



MEDICOVER
HOSPITALS

INAPACT

ISSUE 8

www.medicoverhospitals.in

July_2023

**Excellence
Right Here!!**



EDITORIAL DESK

Dear all readers,
Greetings from Medcover Hospitals



Dr. A. Sharath Reddy

Executive Director
Medcover Hospitals, India

Medcover Hospitals, being one of the largest Multispecialty Hospital Chain in India has created a greater impact in the field of Healthcare by providing quality care focusing on Patient-Centric Approach. We at Medcover always strive to provide effective, timely, and safe Care to all the Patients who visit our facilities across India. At Medcover, we always adopt innovation & automation which have paved way in healthcare providing newer technologies that support with precise diagnosis and newer treatment options Involving AI & Robotics. We have state-of-the-art technology which will cater to our patient needs which in turn result in better patient outcome and increased quality of life. We'll continue to put all our efforts, working closely to provide safe, high-quality medical care to everyone who visits. We look forward to your continued support.



Dr. Sateesh Kumar Kailasam

Group Medical Director
Medcover Hospitals, India

Sharing knowledge is the key to Community education. Medcover hospitals as a group would like to enlighten the healthcare professionals about the advanced technologies and current modalities of treatment in various patients at the same time interested in increasing the awareness in the common public about the same. This platform will help everyone to know the extraordinary work done by the experts at Medcover India . Wishing you all the best to all writers and readers .

INDEX

- **1** Giant Renal Mass Resection:
A Complex Surgical Case Report
- **3** Case Report of a Rare Cause of
Reactive Arthritis: Leptospirosis
- **5** Eclampsia, Peripartum Cardiomyopathy
with Reversible Encephalopathy Syndrome
- **6** Minimally Invasive Mitral Valve
Replacement In A Peripheral Setting.
- **8** A Case Report on Cervical Rib
- **10** Colloid Cyst Of IIIrd Ventricle
- **11** HELLP Syndrome
- **13** Fishbone Removal with Hemoclip Placement
- **14** Impacted Foreign Body in the left Main Bronchus
- **16** Anal neo-sphincter formation with Graciloplasty of
an old perineal injury
- **18** Noteworthy Anaesthetic Management of BK Amputation
- **20** RIRS: A Boon for The Ectopic Kidney Calculi Patients
- **21** Wernicke's Aphasia as the primary presenting feature in a young stroke female with
anti-phospholipid syndrome – The first ever case report from India



Giant Renal Mass Resection: A Complex Surgical Case Report

Medicover Hospitals - Madhapur

Introduction:

Renal masses are a complex clinical entity requiring careful evaluation and management. We present a case of a giant renal mass in a 58-year-old male patient from Sudan who presented with painless hematuria. Through a multidisciplinary approach, including meticulous surgical planning and execution, we successfully resected the renal mass arising from the upper pole of the right kidney. This case report aims to discuss the diagnostic process, and surgical technique employed, and emphasize the importance of comprehensive care in achieving optimal outcomes for complex renal masses.

Case Presentation:

A 58-year-old male patient presented with a two-month history of painless haematuria associated with clots. The patient's evaluation revealed a 17x12x13 cm mass originating from the upper pole of the right kidney, as identified on a CT urogram. Importantly, the mass did not involve the renal vein. The patient had a known history of hypertension and was on antihypertensive medications. Laboratory investigations revealed normal hemoglobin levels (12.7 g/dL), a total leukocyte count of 8400 cells/mm³, serum creatinine of 1.06 mg/dL, and blood urea of 28 mg/dL. Cardiology and Anaesthetists evaluations confirmed the patient's fitness for surgery. Right Radical Nephrectomy was scheduled for July 11th 2023.

Procedure:

Informed consent was obtained from the patient after a detailed discussion of the indications, alternatives, benefits, and risks associated with the procedure. The patient was positioned supine on the operating room table and secured with a safety strap. Pneumatic compression devices were placed on the lower extremities to prevent deep vein thrombosis. After administering intravenous antibiotics and general endotracheal anesthesia, a 16Fr urethral catheter was inserted into the bladder and connected to a drainage bag.

The surgical approach involved a subcostal incision. The incision was deepened using electrocautery, and a generous paranephric space was created by carefully sweeping the peritoneum medially and the retroperitoneal connective tissue superiorly and inferiorly. To optimize exposure, a self-retaining Thompson retractor was appropriately positioned with padding on each retractor blade. The parietal peritoneum was incised on the white line of Toldt, and the colon was reflected medially. Careful mobilization of the hepatic flexure and duodenum allowed for the superior and medial freeing of the kidney.

Sharp and blunt dissection was employed to separate the retroperitoneal fascia overlying the renal vessels, revealing the underlying renal vein. The renal vein was meticulously dissected, mobilized, and encircled with a vessel loop. The gonadal vein was doubly ligated with 3-0 silk ties and divided. With gentle retraction on the renal vein, the main renal artery was identified and dissected for a distance of 2 cm. It was doubly ligated with 2-0 silk and a 3-0 silk suture ligature, and sharply divided. The renal vein was similarly ligated and divided, and the vessel loop was removed. Mobilization of Gerota's fascia was achieved through a combination of sharp and blunt dissection, ensuring meticulous hemostasis with electrocautery. Attention was then directed to the cranial attachments with the adrenal gland, which were carefully divided using Liga Sure, completely freeing the adrenal gland from the superior pole of the kidney. Inferiorly, the ureter was ligated with chromic ties and divided. Once the specimen was completely freed, it was sent to the pathology department for evaluation. The retroperitoneum was irrigated with warm sterile water to ensure thorough cleansing, and hemostasis was





carefully reconfirmed. Prior to closure, thorough inspection of the vascular stumps, visceral organs, and pleura was conducted to ensure their integrity. The self-retaining retractor was then removed.

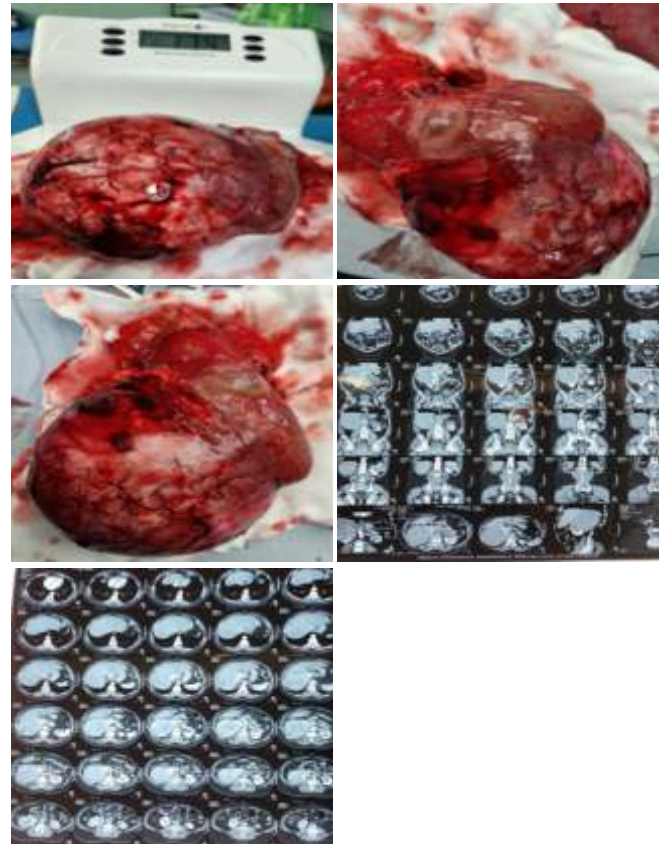
The incision was closed using a running 1-0 loop ethilon to approximate the three muscle layers individually, taking care not to entrap the intercostal neurovascular bundle. Scarpa's fascia was closed with 3-0 vicryl sutures, and the skin was approximated using staplers. A sterile dressing was applied to the incision site. A final count of all instruments, sponges, and needles confirmed accuracy and patient safety. The mass weighed 1.8 kgs.

Outcome and Follow-up:

The patient tolerated the surgical procedure well and was transferred to the recovery room in satisfactory condition. Postoperative care included pain management, close monitoring for potential complications, and appropriate supportive measures. The patient's progress was closely monitored, and follow-up examinations and imaging were scheduled to evaluate his recovery and long-term outcomes. The histopathological evaluation of the resected specimen would provide definitive diagnosis and guide further management decisions.

Conclusion:

We presented a case of successful surgical resection of a giant renal mass in a patient with painless hematuria. The multidisciplinary approach, meticulous surgical planning, and precise execution contributed to the favourable outcome. This case report underscores the importance of comprehensive care involving accurate diagnosis, preoperative evaluation, surgical expertise, and postoperative management to achieve successful outcomes in complex renal masses. Further research, including long-term follow-up and prospective studies, is warranted to assess the patient's oncological and functional outcomes and refine management strategies for similar cases.



Contributors



Dr. Ravi Kumar A V

MBBS, MS, DNB(Urology)
Senior Consultant Urologist and Andrologist



Dr. G. Madhusudhan Reddy

MBBS(OSM), MS(PGIMER), Mch(NIMS)
Consultant Urology and Renal
Transplant Surgeon Andrology





Case Report of a Rare Cause of Reactive Arthritis: Leptospirosis

Medicover Hospitals - Chandanagar

Introduction:

Leptospirosis is a zoonotic disease caused by a spirochetal bacteria of the genus *Leptospira* affecting virtually all mammals. Humans usually acquire leptospirosis through direct contact with the urine of infected animals or a urine-contaminated environment. Human-to-human transmission occurs only very rarely. Leptospirosis may present with a wide variety of clinical manifestations, from a mild illness that may progress to a serious and sometimes fatal disease. Its symptoms may mimic many diseases making the diagnosis difficult and delayed.

In humans, Leptospirosis can cause a wide range of symptoms, including high fever, headache, chills, muscle aches, vomiting, jaundice, red eyes, abdominal pain, diarrhoea, and rash. We present a case which had an unusual presentation.

Case Report:

A 40-year old male presented to the ER with complaints of high-grade fever, acute confusion, yellowish discolouration of eyes and right hip pain for 2 days. The patient had been experiencing occasional right hip pain, limp and fever for the last 7 days. An MRI pelvis was done outside, revealing right hip infective synovitis? Septic arthritis and referred to our centre for further management.

The patient is a known diabetic with uncontrolled sugars and no other comorbidities.

On admission, the patient had altered sensorium, not oriented to time, place and person. The Patient was icteric and had a high-grade fever of 103 F, PR- 120/min, and tachypnoea (28-30/min). He was admitted to ICU and supportive treatment was initiated.

On local examination of the Right hip, the anterior joint line was tender with mild effusion and a painful range of movements. Local rise of temperature could not be appreciated. (Clinical findings were limited due to altered sensorium and high-grade fever).

Although high fever, hip joint pain, and features of sepsis supported the radiological diagnosis of septic arthritis of

the hip joint, local examination of the hip joint was not quite convincing.

Also, it is quite unusual for a young male to develop septic arthritis spontaneously and associated jaundice could not be explained. US-guided hip aspiration of synovial fluid was done.

Around 5ml of yellowish, mildly turbid, non-purulent fluid aspirated and sent for analysis. Analysis was negative for gram stain, AFB stain, making the diagnosis of septic arthritis unlikely. While awaiting cultures, further evaluation was done.

The blood investigations revealed TLC- 32,200, ESR- 35mm, CRP-310, LFT- total bilirubin 11.5 (direct-2.9) ALP- 420, GGT- 113. SGOT/SGPT- WNL. The viral screen for hepatitis A-E was negative.

A provisional diagnosis of reactive synovitis of the hip joint secondary to systemic infection was made and further investigations were sent to look for the primary cause. Medical Gastroenterologist's opinion was taken.

Blood was sent for culture, and fever profile (dengue/ malaria/ widal/ leptospira/ scrub typhus). The patient was started on antipyretic, broad-spectrum antibiotics empirically awaiting fluid analysis and blood reports. The synovial fluid culture showed no bacterial growth after 48hrs and Genexpert was negative. CECT abdomen and pelvis was done to rule out any other source of sepsis.

Leptospira IgM came out to be positive which explained his current condition. On further probing, the patient gave a history of travel to his village and possible contact with cattle. Hence, a diagnosis of reactive arthritis secondary to Leptospirosis was made. The patient was then started on oral doxycycline 100mg twice daily with supportive care. Gradually, the patient started

improving clinically which was evident with fewer fever spikes, decreased confusion, declining trend of ESR, CRP and TLC

The patient was afebrile for >48hrs and the swelling and pain of the right hip had declined. But to our surprise, the patient started developing pain and swelling in the knee





joint, which resolved in 2-3 days. Following treatment with Doxycycline, there was a significant clinical improvement with no fever, the effusion of the knee and hip subsided and the mental state improved. Blood sugars were optimized seeking medical opinion. The patient was discharged under satisfactory condition. There are only a few case reports similar to our case in the literature.

Leptospirosis usually causes hepatic and renal impairment but there was no renal involvement in our case.

Discussion:

The incubation period of the disease is 1–2 weeks but ranges from 1 day to 30 days. Leptospirosis classically manifests as a biphasic illness. The first phase of the disease (septicaemia phase) lasts for about 3–10 days duration and coincides with leptospiremia. This phase is followed by a brief afebrile period of variable duration that, in turn, is followed by the immune phase of illness.

The liver and kidneys are commonly affected. Both organ derangements are reversible. Unfortunately, the distinction between the first and second phases is not always clear; milder cases do not always include the second phase, and severe cases may be monophasic and fulminant.

Immunological manifestation is rare and includes antiphospholipid syndrome and reactive arthritis. Such manifestations are likely to be the result of an immunological cross-reactivity. Antibodies generated in response to Leptospiral infection may cross-react with host antigens and could lead to an inflammatory response. Reactive arthritis refers to an infection-induced systemic illness and is characterized by an aseptic inflammatory joint involvement occurring in a genetically predisposed patient with a bacterial infection localized in a distant organ/system involving the musculoskeletal, ophthalmologic, dermatologic, cardiovascular, and genitourinary systems.

Conclusion:

Reactive arthritis is thus a rare manifestation of leptospirosis. The possibility of leptospirosis should be borne in mind when evaluating patients with reactive arthritis and the propensity of various organisms to produce such a syndrome must be speculated further. A

high degree of clinical suspicion is necessary, particularly in endemic areas. Physicians should be aware of the possibility of reactive arthritis due to leptospirosis, as the disease presents with unusual features.

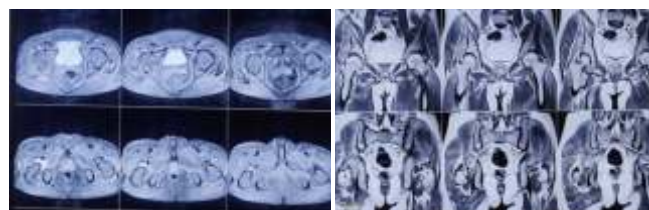


Fig.1 and 2. MRI pelvis - Rt hip joint showing mild effusion with smoothly enhancing and thickened synovium. Rt acetabulum shows patchy hyper intensities on STIR, hypo on T1W1 with post-contrast enhancement. Surrounding muscle oedema noted



Fig 3. Synovial Fluid Aspirate from hip joint - yellowish, mildly turbid, non-purulent.

Contributors



Dr. Shashivardhan

MBBS, MRCS(U.K)
MS(ortho)- NIMS
Fellowship in arthroplasty and Trauma(U.K)
Consultant Orthopaedic and Joint Replacement Surgeon



Dr. Raju Sikilammetla

MBBS, FCCS, CTCCM, IDCCM
Consultant Intensivist



Dr. Dheeraj Kumar Anupa

MBBS, MD, DrNB
Consultant Medical Gastroenterologist ,
Hepatologist and Therapeutic endoscopist





Eclampsia, Peripartum Cardiomyopathy with Reversible Encephalopathy Syndrome

Medicover Hospitals - Karimnagar

Introduction:

Eclampsia, which is considered a complication of severe preeclampsia, is commonly defined as the new onset of grand mal seizure activity and/or unexplained coma during pregnancy or postpartum in a woman with signs or symptoms of Preeclampsia.

Case presentation:

A 22yrs old female, PRIMI, with 34weeks of gestational age with Eclampsia and Type-I DM (on Insulin), presented to ER in the early morning at 4.35 am with C/O of 15 episodes of seizures since (1.00 am) morning, initially evaluated at a local hospital and referred to Medicover hospitals Karimnagar after giving a loading dose of Mgso4 and antihypertensive drugs.

On Examination in ER patient was unconscious with tachycardia (HR 135/m), Tachypnea (RR 36/m) (hypoxia SPO2 70% @ room air), (BP 130/80 mm of hg), BL crept present, the patient was resuscitated and intubated in ER.

P/: cervix was 4-5cm dilated, cephalic ARM done, Fundal height was 34 weeks, 3-contractions/min lasting 30-40sec, FHS-175bpm (tachycardia). The patient was delivered in ER with assisted forceps delivery after the delivery baby was resuscitated in ER by the Pediatrician and shifted to NICU.

A 2D echo was done in view of persistent tachycardia & pink frothy ET secretion. 2D echo showing severe LV dysfunction.

EF=30%, global hypokinesia S/O Peripartum Cardiomyopathy. The patient was managed with Mechanical ventilation, antibiotics, insulin, oxytocin, anti-epileptics, diuretics, Mgso4 infusion and other supportive medication. After stopping sedation, the sensorium was not regained completely eye-opening was present, but not obeying commands, after 8 hours MRI brain was done and showed B/L T2/flair hyperintensities, T1 hypo intensities in B/L front parietal and left occipital lobes, No restricted diffusion on DWI/ADC images. This features s/o: Reversible Encephalopathy Syndrome. After 24 hours, the patient's sensorium improved. Later extubated and shifted to the room side. Both Baby and mother were discharged in stable condition.

Final Diagnosis

- Eclampsia
- Peripartum Cardiomyopathy
- Reversible Encephalopathy Syndrome
- Type-I Diabetes

Conclusion:

The only definitive treatment of Eclampsia is the delivery of the fetus. However, the mother must be stable before delivery with prevention & control of seizures, control of BP, hypoxia corrected and a decision regarding timely delivery.

Contributors



Dr. Prathista Rao M

MBBS, DNB
Consultant Obstetrics & Gynecology



Dr. Upender Reddy Gutha

MBBS, MD, FNB
Consultant Critical Care



Dr. Chandiri Anvesh Reddy

M.B.B.S , MD Radiodiagnosis
Consultant Radiologist





Minimally Invasive Mitral Valve Replacement In A Peripheral Setting

Medicover Hospitals - Nizamabad

Introduction:

Rheumatic valve disease is the most common heart disease in India and it primarily affects the mitral valve. Rheumatic fever increases valve thickness and contracture, making valvuloplasty more difficult than replacement. Traditional mitral valve surgery via a median sternotomy is safe and effective, but it results in a high degree of trauma and a long incision. In the last 2 decades, a minimally invasive technique has been used widely in cardiac surgery. Its prominent advantage in post-surgery recovery and the small incision required makes patients prefer it over a traditional incision.

Traditional mitral valve replacement includes a median sternotomy, followed by successively opening the pericardium, the wall of the right atrium, and the atrial septum to the left atrium, which requires good visibility of the operation, and then proceeding with the valve replacement. It has been shown to have reliable efficacy and safety after decades of use. Because of the large number of incisions and associated trauma, there are many complications, including a high amount of drainage, more blood transfusions and wound infections after the operation, a poor sternal joint, and an incision scar on the thorax. Because some patients are unwilling to undergo surgery, their treatments are delayed. In recent years, the rapid development of MI surgery has resulted in this technique becoming more popular. MI surgery is more easily accepted by patients because of the small incision, minimal trauma and quick recovery. MI surgeries include MIMVR, valve replacement via thoracoscopy, robot-assisted valve replacement, valve replacement through a right-side small incision via thoracoscopy, and other procedures. Valve replacement through a small incision in the right side of the chest via thoracoscopy is widely used because of the surgical approach and equipment costs.

Case Presentation:

A 30 yr old male presented to our hospital with complaints of SOB on exertion and palpitations since last 6 months. On evaluation, he was diagnosed to have Severe Mitral stenosis requiring Mitral Valve replacement.

After a thorough evaluation and workup, we planned for Minimal invasive (Right Antero lateral thoracotomy) instead of conventional Mitral valve replacement (through sternotomy)

After Induction, a Double lumen Endotracheal tube is inserted and right lung is isolated for better visualization of Mediastinal structures.

The patient was placed in a supine position with a slight elevation of Right hemithorax. A small incision is given in the right 5th intercostal space below the nipple, mediastinum is entered and anatomy studied.

A Separate incision is given in the Right groin and the femoral artery is exposed and looped.

Heparin was administered, and SC and IVC cannulation was done with a standard Venous cannula.

Femoral Artery cannulation was done with a long Femoral arterial cannula and went on Cardiopulmonary bypass.

Aorta was cannulated with Long cardioplegia cannulae.

Specially designed Chitwood clamp used for Aortic cross-clamp and Heart arrested with antegrade del Nido cardioplegia.

Left atrium opened and mitral valve was exposed. Valve excised in total with preservation of chordae and replaced with 29mm Mechanical bi-leaflet valve using interrupted multiple Ethibond sutures.

Left atrium closed with 3-0 prolene. Cross clamp released and rhythm restored. Decannulation done and wound was closed in layers.

Complete procedure was uneventful. Patient was shifted to ICU with stable hemodynamics and extubated after 4 hrs.

Drains were removed on pod-2 and patient was discharged on POD-3 in good general condition.





MEDICOVER
HOSPITALS

Conclusion:

The Advantages of MICS include:

- Small scar - Early recovery and early resumption to regular activity/ work - Less bleeding and need of blood transfusions.
- Minimal pain



Contributors



Dr. Karthik Vallala

DNB-CTVS
Consultant Cardiothoracic Surgeon



Dr. Vanu Aleti

MBBS, DA, DNB, PDFC
Consultant Cardiac Anesthesia



Dr. Avinash Dal

MBBS, MS (General Surgery),
M.ch (CTVS)
Chief Cardiothoracic & Vascular Surgeon





A Case Report on Cervical Rib

Introduction:

Cervical ribs are supernumerary ribs arising from mostly the 7th cervical vertebrae believed to be resulting from mutation of HOX genes. The incidence of cervical ribs in the general population is 0.2-1.0%, presenting as a complete or incompletely fused bone. Cervical ribs are usually asymptomatic.

The cervical rib is the development of a transverse process of the 7th cervical vertebra as a fibrous band, extending up to the 1st rib. This fibrous band has a separate center of ossification. It lies below the brachial plexus and subclavian vessels and exerts pressure on them by movements of the upper limb. Symptoms are usually delayed until adolescence because the pressure effect by the rib is not felt until the lowering of the shoulder girdle, which occurs by that age.

Symptoms are more common in people with long necks and sloping shoulders than in those of square build. The rib as a rule is not always palpable and the larger it is the less commonly it produces nervous symptoms.

Sensory loss is rare and if occurs, it is in the distribution of ulnar nerve. Palm is usually worse at the end of the day and symptoms may relieve on overhead abduction of the arm. Vascular symptoms are not as common as nervous symptoms. They are due to compression of the Subclavian artery between the clavicle and cervical rib.

Case Presentation:

An 18-year-old female, student, complained of pain in the left neck region since 3 months associated with left-sided neck swelling, tingling sensation and pain over inner aspect of left upper limb associated weakness of left upper limb on exertion. The swelling of the neck was single, immobile, hard in consistency, smooth surface associated with pain. She has pain and tingling sensation over the inner aspect of left upper limb which is acute on onset, intermittent, dull, non-radiating and exacerbated on activity. Adson's test was positive. Elevated Arm Stress Test was negative.

Intra operatively the cervical rib was seen like an inverted wish bone, articulating with the transverse process of 7th cervical vertebra behind and with an

Medicover Hospitals - Vizianagaram

upward projection of bone from the first rib in front. Subclavian artery is free from any compression. The rib was resected along with the periosteum to prevent any reformation of bone. Post operatively patient had suffered with severe pain at the operative site and numbness of left upper limb for the first two days. Drain was removed on 3rd postoperative day. From the third postoperative day pain and numbness decreased gradually and the patient had recovered well within 7 days. Power was good by 14th postoperative day and spine movements improved. Sutures were removed by 14th postoperative day. She became symptom free at last visit and was able to do routine daily activities without any discomfort.



MRI Bone Window 3d Image



Pre-Operative Chest X-Ray



Intra Operative Image



Post Operative Chest X-Ray





Discussion:

The symptoms associated with a cervical rib must be distinguished from:

1. Ulnar neuritis, in which there is no shoulder pain, no thenar flattening, and no relief on abducting the arm.
2. Herniated cervical disc producing radiculitis. This usually appears at a later age. X-ray may show a narrowed disc space. The pain is intense in the shoulder region.
3. Raynaud's disease.
4. Syringomyelia.
5. Writer's cramp, a hysterical manifestation with no clear clinical syndrome.

At first, it was thought that the circulatory changes were caused by stretching or kinking of the subclavian artery over the cervical rib or by thrombosis within the artery, but Todd advanced a theory of the nervous origin of vascular changes in the hands. He showed anatomically that the lowest trunk of plexus was usually in closer apposition to the first thoracic rib or the cervical rib than the subclavian artery. He suggested that the changes in the arteries were trophic in nature and due to pressure, causing paralysis of the sympathetic fibres which enter the arm in the lowest trunk of the brachial plexus. These fibers are distributed to the peripheral vessels, and irritation of them induces spasms of the arterial wall. The vasa vasorum and eventually such changes in the health of the vessel wall as lead to thrombosis and occlusion. He considered that the artery was too elastic a structure to be damaged by stretching over a cervical rib..

Conclusion:

A case of cervical rib is described in which main group of symptoms associated with this condition was shown, viz., sensory, motor. The rib was unusual in that it was complete and had 2 articulations - one with the 7th cervical vertebra and the other with a projection of bone coming up from the first rib. Following the removal of the rib, there was a marked relief of symptoms. A brief review is given of the various theories about the symptoms associated with cervical ribs. So the sensory and motor changes are undoubtedly due to pressure effects on the brachial plexus as it is nipped between the clavicle and the rib.

Contributors



Dr. K. Tirumala Prasad

M.S., FAIS, FIAGES, ELSA
HOD & Chief
Consultant General and Laparoscopic Surgeon



Dr. K. Murali Krishna

MS, M.Ch
Chief Consultant Brain & Spine Surgeon



Dr. G. Vasubabu

MBBS, M.S(Gen.Surgery) , M.Ch (CTVS).
Consultant Cardio Thoracic & Vascular Surgery



Dr. M. Chanukya

(DNB JR, GS)





Colloid Cyst Of IIIrd Ventricle

Medicover Hospitals - Srikakulam

Introduction:

The third ventricle's benign epithelial-lined cysts, known as "colloid cysts", have distinct imaging characteristics. Acute and deep hydrocephalus can occasionally develop, despite the fact that it is usually asymptomatic. Most colloid cysts are currently asymptomatic and discovered by chance during imaging. Obstructive hydrocephalus is the most frequent problem that a colloid cyst causes when it does create problems. Colloid cysts have additional speculated origins because they have also been discovered in the cerebellum, frontal lobe, and pontomesencephalon. Other causes include lingering respiratory epithelium, an ependymal cyst from the diencephalon, and neuroepithelial invagination of the lateral ventricle, which results in the formation of a cyst. The appropriate therapy and treatment will vary depending on whether the colloidal cyst is symptomatic or discovered by chance.

Case Presentation:

This 34-year female with no known co-morbidities presented with complaints of CSF rhinorrhea associated with seizures over since last five months, so all necessary investigations were done like CECT brain & post MRI scan brain showed well-defined altered intensity lesions involving the anterior wall of IIIrd ventricle indenting the septum pellucidum & bilateral foramen of Munro. Post-evaluation was posted for colloid cyst excision.

Discussion:

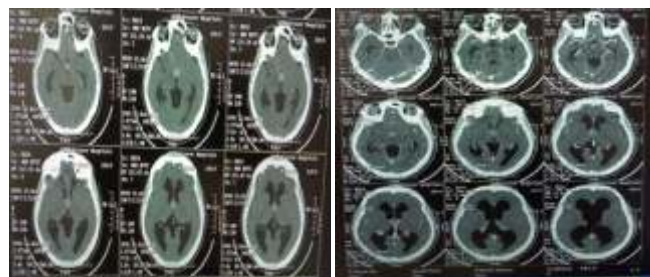
The patient underwent transcortical colloid cyst excision through mini craniotomy at the right Kocher's point under microscopic assistance, EVD placement was done.

Postoperatively condition was uneventful. So EVD was removed after two days, antiepileptic dosage decreased, and CSF rhinorrhea subsided in view of the case presentation of CSF rhinorrhea colloid cyst excision completely resolved the problem.

The patient was in regular follow-up for six months with no complications, and the condition was completely resolved, and antiepileptics were tapered with accordingly.

Conclusion:

Colloid cyst IIIrd ventricle with a classic presentation of CSF rhinorrhea is rare. Some colloid cysts can be observed without problems for years or even decades. Others may develop gradually or result in subacute or acute hydrocephalus. The prognosis is good with complete surgical resection, and colloid cysts seldom return following complete resection. Colloid cysts have been associated with a few rare incidences of rapid mortality, typically attributed to acute obstructive hydrocephalus.



Contributor



Dr. P. Muralidhara Rao

MS (General Surgery), MCH (Neurosurgery)
Consultant Neurosurgeon





HELLP Syndrome

Introduction:

A 24-year-old female presented to the ER, referred from a peripheral hospital with altered sensorium and inotropic support. She was admitted and fully investigated.

A detailed history of the patient revealed the following facts:

Her obstetric history was G2P2L1 at 37 weeks of gestation with a previous Lower section cesarean section. She had initial complaints of loose stools, fever and headache for a duration of 2 days along with anasarca. She was taken up for Emergency Caesarean section at a peripheral hospital and delivered a stillborn baby. During the caesarean section she had an episode of seizure followed by altered sensorium and had to be temporarily intubated on the operating table itself.

Case Presentation:

At the time of admission at Medicover hospital, Kakinada, she presented with altered sensorium and was on inotropic support. Her blood investigations revealed deranged liver function parameters, renal function parameters, anemia, elevated blood counts and elevated procalcitonin levels.

- LDH- 2863 IU/L
- Hb- 6.8mg/dl
- Platelet count- 55,000/ml
- WBC count- 30,000/ml
- Serum Creatinine- 1.9 mg/dl
- B. Urea- 65mg/dl
- Serum Magnesium- 5mg/dl
- TSH- 12.4
- Serum Procalcitonin- 92.50 ng/ml
- SGPT- 331 U/L
- SGOT- 680 U/L
- Total Bilirubin- 2.47 mg/dl

Medicover Hospitals - Kakinada

CT Brain showed

- Cerebral Hemispheres: The cerebral grey and white matter appear normal. No focal lesion is seen in the cerebral parenchyma.
- Basal Ganglia and Thalami: Acute hemorrhage measuring approx. 20.7 x 12 x 30 mm (TRAN x AP x CC) seen along the anterior limb of right internal capsule and corona radiata. Large acute IVH seen involving all the 4 ventricles, possibly extended from the above-described internal capsular bleed. Minimal SAH in the ambient and interpeduncular cisterns.

Discussion:

The differential diagnosis based on the clinical presentations and investigations were

- Preeclampsia complicated pregnancy/HELLP
- Acute fatty liver of pregnancy
- Thrombotic thrombocytopenic purpura/HUS
- Septic Acute tubular necrosis

The patient started rapidly deteriorating towards renal failure and was initiated on hemodialysis along with FFP & PRBC transfusion. The patient's condition further deteriorated with worsening CBP parameters towards septic encephalopathy.





Conclusion:

The patient was on mechanical ventilatory support with endotracheal intubation for 7 days followed by tracheostomy ventilatory support for 7 days. She was treated with hemodialysis, antibiotics, antivirals, antifungals, medication for hyper ammonia and other supportive management.

The total length of her stay in our hospital was for 30 days and the patient was hemodynamically stable at the time of discharge with final diagnosis being HELLP syndrome (haemolysis, elevated liver enzymes, and low platelet count).

Contributors



Dr. B Laxmi Praveena

MBBS, MS OBG, DGO
Senior Consultant Obstetrics & Gynecology



Dr. Anil Kumar Ch

MBBS, MD Paediatrics, DM Nephrology
Consultant Nephrologist



Dr. Rohit Lakkapragada

DrNB Neurology
Consultant Neurologist



Dr. Govinda Reddy Karri

MBBS, DNB, EDIR, DIP ICRI, MNAMS
Consultant Radiologist



Dr. Jagadeeswara Rao Amballa

MBBS, MD, IDCCM
Consultant Critical Care





Fishbone Removal with Hemoclip Placement

Medicover Hospitals - Kurnool

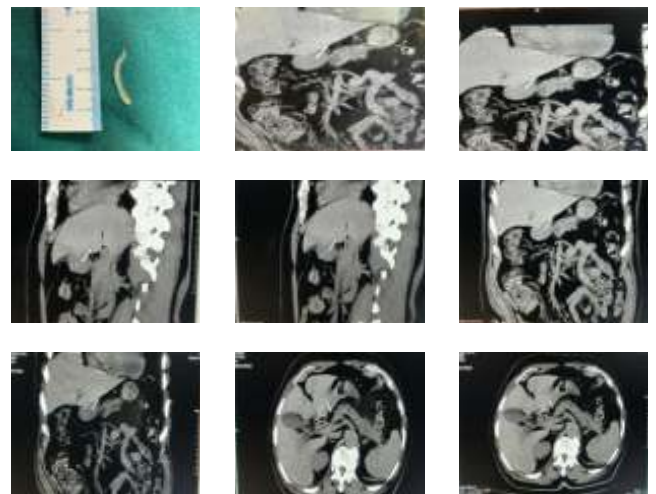
Introduction:

Fishbone removal with hemoclip placement is a medical procedure to extract fishbones stuck in the gastrointestinal tract. Using an endoscope, a flexible tube with a camera, the doctor locates and removes the fishbone. If there's any tissue injury, a hemoclip is placed to promote healing and prevent bleeding. Prompt medical attention is vital to avoid complications or further harm. Patients may receive pain relief and dietary instructions post-procedure. Endoscopy allows for precise intervention, ensuring safe and effective fishbone removal with minimal discomfort for the patient.

Case Report:

An 85-year-old geriatric male patient presented to Gastro OPD with complaints of epigastric discomfort with no history of Malena, weight loss, fever, vomiting, or loose stools. On examination, the patient was conscious, coherent, and afebrile, with a pulse rate of 80 beats per minute and a blood pressure of 130/80. On the per-abdominal examination, there was no tenderness and no organomegaly. The patient was advised to undergo routine examinations like CBP, serum electrolytes, and RFT, which are within normal limits. The patient was further subjected to ultrasonography, which was normal. The patient was advised to undergo an upper GI endoscopy, which showed a fish bone piercing the stomach wall at the antrum, which was moving with peristalsis. The patient was advised to undergo a CT abdomen to determine the length of the fishbone and any organ damage due to the fishbone. CT abdomen revealed fish bone piercing the stomach wall extending to the left lobe of the liver. There was no injury to the surrounding organs and vessels. The patient was advised to undergo fishbone removal by endoscopy. After a pre-anesthesia checkup with the patient, the patient was taken up for fishbone removal by endoscopy. Fishbone was removed with rat tooth forceps, in toto, and hemoclips were placed. Hemoclips were placed at the site of fish bone removal to prevent any leak of gastric content into the peritoneum. The post-procedure was

uneventful and without any complications. A repeat CT abdomen was done on the next day, which was normal, and the patient recovered without any complications and was discharged in healthy conditions.



Conclusion:

After thorough evaluations, fishbone removal with hemoclip placement was successfully carried out using endoscopy. Hemo clips were strategically placed to prevent gastric content leakage into the peritoneum. Post-procedure, a repeat CT abdomen confirmed no organ damage, and the patient recovered without complications. Timely and comprehensive medical intervention ensured a positive outcome, leading to the patient's discharge in a healthy condition. This case highlights the importance of prompt diagnosis and appropriate endoscopic management in fishbone-related gastrointestinal incidents.

Contributor



Dr. P. Abdul Samad

MBBS MD (General Medicine)
DM (Gastroenterology)
Consultant Gastroenterologist





Impacted Foreign Body in the left Main Bronchus

Medicover Hospitals - Nellore

Introduction:

Foreign body aspiration (FBA) is more common in children than in adults. Hence, it is rarely considered in adults unless the patient gives a clear history of aspiration. Depending on the composition of the foreign body and duration of retention in the tracheobronchial tree, inflammatory reactions in the tissue, at the site of retention may vary. Nevertheless, it should be diagnosed early so that sequelae caused by its retention are prevented. We present a case of chicken bone aspiration by a 66-year-old male patient who was diagnosed on computed tomography (CT) thorax when the patient presented as post obstructive collapse and secondary infection.

Case Report

A 66-year-old man presented with a 6-month history of dry cough. He has a history of recurring respiratory illnesses. He was a nonsmoker with no prior exposure to biomass fuel. There was no previous history of wheezing episodes. Everything was normal upon examination. His chest radiograph came out normal. He was advised to get an HRCT thorax. HRCT thorax showed the presence of a foreign body in the left lower lobe bronchus [Figure 1] There with a subsegmental collapse of the Left UL [Figure 2]. The patient was planned for flexible bronchoscopy which showed a deeply impacted foreign body buried under the granulation tissue causing near total occlusion of the left main bronchus and the bronchoscope could not be negotiated beyond the impacted site [Figure 3] by using a Fogarty balloon, and zero-tip foreign body retrieval basket the foreign body – Bone was successfully removed from the left main bronchus. After 7 days, a repeat check bronchoscopy revealed normal lumen patency and minor granulation, [Figure 4] and the bronchoscope could be manoeuvred beyond the affected location. Antibiotics and low-dose steroids were administered to the patient. The patient has noticed symptom relief.

Discussion:

Aspiration of a foreign body develops an acute onset of coughing and choking sensation. However, once these initial feelings have subsided, the incident may be

forgotten. Diagnosis of FBA is challenging if the patient does not recall the past. It may go unnoticed until the patient develops either recurring secondary infection distal to blockage or bronchiectasis or changes in atelectasis, which prompts numerous examinations to determine the underlying cause.

Tissue reaction to a foreign substance varies depending on its retention time and composition. The longer it is retained, the more granulation and impaction there will be in the surrounding tissue. Foreign bodies made of metal, plastic, and other inert materials will cause less inflammation of the tissue than those of organic nature such as nuts and grains.

If the foreign body is not radiopaque, there may be a delay in diagnosis due to non-visualization of the chest radiograph. When air trapping beyond the occluded segment is suspected, a chest radiograph in the inspiratory and expiratory phases may aid in diagnosis. CT thorax reveals a foreign body as a thick mass within a bronchial lumen. Furthermore, secondary alterations caused by air trappings, such as volume loss, bronchiectasis, and hyper lucency, are highly visible on the CT thorax. According to research by Davies et al., children with FBA on the left side with indications of collapse consolidation on the initial chest radiograph have a higher risk of experiencing long-term problems.

Flexible bronchoscopy is the most commonly utilized initial diagnostic technique for FBA in adults. In most cases, it enables successful removal. Flexible bronchoscopy can also be performed in individuals who are already intubated when they visit. Following the removal of the foreign body during bronchoscopy, a "second look" should always be performed to identify any other foreign bodies, FBA problems, and iatrogenic injuries.





Conclusion:

This case report emphasizes the need of detecting and removing an aspirated foreign body as quickly as possible. If left in the tracheobronchial tree for an extended period of time, post-obstructive consequences such as bronchiectasis and recurrent secondary infection are possible. Because the foreign body in this patient was made of chicken bone, the inflammation at the site of retention must have been less severe, and it was removed using a flexible bronchoscope.

Figure 1



Figure 2



Figure 3



Figure 4



Figure 5



Contributor



Dr. Katamreddy Kowshik Reddy

MBBS, MD (Pulmonary Medicine)
Consultant Clinical & Interventional Pulmonologist
Fellowship Interventional Pulmonology





Anal neo-sphincter formation with Graciloplasty of an old perineal injury

Medicover Hospitals - Aurangabad

Introduction:

Complications that might happen during vaginal delivery include obstetric anal sphincter injury. The majority of women with Obstetric anal sphincter injury have no symptoms, but some of them have the risk of having incontinence as they get older or have more children. These wounds, which are also known as third- and fourth-degree perineal lacerations, affect the anal sphincter complex and, in more serious cases, the anal mucosa. Early detection of these damages is essential to define an immediate therapeutic approach and prevent the emergence of late-onset effects, such as fecal incontinence. The gracilis muscle translocation for anal incontinence is not a unique procedure, but it allows us to treat patients more effectively and enhance Quality of life.

Case Presentation:

A 50-year-old woman came to OPD with complaints of Anal incontinence since 25 years. She had a difficult, unattended home delivery with a 3rd degree of perineal tear. This tear went unnoticed and unrepaired; she has been living with anal incontinence since then. This was affecting her social life and quality of life.

A team consisting of a gynaecologist, general surgeon and plastic surgeon came together, and after detailed history, examination and counseling, a treatment plan, '**Neo sphincter construction with transposition of autologous Gracilis muscle**', was made. The patient has explained the extent of surgery, possible risks and complications, and needed post-op care and precautions.

Thorough bowel preparation was done. The patient was given a spinal with epidural anaesthesia, and a Lithotomy position was given. The Gracilis muscle flap with intact blood and nerve supply was harvested. A tunnel was created by blunt dissection around the anal canal. The muscle was threaded around the anal canal and finally inserted into the ipsilateral ischial tuberosity. Post-operative mobilization, physiotherapy and diet were monitored. The patient was kept pain-free with the epidural infusion. The patient gained complete anal

continence to solids and liquids. The Patient was discharged on day 7. Post Op instructions like avoiding squatting, abduction and regular exercise to strengthen the Gracilis muscle were given to the patient.

Discussion:

Anal incontinence (AI) is one of the most psychologically and socially debilitating conditions in an otherwise healthy individual. It can lead to social isolation, loss of self-esteem, self-confidence and depression. AI affects around 11% - 15% of the general population. The most common cause of AI is a physical injury of the anal sphincter during childbirth, followed by iatrogenic injuries during fistulotomy and haemorrhoidectomy, and direct trauma to the perineum after traffic accidents or war injuries.

Patients with limited sphincter defects should undergo overlapping sphincteroplasty, whereas patients with intact sphincters can get sacral nerve stimulation or biofeedback therapy. Only patients with absent, severely damaged, destroyed and unusable anal sphincters are candidates for sphincter substitutions with muscle transposition.

Previously, in 1902, Charles Chetwood used the muscle in close proximity to the anus, Gluteus Maximus, to effectively replace the anal sphincters. But Gluteus is a bulky, fatigue-prone muscle with high donor site morbidity. Long skeletal muscles like the Adductor longus and Sartorius were also used, but the results were unsatisfactory.

Gracilis muscle transposition was first described by Pickrell et al. in 1952. The gracilis is the most superficial adductor of the thigh. As its adjacent muscles take over its function, there is minimal donor site morbidity when used. This superficial muscle has a constant and proximal neurovascular supply, enabling effortless dissection and providing sufficient muscle length to overlap around the anus. Hence, Gracilis is the muscle of choice for this procedure.





Like all skeletal muscles, Gracilis has a preponderance of Type II, fatigue-prone, fast-twitch muscle fibers and is incapable of sustained and prolonged forceful contraction, being its major limitation. Thus, these patients can contract the anus only briefly while consciously concentrating on its contraction.

Like all surgeries, this procedure has some known complications like wound complications, tendon detachment, necrosis of the neo-anus, functional failure and constipation.

Conclusion:

Graciloplasty, done in a patient with accurate diagnosis and case selection, by a skilled team of surgeons, with continuous pain relief and regular physiotherapy, can improve the quality of life in a patient distressed with anal incontinence.

Contributors



Dr. Jankidevi Swaroop Borade

MBBS, MS
Consultant Obstetrician and Gynecologist



Dr. Swaroop Borade

MBBS, MS (General Surgery),
FMAS, FIAGES
Consultant General &
Advance Laparoscopic Surgeon



Dr. Anuradha Yadav

MBBS, DNB (Plastic Surgery)
Consultant Plastic Surgeon



Dr. Sunil Murke

MBBS, MD (Anaesthesia)
Sr. Consultant Anaesthesia





Noteworthy Anaesthetic Management of BK Amputation

Medicover Hospitals - Navi Mumbai

Introduction:

A below-knee amputation (BKA), sometimes known as a below-the-knee amputation, is a transtibial amputation in which the distal tibia, fibula, ankle joint, and associated soft tissue components are removed. Amputation of the lower extremities is a life-saving treatment. In more than 50% of instances, lower limb ischemia, peripheral artery disease, and diabetes are thought to be the primary causes of limb amputations. Diabetes-related issues such as peripheral vascular disease, open wounds, and infection are the main causes of BKA. The second most common reason for lower-extremity amputations is trauma. Amputations below the knee typically have better functional outcomes than amputations above the knee.

Case Report:

A 60-year-old male patient was admitted for left below-knee amputation in view of dry gangrene. The patient was Hypertensive, with Diabetes mellitus, Coronary angioplasty (PTCA) to the Right coronary artery(RCA) and Left anterior descending(LAD) branches, one month ago with Dual Antiplatelets to avoid stent thrombosis. This patient also had Peripheral Vascular Disease with 80% occlusion in the Popliteal artery, 90% in the Anterior Tibial artery and 100% Posterior Tibial artery. He developed gangrene over his left foot involving the third toe mainly. He underwent 3rd toe amputation under local anaesthesia one month ago after PTCA. However, gangrene spread to other toes and feet. He also developed Maggots in the left lower limb of the gangrenous foot. This required Below Knee Amputation on an emergency basis. The concerns faced by us (Anesthesiologists) were 1) Continued use of antiplatelets and anticoagulants that contraindicated the use of neuraxial blockade (spinal anesthesia / lumbar/sciatic plexus block), 2) Multiple comorbidities and recent history of Myocardial ischemia and angioplasty will increase complications of General anesthesia and require postoperative ICU and Ventilatory support All routine blood reports were done. Hb -9g%, PT/INR - 13.5/1.1. Rest all reports were normal.

This patient was given Left sided Popliteal block with Left Femoral and Lateral cutaneous nerve block with Ultrasound guidance. 0.5% Bupivacaine and 2% Lignocaine + Adrenaline were used for the block within recommended dosage to prevent Local Anesthetic Toxicity. The onset of action was within 10 minutes, and no sedation or additional anesthesia was required for this case. Vitals were stable throughout the procedure with no significant changes in Heart rate, Blood pressure or Saturation as is expected during anesthesia and surgery. We transfused 1-pint PRBC as blood loss was 200ml with pre-operative Hb-9g% to maintain oxygenation in a recent case of MI, as recommended by cardiologists. As hemodynamics was stable throughout the procedure, the patient was observed in the recovery room for 1 hour and then shifted to the ward (No ICU admission as anticipated). The blocking effect lasted for 15-16 hours. Later, the Patient was given only IV Paracetamol 1 gram TDS for the next 24 hours. No additional analgesia was required.

Discussion:

Lower-extremity amputation is a treatment that saves lives. In more than 50% of instances, lower limb ischemia, peripheral artery disease, and diabetes are thought to be the main causes of limb amputations. The second most common reason for lower-extremity amputations is trauma. There are three main groups of reasons to move forward with a BKA. These include critical situations where saving limbs takes a back seat to treat the underlying cause of necrotizing infections or hemorrhagic injuries. The most important reason against doing a non-urgent BKA is vascular insufficiency at the anticipated amputation location. When a BKA is done to treat an infection or an acute soft tissue injury, a second procedure can be required if the infection was not completely resected or if the distal skin edges continue to demarcate.





MEDICOVER
HOSPITALS

Conclusion:

USG-guided nerve blocks are an effective & innovative method of anesthesia with Maximum Positive results & Minimal complications. They can be successfully used as a sole anesthetic modality or in combination with general anesthesia. Nerve blocks with Ultrasound guidance give almost 100% success in expert hands and improve Patients' outcome, reduces complications, provides excellent pain relief, prevents chronic pain, fastens discharge, Lesser hospital stay and a Content Patient.

Contributors



Dr. Jayashree Venkatesan

MD, DNB Anesthesiology,
PDCC (Regional Anesthesia),
EDRA (European Diploma)
Consultant Anaesthesiologist



Dr. Aishwarya Vishal Bandewar

MBBS MD Anaesthesia
Senior Consultant Anesthesia



Dr. Josna Dhammdeep Humane

MBBS, MD Anaesthesia
Consultant Anaesthesia





RIRS: A Boon for The Ectopic Kidney Calculi Patients

Medicover Hospitals - Sangamner

Introduction:

The metanephrons of the kidney start to originate from the sacral area and ascend cranially to the final position in the retroperitoneum. Whenever the ascent of the kidney is hampered or is halted, it leads to the ectopic kidney. The incidence of ectopic kidney in autopsy series is around 1 in 900 (1). The abnormal location leads to abnormal anatomy and rotation of the kidney in addition to structural and architectural abnormalities. There are also associated renal concentration and filtration abnormalities leading to more stone formation. Stone formation is one of the commonest diseases in these patients. There are various treatment modalities that can be utilised to treat these renal these calculi, e.g. extracorporeal shock wave lithotripsy (ESWL), laparoscopy-assisted percutaneous nephrolithotomy (PCNL), retrograde intra-renal surgery (RIRS) using the flexible ureteroscope, laparoscopic/robotic pyelolithotomy and open surgery. We here describe a case of RIRS for a stone in the pelvis of the ectopic left kidney located on the right side, just below the right kidney.

Case Report:

A 33-year young male came to our outpatient department with complaints of intermittent pain right side of the abdomen for 2-3 months, mild initially but severe for the last 24 hours. His medical history was unremarkable. Physical examination suggested mild tenderness right iliac fossa. Ultrasonography and intravenous pyelography (Fig. 1) suggested an ectopic left kidney located on the right side below the right kidney in the right iliac fossa and not fused or attached to the right kidney with a large 21mm pelvic calculus with mild hydronephrosis. His urine culture came positive, and he was started on antibiotics as per the antibiotic sensitivity. He later underwent retrograde intra-renal surgery where a stone was completely lased and a double J stent was kept at the end of the procedure. Patient was discharged on second post-op day. There were no post-op complications. Repeat sonography and x-ray of the kidney-ureter-bladder showed no residual calculus (Fig. 2). The double J stent was removed after two weeks.

Fig.1



Intravenous Pyelography

Fig.2



Post-op X-Ray KUB

RIRS is a very good option to treat stones in an ectopic kidney. It may require more than one session sometimes, but considering the minimal invasive nature, the bothersome is less. Disposable ureteroscopes have further revolutionised the armamentarium of the urologist, who can now offer a personalised treatment plan for each patient. RIRS is a boon to the urologists as well as the patients.

Contributor



Dr. Sanjay P Dhangar

MBBS, DNB (Gen Surgery), DNB(Urology)
MNAS, FIMAR, FSASS, FAIS, CCIPR (FICCI)
Fellow American College of Surgeons (FACS)
Consultant Urologist





Wernicke's Aphasia as the primary presenting feature in a young stroke female with anti-phospholipid syndrome – The first ever case report from India

Medicover Hospitals - Nashik

Introduction:

AWernicke's Aphasia, also known as receptive aphasia, have trouble understanding spoken and written language. In roughly 95% of right-handed people and 70% of left-handed people, damage to the posterior superior temporal gyrus, a part of the dominant cerebral hemisphere, is what frequently causes it. Wernicke's aphasia patients frequently exhibit fluent speech, but they may also use extended, meaningless sentences, extra words, or even make up their own words.

Case Presentation:

A 29 year old female came with a chief complaint of sudden onset of difficulty in speaking and comprehending words, repetition of irrelevant words and sentences, difficulty in understanding and following orders or commands and also reading and writing and restlessness since 6 hours. There was no history of headache, loss of consciousness, nausea or vomiting, limb weakness or deviation angle of the mouth, vision disturbance or TIA. No history of fever, night sweat, loss of appetite or weight loss. She had no history of hallucinations or abnormal behaviour before and no record of any psychiatric illness.

On examination, there was no pallor, cyanosis, clubbing, pedal oedema, lymphadenopathy or thyroid swelling. Vitals - PR-78/min, B.P - 124/80mm of Hg. CNS Examination- Patient was conscious but irritable and agitated. Her speech was evaluated-Spontaneous speech with good Fluency (Repetitive talks, neologism present) Repetition - impaired, Comprehension - impaired, Naming - impaired, Reading & writing - not cooperative.

Pupils bilateral- 3mm Reactive, fundus- normal, EOM-Full, No ptosis, no facial lag, Other Cranial nerves examination - normal, Motor system: tone -normal, power 5/5 all 4 limbs, DTR'S - 2+, plantar - flexors, Sensory-could not be assessed, no cerebellar signs, no meningeal signs / no neck stiffness, other systemic examination-normal.

There was no significant medical history except the history of spontaneous abortion (First trimester) 2 years

back. Routine blood investigations and 2D Echo were normal. Vit B12 level was significantly low at 80 pg/ml corresponding to her purely vegetarian diet. MRI brain was suggestive of acute infarct in left temporoparietal region involving the inferior branches of the M2 segment of left MCA (Fig 1A&B). However, MRI angiography and venogram were normal.

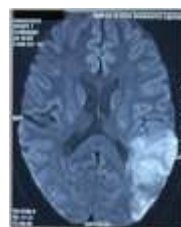


Fig. 1A

Fig. 1A: MRI showing diffusion restriction in inferior division of M2 of left MCA

Fig 1B: ADC sequence confirms acute infarct in same area.

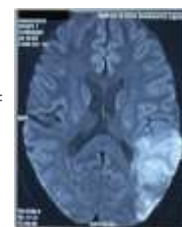


Fig. 1B

Considering the young age of the patient and history of spontaneous abortion, ANA Blot and thrombophilia profile with APLA Ab was sent. Homocysteine levels was found to be >50. As she presented after 6 hours of the onset of symptoms (beyond the window period), thrombolysis was not considered in management. Meanwhile, she was treated conservatively with anti-coagulants and anti-platelets and was given the support of speech therapy. Patient showed improvement and started recognising, understanding and partially obeyed commands. Reading and writing were significantly improved within 3 days of starting treatment. Workup for the previously sent autoimmune disorder revealed a high titre of anti- β 2 glycoprotein I (β 2GPI) IgG (79 U/mL) (Fig. 2) and anti-Cardiolipin (aCL) IgG was negative 1.5 U/mL antibodies, and a low titre of anti- β 2GPI (2.3 U/mL); whereas, antiplatelets antibody, Antinuclear antibody, anti-ds-DNA, Anti-Mitochondrial antibody (AMA), Antineutrophil cytoplasmic antibody (ANCA), Anti-Liver-Kidney Microsomal Antibody (LKM) and Anti-Smooth Muscle Antibody (ASMA) were negative. Lupus Anticoagulant (LAC) was also found to be positive (Fig. 3). The ultrasound abdomen exam was normal.





Fig.2:

Investigation	Observed Value	Unit	Biological Reference Interval
Thrombophilia Profile-Maxi™			
Beta-2-Glycoprotein 1 IgG (Serum, Immunoenzymassay)	Positive, 23	Unit	Negative: < 7.0 Positive: > 10.0 Weak Positive: 7.0-10.0 Please note change in Reference range, method and unit

Fig.3:

Investigation	Observed Value	Unit	Biological Reference Interval
DRVV Screen Ratio	1.72	—	0.85-1.20
DRVV CONFIRM (Control plasma)			
DRVV Confirm (Test)	41.2	sec	31.04-40.55
DRVV Confirm Control	35.0	sec	—
DRVV Confirm Ratio	1.18	—	0.89-1.16
Normalized Ratio	1.48	—	<= 1.20
LUPUS ANTICOAGULANT (Control plasma)	PRESENT		Absent

Medical Remark: See Remark - 4. Correlate clinically.

The anticoagulation therapy was carried on with good response and then shifted on to oral anticoagulation therapy.

Conclusion:

On the basis of medical history, clinical and laboratory features and ruling out associated autoimmune diseases, diagnosis of primary antiphospholipid syndrome was made. To the best of our knowledge, this is the first case report of Wernicke's aphasia as the primary and solo presentation in a young stroke patient with anti-phospholipid syndrome.

Contributor



Dr. Vishal Sawale

MBBS, MD Medicine, DM Neurology
Consultant Neurologist & Stroke Specialist



PROUDLY PRESENTING

Medicover Journal of Medicine (MJM)

in association with **Wolter Kluwer** (Publishing Partner)

COMING SOON!!

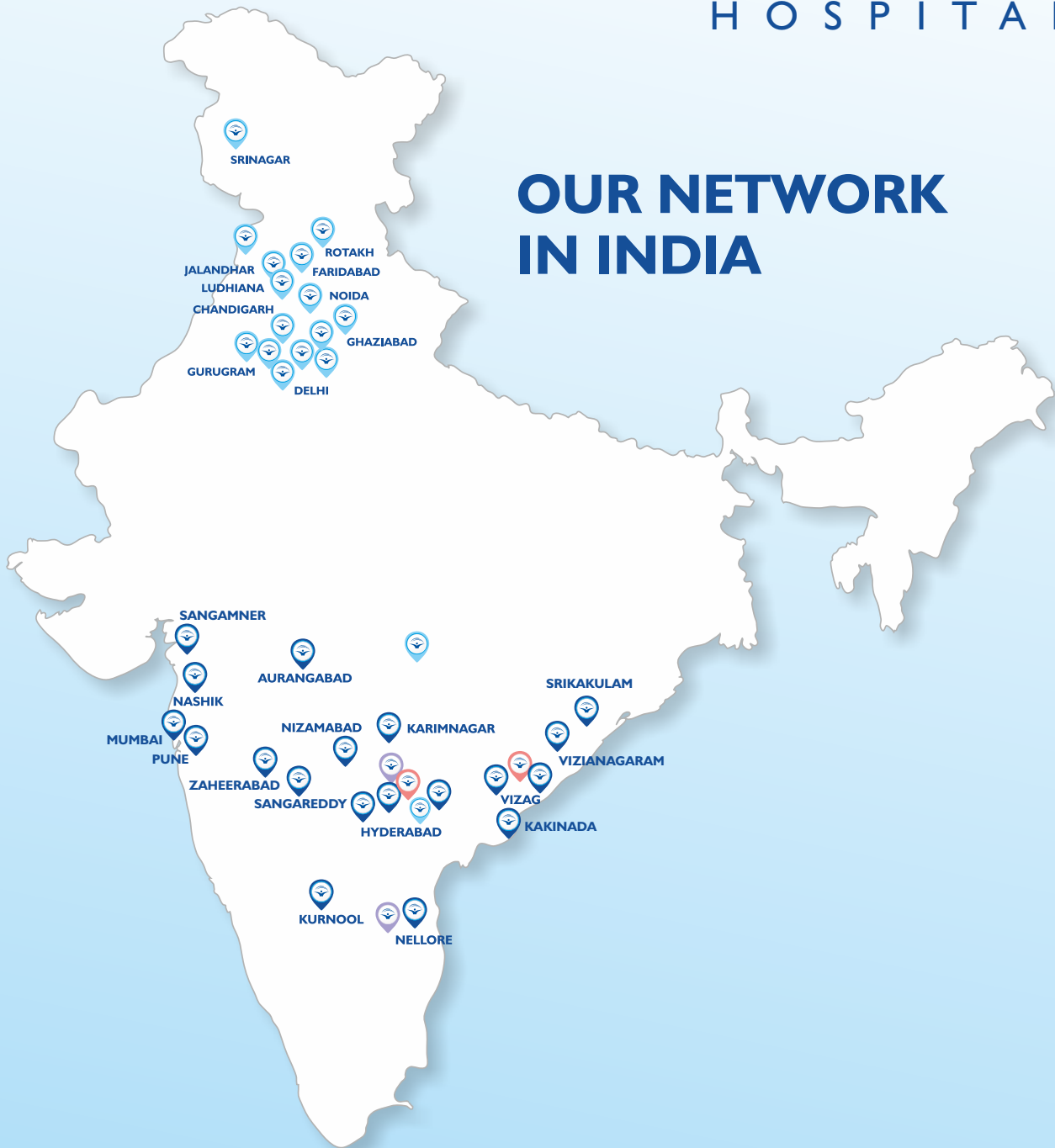


**STAY
TUNED
FOR
THE FIRST
COPY**



MEDICOVER
HOSPITALS

OUR NETWORK IN INDIA



 18

**Multispecialty
Hospitals**

 4

**Cancer
Institutes**

 2

**Women & Child
Hospitals**

5093

Beds

 23

**Fertility
Centers**