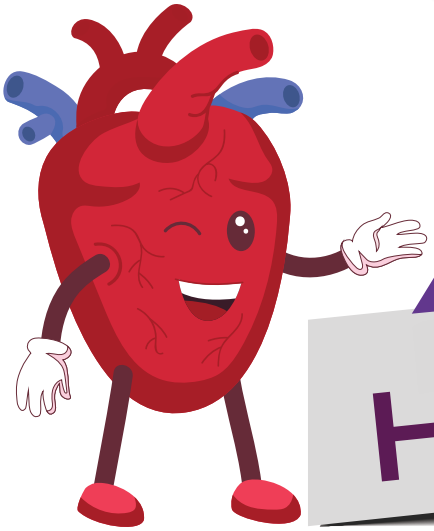
Sri Ramakrishna
Hospital (Multi-Speciality)

pulse

50 Years of Excellence



VOLUME 55 | ISSUE 1 | SEPTEMBER 2025

WORLD HEART DAY

Sep 29th, 2025

Shri.R.Sundar
Managing Trustee

As we step into September, I am filled with immense pride and gratitude for the incredible journey we have shared at Sri Ramakrishna Hospital. This past month has been a testament to our unwavering commitment to health-care excellence and our relentless pursuit of providing compassionate care to every individual who walks through our doors.

September holds special significance as we observe two important global events. On September 29th, we mark World Heart Day. This is a powerful reminder of the importance of cardiovascular health. We encourage every-one to take proactive steps—be it through a healthy diet, regular exercise, or timely check-ups—to protect their hearts. Our cardiology department is always ready to provide expert advice and care.

I want to extend my heartfelt thanks to our dedicated team of doctors, nurses, and support staff. Your tireless efforts and dedication are the pillars of our success. And to our patients and their families, thank you for placing your trust in us. We are honored to be a part of your health journey.

Dr.S.Rajagopal
Medical Director

As Medical Director, my primary goal is to ensure that our clinical practices are not only world-class but also rooted in empathy and patient-centric care.

September month presents a moment to reflect on two crucial health observances. On September 29th, we observe the World heart day and World Day of the Deaf. It's a reminder for us to continue our efforts to make our healthcare services more accessible and inclusive for everyone, regardless of their ability.

The health and safety of our patients are our top priority. We are meticulously following all safety protocols and have implemented robust measures to ensure a safe and sterile environment for everyone.
Let us continue to uphold the high standards of medical ethics and care that Sri Ramakrishna Hospital is known for.

WORLD RECORDS UNION - ORGAN DONATION

Sri Ramakrishna Hospital creates a new global benchmark in organ donation, which Sets a new world record with 45,861 organ donation pledges in three months

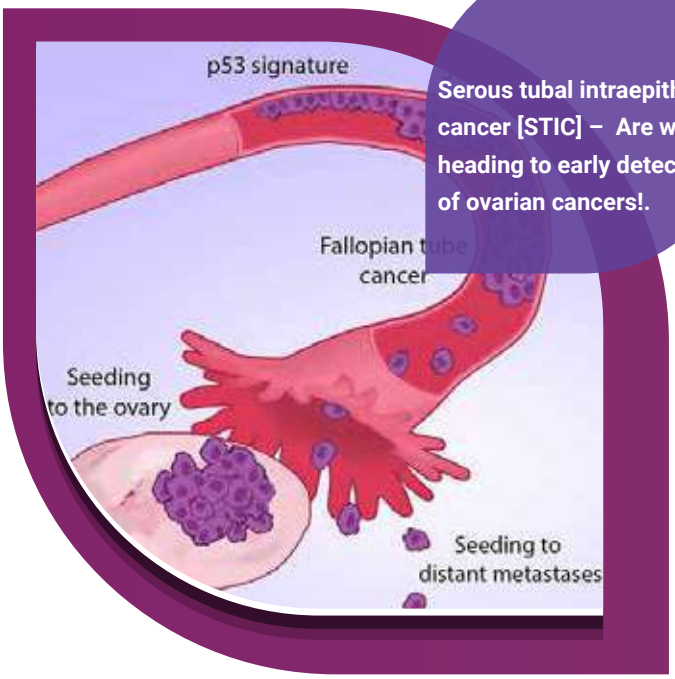
Following its Guinness World Record in 2016 where the most people (13,206) to signed up as organ donors in a single day, Sri Ramakrishna Hospital, a leading healthcare institution in Tamil Nadu, has once again made a significant global impact in the field of organ donation. The hospital has now secured a new world record for receiving the highest number of organ donation pledges in a three-month period. It received a remarkable 45,861 pledges between February and April 2025, a record officially.

The official citation was presented to the hospital management at a special ceremony held at the ITC Grand Chola on Friday, August 8, 2025. Representatives from the World Records Union, Ms. Alice Raynaud and Records Officer Ms. Shareefa Haneef, presented the citation to Shri. R. Sundar, Managing Trustee of SNR Sons Charitable Trust and Sri Ramakrishna Hospital along with Shri. C. V Ramkumar (Chief Executive Officer), Shri. D. Mahesh Kumar (Chief Administrative Officer), Dr. S. Alagappan (Medical Superintendent), Mr. D. Viswanath (Head - Information Technology) and Dr. S. Prahadeeshwaran (Head - Public Relations) of SNR Sons Charitable Trust. The event was graced by the presence of Tamil Nadu's Health Minister, Ma. Subramanian, and Mr. N. Gopalakrishnan, Member Secretary of the Transplant Authority of the Government of Tamil Nadu (TRANSTAN).


WORLD RECORDS UNION

CERTIFICATE

The most number of digital organ donation pledges received in a span of three months on a bespoke platform is 45,861, and was achieved by Sri Ramakrishna Hospital, a unit of SNR Sons Trust, Coimbatore, Tamil Nadu (India), between February and April 2025.The pledges came from individuals worldwide, showcasing the global reach of the initiative, which set a benchmark in organ donation awareness through technology driven engagement.



Serous tubal intraepithelial cancer [STIC] – Are we heading to early detection of ovarian cancers!.

INTRODUCTION

Ovarian cancers are the life threatening gynec cancers with poor prognosis and high mortality. Owing to the challenges like lack of early detection, no effective screening and diagnosed at advanced stage, the outcome is not favorable to the affected population.

Case report:

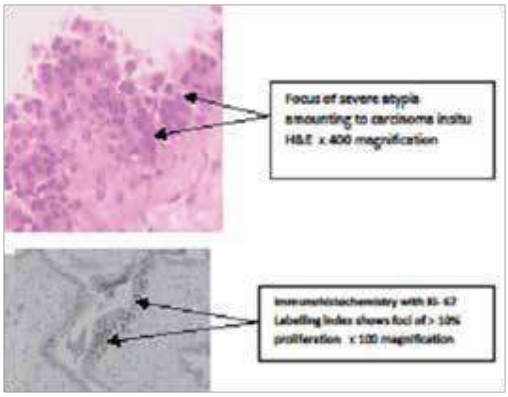
54 years old, multiparous lady reported with the complaints of heavy menstrual bleeding per vaginum, easy fatiguability and general weakness for past3 months. Bowel and bladder habits normal, she was on treatment for hypothyroidism. History of similar episode 3 years ago and was treated for severe anemia and symptoms resolved. No history of loss of appetite or weight. Earlier advised endometrial sampling with LNG Intra uterine device and patient opted out. During the interim period no significant health issues but for occasional use of inhaler for wheezing.

Clinically, Patient was severely anemic, average BMI, normo tensive and systemic examinations normal. Local examination revealed endocervical polyp protruding through os , uterus enlarged to 8 weeks size and no forniccal abnormality. On evaluation Hemoglobin was 5 gm/dl, microcytic hypochromic anemia and other indices normal. Ultrasonography revealed enlarged uterus, suggestive of Adenomyosis with normal ovaries and Pouch of Douglas. Other viscera normal.

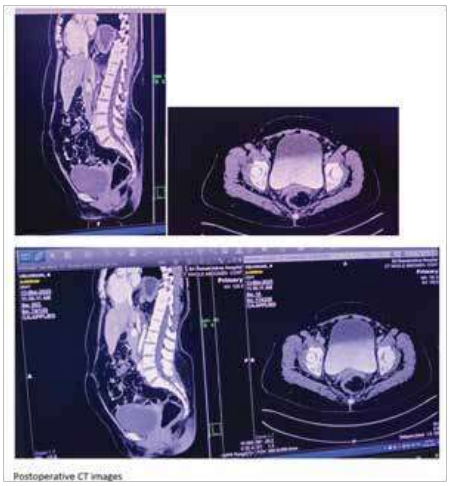
Figure 1

In view of the age, delayed menopause and USG findings surgery was planned. Preoperatively 3 units of PRBC given and proceeded for Non descend vaginal hysterectomy [NDVH}with bilateral salpingo oopherectomy done. Vaginal Vault closed after haemostasis. Postoperative period uneventful and patient discharged on third postoperative day.

Gross examination of specimen revealed an endometrial polyp, small fibroid with both ovaries having simple cysts without any solid areas and unremarkable tubes. Histologically – Chronic cervicitis with focal squamous metaplasia, disordered proliferative endometrium and benign polyp. Both ovaries normal, Both fallopian tubes with Serous Tubal intraepithelial carcinoma(STIC)IHC- Negative for p53, Ki-67 labelling index is 13% [on slide control for both markers positive]



Oncology team involved in the follow up. In view of complete surgical removal, no adjuvant chemotherapy was advocated. Computerized Tomography scan done after one month showed soft tissue thickening with enhancement in bilateral adnexa-likely postoperative change, large sliding Hiatus hernia.



Patient is doing well and advised periodical follow up. She was advised genetic testing for BRAC½ mutation and yet to comply with it. Having encountered the "STIC lesion " in a benign condition prompted the urge to explore and present this article.

Discussion:

Pelvic serous high-grade carcinomas [HGSCs] include Carcinoma of ovary, fallopian tube and peritoneum. 5 years survival irrespective of stage is between 35-45% . Majority are diagnosed at advanced stage and their 5-year survival rate is 5-25%. Earlier theories postulated were incessant ovulation, use of gonadotrophins etc. attributing to the development of ovarian cancers.

Surgical specimens obtained from Risk Reducing Salpingo oophorectomies [RRSO] for high risk individuals like BRCA 1 &2 mutation has paved the way to identify Serous tubal intra epithelial cancer[STIC}.Discovered in 2001 by Piek et al as the potential precursor of ovarian cancers. Eventually this led to assess the clinical significance and utility in early detection.

Subsequently the protocol for analysis of tubes developed based on the phenotypic, molecular and immunological criteria, namely SEE FIM protocol [Sectioning and extensively examining the Fimbrial end.

Subsequent to STIC three other lesions are also recognized-p53 signature, Secretory cell outgrowth [SCOUT] and intra epithelial lesion [STIL]. The clinical significance of these is not yet established, STIC can progress to invade the underlying mucosa or detach from the lumen and spread to peritoneal surfaces with several key processes in between.

Clinical significance:

The detection rate of STIC in RRSO is 1.7% and there is a wide range of detection 0-2.29% revealing the rarity of the entity. The studies have shown that occurrence of HGSC after identifying STIC lesion ranges from 7-10.5 % at 5 years, 20.9-27.5% at 10 years.

If STIC is reported in specimens of benign conditions genetic testing to be offered to the patients and surgical negative staging to be confirmed and additional sectioning to be done to rule out the focus of HGSC. Considering the development of HGSC after 6.5 years approximately, close monitoring of this cohort is mandatory. Additional adjuvant chemotherapy may offer benefit of reducing the likelihood of subsequent HGSC in high-risk individuals. Chemotherapy choice and therapy to be assigned individually with caution.

After identification of STIC the Chances of "opportunistic Salpingectomy" increased and led to better understanding of STIC diagnostic criteria and is grouped under risk reducing surgery in view of these researches. Usually, RRSO are undertaken in high-risk individuals at 35-40 years as per National and 40-45 years as per international guidelines. New proposals of early salpingectomy and late oopherectomy to address the possibility of STIC lesions and timely prevention before 50 years of age are recommended.

The absence of an invasive disease and completely surgical negative staging with STIC identification periodical follow up remains the choice. The regimen is check up at 6 months interval comprising of clinical examination, CA 125 /He-4 sampling and pelvic ultrasonography. CT may be considered as institutional protocol..

Flexible micro laparoscopy, autofluorescence imaging, brush cytology from uterine cavity also tried in the past to identify the precursor lesions.

Conclusion:

Carcinogenesis and early detection of ovarian malignancy is evolving rapidly. The identification of STIC lesions is one important milestone in that but the long term implications and guidelines regarding follow up are yet to be established by future researches.

Dr. M. BANUMATHY
Consultant Obstetrician & Gynaecologist. HOD (Academic)
MBBS, DGO, DNB, FICOG

MICROWAVE ABLATION OF ADENOMYOSIS - A CASE REPORT

A 42 year old nulliparous female had complaints of heavy menstrual bleeding and dysmenorrhoea since 10 years. Had a open myomectomy 1 year back. She had tried medical management but symptoms failed to resolve and she is desirous of fertility. On evaluation, ultrasound showed Enlarged uterus of size12cm with type 1-3 adenomyosis in posterior wall of uterus and bilateral ovaries small with 2 antral follicles(AMH- 0.04). H/O previous 3 failed IVF cycles.She needs relief from dysmenorrhea and to improve Ovarian function as the couple denies donor option. Management option with laparoscopic bilateral ovarian stem cell injection and microwave ablation of adenomyosis discussed. Couple opt to try the procedure.

PROCEDURE AND INTERVENTION:

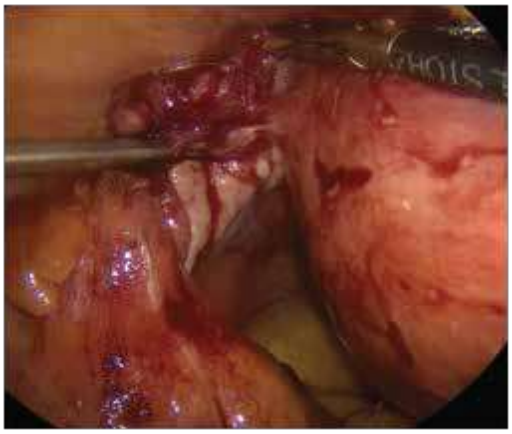
The intervention was conducted collaboratively with a hematologist and an interventional radiologist, ensuring precision and patient safety.

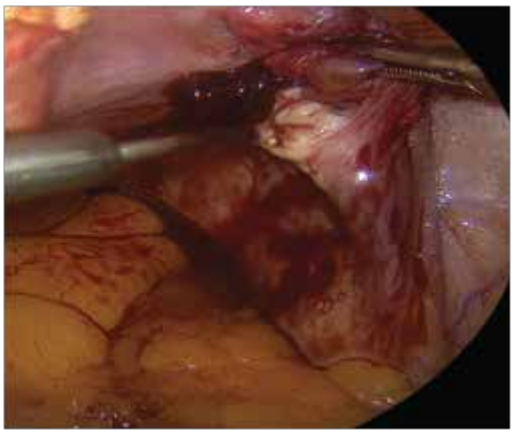
1.Bone Marrow Aspiration & Cell Preparations

Right iliac crest identified,Bone marrow aspirated and stem cells prepared for ovarian injections.

2.Laparoscopic Adhesiolysis& Ovarian Injection

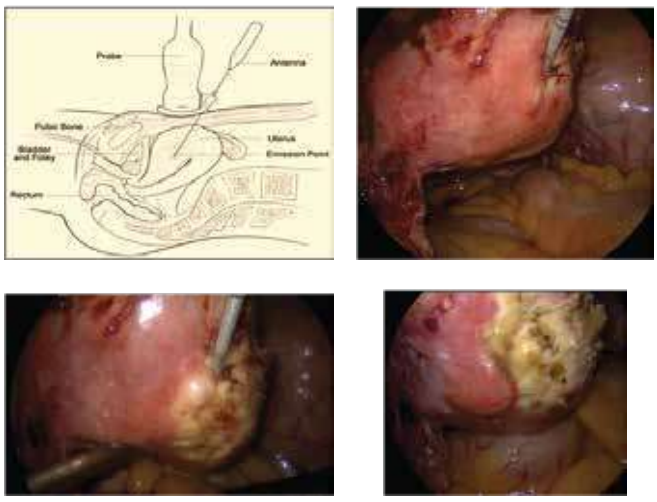
Then, Laparoscopy introduced, Uterus enlarged with posterior wall adenomyosis and bilateral small ovaries. Extensive omental and bowel adhesions to the uterus meticulously lysed. Stem cells injected into both small-appearing ovaries.





3.PMWA of Adenomyosis Foci

Microwave antenna inserted suprapubically into posterior wall adenomyosis under laparoscopic guidance. Heat energy introduced to induce protein coagulation and tissue necrosis at 60 °C.PMWA precisely targets lesions, causing shrinkage and eventual disappearance, while meticulously preserving surrounding healthy tissues and organs.



Discussion:

- Adenomyosis is defined as the benign invasion of the endometrium into the myometrium producing a diffusely enlarged uterus which microscopically exhibits ectopic, non-neoplastic, endometrial glands surrounded by hypertrophic-hyperplastic musculature.
- According to their pattern of involvement, classified as diffuse when the endometrial glands or stroma are dispersed within the myometrium and as focal when the lesions are localized.
- Adenomyosis is a debilitating gynecologic condition that affects both multiparous older women and nulliparous younger women, causing a variety of symptoms such as dysmenorrhea, menorrhagia, and infertility.
- Standard treatment is considered surgical-hysterectomy, the curative therapeutic option but unsuitable for patients demanding fertility and organ preservation. Medical treatments like OCP, Gonadotropin releasing hormone (GnRH) analogues, Levonorgestrel releasing intrauterine devices and conservative surgical resection, preserving healthy remaining tissue are attempted.
- In percutaneous microwave ablation, the principle is to completely damage the adenomyosis lesions without hampering the adjacent organs. The ablation range can be monitored under the guidance of real-time B-mode ultrasound imaging, and the actual range of tissue necrosis can be quickly evaluated by observing the non-perfused area on intra-procedural CEUS.
- Post ablation, common minor complications include lower abdominal pain, fever, vaginal discharge, and slight vaginal bleeding. Generally, no additional invasive treatment is required, and post-ablation discomfort usually disappears within a short time.
- Hence, Percutaneous microwave ablation has several advantages, such as higher effectiveness, less time consumption, and fewer complications.

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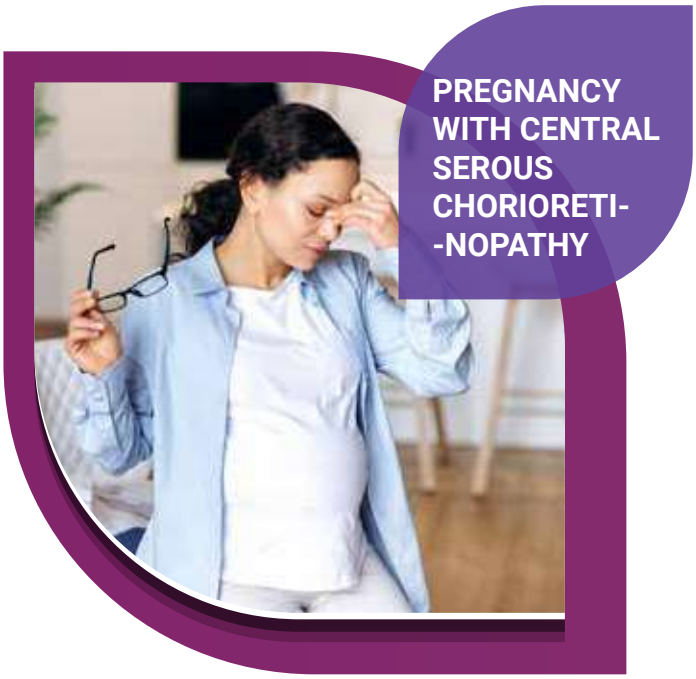


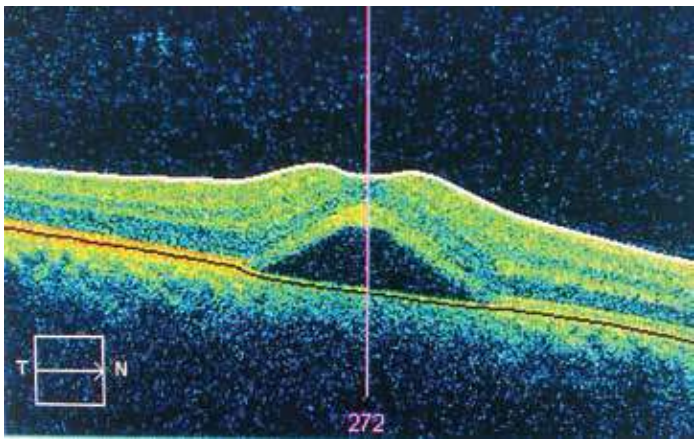
PREGNANCY WITH CENTRAL SEROUS CHORIORETI--NOPATHY

PREGNANCY WITH CENTRAL SEROUS CHORIO-RETINOPATHY– RARE CASE REPORT

INTRODUCTION :

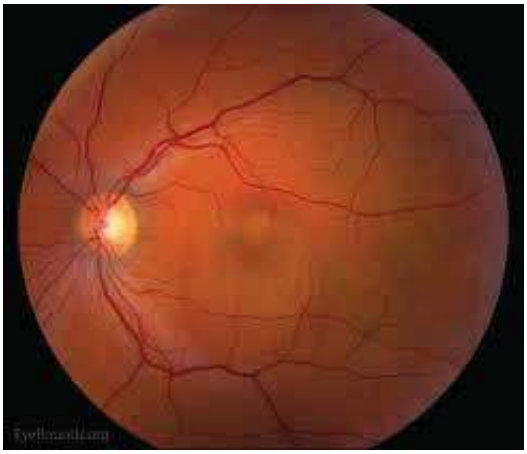
Central serous chorioretinopathy otherwise called as central serous retinopathy (CSR)is a maculopathy characterized by serous detachment of the neurosensory retina .Most common symptoms are blurring of vision , metamorphopsia , decreased visual acuity , central scotoma and colour vision . Incidence is 0.1% in general population , 6-8 times more common in men , and average age of occurrence is 20-50yrs.

We are presenting a case of 26yrs old female with central serous chorioretinopathy in third trimester of pregnancy.



CASE REPORT :

26yrs old primigravida presented with complaints of blurring of vision and diplopia in left eye at 36weeks of gestational age . She was our regular Antenatal patient with an uncomplicated pregnancy . General examination was normal . Right eye examination was normal . Left eye was with decreased visual acuity . Ophthamological examination revealed visual acuity in the left eye limited to counting the finger at 2meters . It was diagnosed as CSCR by fundal examination and was confirmed by optical coherence tomography (OCT) of macula . Patient had normal vaginal delivery at 39weeks of gestation without any complication.



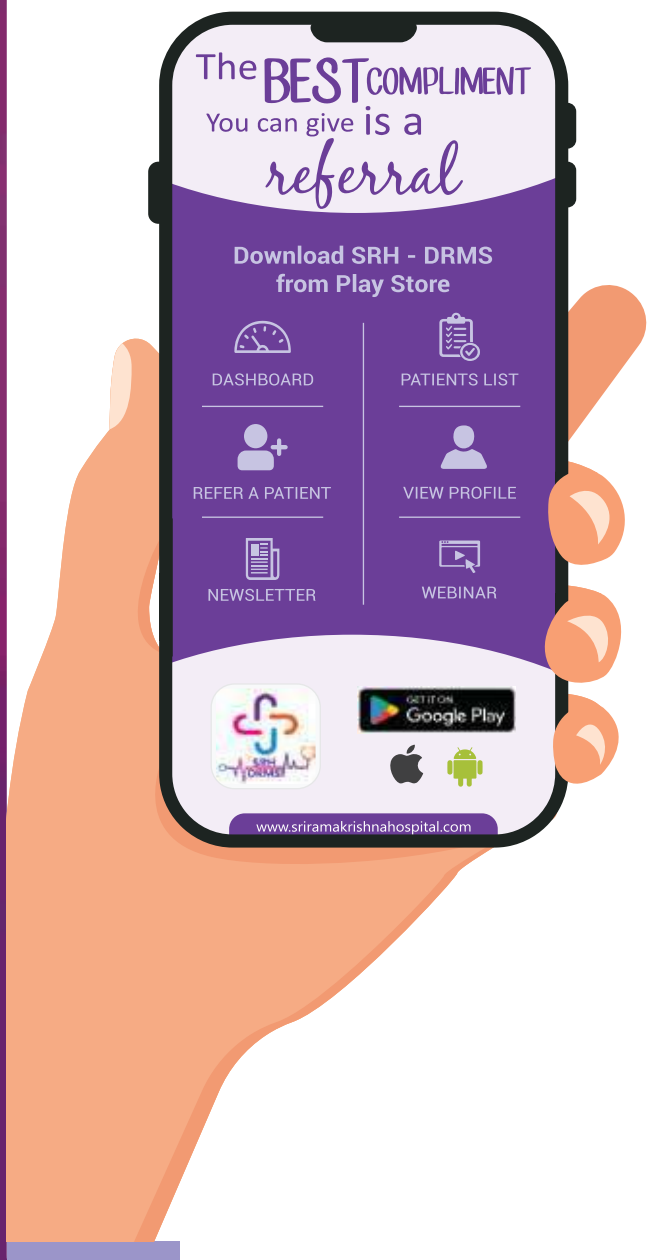
DISCUSSION :

In pregnancy CSR incidence is 0.008%per year . It is a self limited disease with visual acuity returning to normal level within a few months. It is characterized by serous detachment of retina often presenting with blurred vision and visual distorsion. Presentation is mostly unilateral but can be bilateral. It typically occurs in third trimester of an otherwise uncomplicated pregnancy and usually resolves spontaneously within 3months post partum with excellent visual recovery.

Most of the time the disease does not require any treatment . The patient being kept under observation by monitoring visual acuity and performing optical coherence tomography(OCT) of the macula. Proposed causes of the disease include hormones ,hemodynamic changes such as increased steroids and changes in blood volume . The condition is linked to increased endogenous corticosteroid levels and potentially hormonal changes during pregnancy . CSCR can recur in subsequent pregnancies.

Now the patient is 40days postpartum and is in the recovery period

Dr. R. LALITHA
Consultant Obstetrician & Gynaecologist - HOD
MBBS, DGO.



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.

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A Promise kept: our commitment to the safety of the guardian angels– live liver donors

- Dr. Premchandar Velusamy

Living donor liver transplantation (LDLT) is a remarkable medical procedure that offers a new lease on life to patients with end-stage liver disease. There is an increasing shortage of deceased donors mainly due to lack of awareness and hesitation to donate organs after brain death.

In our practice, we get an opportunity to meet these guardian angels living amongst us, who are healthy individuals donating a portion of their liver to their loved ones. The success of this complex procedure hinges on the comprehensive evaluation and meticulous care of the living liver donor, a process that ensures their safety and a favourable outcome for both the donor and the liver recipient. This article is about our commitment to the safety of the guardian angels– live liver donors.

The Meticulous Evaluation Process: A Journey of Care

The journey for a prospective living liver donor begins with the decision based on selfless love to save a family member who needs a transplant for their survival. Understanding the process of living liver donation and creating awareness on its safety is a contribution that every health care worker could do.

It's a multi-stage process designed to assess their physical and psychological fitness for donation. This is not merely a medical examination; it is a comprehensive and holistic assessment that prioritizes the prospective live liver donor's well-being above all else.

1) Initial Screening and Counselling: The first step involves an in-depth discussion with the transplant team, including a transplant surgeon, gastroenterologist and a transplant coordinator or a social worker. The prospective donor is educated about the risks, benefits, and long-term implications of live liver donation. Their motivations are explored, and they are assured that the donation is entirely voluntary and they can withdraw from their decision to donate at any point without any consequences.

A key component of this stage is ensuring that the donor's decision is completely voluntary, autonomous and free from any external pressure. As transplant physicians, it is our duty to create an environment for the donor to take their decision without any external pressure.

2) Eligibility criteria:

a) Age – between 18 and 50 years. People who are willing to donate & whose age is above 50 years will be included only after due discussion of multidisciplinary team - provided their comorbid illness is well controlled and they fulfill other criteria.

b) Blood group- blood group matching is not mandatory but preferred. ABO incompatible transplant might not be feasible in some recipient conditions so the transplant surgeons takes the decision of going forward with the evaluation of donor at this stage.

c) Weight & height- BMI will be calculated with these data: preferred BMI would be above 18.5 & below 30. People who are obese can still be accepted as a donor, subject to willingness to follow strict diet and exercise rehabilitation measures. After 6-8 week period clinical status will be reassessed and accepted as donors only if they fulfill the criteria.

d) Relationship – Close family relatives like mother, father, wife, husband, daughter, son, sister & brother are the most common people who come forward to donation. They will be subjected to verification with due documents by a transplant authorization committee at district level appointed by TRANSTAN (a government authority for transplants in the state). They will have to produce necessary documents for proof of relationship including official certificates and notary documents.

e) Comorbid illness – people with well controlled comorbidities can be accepted as donor after detailed evaluation of those diseases provided it does not increase the risk of overall procedure.

3) **Medical and Laboratory Workup:**

A thorough physical examination is performed, followed by a battery of laboratory tests.

a) After fulfilling all the above criteria, they will be getting their first set of blood tests which include blood grouping, fasting glucose, fasting lipid profile, liver function tests, viral markers (hepatitis B and C, HIV), and complete blood counts along with USG scan of the abdomen + liver elastography.

We focus on the general condition of the donor, common comorbid illness and markers specific for certain liver diseases including autoimmune markers, Wilsons disease, viral markers. These tests help in assessing the donor's overall health and ruling out any underlying medical conditions that could pose a risk during or after the operation. Only if the first set of clinical examination & investigations are finished, they will be proceeding to the second battery of investigations along with consultations.

b) Psychiatric evaluation – is performed to have an independent assessment of prospective donor's ability to understand the magnitude of decision to donate. We assess the mental and emotional stability of the donor to take the decision of donation.

We create an environment at each consultation to have personal conversation with the donor to prevent any external pressure on the donor to agree for the operation.

c) Donor Advocate – we have a physician consultation as a part of evaluation to assess the donor without any coercion on donation.

d) Medical gastroenterologist – to have an independent assessment of prospective donor's medical issues that could make her or him unsuitable for donation. Also to rule out the probable underlying medical condition which could make them unsuitable like incase of transplants happening in a recipient due to a genetic liver disease or disease which could run in families.

e) Gynaecology - for female donors to rule out infections and underlying premalignant or malignancies. PAP smear is mandatory along with radiological investigations.

f) Cardiac status – potential living donor will undergo a hepatectomy which is a major operation and so they will undergo detailed cardiac evaluation. They undergo ECG, ECHO & a Treadmill test or Dobutamine Stress echo.

After they consult the cardiologist and he clinically clears them for surgery under low risk for perioperative complications we proceed for the next battery of investigations.

g) Quality & Quantity of liver – we do radiological imaging techniques to assess the liver

i) CECT abdomen and Pelvis – to look for

(1) Liver attenuation index (LAI) which can help us assess the fatty liver. LAI of +5 or more is preferred.

(2) Liver volumetry – CT liver volumetry gives a highly accurate information on total liver volume, right lobe liver volume and left lobe liver volume. Our priority remains donor safety and principal target is to have a remnant liver volume of above 30% which has been proven safe across the globe.

(3) Anatomy – suitability and technical feasibility of undergoing a donor hepatectomy.

(4) Venous drainage and need for reconstruction of vascular outflow of liver to improvise the recipient liver function and in-turn their outcomes.

ii) MRCP to assess biliary system and get a detailed view of the bile duct anatomy which gives invaluable information to donor and recipient surgeons.

This evaluation primarily aims at donor safety & that the donor is fit and safe to undergo this major surgery. Also to ensure the donor about the safety of the support system in place. All these clinical assessments and investigations are compiled and reassessed by the liver anaesthesia and intensive care team. We then proceed for further discussion in transplant meeting with all the team members of transplant team.

4) TRANSTAN & District Transplant committee

The Donor & Recipient are presented to the committee with all the evaluation documents including investigations & consultations, proof of relationship, notary documents etc.

5) Final preparation before the surgery

After we receive the approval letter from the committee, we fix a date for the operation. The donor will be admitted a day prior to surgery. They will be subjected to physical examination, blood investigations & lower limb venous doppler (to rule out venous thrombosis) to ensure further safety during the perioperative period.

6) The Surgical Procedure: A Symphony of Precision and Expertise

The surgery on the donor is carried out with utmost precision and care by well-trained team of experts led by a senior anaesthesiologist, a team of highly skilled expert transplant surgeons, well-trained specialist nurses, anaesthesia technicians, highly supportive radiology team, and other allied team members who work together to make the major hepatectomy a smooth one. Donor will be received in the operating room by the Anaesthesiology team and prepared for surgery under General anaesthesia. Throughout the surgery, the donor's vital signs are meticulously monitored by an expert anaesthesiology team ensuring the donor's stability throughout the procedure. The surgeons focus on the careful dissection of the liver using latest technological equipment including CUSA machine, advanced retractors, latest electrocautery, C-arm machines and equipments used for precise haemostasis and a safe surgery focusing on donor safety. The surgeons use a minimally invasive approach whenever possible to reduce post-operative pain and speed up recovery.

Post-operative Care: A Journey of Recovery

The care of the living donor does not end with the operation. A dedicated team ensures a smooth and comfortable recovery.

A.Intensive Care Unit (ICU) Stay: Immediately after the surgery, the donor is transferred to the ICU for close monitoring.

1. Pain Management: A top priority is to manage post-operative pain effectively. Meticulous pain management is not just about comfort; it is a critical component of the donor's recovery, facilitating early mobilization, deep breathing exercises, and a faster return to normal life.

Nerve blocks, PCA pumps, medications targeting multiple pain pathways form our analgesia armamentarium. Multi model analgesia is our standard of care for live liver donors.

- Psychological Support: The donor's pain experience is not just physical; it is also influenced by anxiety, stress, and their emotional state. Psychologists and social workers are part of the team to provide counselling and support, which can help the donor cope with pain more effectively.
- Non-Pharmacological Pain Relief: Techniques like heat/cold therapy, relaxation exercises, guided imagery, and distraction are encouraged. These methods give the donor a sense of control over their pain and can reduce their reliance on medication.

A dedicated and compassionate approach including a meticulous pain assessment by our critical care nurse ensures a comfortable recovery to our donors.

2. Mobilization: Within a day, the donor is encouraged to sit up and walk with the help of a physical therapist. Early mobilization is vital to prevent complications like venous thrombosis.

3. Nutritional Support: The donor's diet is gradually advanced from clear liquids to a regular diet.

Donors are given appropriate medication to ensure their safety and making their recovery a comfortable one. Donor stays in the ICU for 48-72 hours after the surgery before they get transferred to expert nursing care in the ward.

B. Hospital Stay and Recovery: Once the donor is moved to a regular ward. Nurses and physiotherapists assist with physiotherapy along with safe mobilization, which is crucial for preventing complications. The diet is gradually advanced, and the donor is encouraged to walk and perform breathing exercises which helping them return to their daily routine by the time of discharge, which is typically on post operative day 7..

C. Discharge and Follow-up: The donor is typically discharged within 7-10 days. However, the care continues with regular follow-up appointments. These visits are essential to monitor the donor's liver function, assess their physical and psychological recovery, and provide ongoing support which continues on a weekly visit for a month followed by individualised visit schedule.

Conclusion

The process of living donor liver donation is a testament to the marvels of modern medicine and the selfless act of giving. The meticulous care taken at each step—from the initial evaluation to the post-operative period—is what makes this procedure safe and successful. It is a journey built on a foundation of compassion, expertise, and a profound commitment to the well-being of the donor, ensuring that their act of generosity truly becomes a gift of life.

Understanding the intricate process of living donor liver transplantation (LDLT) is crucial for providing accurate information and compassionate guidance. By understanding this process, you can provide invaluable support to the donors, helping them navigate this life-changing journey with confidence and a clear understanding of the care they will receive. As a transplant team maximizing the chances of a successful transplant for the recipient is second only to donor safety.

A commitment to the donor's well-being is a core principle of living liver transplantation, ensuring that the remarkable act of giving is supported by the highest standard of care.

A Promise to the safety of the live liver donors is our prime motive as a transplant team.

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Senior Consultant Surgeon
M.S., DNB.(Surg Gastro)., PDF(Liver Transplantation)

Dr. B. KESAVAN
Consultant Surgeon
MS., MCH (Surgical Gastroenterology)., FLS

Dr. V. PREM CHANDAR
Senior consultant Anaesthesiology
MBBS, MD.,PDF

Dr. R. JAYAPAL
Consultant Surgeon
M.S., MCH (G.I. Surg & Liver Transplantation, AIIMS, New Delhi)

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WORLD ORGAN DONATION DAY - 2025

Sri Ramakrishna Hospital Celebrates World Organ Donation Day with Awareness Event Honoring Live Liver Donors

Sri Ramakrishna Hospital observed World Organ Donation Day on August 13, 2025, with a meaningful awareness event themed **"Celebrating the Gift of Life: Honouring Our Live Liver Donors."** The program was graced by our Managing Trustee, **Thiru R. Sundar**, as Chief Guest, along with Joint Managing Trustee **Shri R. Narendran**, hospital leadership, doctors, nurses, and students, underscoring the institution's strong commitment to promoting the noble cause of organ donation.

The event highlighted the growing importance of living donor liver transplantation and paid tribute to the extraordinary courage of donors who have given a part of themselves to save their loved ones. The occasion featured a vibrant flash mob by Allied Health Sciences students, an emotional video of patient testimonials, and the felicitation of live liver donors for their selfless contributions.

Special appreciation was extended to the hospital's Liver Transplant Team – **Dr. Anand Bharathan, Dr. B. Kesavan, Dr. R. Jayapal, and Dr. V. Prem Chandar** – for their expertise and dedication in saving lives. The program concluded with a strong message that organ donation is truly the gift of life, reaffirming Sri Ramakrishna Hospital's mission to inspire positive change and create a healthier, more compassionate community.