Sri Ramakrishna
Hospital (Multi-Speciality)

VOLUME 53 | ISSUE 1 | JULY 2025

pulse

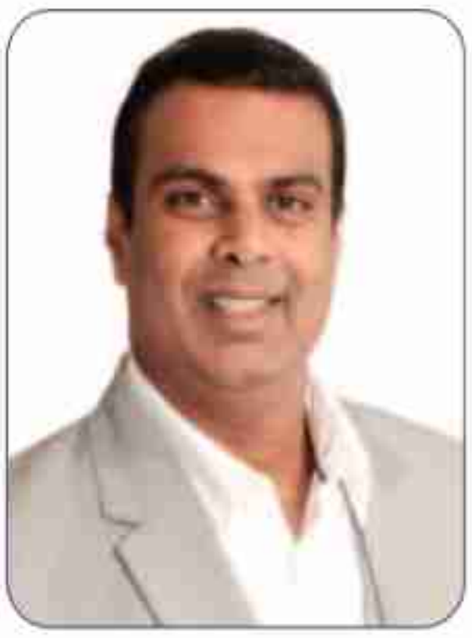
49 YEARS OF EXCELLENCE

In your hands, we find hope,
healing, and humanity.

HAPPY DOCTORS Day

1st, July, 2025

Sri Ramakrishna Hospital
pulse



Shri.R.Sundar
Managing Trustee

As we step into July, we are reminded of the strength and compassion that lie at the core of healthcare. **Doctor's Day (July 1st)** is a heartfelt reminder of the immeasurable value doctors bring into our lives. At Sri Ramakrishna Hospital, we are privileged to have a team of doctors whose dedication, knowledge, and humane approach continue to inspire confidence and healing.

We also mark **World IVF Day (July 25th)** — a celebration of scientific progress and emotional triumph. Our Fertility and IVF Centre has played a pivotal role in fulfilling the dreams of parenthood for many. With advanced technology and empathetic care, we continue to deliver hope.

Beyond these significant days, July also inspires us to embrace continuous improvement, invest in training, strengthen patient trust, and reaffirm our vision for a healthier society. Let us continue to build a future where healthcare is more inclusive, innovative, and empathetic.

The best way to find yourself is to lose yourself in the service of others
- Mahatma Gandhi

Dr.S.Rajagopal
Medical Director

July is a special month as we come together to observe **Doctor's Day** — a tribute to every doctor who walks the extra mile for their patients. At Sri Ramakrishna Hospital, we are proud of our medical team's relentless pursuit of excellence, even in the most challenging of times.

This month also highlights **World IVF Day**, a significant milestone in the field of reproductive medicine. Our Fertility and IVF team has helped hundreds of families experience the joy of parenthood through personalised care and cutting-edge treatments.

Let July also be a time of reflection and learning. Whether through collaborative care, quality improvements, or research breakthroughs, let us continue striving to raise the bar and redefine excellence.

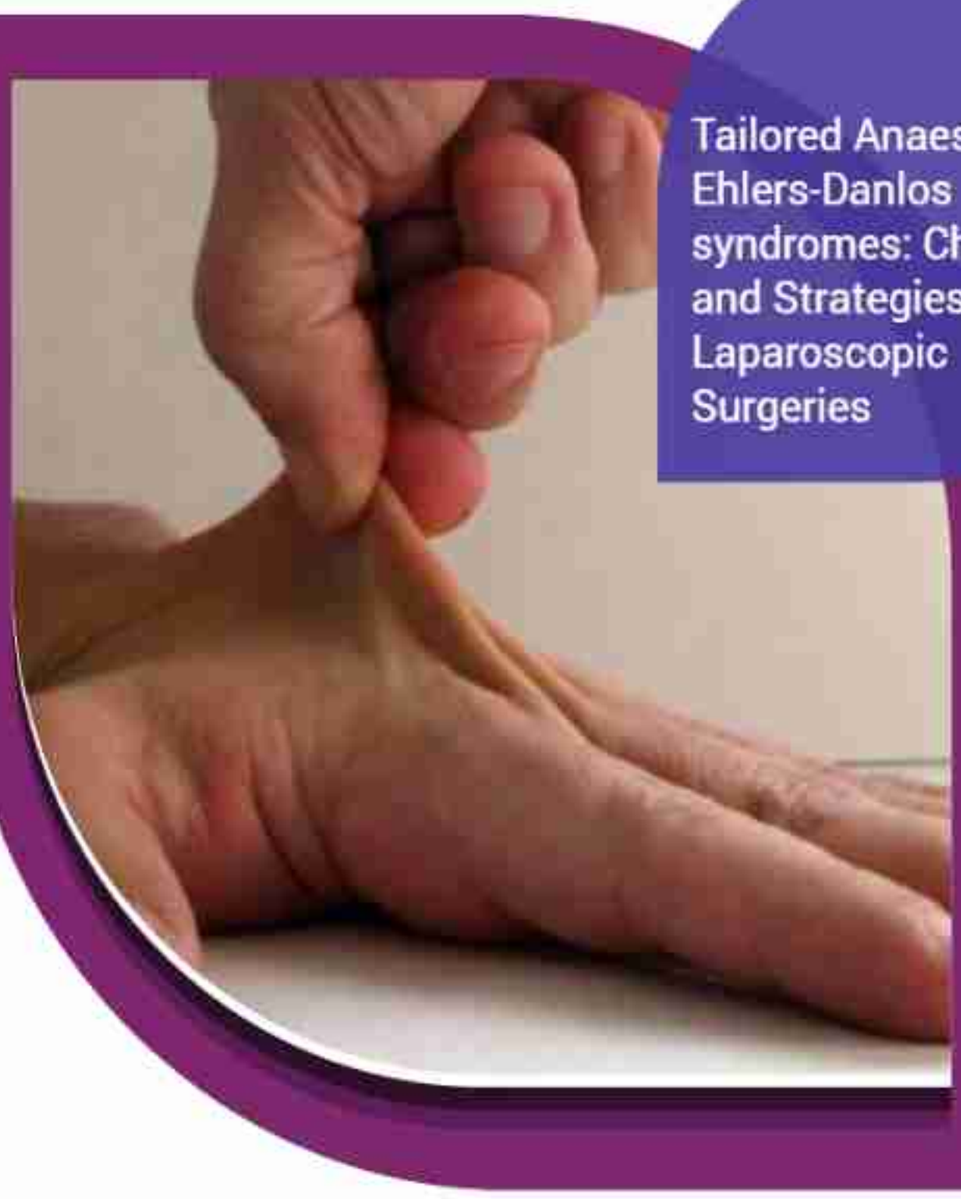
Wherever the art of Medicine is loved, there is also a love of Humanity
- Hippocrates

50th Hospital Day Celebration

Sri Ramakrishna Hospital celebrated its **Internal 50th Year Hospital Day** on **21st June 2025** at **Velumaniammal Mandapam**, marking a significant milestone in the institution's journey. The event brought together doctors, nurses, administrative staff, and support teams who have played a vital role in shaping the hospital's legacy of care and excellence.

The celebration was presided over by **Managing Trustee Shri R. Sundar** and **Joint Managing Trustee Shri R. Narendran**, who delivered the **Presidential Address**. They reflected on the hospital's remarkable 50-year journey and expressed deep appreciation for the unwavering dedication of every staff member. Their inspiring words encouraged all present to continue upholding the institution's values of compassion, service, and medical innovation.

The event also featured **cultural performances** by staff members, showcasing their creativity and talent beyond the workplace. Energetic dances, soulful music, and entertaining skits lit up the evening, creating a vibrant and festive atmosphere. The celebration concluded with a **prize distribution ceremony** where winners of first prizes in various competitions were honored, making the occasion a truly memorable one for the entire hospital family.



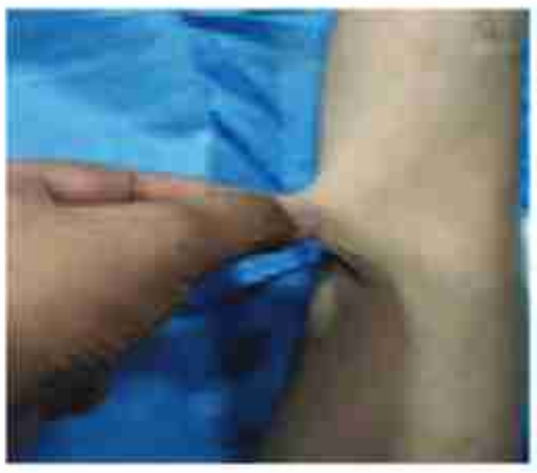
Tailored Anaesthesia in Ehlers-Danlos syndromes: Challenges and Strategies in Laparoscopic Surgeries

Ehlers-Danlos Syndrome (EDS) is a group of connective tissue disorders that affect the skin, joints, and blood vessel walls. It is caused by genetic mutations that impact the structure or production of collagen, a key protein that gives tissues strength and elasticity.

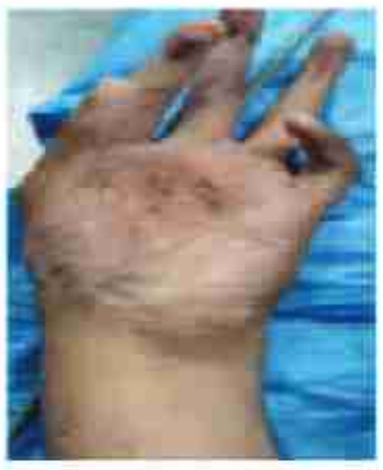
Common features of EDS include:

- Joint hypermobility (loose, unstable joints)
- Skin hyperextensibility (stretchy skin)
- Fragile skin that bruises easily and heals poorly
- Chronic pain and fatigue
- Frequent joint dislocations or subluxations
- Kyphoscoliosis
- Cardiovascular complications

Extension is restricted due to temporomandibular joint instability



Skin extensibility



Fragile skin

Anaesthetic Challenges

Patients with Ehlers-Danlos Syndrome present several unique challenges during anaesthesia due to the fragility of their connective tissues. Airway management can be difficult as tissues are easily damaged, increasing the risk of bleeding and mucosal tears during intubation. Temporomandibular joint (TMJ) instability and cervical spine hypermobility may complicate head and neck positioning, necessitating gentle airway techniques and the use of video-laryngoscopy or fiberoptic intubation.

Vascular fragility is another major concern. These patients are prone to bruising, hematoma formation, and even vessel rupture. Intravenous access may be difficult, and ultrasound guidance is often required. Joint hypermobility increases the risk of dislocation during positioning, so joints should be well-padded and overextension avoided.

Skin fragility is a common condition, and the skin may bruise or tear easily. Adhesives and tapes should be used cautiously or replaced with non-adhesive alternatives. Some patients, especially those with hypermobile Ehlers-Danlos syndrome (EDS), may exhibit reduced responsiveness to local anaesthetics, requiring higher doses and careful monitoring.

Autonomic dysfunction, including blood pressure instability, is also a concern. Close intraoperative fluid and hemodynamic monitoring is essential. Pain sensitivity is heightened in EDS, making effective pain control important, ideally using a multimodal analgesic approach.

Finally, delayed wound healing and scarring may occur. Gentle surgical technique and minimal tissue handling are essential. Overall, anaesthetic care in EDS patients requires careful planning, individualised strategies, and a multidisciplinary approach to ensure safety and positive outcomes.

Anaesthetic Management of a patient who presented for surgery at SRH

Preoperative preparation:

A 31-year-old male with a known case of Ehlers-Danlos Syndrome was scheduled for elective laparoscopic cholecystectomy due to symptomatic cholelithiasis. Pre-anaesthetic evaluation revealed hypermobile joints, fragile skin, easy bruising, and a history of frequent subluxations involving multiple joints was managedconservatively. Laboratory investigations were within normal range. There was no cardiovascular or neurological involvement. Airway assessment showed a Mallampati class III.

The patient was thoroughly evaluated and counselled before surgery. Preoperative planning in EDS necessitates coordinated care by a dedicated team of anaesthesiologist, surgeon, orthopaedician, cardiologist, and neurologist. The operating room was prepared with a difficult airway cart and all necessary equipment. The peripheral IV line was inserted under ultrasound guidance. All standard monitors were connected.

Patient positioning:

Padding was used to reduce shear forces and external tissue pressure. The eyes and all bony prominences were adequately padded and protected. Adhesive tapes and wound dressing were avoided due to the risk of severe skin damage. Patient handling was done with caution, as even minor shear forces might result in severe degloving injuries.

Airway management and ventilator strategies:

After adequate preoxygenation, the patient was induced with fentanyl, propofol, and succinylcholine. Anaesthesia was maintained with a mixture of air, oxygen, and sevoflurane. Given the difficult airway, a video-laryngoscope was used for intubation. Low tidal volume ventilation 6- 8 mL/kg of ideal body weight was employed to minimise the risk of alveolar overdistension. Controlled ventilation was used, with vigilant monitoring of airway pressures to avoid excessive peak or plateau pressures. Positive end-expiratory pressure (PEEP) was applied judiciously to optimise oxygenation while minimising the risk of volutrauma. Additionally, due to the underlying connective tissue fragility and the effects of pneumoperitoneum, the patient was closely monitored for signs of pneumothorax, which could develop spontaneously or secondary to increased intrathoracic pressures during insufflation. Cuff pressure was checked frequently and kept as low as possible to avoid mucosal injury. Due to skin distensibility and to prevent vascular damage, low-flow insufflation pressure (less than 10mm Hg) was used during laparoscopy.

Normocapnia was maintained throughout the procedure, with anend-tidal carbon dioxide level of 35-40 mmHg. At the end of the procedure, the patient was extubated once fully awake, with intact airway reflexes and satisfactory spontaneous breathing.The intraoperative period was uneventful.

Post-operative care:

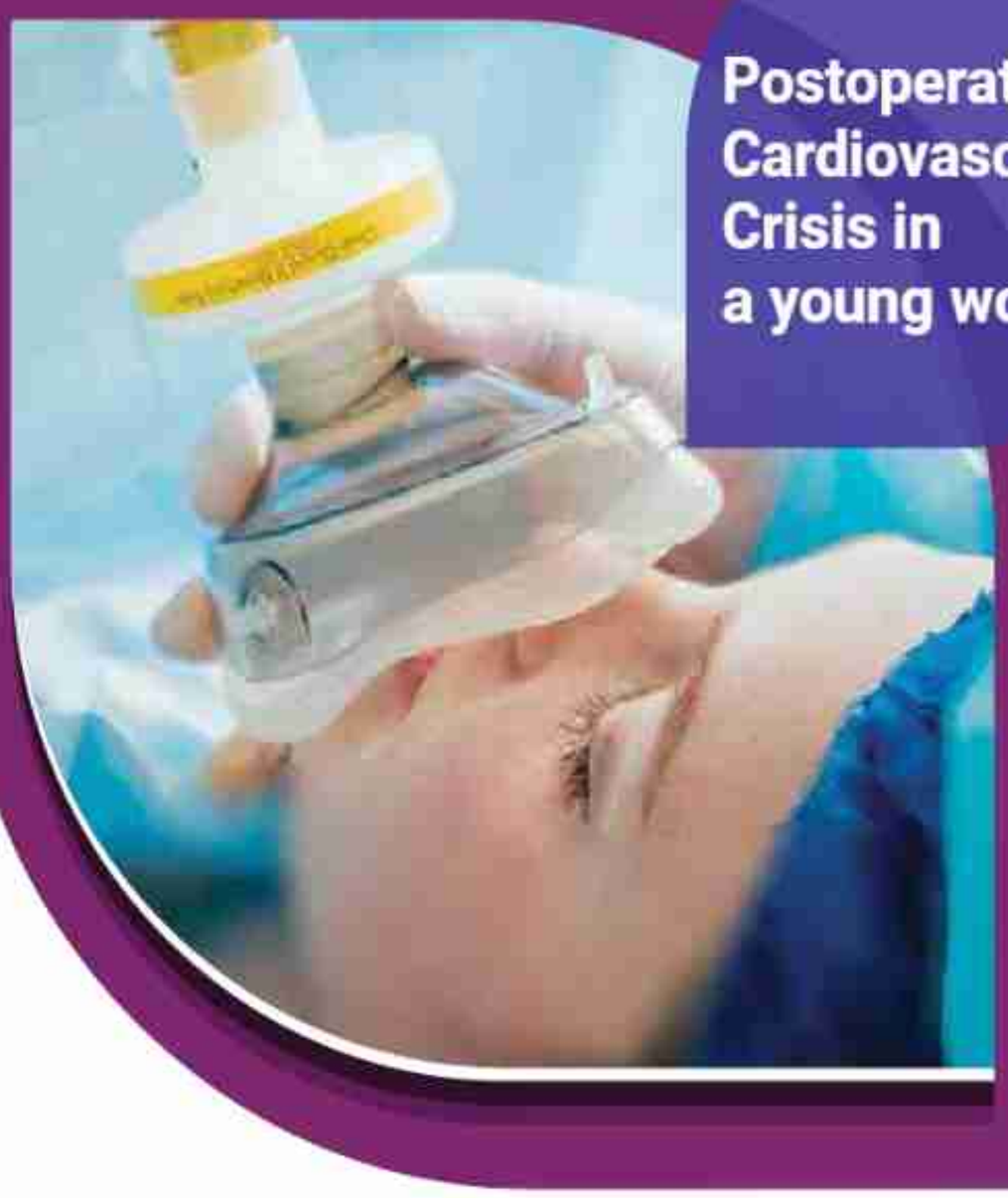
Early mobilisation was initiated. The patient was checked thoroughly for the development of bleeding and hematomas at the operation site. Postoperative analgesia was managed with intravenous paracetamol 1 gram every six hours. The patient was shifted to the surgical postoperative ward for 24 hours of observation.

Summary:

Patients with Ehlers-Danlos Syndrome present distinct anaesthetic challenges due to their connective tissue fragility, vascular vulnerability, joint hypermobility, and potential airway difficulties. This case underscores the importance of thorough preoperative assessment, meticulous intraoperative management, and individualised postoperative care to ensure patient safety. A multidisciplinary, patient-centred approach—with an emphasis on gentle handling, precise technique, and vigilant monitoring—is essential for achieving positive outcomes in surgical procedures involving EDS patients.

Dr. PREETHI A
Registrar Anesthesiology
MBBS, MD Anesthesiology

Dr. PRABHA UDAYAKUMAR
Consultant Anaesthesiologist & HOD
MD (Anaesthesiology)



Postoperative Cardiovascular Crisis in a young woman

Postoperative Cardiovascular Crisis in a young woman following Suction Evacuation and Laparoscopic Sterilization: A Case Report.

This case underscores the need for thorough preoperative evaluation and the ability to manage rare but severe complications following anesthesia, particularly in patients withunremarkable preoperative evaluations.Sudden postoperative cardiovascular collapse can be a manifestation of underlying undiagnosed conditions, necessitating immediate and coordinated action.

A 31-year-old female,with no co-morbidities,having a BMI of 28, with a surgical history of two uneventful lower segment cesarean sections (7 and 6 years ago), was scheduled for suction evacuation and laparoscopic sterilization.

The preoperative assessment was conducted by an experienced anesthesiologist. The patient was classified as ASA Grade I, with normal vital signs and investigations within normal limits. NPO status was adequate.

The patient underwent the surgical procedure under general anesthesia with standard GA drugs and monitoring. She was positioned in lithotomy with a head-down tilt. Intra-op her hemodynamics were stable (MAP: 70-90 mmHg, HR: 80-90 bpm, SpO_2: 99-100% on FiO_2 0.5). The procedure was uneventful and lasted 30 minutes. However, recovery from anesthesia was delayed, with extubation occurring 15 minutes after the surgery.

After extubation, the patient was shifted to the recovery room. Suddenly, the patient became dyspneic and tachypneic, and her oxygen saturation dropped to 84–85% despite oxygen supplementation. She also developed borderline hypotension, with a blood pressure of 90–80/60–50 mmHg. Auscultation revealed bilateral basal crepitations.Intravenous furosemide (20 mg) and hydrocortisone (100 mg) were administered. Gradually the oxygen saturation improved to 94-95% with oxygen support.

Bedside 2D echocardiography and chest X Ray were obtained.2D Echo of the patient showed severe LV dysfunction with global hypokinesia (EF-30%), aortic root aneurysmally dilated, moderate aortic regurgitation, moderate pulmonary arterial hypertension(RVSP-60), dilated IVC and suspected aortic dissection.Chest Xray showed mild cardiomegaly and pulmonary opacities in bilateral lower zones. As per cardiologist's advice, patient was shifted to ICU for further management and further evaluation.The patient was started on dopamine infusion and BiPAP support.Patient was in ICU for 2 days during which period dopamine and BIPAP was weaned.Echo showed improvement in EF of 60% .Patient shifted to Post op ward and was asked to follow up with cardiologist.

CT angiogram was taken and it revealed large aneurysm of noncoronary sinus of valsalva which projects into the right atrium abutting AV valve,dilated aortic root and ascending aorta and features of pulmonary hypertension.

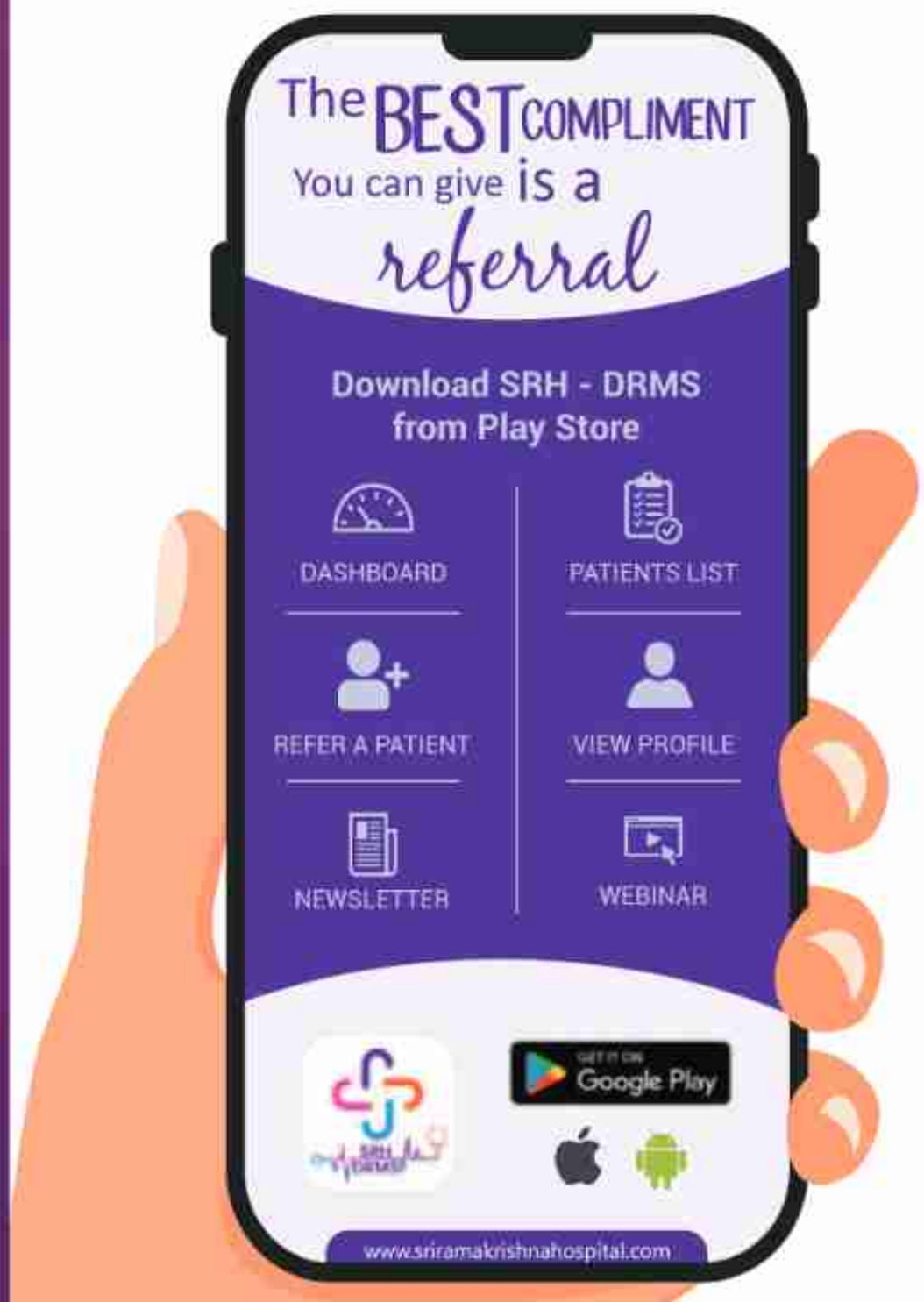
The delayed recovery and subsequent cardiovascular collapse in this case revealed a previously undiagnosed critical cardiovascular condition. Severe cardiac pathology likely contributed to the patient's symptoms. A detailed preoperative assessment with the help of available investigations could potentially have identified the condition earlier. Prompt intervention and effective multidisciplinary communication were pivotal in stabilizing the patient.

In conclusion, this case highlights the importance of maintaining a high index of suspicion for occult cardiac pathology, even in young patients with seemingly normal preoperative evaluations. The unexpected postoperative cardiovascular collapse unmasked a severe underlying cardiac condition of the patient.

This emphasizes the need of reconsidering usage available investigation tools for the preoperative assessment even in young and asymptomatic patients, vigilant intraoperative and postoperative monitoring, as well as the critical role of timely diagnosis and multidisciplinary intervention in managing rare but life-threatening complications.

Dr. TAJ THOMAS
Registrar Anesthesiology
MBBS, DNB Anesthesia,
Fellowship in Regional Anesthesia

Dr. PRABHA UDAYAKUMAR
Consultant Anaesthesiologist & HOD
MD (Anaesthesiology)



Dear Sir/ Madam,

Warm Greetings from Sri Ramakrishna Hospital, Coimbatore.

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

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

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

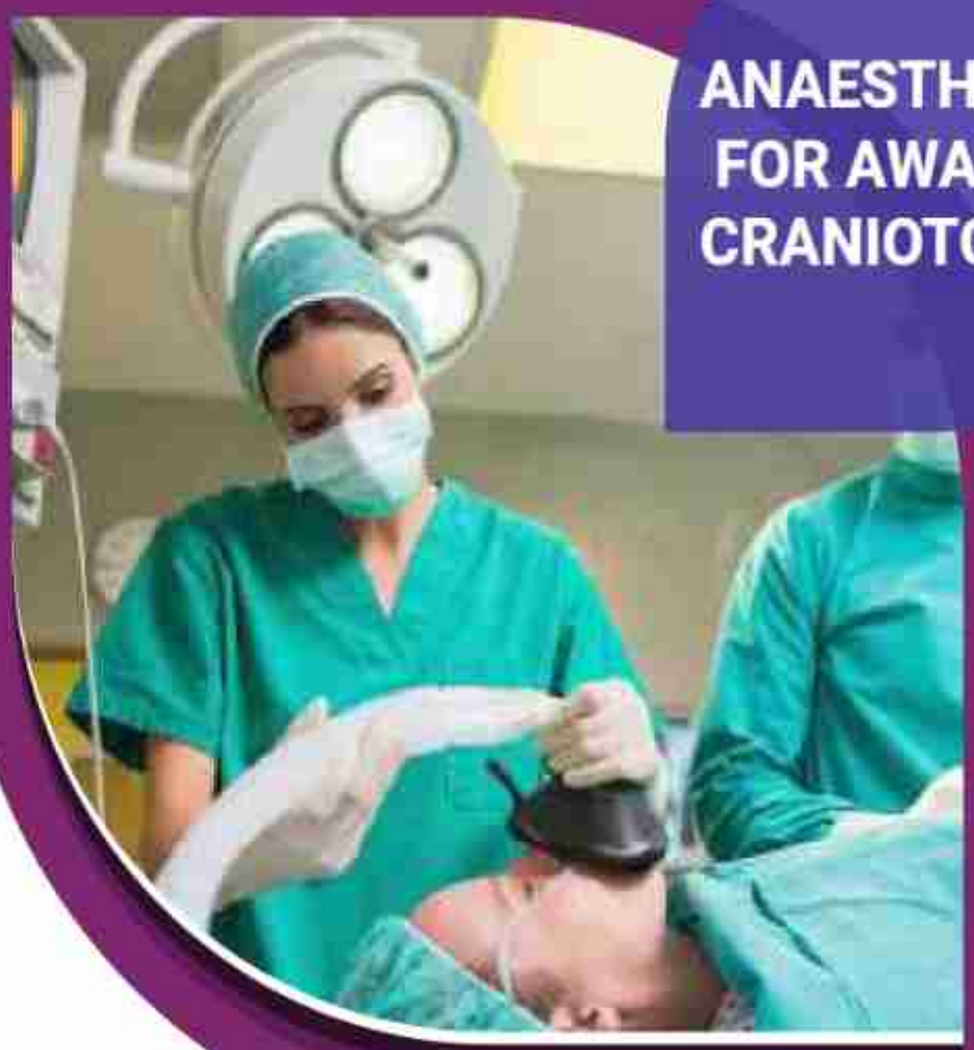
Google Play Store Link for Android:
https://play.google.com/store/apps/details?id=com.drms.prod&pcampaignid=web_share

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

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

SANTHOSH VIJAYAKUMAR
Head - Corporate Relations & International Affairs
+91-422-450-0000 I Extn: 1870
sv@snrsonstrust.org

ANAESTHESIA FOR AWAKE CRANIOTOMY



Introduction

The Brain Speaks—We Listen

In modern neurosurgery, awake craniotomy stands as a remarkable confluence of technology, precision, and human interaction. It allows the brain to "speak for itself," guiding surgeons safely through the complex landscape of eloquent cortex. While its use in tumor and epilepsy surgeries is well documented, performing an awake craniotomy for trigeminal neuralgia (TN) is an exceptionally rare undertaking, attempted only in the most advanced neurosurgical centers worldwide.

With immense pride and clinical focus, Sri Ramakrishna Hospital is one of the few centres worldwide to perform an awake craniotomy specifically for Trigeminal Neuralgia. This landmark case underscores our commitment to function-preserving neurosurgery, driven by a collaborative, multidisciplinary approach.

Why Awake Craniotomy for Trigeminal Neuralgia?

Trigeminal neuralgia is a debilitating neuropathic facial pain, often responsive to conservative measures with anticonvulsant medications. With the introduction of newer drugs including botulinum toxin A , they provide good pain relief immediately, but however the efficacy declines with time and the intensity and frequency of painful episodes increases. A definitive treatment modality in these patients and in select patients with cortical or brainstem involvement, surgery becomes necessary. Microvascular decompression is the treatment of choice in these patients with the highest success rate with minimal risk of recurrent pain. Awake craniotomy for microvascular decompression offers a safe, dynamic intraoperative environment where real-time patient feedback helps preserve function and offers definitive pain relief.

Awake Yet Anaesthetised: Understanding the Paradox

It may sound contradictory—why anaesthetize a patient who is meant to be awake during surgery?

The answer lies in the careful orchestration of consciousness. Anaesthetic management in awake craniotomy is not about putting the patient to sleep—it's about fine-tuning their conscious state to match the surgical timeline, such that the patient is sedated during the initial painful stages of the surgery, kept awake during the mapping of the lesion and maybe put to sleep again during the closure of the procedure.

The anaesthesia team ensures the patient remains:

- Pain-free, via targeted regional anaesthesia (scalp blocks using long-acting local anaesthetics like bupivacaine with adrenaline and lignocaine)
- Comfortable and calm, through controlled sedation (moderate sedation) with analgesics and sedatives during non-critical stages (scalp incision, craniotomy and duramater incision)
- Fully awake and cooperative, during the identification and decompression the trigeminal nerve from the adjacent blood vessel by the application of teflon patch ,while providing adequate analgesia.
- Airway-safe, despite being in a fixed head position throughout surgery
- Establish verbal contact with the patient during the critical surgical steps to minimise iatrogenic neurological damage while providing constant reassurance
- Minimising hemodynamic fluctuations during the procedure

Anaesthetic Principles and Protocol

While the surgery is termed "awake," anaesthesia remains a critical component throughout the procedure. The anaesthetic management begins in the preoperative period with optimisation of co morbidities , psychological counselling and appropriate premedication.

A thorough discussion with the patient regarding the various stages of the procedure is vital in establishing a rapport. Patients who cannot lie still, obese with compromised airway, recurrent seizures and severe excruciating continuous pain are relative contraindications to awake craniotomy. Premedication with anxiolytics and antiemetics is recommended for all patients.

On the day of surgery, establish good communication with the patient even while in the pre operative room. This level of interaction makes the patient an active member of the surgical team, influencing surgical decisions and outcomes. They are not merely a subject—they are a conscious collaborator.

Once in the operation theatre, the patient is asked to lie in the semi lateral position, and adequate padding provided to avoid any pressure effects. The ASA standard monitors including SpO2, NIBP and pulse oximetry are connected . A wide bore intravenous access is placed under local anaesthetic infiltration. An arterial line is secured on the non dependent hand and transduced to allow continuous monitoring of blood pressure.

Oxygen is provided through a nasal cannula and end tidal CO2 is also monitored to assess the adequacy of ventilation. A good rapport with the patient is paramount during every stage of the procedure and the patient is always kept aware of the sequence of events.

The patient is sedated with propofol and dexmedetomidine bolus and infusion titrated to body weight , analgesia is provided with bolus doses of fentanyl. When the patient is asleep ,scalp block is done using 2% lignocaine and 0.5 % bupivacaine , dose titrated based on patient's weight. The depth of sedation is monitored based on the Ramsay sedation scale.

The patient is kept sedated (scale of 4-6) during the scalp incision , craniotomy and opening of the duramater which are perceived to be painful.

Though the areas surrounding the brain have pain receptors, brain has no pain receptors. More importantly, functional regions of the brain cannot be safely navigated without real-time feedback from the patient. This warrants an awake patient with a target sedation scale between 2-3 by reducing the dose of propofol and dexmedetomidine infusions. The patient is gradually allowed to wake up to reach the target sedation level and respond to verbal stimuli . Under microscopic dissection, the trigeminal nerve at its anatomical location is identified. As the trigeminal nerve is reached , a sudden increase in blood pressure is noted and the patient complains of pain. This confirms the correct identification of the trigeminal nerve . The blood vessel compressing the nerve is identified and teflon patch is used to decompress the nerve. The absence of pain is confirmed by the patient immediately after decompression . The sedation maybe restarted after confirmation of pain relief on decompression and wound closure done.

The patient is shifted to the post operative ward for observation over the next 24 hours. A total of 39 patients have been managed under awake craniotomy in our institution so far. None of them had recurrent or residual pain. One patient had cerebellar haemorrhage which was treated conservatively. All patients were discharged on the 5th post operative day.

This awake protocol demands constant communication between the anaesthesia, surgical, and neurophysiology teams. The transition between sedation and wakefulness must be seamless, requiring detailed preoperative psychological preparation and intraoperative reassurance. The patient's verbal responses—reporting sensations such as tingling, pain relief, or numbness—guided the surgical approach in real time.

The gold standard in awake craniotomy is the real-time response of the patient.

Teamwork: The Cornerstone of Awake Neurosurgery

This procedure would not be possible without a synchronized, multidisciplinary effort. At Sri Ramakrishna Hospital, our awake craniotomy protocol involved:

- Preoperative psychological preparation and detailed counselling
- An experienced neuroanaesthesia team to manage consciousness, airway, and hemodynamics
- A skilled neurosurgical team adept at cortical mapping and microdissection
- Neurophysiology support to correlate stimulation with cortical response
- Intraoperative nursing and critical care teams ensuring safety and sterility

Every phase of this surgery demands shared vigilance and seamless communication. In an awake craniotomy, seconds matter—and so do words, especially when they come from the patient.

Conclusion: The Future is Awake

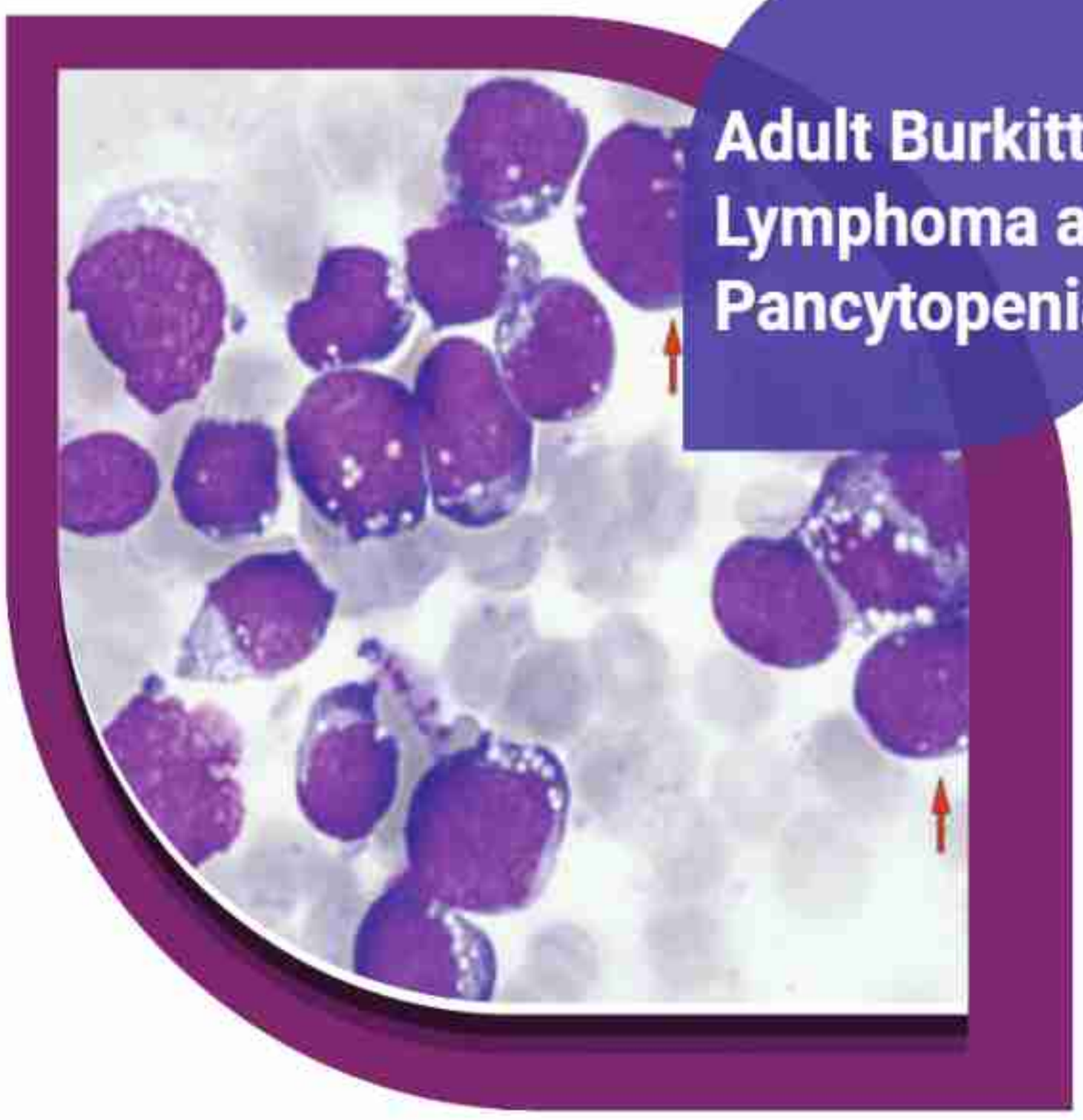
This case series marks more than a surgical achievement—it represents a paradigm shift in how we treat complex neurological conditions. By keeping the patient awake, we safeguard function, reduce neurological morbidity, and individualise treatment in real time.

At Sri Ramakrishna Hospital, we are proud to be one of the few centers globally to perform awake craniotomy for trigeminal neuralgia. With every such case, we push the boundaries of what is possible—not just in neurosurgery, but in conscious, collaborative care.

As we look ahead, one thing is clear:
The future of brain surgery isn't asleep—it's awake.

Dr. RAMYA.A
Consultant Anaesthesiologist
MBBS, DA, DNB (Anaesthesiology)

Dr. PRABHA UDAYAKUMAR
Consultant Anaesthesiologist & HOD
MD (Anaesthesiology)



Adult Burkitt Lymphoma as Pancytopenia

Adult Burkitt Lymphoma as Pancytopenia- a rare case report.

Introduction: Burkitt Lymphoma (BL) is a rare and highly aggressive B cell neoplasm comprises 30 percent of non-endemic pediatric lymphomas, but less than 1 percent of adult non-Hodgkin lymphomas . It is endemic in Africa and sporadic in other parts of the world and is usually diagnosed in children and young adults but rarely in adults.The World Health Organization characterizes Burkitt's lymphoma into 3 types: Endemic, Sporadic, and Immunodeficiency-associated. Endemic Burkitt's lymphoma is associated with EpsteinBarr virus (EBV) in 95% of cases and is most commonly found in equatorial Africa and Papua New Guinea. The sporadic (or American) type is associated with EBV only 15% of the time, while the immunodeficiency-associated type is seen in patients with HIV, allograft recipients, and those with congenital immunodeficiency. Patients with BL usually present with rapidly growing tumor masses and often have evidence of Tumor Lysis Syndrome (TLS).Rarely, BL involves only the BM, which was previously referred to "L3" acute lymphocytic leukemia (ALL-L3). We present a rare case of Burkitt Lymphoma in adult presenting as serve pancytopenia.

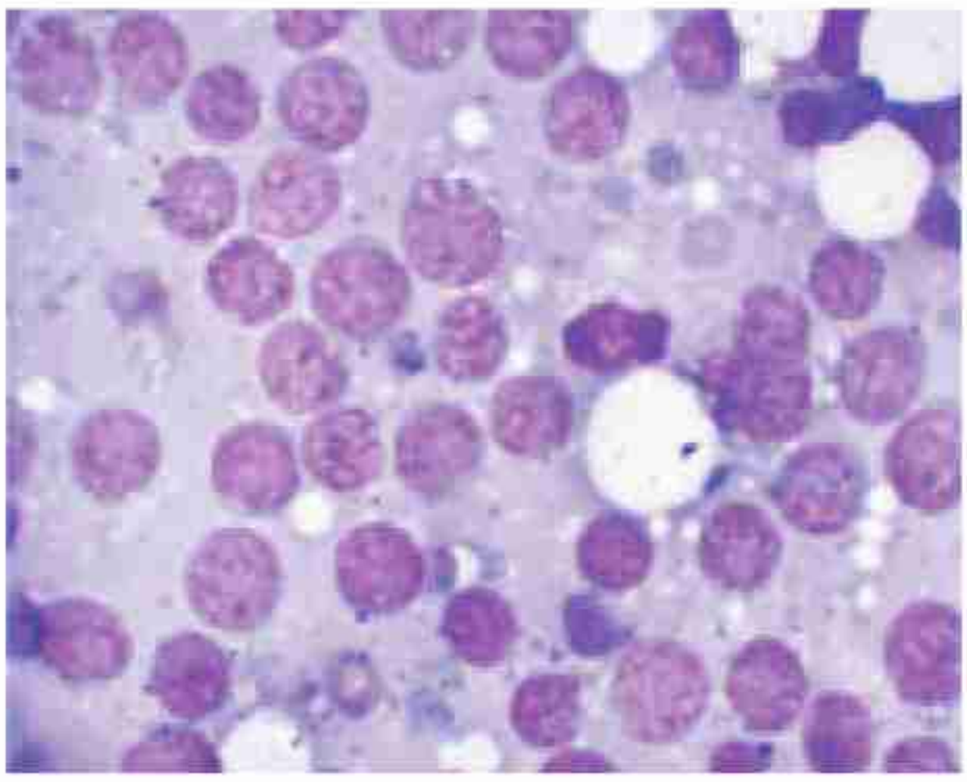
Case report: A 60-year-old gentleman presented to the hospital with a one-week history of fever, intermittent in nature along with diffuse night sweats. He also had extreme fatigability, severe bone pain all over the body, which makes him difficult to walk and wheel chair bound. He had loss of weight (approx. 8kg) in 1 week time, loss of appetite, with shortness of breath even walking for few steps. He denies any history of bleeding manifestations (Gum bleeding, Hemoptysis, Malena) or abdominal pain or any swelling. He has Type II Diabetes Mellitus and Systemic Hypertension but both were well controlled on medications. His personal and family history was noncontributory.

On examination he was severely Pallor, however he was not icteric or cyanotic. His neck examination did not reveal any cervical lymph nodes, however he had bilateral axillary and inguinal nodes, which are non-tender, firm in consistency, largest measuring about 1.5x1cm. Abdomen examination did not reveal any hepato-splenomegaly. His hemodynamics was stable at presentation.

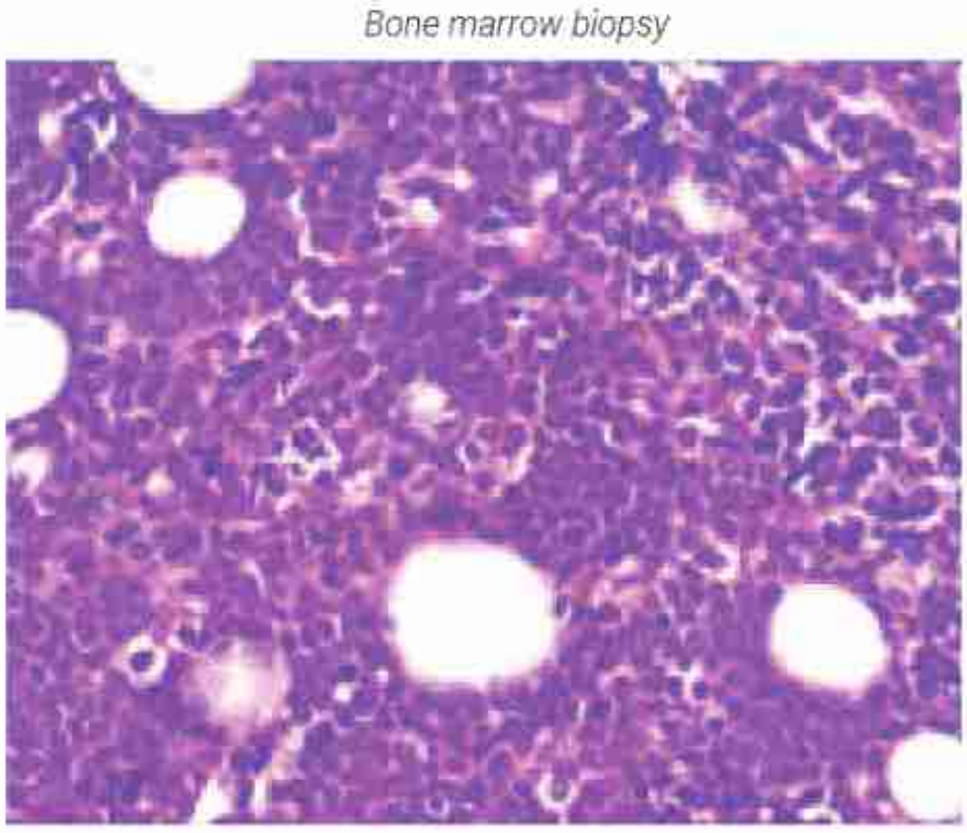
Initial blood work showed severe pancytopenia, Hemoglobin of 67 g/L, WBC 3.7 × 109 L with Lymphocytic predominance (Lymph-54%, Neutrophils- 16%, Monocytes- 34%), and severe thrombocytopenia (Platelets of 6000/ul). Peripheral smear showed **Leucoerythroblastic** blood picture with neutropenia and severe thrombocytopenia, which warranted Bone marrow study. Infective etiology workup like Dengue, Scrub Typhus, Leptospirosis, Typhoid and Viral markers (HIV, HCV, and HBV) were negative. Biochemical parameters like **LDH – 1078** was very high. He also had spontaneous biochemical TLS at presentation with **Hyperuricemia (Uric acid- 14.8)**, **Hyperphosphatemia (5.8mg/dl)** with normal calcium, magnesium values.The alanine aminotransferase (ALT), aspartate aminotransferase (AST), bilirubin (BIL), and serum creatinine (Cr) values were all normal.

Bone marrow study was performed, which was 'Dry tap' without any aspiration sample (Flow cytometry could not be performed). However imprint cytology was done which suggested Hematolymphoid Malignancy. Bone marrow biopsy showed findings that are consistent with **High grade B-cell Non-Hodgkin lymphoma**. Immunohistochemistry(IHC) was **strongly positive for CD20, C-MYC**, and negative for CD34, TdT, and BCL-2. **Ki67 was 100%**, which was consistent with Burkitt's lymphoma. CSF analysis was done which was negative for the disease involvement.

Bone marrow imprint Cytology

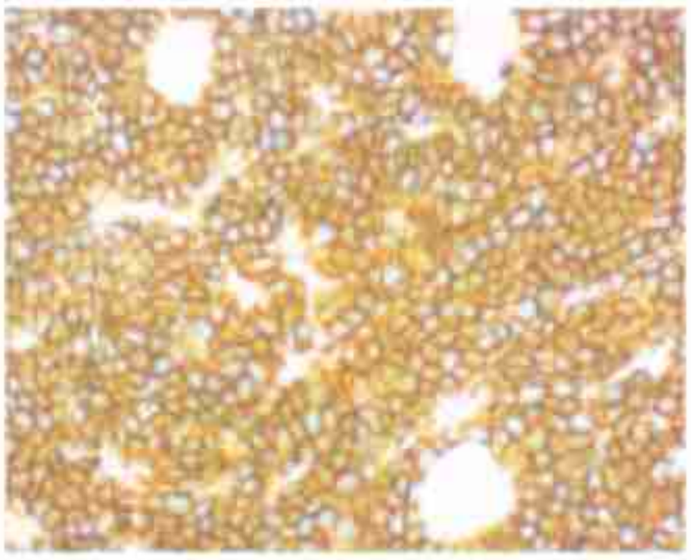


Bone marrow biopsy

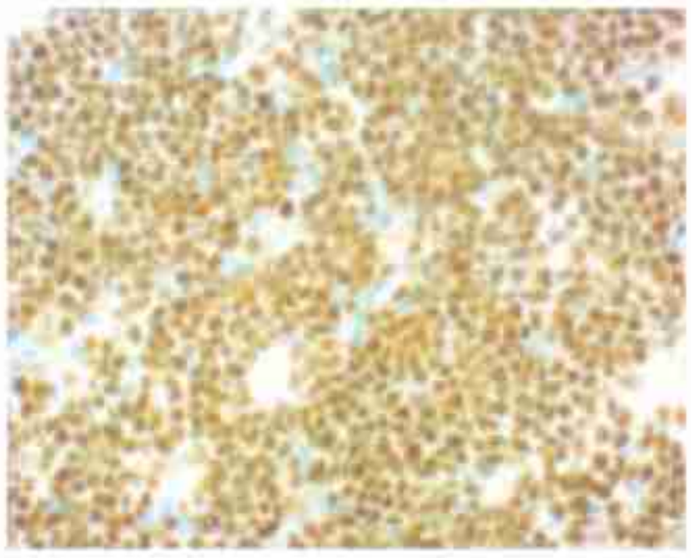


Bone marrow Imprint : Bone marrow Trephine biopsy

CD20

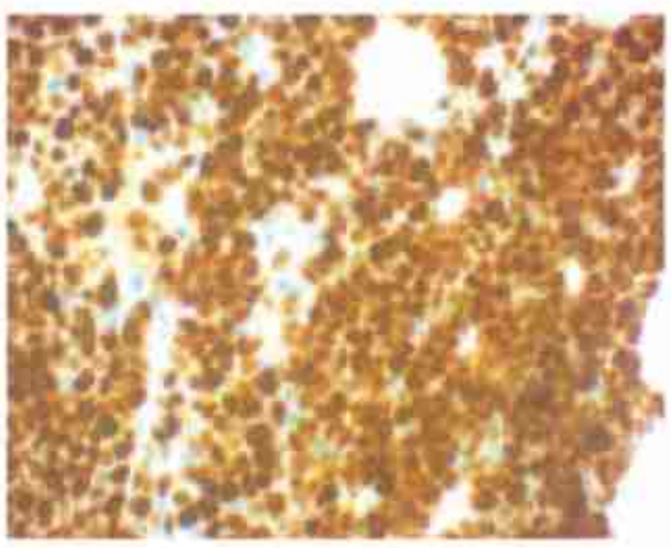


C-MYC

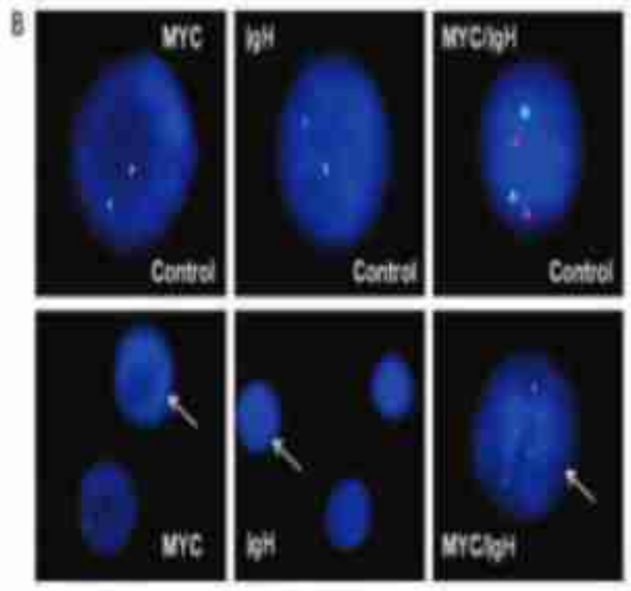


TDT

Ki-67



FISH- t(8:14) Positive.



PET-CT

He was immediately started on chemotherapy. In view of his comorbidity and general conditions, he was initially started with low intensity chemotherapy R-CHOP.He responded exceptionlly well to the chemotherapy and his blood counts became normalised after the first cycle of chemotherapy. Hb - 108 g/l, WBC - $6.7x10^{9/l}$, (N-63%, L-21%), Plt - 370000/ul. Since he tolerated the chemotherapy well, further therapy was intensified to HYPER-CVAD (with dose adjustments). He sustained multiple complications during the course of treatment like Febrile Neutropenia, MDR (Multi Drug Resistant) sepsis and Axonal Neuropathy. Despite all, he was managed well and he attained Complete Remission(CR1).
Although Burkitt lymphoma is one of the most aggressive types of cancer it is also one of the most curable malignancy.

Burkitt lymphoma is an extremely rapidly growing tumor with a high sensitivity to chemotherapy. t(8;14) chromosome translocation, which results from the translocation of the MYC gene locus on chromosome 8 and IgH locus on chromosome 14, is a hallmark of BL. Burkitt's Lymphoma should be treated as a medical emergency with prompt diagnosis and initiation of appropriate therapy is essential for optimal outcome.

Dr. T. SETHUMADHAVAN
Consultant Oncopathologist
MBBS, MD(Pathology),
PDF(Oncopathology)

Dr. SRIDHAR GOPAL
Consultant Haemto-Oncologist & Physician
MD, Fellowship in
Clinical Haematology

WORLD BLOOD DONOR DAY - 2025

World Blood Donor Day Celebration at Sri Ramakrishna Hospital

Sri Ramakrishna Hospital commemorated World Blood Donor Day on 14th June 2025 with a meaningful event dedicated to honoring voluntary blood donors. This global observance serves as a reminder of the vital role blood donors play in saving lives and supporting emergency care. The celebration brought together healthcare professionals, staff, and well-wishers to express gratitude to those who consistently contribute to this noble cause.

The event was marked by the enthusiastic participation of around 60 voluntary donors, many of whom have been regular contributors over the years. Their selfless act of donating blood continues to make a difference in countless lives. The hospital acknowledged their commitment with words of appreciation and a warm ceremony to celebrate their life-saving contributions.

Managing Trustee Mr. R. Sundar graced the occasion and officially launched the Privilege Card for repeat donors – an initiative to honor and encourage regular blood donation. This exclusive card is designed to recognize and reward repeat blood donors with special benefits and privileges at the hospital. The initiative reflects the hospital's deep respect for donors and aims to inspire more individuals to join the movement of regular blood donation

Through this celebration and new initiative, Sri Ramakrishna Hospital reaffirmed its dedication to creating a healthier community. By encouraging consistent voluntary donation and recognizing donor efforts, the hospital continues to uphold its mission of compassionate care and public health leadership.