sri Ramakrishna Hospital has been awarded the "Excellence in Fast-Growing Hospital (South)" at the "Sanjeevani Healthcare Excellence Awards 2024", organized in collaboration with SEPC and BW. The award was presented to Shri R. Sundar, Managing Trustee, SNR Sons Charitable Trust, Dr. S. Alagappan, Medical Superintendent, Sri Ramakrishna Hospital at the grand event, held at the Yashobhoomi New Convention Center in New Delhi on 16.12.2024.

The award ceremony, part of Sanjeevani 2024, witnessed a large congregation of healthcare leaders, gathered to discuss and exchange ideas about the future of medical tourism, global Healthcare Access, and the role of Hospitals in bridging the healthcare gap across regions. Among the key discussions was a panel session on "Global Health Access: Opportunities and Challenges for Government-Sponsored Patients."

Shri. R. Sundar, a key speaker in the session addressed the ongoing challenges facing the healthcare industry in India and around the world. He highlighted Sri Ramakrishna Hospital's dedication to providing world-class healthcare solutions, citing the hospital's ability to blend modern technologies with compassionate patient care as a cornerstone of its success.



Carpal Tunnel Syndrome: Understanding the Numbness and Pain

Carpal tunnel syndrome (CTS) is a common condition that causes pain, numbness, and tingling in the hand and arm. It occurs when the median nerve, which runs through the wrist and into the hand, gets compressed. This compression can lead to a variety of symptoms, including weakness in the hand and difficulty with fine motor skills.

What is the carpal tunnel?

The carpal tunnel is a narrow passageway located on the palmar side of the wrist. It's formed by the carpal bones, which are small bones that make up the wrist joint and the Transverse carpal ligament above. The median nerve and tendons that bend the fingers pass through this tunnel.

What causes carpal tunnel syndrome?

The exact cause of carpal tunnel syndrome is often unknown, but several factors can increase the risk:

- **Repetitive hand motions:** Activities that involve repetitive hand motions, such as typing, using a keyboard, or playing a musical instrument, can irritate the tendons in the wrist and compress the median nerve.
- **Pregnancy:** Hormonal changes during pregnancy can cause fluid retention, which can lead to swelling in the wrist and compress the median nerve.
- **Medical conditions:** Certain medical conditions, such as rheumatoid arthritis, diabetes, and hypothyroidism, can increase the risk of carpal tunnel syndrome.
- Obesity: Excess weight can put additional pressure on the wrist and increase the risk of developing carpal tunnel syndrome.
- Wrist injuries: Past injuries to the wrist, such as fractures or sprains, can increase the risk of developing carpal tunnel syndrome.

Symptoms of carpal tunnel syndrome

The most common symptoms of carpal tunnel syndrome include:

- Numbness, tingling, or burning sensations in the thumb, index finger, middle finger, and half of the ring finger.
- Weakness in the hand, particularly when gripping objects.
- Pain in the wrist, hand, or forearm that may radiate up the arm.
- Difficulty with fine motor skills, such as buttoning clothes or turning a key.
- Waking up at night with numbness or pain in the hand.

Diagnosis of carpal tunnel syndrome

- **Clinical exam:** Look for signs of sensory weakness, by measuring response to touch, pain, vibration and 2 point discrimination. Motor weakness is tested by the contraction of the thenar muscles and grip strength. Phalens, Durkan's and Tinel's signs are checked.
- **Nerve conduction studies:** This test measures the speed at which electrical signals travel through the median nerve. A diagnosis of severity of the CTS can be made

- **Electromyography (EMG):** This test measures the electrical activity of the muscles in the hand.
- X-rays and ultrasound can help rule out other conditions that may be causing the symptoms.

Treatment of carpal tunnel syndrome

The treatment of carpal tunnel syndrome will depend on the severity of the symptoms. In mild cases, conservative treatments may be sufficient, such as:

- **Wrist splints:** Wearing a wrist splint at night can help keep the wrist in a neutral position and reduce pressure on the median nerve.
- **Over-the-counter pain relievers:** Nonsteroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen can help relieve pain and inflammation.
- **Physical therapy:** A physical therapist can teach exercises to strengthen the muscles of the hand and wrist and improve flexibility.
- **Occupational therapy:** An occupational therapist can help modify work and home activities to reduce stress on the wrist.

Surgery

In more severe cases of carpal tunnel syndrome, surgery may be necessary to relieve pressure on the median nerve. Carpal tunnel release surgery is a minimally invasive procedure that involves cutting the ligament that forms the roof of the carpal tunnel. This procedure can significantly improve symptoms and restore function to the hand.

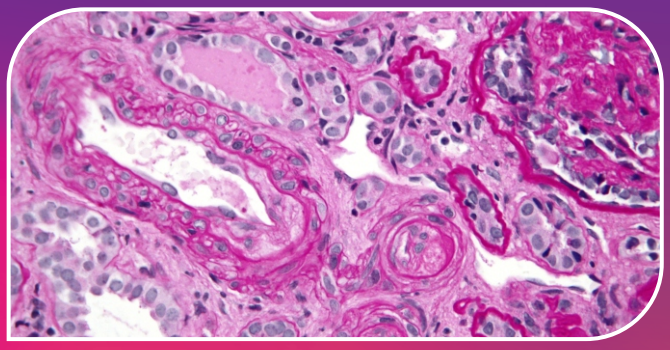
Prevention of carpal tunnel syndrome

While there is no guaranteed way to prevent carpal tunnel syndrome, you can take steps to reduce your risk:

- **Good posture:** Maintain good posture when working at a computer or performing other repetitive tasks.
- **Frequent breaks:** Take frequent breaks from activities that involve repetitive hand motions.
- **Wrist stretches:** Stretch your wrists regularly to improve flexibility.
- **Ergonomic workstation:** Use an ergonomic keyboard and mouse to reduce stress on your wrist.
- **Avoid repetitive motions:** If possible, avoid activities that involve repetitive hand motions.

Carpal tunnel syndrome is a common condition that can cause significant pain and discomfort. If you experience symptoms of carpal tunnel syndrome, it's important to see a doctor for diagnosis and treatment. With early intervention, most people with carpal tunnel syndrome can experience significant relief of symptoms.

Dr. S. BHAGAVATH KUMAR
MS (Gen. Surgery), MCh (Plastic Surgery), Fellowship (American Board)
Consultant Plastic Surgeon



Microvascular APS

A 32 years old female had her disease onset 5 years ago. At that time, she was found to have recurrent episodes of bicytopenia – Autoimmune Hemolytic Anemia and thrombocytopenia. She was evaluated for connective tissue disease (CTD). The initial investigations revealed ANA positivity- Homogeneous 3 +, but ANA profile turned out to be negative. Anti Phospholipid antibody screening showed Lupus anti coagulant positivity there was no clinical features of Lupus at that time. She was diagnosed as probable lupus with secondary APS and hematological involvement and was started on HCQ and low dose Aspirin.

She was asymptomatic for nearly 5 years. Five years later, she developed exertional dyspnea. ECHO showed valvular heart disease with bicuspid aortic valve and severe AR and AS while other blood investigations turned out to be normal. She was managed conservatively with beta blockers and diuretics with background HCQ and aspirin.

1 month later, she developed severe thrombocytopenia and anemia with hematuria. Further investigations shown AKI with creatinine levels upto 2.2 mg/dl. She was provisionally diagnosed as probable lupus nephritis with hematological flare. Her ANA profile was repeated which was still negative with persistent lupus anticoagulant positivity.

Complement levels were normal. Renal biopsy was deferred at that time due to low platelet counts. She was initiated on pulse steroids with cyclophosphamide and weekly inj.Romiplostim. Her platelet counts and renal parameters started to improve.

Two weeks later, she developed weakness in right upper limb. Imaging shown Multifocal acute and chronic infarcts in watershed territories which was thought to be due to APS. She was reinitiated on antiplatelets and immunosuppression continued.

After stabilization, renal biopsy was done which shown chronic mild Thrombotic Microangiopathy and no evidence of lupus nephritis. The big question is: Is it still lupus now? AIHA and Thrombocytopenia can occur in primary APS also. Her Valvular heart disease was reevaluated; Trans esophageal ECHO shown libmann sacks endocarditis, which can occur in both SLE as well as APS. With this evidence, her diagnosis was revised as primary APS with predominant microvascular manifestations. She was started on Inj.LMWH bridging with acitrom and further doses of cyclophosphamide stopped. Steroids and HCQ continued. However, 1 week later, she had an episode of acute pulmonary edema. ECG shown severe ST depression in all leads with NT pro BNP value more than 18000. ECHO revealed EF of 35% with severe AR and moderate AS. Her coronary angiogram showed normal coronaries; so the pulmonary edema maybe either due to worsening AR or coronary microvascular thrombosis secondary to APS. Investigations revealed low platelet counts along with raised creatinine again (worsening TMA). She was initiated on plasma exchange in view of recurrent TMA. Platelet count and creatinine started to improve. She

was given Inj. Rituximab for microvascular APS. Aortic valve replacement was done 1 month later and she is stable now.

Macrovascular thrombosis is the characteristic hallmark of Anti Phospholipid Syndrome and veins are more frequently affected than arteries. However, thrombosis of the microvasculature may occur as a part of clinical manifestation, either before or after the development of macrovascular manifestations. It often occurs as a part of Catastrophic APS, although acute isolated and chronic manifestations may also occur. The diagnosis of microvascular manifestations is particularly challenging because, in addition to their rarity, it requires appropriate imaging and histopathology for confirmation.

10 to 20% of aPL positive patients develop livedo, the most frequently associated cutaneous microvascular manifestations with APS. DAH can occur in 2 to 12% of patients, whereas biopsy proven aPL associated Nephropathy occur in 3% of patients. The aPL positive patients can rarely develop cardiac ischemia/ infarct with non obstructive coronary artery disease due to microvascular thrombosis.

Non thrombotic manifestations is often encountered in APS patients, with most of them being mild to moderate thrombocytopenia. Cardiac valve disease (vegetations, thickening, or both) is a late manifestation. Rarely, nonfocal neurologic manifestations like cognitive dysfunction can also occur in APS.

In general, the treatment of these microvascular and non thrombotic manifestations include glucocorticoids along with other immunomodulators, particularly Mycophenolate mofetil. Rituximab, Ivlg, plasma exchange, cyclophosphamide maybe used in case of refractory symptoms.

Dr.NAGENDRAN.R
MBBS, MD (General Medicine), DM (Rheumatology)

Consultant Rheumatologist

"GIFT ORGANS GIVE LIFE"
ONLINE ORGAN DONATION CAMPAIGN LAUNCH- 20.12.24

Sri Ramakrishna Hospital, a dedicated institution committed to enhancing health awareness and promoting organ donation through educating the public launched voluntary Online Organ Donation Drive Campaign – "Gift Organs Give Life" partnered with Transplant Authority of the Government of Tamil Nadu (TRANSTAN) and the National Organ and Tissue Transplant Organization (NOTTO).

The campaign aims to achieve 1 lakh and above registrations for voluntary organ donations within a span of three months, from January 1 2025 to March 31 2025. aimed at fostering a culture of generosity and saving countless lives.

This voluntary online Organ donation drive was launched by Tamil Nadu State's Health and Family Welfare Minister Thiru. Ma. Subramanian, along with SNR Sons Charitable Trust Managing Trustee Shri. R. Sundar, Chief Executive Officer Shri. C. V. Ramkumar, Chief Administrative Officer Shri. D. Maheshkumar and Sri Ramakrishna Hospital Medical Superintendent Dr.S.Alagappan, TRANSTAN Member Secretary Dr. N. Gopalakrishnan at Chennai.

Sri Ramakrishna Hospital
(Multi-Speciality)

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360° Health Care

Sri Ramakrishna Hospital

(Multi-Speciality)

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