



SRI RAMAKRISHNA
HOSPITAL

pulse

Happenings at Sri Ramakrishna...



WORLD HEART DAY

29th September
2026

Take care of your heart—
it's the rhythm of life



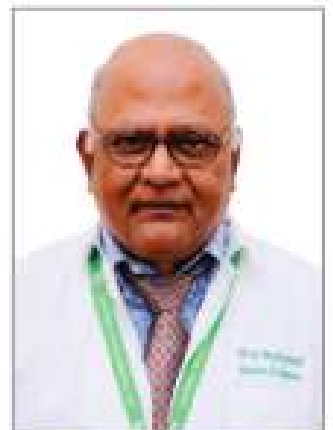
As we enter September, Sri Ramakrishna Hospital continues its journey of growth and excellence with a strong focus on advancing healthcare, strengthening our infrastructure and enhancing the overall patient experience. Our commitment remains to provide quality healthcare that combines medical expertise, modern technology, compassionate service and efficient management, while responding to the evolving healthcare needs of the community. A significant addition to our healthcare infrastructure is the new Siemens-equipped Cath Lab, which further strengthens our cardiac care capabilities. This advanced facility represents an important step in our continued efforts to bring sophisticated technology and specialised cardiac interventions closer to our patients, ensuring timely and comprehensive care. Our progress is made possible by the collective efforts of our doctors, nurses, technicians, administrative teams and every member of the Sri Ramakrishna Hospital family.



Dr.Sundar Ramakrishnan
Managing Trustee

As an institution, we continue to focus on strengthening our systems, embracing innovation and creating an environment that prioritises patient safety, quality and service excellence. As we mark several important healthcare observances this month, including World Heart Day, we are reminded that building a healthier society requires collective responsibility. We look forward to continuing our journey with renewed commitment, innovation and compassion, creating meaningful milestones in healthcare and making a lasting difference to the communities we serve.

September is a month that brings attention to several important areas of healthcare. World Heart Day on September 29 reminds us of the importance of cardiovascular health and prevention, while World Pharmacists Day on September 25 recognises the essential role of pharmacists in medication safety and patient care. These observances encourage us to strengthen awareness and promote healthier choices across the community. Heart health remains a significant medical priority, and early detection can make a vital difference in patient outcomes. Regular health screenings, appropriate lifestyle changes and timely medical intervention are essential in preventing and managing cardiovascular conditions. The addition of our new Siemens-equipped Cath Lab further enhances our ability to provide advanced diagnostic and interventional cardiac care with precision and efficiency.



Dr.S.Rajagopal
Medical Director

September also marks the International Day of Sign Languages and World Day of the Deaf, highlighting the importance of communication, accessibility and inclusion in healthcare. Every patient deserves to understand their health condition and treatment clearly and receive care with dignity, irrespective of communication barriers. Creating a more inclusive healthcare environment is an important part of our responsibility as medical professionals. At Sri Ramakrishna Hospital, excellence in healthcare is built through teamwork and continuous learning. Our doctors, nurses, pharmacists, technicians and allied healthcare professionals work together to provide comprehensive, evidence-based and patient-centred care. As we observe these important healthcare days, let us renew our commitment to prevention, timely treatment, inclusive care and better health outcomes for all.

Editorial Team

Dr.N.Loganathan
Pulmonologist

Dr.S.Prahadeeshwaran
General Manager - Public Relations

Mr.Santhosh Vijayakumar
Head - Corporate Relations & International Affairs

BREASTFEEDING AWARENESS RALLY

Sri Ramakrishna Hospital, jointly with Sri Ramakrishna Institute of Paramedical Sciences – College of Nursing, conducted a Breastfeeding Awareness Rally on 4 August 2026 at Race Course, Coimbatore, as part of Breastfeeding Week. The initiative aimed to create awareness about the importance of breastfeeding and encourage mothers and families to understand its vital role in ensuring the health and well-being of infants.



The rally was flagged off by Thiru. Pavan Kumar G. Goriyappanavar, I.A.S., District Collector, Coimbatore, along with Dr. Sundar Ramakrishnan, Managing Trustee, SNR Sons Charitable Trust, in the presence of Shri C. V. Ramkumar, Chief Executive Officer, and Shri D. Mahesh Kumar, Chief Administrative Officer. Their presence and support added significance to the awareness initiative and reinforced the institution's commitment to promoting maternal and child health.

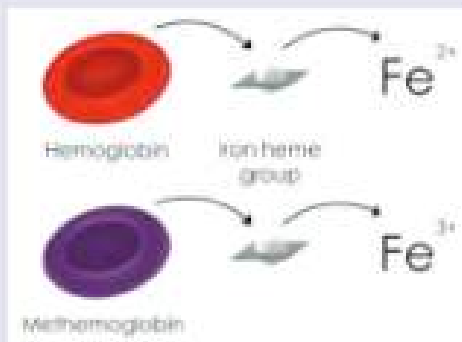
The programme was initiated under the guidance of Dr. S. Rajagopal, Medical Director, and Dr. S. Alagappan, Medical Superintendent, whose leadership played an important role in bringing together the hospital and academic teams for this community-focused initiative. The event was further supported by Dr. Siddhartha Buddhavarapu, Consultant Neonatologist, Dr. G. Suja Mariam, Consultant Neonatologist, and Dr. S. Grijia Kumari, Principal, College of Nursing. The nursing students actively participated in the rally and took the message of breastfeeding to the public through an engaging flash mob and awareness activities. Through their energetic performances and simple, impactful messages, the students highlighted the importance of exclusive breastfeeding, the nutritional benefits of breast milk and the role of breastfeeding in supporting the healthy growth and development of babies. The rally served as a meaningful platform to spread awareness and encourage the community to support and promote breastfeeding. The collaborative efforts of Sri Ramakrishna Hospital and the College of Nursing demonstrated the institution's continued commitment to maternal and child health, while empowering students to become responsible healthcare ambassadors and advocates for healthier communities.



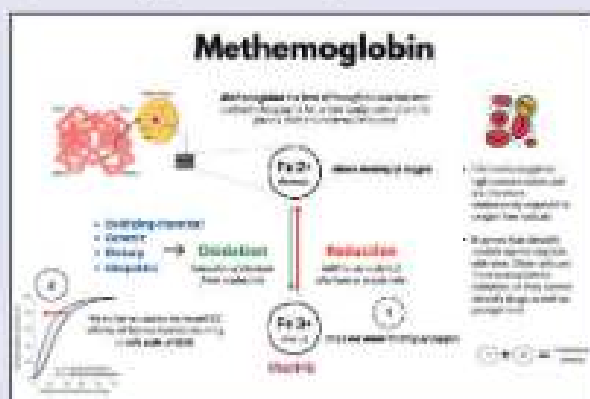


A rare and critical clinical scenario - Ectopic pregnancy in a woman with methemoglobinemia

Methemoglobinemia is a disorder in which the iron in haemoglobin is oxidized from its normal ferrous (Fe^{2+}) state to the ferric (Fe^{3+}) state.



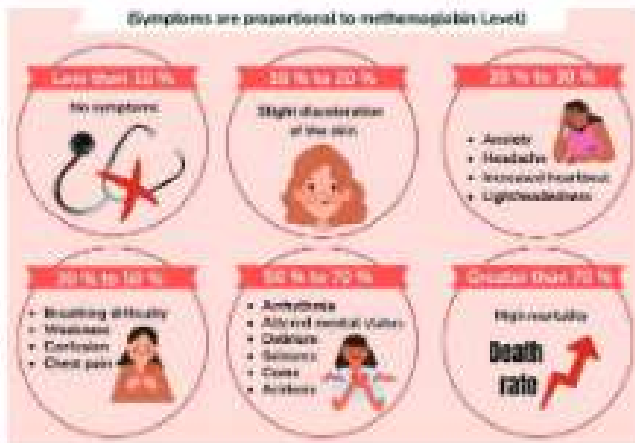
This oxidized form, known as methaemoglobin, is unable to bind and transport oxygen effectively, resulting in impaired oxygen delivery to body tissues. Under normal physiological conditions, less than 1% of total haemoglobin exists as methaemoglobin because protective enzymatic systems continuously convert it back to functional haemoglobin. When these protective mechanisms fail or become overwhelmed, methaemoglobin accumulates, leading to tissue hypoxia despite adequate oxygen availability.



The condition may be either congenital or acquired. Acquired methemoglobinemia is the more common form and usually develops following exposure to oxidizing medications or

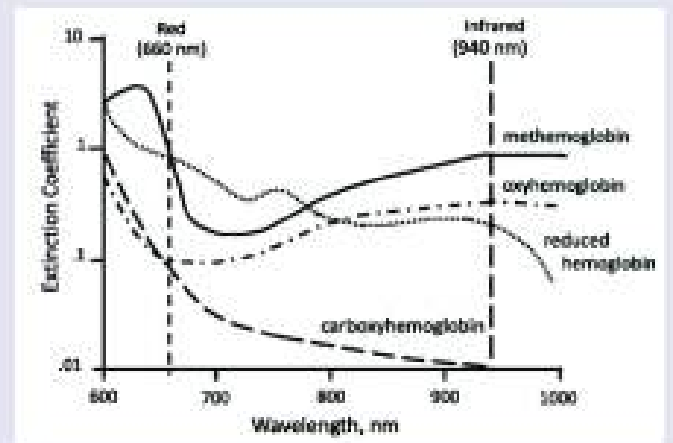
chemicals, including certain antibiotics, local anesthetics, nitrates, and industrial compounds. Congenital methemoglobinemia results from inherited deficiencies of cytochrome b5 reductase enzyme or from structural abnormalities of haemoglobin, such as Haemoglobin M variants, which impair the reduction of methaemoglobin back to its normal state. The clinical manifestations of methemoglobinemia depend on the percentage of methaemoglobin present in the blood. Levels below 15% are generally associated with cyanosis but minimal symptoms. Concentrations between 20% and 50% produce moderate symptoms such as headache, dizziness, fatigue, dyspnea, tachycardia, and exercise intolerance. As levels increase to 50–70%, patients develop severe manifestations including altered mental status, metabolic acidosis, arrhythmias, seizures, and profound hypoxia. Methaemoglobin levels exceeding 70% are considered life-threatening and may result in cardiovascular collapse and death if not treated immediately.

Case Report: This is the report about a case of Ectopic pregnancy complicated by methaemoglobinemia. A 24 year old women was referred with unruptured ectopic pregnancy with altered liver enzymes. Ectopic pregnancy was confirmed with raised beta HCG and ultrasound. Clinically she had refractory cyanosis unresponsive to oxygen therapy. saturation remanining at 80-85% despite adequate oxygenation. High methheamoglobin level was diagnsoed with ABG. Since she was not responding to medical management. She was



taken up for surgical management of ectopic pregnancy after treating with intravenous methylene blue. Multidisciplinary team was involved and had uneventful intraoperative and postoperative period. Genetic workup showed an autosomal recessive CYB5R-3 gene of homozygous variant which also confirmed methaemoglobinemia. She gives a family history of her father and brother suffering from similar issue which was also confirmed as congenital methaemoglobinemia. Patient was discharged with daily oral ascorbic acid. Since methylene blue and ascorbic acid were antidotes.

Discussion: Definitive diagnosis of methaemoglobin is established by co-oximetry, which directly measures methaemoglobin concentration in the blood. Clinical examination often reveals persistent central cyanosis that does not improve with supplemental oxygen, providing an important clue to the diagnosis.



Transmitted light absorbance spectra of four hemoglobin species: oxyhemoglobin, reduced hemoglobin, carboxyhemoglobin, and methemoglobin

Management depends on disease severity and the patient's clinical condition. Immediate treatment includes discontinuation of the offending agent, administration of supplemental oxygen, and supportive care. Intravenous methylene blue (1–2 mg/kg over five minutes) is the first-line antidote for symptomatic patients, provided G6PD deficiency has been excluded. In severe or refractory cases, additional interventions such as exchange transfusion or hyperbaric oxygen therapy may be necessary to restore adequate tissue oxygenation.

Overall, methaemoglobinemia is a potentially life-threatening yet treatable disorder when recognized promptly. Early diagnosis through clinical suspicion and laboratory confirmation, coupled with timely therapeutic intervention and preventive counselling, is essential for minimizing complications and improving patient outcomes.

Dr. R. LALITHA
MBBS, DGO,

Consultant Obstetrician &
Gynaecologist - HOD





Save MotherSave Womb Too!

Pregnancy poses a woman into many risk factors to such an extent of losing her life itself. Abnormal placental attachment deeply into uterine wall with defective choriodecidual space leads to torrential hemorrhage. Any prior surgical uterine trauma like C Section, Curettage, Myomectomy, Hysteroscopy, IVF conception may predispose to this condition called "Placenta Accreta Spectrum". Though not preventable, improved quality care of this situation is a good attempt to prevent maternal mortality.

Here we report a successful management of a patient with Placenta Accreta by Multidisciplinary team approach.

Mrs. V, 34 years old G2 P1 at 35 weeks of gestation diagnosed recently as placenta accreta, referred for further management to our institution for tertiary care.

She is married for 9 years, Nonconsanguineous marriage, Previous term LSCS for breech presentation 8 years ago. Inter pregnancy period no conception or contraception use.

Present pregnancy booked and immunized, normal weight gain. First trimester screening normal, screened for GDM. Diagnosed to have gestational hypertension on anti-hypertensive therapy. Growth scan revealed SLF - of 2 kg, adequate liquor, Doppler normal. Placenta is bilobed, one lobe in the right lateral wall. The large succenturiate lobe in lower segment reaching up to internal os- Previa, cervix not visualized

separately. There are prominent sub placental and peri uterine vessels with the loss of expected T2W low signal myometrial lines in MRI confirming the placental localization and adherence-Accreta. Prophylactic steroids given to plan for delivery and low dose Aspirin stopped.

Clinically she is obese, normotensive, afebrile systemic examination normal, per abdomen Uterus corresponding to gestational age, relaxed, cephalic presentation and fetal heart of 140/mt. and no vaginal discharge.

In view of the situation, planned delivery involving Interventional radiologist, anesthetist, Neonatologist.

On the day of surgery, preoperatively bilateral Internal iliac artery balloon placed under LA. Under General Anaesthesia, through midline incision abdomen opened. Intra operative USG done to identify placental localization. Incision on uterus done to avoid placenta. Delivered an alive female baby with good APGAR handed over to neonatologist. Internal iliac Arteries occlusion done after baby delivery, uterotonics started. Upper lobe of placenta got separated spontaneously. Lower lobe adherent and covering the internal os. Meticulously removed completely in piecemeal and estimated blood loss was 1200 ml. Urinary bladder integrity verified. Foley catheter inserted trans vaginally into uterine cavity and the balloon inflated with 50 ml Saline and

and lodged in cervical region for compression to control surface oozing subsequently. After complete hemostasis uterine incision closed, both tubes and ovaries normal. 2 units of PRBC given intraoperatively. Peritoneal toileting done and Abdomen closed in layers. Postoperatively Inj.Methotrexate 50 mg intramuscularly given prophylactically to address the involution of trophoblastic tissue if any left behind.

Postoperative period uneventful. Foley balloon deflated and removed after 30 hours. No undue bleeding PV. At the end of 6 weeks uterus involuted well and Anti-hypertensive drugs withdrawn, suggested to follow barrier contraception.



Images: MRI, Intra operative after haemostasis

Proper planning, intraoperative ultrasonography, prophylactic vascular occlusion catheter placement, surgeons' expertise, intensive monitoring by Anesthetic and Intensive care team helped to minimize blood loss and salvage the uterus. Surgical menopause is the lifesaving last resort in these situations. We sincerely thank the multidisciplinary team of Surgeon, Sonologist, Interventional Radiologist, Anesthetist, Intensivist, Neonatologist and Hematologist in saving the mother and salvaging the uterus as well.



Dr. M. BANUMATHY

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Laparoscopic Pectopexy – A Minimally Invasive Approach To Restoring Apical Support (Vault prolapse)

Introduction: Uterine or Vaginal vault prolapse affects, 6-8% of adult women especially post menopausal women. This Condition severely impacts a woman's quality of life, causing discomfort, urinary and bowel dysfunction, and sexual disturbances. Surgical intervention is the definitive treatment for symptomatic apical prolapse. Pectopexy, aiming to restore the normal position of the vaginal vault by attaching it to the Iliopectineal ligaments using mesh for reinforcement.

Case Report: A 53 year old P1L1 with previous Normal Vaginal Delivery came with complaints of mass descending per vaginum for past 2-3 years which has progressively worsened over the preceding six months. She had undergone laparoscopic hysterectomy 13 years back elsewhere for abnormal uterine bleeding.

Clinical Examination revealed Third degree vault prolapse associated with mild Cystocele.

The Patient underwent Laparoscopic Pectopexy. The procedure was performed using 4 Port technique- A 10 mm Primary port and three 5 mm accessory port. Vaginal apex was elevated. Anterior and posterior peritoneum are separated from the apex. And Bilateral Iliopectineal ligament was exposed by meticulous dissection. A Prolene Mesh was fashioned into a 'T' shaped configuration and introduced into the abdominal cavity. The lower portion of the mesh was anchored to the vaginal apex using non-absorbable Ethibond suture, while the two lateral arms were secured bilaterally to the Iliopectineal ligaments using tackers. Lastly whole mesh is peritonised using vicryl in continuous suture technique. This provided bilateral lateral support to the vaginal apex and restored the vault towards its normal anatomical position.

The urinary catheter was retained for 48 hours, and was removed. The patient was discharged on postoperative day 3 with no reported perioperative complications.

The uncomplicated recovery highlights one of the importance of minimally invasive pelvic reconstructive surgery, effective restoration of pelvic support while limiting abdominal surgical morbidity.

Discussion: Laparoscopic Sacrocolpopexy remains an established procedure for apical prolapse. But is associated with more gastrointestinal complications and the risk of damage to hypogastric nerve.

Laparoscopic pectopexy is a relatively new technique for treating apical prolapse, to securely reattach the vaginal vault or the uterus with the lateral parts of the Iliopectineal ligament, thereby having less to no incidence of the above mentioned complications. It also provides better anatomical and surgical outcomes.

Nonetheless, there are concerns regarding mesh-related complications, although the incidence of such issues is generally low. Hence, as with any mesh-based pelvic reconstructive procedure, appropriate patient selection, careful anatomical identification and meticulous mesh placement are essential.

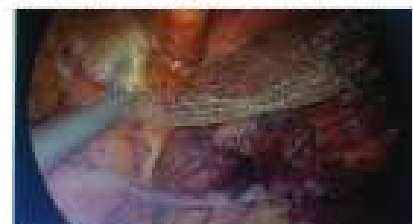


Image showing mesh being fixed to Iliopectineal ligament using tackers

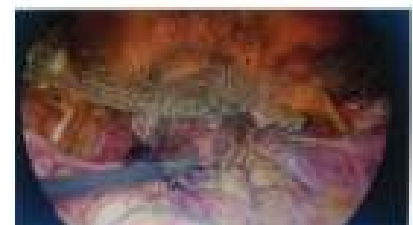


Image of mesh after attachment to vaginal vault apex and bilateral Iliopectineal ligament



Image after peritonisation of mesh

UNICORNUATE UTERUS WITH NON-COMMUNICATING RUDIMENTARY HORN- A RARE CAUSE OF DYSMENORRHOEA: A CASE REPORT

Introduction: Unicornuate uterus is a rare Müllerian anomaly resulting from failed or abnormal development of one of the Müllerian ducts leading to the formation of a normally developed uterus on one side and a rudimentary or absent horn on the other. (1) It occurs in approximately one in 1,000 to one in 5,400 women with a rudimentary horn present in 74-90% of cases. (1) Patients commonly present with dysmenorrhoea, chronic pelvic pain, dyspareunia, infertility or less frequently, ectopic pregnancy.

Case Description: A 28-year-old unmarried female presented with complaint of severe dysmenorrhoea for the past 5 years, with poor response to conservative medical management. She attained menarche at 13 years of age and had regular menstrual cycles, with normal menstrual flow for 3-5 days. She had a history of laparoscopic appendicectomy 7 years ago. On general examination, the patient was hemodynamically stable, with normal pulse rate and blood pressure. Abdominal examination revealed no tenderness, guarding, rigidity or palpable masses. A transabdominal ultrasonography was performed, which showed a left broad ligament fibroid measuring 29x28 mm and an anteverted uterus of normal size with an anterior wall intramural fibroid measuring 20x18.2 mm. Both ovaries showed a polycystic ovarian morphology and both kidneys appeared normal. Further evaluation with plain MRI of the abdomen revealed a right-sided unicornuate uterus with a non-communicating rudimentary left horn containing endometrial lining. A posterior wall intramural fibroid measuring 2.7x2.2cm was noted. The left ovary showed small hemorrhagic cysts while the right ovary was unremarkable. Based on the imaging findings, a diagnosis of unicornuate uterus with a non-communicating functional rudimentary horn was made. The patient was planned for laparoscopic resection of the rudimentary horn. On laparoscopy a well-developed right-sided unicornuate uterus with normal right fallopian tube and ovary and a left-sided non-communicating rudimentary horn with left fallopian tube and ovary was identified. The left ovary was enlarged and contained an endometriotic cyst

measuring approximately 3x2.5cm. Laparoscopic excision of the rudimentary left horn along with the left fallopian tube was performed. Left ovarian endometriotic cystectomy was also carried out. The round ligament attached to the unicornuate horn was fixed to the unicornuate uterus to achieve the anatomical uterine support. On cut-section of the left rudimentary horn, functional endometrium was noted. The resected specimen was sent for histopathological examination. The procedure was completed without intraoperative complications. The patient had an uneventful postoperative recovery and was discharged in stable condition.



Fig 1. Intra-op image of rudimentary left horn (black arrow), right unicornuate uterus (yellow arrow) and with filmy connection (blue arrow) in between. Left ovary enlarged with endometriotic cyst (green arrow)

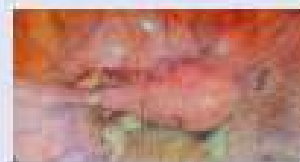


Fig 2. Post-procedure intra-op image of unicornuate uterus sutured to the left round ligament



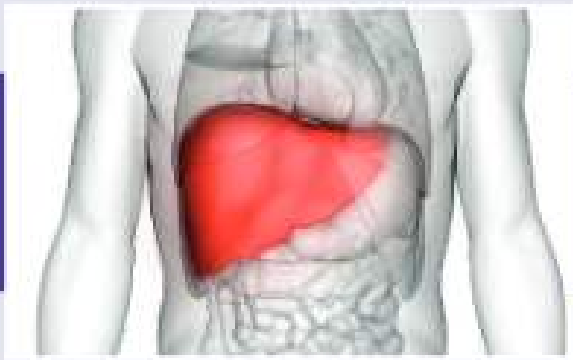
Fig 3. Excised specimen of rudimentary horn incised in midline to visualize the endometrium

Discussion: A functional non-communicating rudimentary horn is associated with a high incidence of dysmenorrhoea, endometriosis, and cornual pregnancy. (4) In such cases, the absence of an outflow tract results in the retention of menstrual blood and retrograde menstruation through the ipsilateral fallopian tube. Laparoscopic resection is technically less demanding when the rudimentary horn is connected to the unicornuate uterus by a flimsy attachment, as observed in our patient. However, when the horn is firmly attached, the procedure becomes more challenging, requiring meticulous identification of the ureter, adequate haemostasis, and careful reconstruction of the uterine remnant while preserving the endometrial lining.

Dr. M. KANMANI

MBBS, MD, DNB(OG), Fellowship in Endogynaecology, Diploma in Urogynaecology, DIMAS, Fellowship in Cosmetic Gynaecology.
Consultant Obstetrician, Uro and Cosmetic Gynaecologist





When should a patient be referred for Liver Transplantation?

Working together for a better liver care and better outcomes.

Liver transplantation is the only curative treatment for decompensated liver disease, but an important factor for its success is timely referral.

The right referral is not simply about sending a patient to a transplant centre. It is about giving the patient the right opportunity, at the right time.

When should this patient be referred for transplant evaluation?

Cirrhosis may remain compensated for years. A patient may still appear reasonably well, with laboratory values that do not seem alarming, while the disease is already changing trajectory.

Ascites, hepatic encephalopathy, variceal bleeding, and hepatorenal syndrome are signals informing the declining hepatic reserve and physiological resilience. Frailty, sarcopenia, renal dysfunction, and recurrent infections may further accelerate deterioration.

1. The First Decompensating Event Should Change the Conversation

A first major decompensating event should prompt transplant discussion, particularly when accompanied by impaired synthetic function or recurrent complications.

Ascites: Recurrent ascites, diuretic intolerance, repeated large-volume paracenteses, SBP, or renal dysfunction (HRS) should substantially lower the threshold for referral.

Hepatic encephalopathy: Recurrent HE, falls, cognitive impairment, or increasing dependence on caregivers should prompt early assessment even after successful treatment of the precipitating factor.

Variceal haemorrhage: A significant variceal bleed should prompt assessment of hepatic reserve, renal function, recurrent bleeding risk, and transplant candidacy.

2. MELD Is Important—But the Trend Matters

MELD-based scores are fundamental to prognostication.

As a practical approach, a MELD-Na/MELD 3.0 – MELD score of 15 & above, particularly if rising, should prompt consideration of transplant evaluation.

A rapidly rising MELD, recurrent admissions, renal dysfunction, or deteriorating functional status may be more concerning than a single stable score.

Numbers guide us. The patient guides the decision.

3. Frailty: The Warning Signal we should not overlook

Two patients with identical MELD scores may have very different physiological reserves. Look for:

- Unintentional weight loss and muscle wasting
- Reduced walking capacity or exercise tolerance
- Falls
- Poor appetite or oral intake
- Dependence in activities of daily living
- Recurrent hospitalisation

Frailty should lower the threshold for referral, not raise it.

4. Acute Liver Failure: Call Early

Acute liver failure is fundamentally different from chronic liver disease. A patient with acute severe liver injury, coagulopathy, and hepatic encephalopathy without established cirrhosis can deteriorate rapidly.

Common causes include paracetamol toxicity, acute viral hepatitis, drug-induced liver injury, autoimmune hepatitis, and Wilson disease.

Some patients recover without transplantation; others require urgent transplantation. Early specialist involvement allows appropriate prognostic assessment, intensive care, organ support, and consideration of emergency listing where applicable.

5. HCC: Refer While There Is Still a Window

Hepatocellular carcinoma is another situation where timing may determine whether transplantation remains

an option. Patients outside Milan should not automatically be labelled "not for transplant."

Selected patients may be suitable for downstaging with TACE, TARE/Y-90, ablation, SBRT, or other appropriately selected locoregional therapies.

Tumour biology remains critical. AFP level and trajectory, vascular invasion, radiological response, and behaviour following treatment contribute to assessing whether transplantation remains oncologically appropriate.

6. When MELD Does Not Tell the Whole Story

Some patients have substantial morbidity despite relatively modest MELD scores. Early transplant-centre discussion should be considered in selected patients with:

- Hepatopulmonary syndrome: unexplained hypoxaemia, platypnoea, or orthodeoxia.
- Portopulmonary hypertension: early recognition is important because significant pulmonary hypertension can increase transplant risk, while appropriate treatment may improve candidacy.
- Recurrent cholangitis: particularly in PSC and complex biliary disease.
- Metabolic liver disease.

7. Why Early Referral Matters

Successful liver transplantation can restore hepatic function, reverse many manifestations of advanced liver disease, and allow patients to return to meaningful daily activities, employment, family life, and social independence.

Quality of life is therefore not a secondary consideration in liver transplantation.

The relevant question is not simply:

"Is this patient sick enough for a transplant?"

It is:

"Could transplantation give this patient a substantially longer and better life, and are we still at a stage where we can offer it safely?"

8. The Hidden Cost of Late Referral

Advanced liver disease may require repeated admissions for ascites, SBP, variceal bleeding, encephalopathy, infections, acute kidney injury,

hepatorenal syndrome, dialysis, endoscopic procedures, blood products, ICU care, or rehabilitation. The burden extends beyond hospital costs and may include:

- Loss of patient or caregiver income
- Travel and accommodation expenses
- Repeated investigations and procedures
- Medication, dialysis, and ICU costs
- Borrowing, depletion of savings, or sale of assets
- Emotional exhaustion

In some patients, particularly those experiencing prolonged ICU care, dialysis, and recurrent admissions, the cumulative cost of managing advanced liver failure may become enormous and can approach or even exceed eventual transplant-related expenditure. Early referral allows patients and families to understand the likely disease trajectory, explore living- or deceased-donor pathways where appropriate, plan financially, and make informed decisions before each new complication becomes an emergency. Early referral protects not only physiological reserve, but also financial and emotional reserve.

9. Living-Donor Transplantation: Planning Rather Than Waiting

In centres with an experienced living-donor liver transplant programme like ours, timing may differ from systems dependent entirely on deceased-donor allocation.

A patient may not yet have a sufficiently high allocation score to receive a deceased-donor graft within a reasonable timeframe, while continued deterioration may make waiting increasingly hazardous.

Living-donor transplantation can potentially allow transplantation to be planned before profound decompensation and frailty develop.

10. What Happens After Referral?

Referral does not mean listing, and it does not automatically mean surgery.

The transplant team essentially asks three questions: Is the patient likely to benefit?

Can the patient safely undergo transplantation?

Can the patient successfully live with a transplanted organ?

The outcome may therefore be:
 Transplant now
 Continue medical management and follow closely
 Optimise before transplantation

Transplantation is not the safest option

All are legitimate outcomes of a thoughtful transplant assessment.

If you are beginning to wonder whether transplantation may become necessary, start the conversation.

Referral is not a transfer of responsibility. It is an invitation to work together.

You know the patient—their history, family, values, challenges, and journey through illness. The transplant team brings transplant-specific expertise, multidisciplinary assessment, and experience in managing patients before, during, and after transplantation.

Our commitment remains the same: patient safety, empathy, informed decision-making, and long-term wellbeing.

A transplant programme should not measure its success only by the number of transplants performed.

It should also be measured by whether the right patient received the right treatment at the right time—and whether that treatment allowed the patient to return to a meaningful life.

The Message is Simple

Early referral preserves options. Timely transplantation can transform lives.

A transplant centre should be a place for optimisation, not simply a place to arrive when every other option has failed.

The best time to refer is not when the patient is dying from liver failure. It is when there is still a realistic opportunity to change the course of that journey—and give the patient the possibility of a longer, healthier, and more meaningful life.

Timely referral saves lives. Early referral does not commit a patient to transplantation; it preserves the opportunity for transplantation if and when it becomes necessary.

Our transplant programme is built around patient safety, technical excellence, scientific rigour, empathy, ethical practice, and partnership with the referring physician.

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Department of HPB, GI Surgery and Liver Transplantation



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Consultant Surgeon

ADVANCING CARDIAC CARE WITH A NEWLY RENOVATED CATH LAB

Sri Ramakrishna Hospital has further strengthened its commitment to advanced cardiac care with the complete renovation of its Cath Lab and installation of the Siemens Healthineers Artis one interventional angiography system. The newly upgraded facility represents a significant advancement in the hospital's cardiac care infrastructure, bringing state-of-the-art imaging technology and modern interventional capabilities to support precise and efficient procedures.



The newly renovated Cath Lab was inaugurated by Dr. Sundar Ramakrishnan, Managing Trustee, SNR Sons Charitable Trust, and Shri N. Narendran, Joint Managing Trustee, SNR Sons Charitable Trust. The occasion was graced by Shri C. V. Ramkumar, Chief Executive Officer, and Shri D. Mahesh Kumar, Chief Administrative Officer, along with Dr. S. Rajagopal, Medical Director and Dr. S. Alagappan, Medical Superintendent, Sri Ramakrishna Hospital. The inauguration was also attended by members of the Cardiology Department and other medical and administrative teams.

The Siemens Artis one is designed to provide high-quality imaging with next-generation tools for interventional procedures. Its features include advanced 2D and integrated 3D imaging, real-time stent enhancement through ClearStent Live, and HeartSweep, which can assist in acquiring multiple coronary angulations to identify suitable projections for treatment. The system also incorporates Siemens' CARE+CLEAR technology, designed to support high image quality while optimising radiation dose. This transformation marks another important milestone in Sri Ramakrishna Hospital's continued pursuit of excellence in cardiac care. With advanced technology, a comprehensive cardiac team and a patient-centred approach, the newly renovated Cath Lab further enhances the hospital's ability to provide sophisticated interventional cardiac services. The initiative reflects the institution's ongoing commitment to bringing modern medical advancements closer to the community and strengthening its position as a centre for advanced cardiac care.





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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