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Right Here!!**



EDITORIAL DESK

Dear all readers,
Greetings from Medicover Hospitals



Dr. A. Sharath Reddy

Executive Director
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Medicover 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 Medicover always strive to provide effective, timely, and safe Care to all the Patients who visit our facilities across India. At Medicover, 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
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Sharing knowledge is the key to Community education. Medicover 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 Medicover India . Wishing you all the best to all writers and readers .

INDEX

- **1** A Tale of Tandem Occlusion
- **3** Impella Assited PCI
- **4** Management Of Complete Transverse Vaginal Septum
- **7** A Case Report of Multiple (20) Myomectomies
- **9** Ruptured Sinus Of Valsalva Aneurysm
- **10** Surgical Decision Making In A Patient with Concomitant Cervical & Lumbar Spinal Canal Stenosis
- **12** Iron Deficiency Anemia Presenting as Restless Legs Syndrome
- **13** High-grade Spindle Cell Sarcoma of The Scrotum - A Rare Clinical Entity
- **15** Sphincter Preservation For Rectal Cancers - ISR Technique
- **16** Minimally Invasive Management of An Aortic Ticking Time Bomb TEVAR (Thoracic Endovascular Aortic Repair)
- **18** A Rare Occurence Of Hydatid Cyst Over The Abdominal Wall (Muscular Hydatid)
- **20** Enrofloxacin Poisioning-a Veterinary Floroquinolone Toxicity
- **21** The Baffling Ammonia !!
- **23** Neurogenic Scoliosis with Diastometamyelia
- **25** Idiopathic Epidural Lipomatosis - A Rare Case
- **26** Modified Martius Flap Ventral Onlay Urethroplasty For Recurrent Stricture Urethra
- **28** Angioedema as Initial Presentation of SLE



A Tale of Tandem Occlusion

Medicover Hospitals - Madhapur

Case Report:

A 60 Year male, hypertensive presented with history of sudden onset left sided weakness and right preferential gaze. He was brought to hospital within two hours of onset of symptoms. He was admitted two months back with sudden onset left sided mild weakness and was found to be having right ICA origin stenosis with thrombus insitu causing critical stenosis. Flow distal to the thrombus was complete and intracranial filling was normal hence patient was managed with single antiplatelet and anticoagulation. He recovered completely in one month. Present event happened two months after two months of first stroke and while patient is on Tab Apixaban 5mg twice daily and Tab Clopidogrel 75mg once a day. On examination patient was having right sided preferential gaze, dysarthria, left upper limb 0/5 and left lower limb 2/5 power. NIHSS was 16/42. He was taken for immediate MRI with MR angiogram which showed right ICA occlusion right ICA water shed infarctions and right caudate nucleus early changes of diffusion restriction. As patient has stroke two months and also he was apixaban thrombolysis was differed and immediately taken for mechanical thrombectomy.

Procedural details:

Right CCA shoots showed right ICA occluded from origin. With micro wire right ICA is passed and initial dilatation done with 3mm balloon. Later aspiration catheter was taken into horizontal segment and ICA shoots were taken. ICA shoots revealed terminal ICA complete occlusion with massive thrombus insitu, i.e., tandem occlusion of right ICA and MCA. Aspiration thrombectomy done with penumbra ACE 68 catheter and about 10cm organized red clot retrieved. TICI 3 recanalization achieved and proximal segment of ICA shoots were taken which showed critical right ICA stenosis. Patient was taken for carotid stenting with

40mm*6mm*8mm tapered aculink stent, achieved good recanalization with TICI 3 intracranial flow.

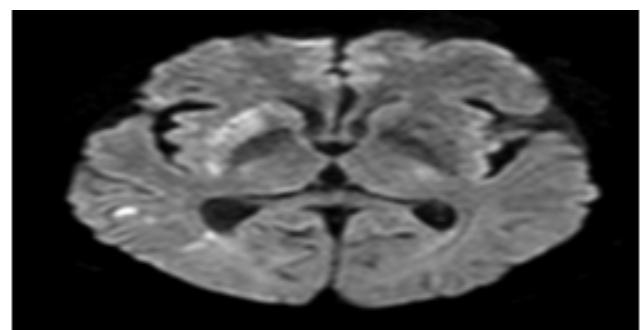


Fig1: Right ICA watershed infarctions and right lentiform nucleus early infarctions present

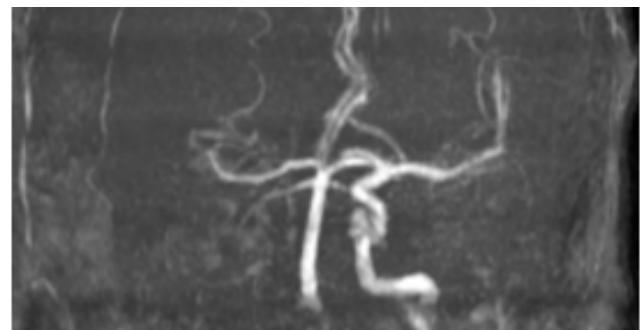


Fig 2 : Right ICA occluded and no intracranial flow.



Fig 3:
CCA shoots showing ICA occlusion from origin (black arrow).



Fig 4: ICA origin dilation done with 3mm balloon





Fig 5 : Right terminal large thrombus with occluded MCA.



Fig 6: TICI 3 recanalization after thrombectomy



Fig 7: Right ICA proximal critical stenosis

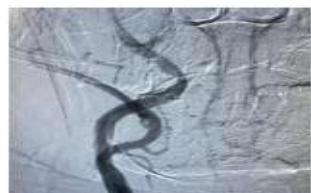


Fig 8: Proximal ICA stenting done with good recanalization



Fig 9 : Nearly 10cms long thrombus retrieved



Fig 10 : One week follow of patient (NIHSS)

The patient recovered near completely after the thrombectomy, and during one week's follow-up, his NIHSS was 1/42.(Left u/l drift present)

Discussion:

Acute stroke due to intracranial large vessel occlusion (LVO) in combination with a concomitant extracranial carotid artery pathology (ie, tandem lesion), such as atherosclerotic stenosis or artery dissection, accounts for about 15% to 30% of all LVO strokes. Tandem lesions can be technically challenging for the neuro interventionalist in terms of the decision for stenting versus percutaneous transluminal angioplasty alone and an extracranial versus intracranial-first approach.

Conclusion:

Treating tandem lesions with the best medical treatment alone, including intravenous thrombolysis (IVT), is associated with poor functional outcomes in up to 80% of patients. Mechanical thrombectomy (MT) is the first-line treatment for intracranial LVO. Data on mechanical thrombectomy first followed by emergency or Extracranial stenting first followed by mechanical thrombectomy is still sparse. In the present case, we have done mechanical thrombectomy followed by stenting of the right ICA will excellent function outcomes.

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Impella Assisted PCI

Medicover Hospitals - Madhapur

Case History:

A 71 years old male K/C/O Type II Diabetes Mellitus, S/P PTCA to LAD, Ramus and Distal RCA (2006 and 2012) with Moderate LV Dysfunction (LVEF- 38%) presented with recurrent chest pain with shortness of breath for which he was hospitalized outside twice in last two weeks. When he presented in out patient department he went into severe perspiration and shortness of breath with few steps. He was shifted to emergency immediately where his systolic pressure found to be dropped to 70 from 110 in OP. 2D ECHO revealed severe MR moderate LV dysfunction and clinical examination of lungs revealed pulmonary edema. He got improved with rest in next 15 minutes with minimal Inotropes support. CAG done outside was reviewed which confirmed patent stent in ostial LAD with 99% lesion in ostial LCX and total occlusion of distal RCA filling retrogradely from left system. Heart team discussion was done regarding CABG + MVR vs Protected PCI followed by mitral clip if MR is persistent. Age and high surgical risk favoured protected PCI followed by mitral clip if needed. Protected PCI with Impella support was done to LM bifurcation and RCA CTO. Laser was used as antegrade gare didn't cross RCA CTO. Final result of LM bifurcation and distal RCA was good both angiographically and imaging wise. Impella removed post procedure after gradual vein off of flow and confirmation of adequate map and good peripheral flow. Next 24 hours his RWMA was responded favourably with gradual increase in LV function coupled with progressive decline in mitral regurgitation. He was discharged in day 4 with no mitral regurgitation and mild LV dysfunction and able to carry out all his activities without any symptoms.



1: Impella placed into LV,
Coronary Angio showing >95%
lesion in ostial LCX



Fig 2:
Post LMCA bifurcation stenting



Fig 3: Dual injection
showing total occlusion of distal RCA

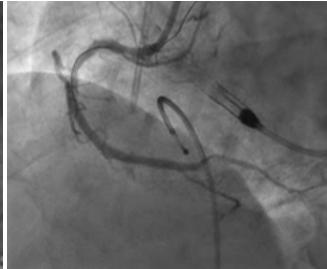


Fig 4: Post CTO PCI to RCA

Discussion:

Treating patients with LV dysfunction and significant mitral regurgitation and complex coronary artery disease like LMCA bifurcation or Chronic total occlusions is like walking a tight rope. Any hemodynamic instability during procedure, for which these patients are vulnerable, is going to interrupt procedure and sometimes it can be fatal. Protected PCI with Impella would prevent hemodynamic fluctuations and gives operator adequate uninterrupted time to achieve better revascularization of coronary revascularization of coronaries which changes outcomes of these patients in long run.

Conclusion:

Protected PCI (Percutaneous Coronary Intervention) with the Impella support helps to temporarily assist the pumping function of the heart. Impella support assists in preserving hemodynamic stability and offers left ventricular unloading during the treatment. This enables more thorough PCI and revascularization. In high-risk PCI, the Impella can provide enough hemodynamic support, potentially reducing morbidity and mortality.

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Management Of Complete Transverse Vaginal Septum

Medicover Woman & Child Hospitals - Hi-tec City

Introduction-

The transverse vaginal septum or vaginal septum is a rare abnormality of the female genital tract with an incidence of 1 in 30,000. This is caused by a defect in the fusion and/or recanalization of the urogenital sinus and Mullerian organs. The transverse vaginal septum can develop anywhere in the vagina, and its most common locations are in the lower part of the vagina, 72% of the septum's are in the lower part of the vagina, 22% in the central region and 6% in the upper part of the vagina. These septa are usually no more than 1 cm thick. These structural obstacles can completely obstruct the vagina and cause haematocolpos associated with cyclic pelvic pain. The diagnosis of a vaginal septum is based on a careful clinical gynaecological examination, especially on an ultrasound scan via the abdomen or transrectal or even transperineal ultrasound and, in more complex cases, an MRI scan. The treatment is surgical and should be carried out as early as possible. The surgical approach will depend on the location, depth, and thickness of the septum and the surgeon's expertise. A minimally invasive procedure, such as laparoscopy, has fewer surgical complications and faster recovery than a laparotomy. Management of TVS requires local excision with end-to-end anastomosis of the vagina and the use of skin grafts if needed.

Case presentation:

A 22-year-old woman married for one year with severe persistent right iliac fossa pain presented to the gynaecology outpatient clinic in our hospital. She disclosed a history of primary amenorrhoea and cyclical

lower abdominal pain on and off. On physical examination, her height was 160 cm, breast development was normal for her age, and other secondary sexual characteristics were normal for her age, on the examination: per abdomen-soft, with no palpable mass. On Pelvic Examination: External genitalia normal. Speculum examination revealed a blind-ending vagina 6cm from the introitus and Could not visualise cervical external os. She had no known medical problems and no family history of genetic abnormalities. Transvaginal ultrasonography revealed a 77x63mm blood-filled cyst present in the posterior vaginal wall. These findings were consistent with haematocolpos. MRI revealed a large cystic lesion in the vaginal cavity with mild haemorrhage, the cyst appears to communicate with the endocervical canal-? Haematocolpos. Based on history, findings, and scan reports, the transverse vaginal septum diagnosis was confirmed.

The patient was admitted and planned for excision of the transverse vaginal septum by double set-up. Examination under anaesthesia revealed a blind-ending vagina with no bulge, and the location of the septum was high and thick, so proceeded with a laparoscopic approach. Intra-operative findings are- uterus normal size, bilateral tubes and ovaries are normal,

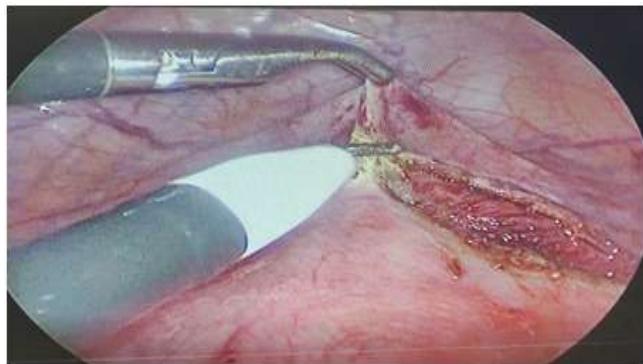




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Procedure:

UV fold opened, bladder pushed down, evidence of vaginal bulge noted, anterior colpotomy done, frank pus drained. Pus sent for HPE and TB-PCR. A transverse vaginal septum was identified, and excision was done laparoscopically with guidance from the vaginal assistant. Complete septum excision and anterior and posterior fornix reconstruction were done, followed by cervical dilatation. After cervical dilatation, hysteroscopy done-no abnormality was detected. A mould was prepared and kept in the vagina. On the second post-operative day, mould was removed, and the patient explained the procedure of vaginal dilatation with dilators after applying estrogen cream and discharged in stable condition. On a follow-up visit after one week, no vaginal stenosis with good vaginal mucosa was noted, and after two months she had normal menstrual cycles.



UV fold incised



Bladder separated



Anterior colpotomy done



Purulent pus in vaginal cavity



Posterior vaginal wall
after draining pus





Septum incised



Anterior colpotomy sutured

Discussion:

One of the main causes of haematocolpos is the transverse vaginal septum. This transverse vaginal septum results from incomplete channeling of the vaginal plate or failure of the paramesonephric ducts to meet the urogenital sinus.

The vaginal septum was first described in 1877. However, they remain rare due to the low frequency of this anomaly. The diagnosis of the transverse vaginal septum is made either pre-puberty or post-puberty. In the post-pubertal period, the presentation will depend on whether the septum is complete or perforated. A complete septum will present with non-specific symptoms like pain in the lower abdomen, pain in the lower back, constipation, or urinary retention associated with primary amenorrhea, while a perforated septum will generally present with dyspareunia and dysmenorrhea. MRI is the gold

standard for diagnosing abnormal anatomy in the vagina. There are various treatments and techniques which are available.

In our case, we noticed a septum in the upper part of the vagina. Through the laparoscopic approach, we drained the collection and identified the septum, followed by complete excision of the septum followed by reconstruction of fornices. Two months after surgery vaginal mucosa was smooth with good vaginal length, and the patient had a normal menstrual cycle.

Conclusion-

The transverse vaginal septum remains a rare anomaly of the female genital tract. Hematocolpos remains the main consequence of these septum's. The management is by surgery while taking into account the risks of postoperative stenosis. The excision of the septum and dilatation of the vagina with serial dilators with estradiol cream prevent stenosis and failure of the operation. The management-surgical approach depends on the location, thickness of the septum and expertise of the surgeon.

Contributor



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A Case Report of Multiple (20) Myomectomies

Medicover Hospitals - Begumpet

Introduction:

Fibroid Uterus, also called Uterine leiomyoma, are the most frequently encountered benign tumour of the Uterus. Incidence of Uterine Fibroid increases as women grow older, and they may occur in more than 30% of women of age 40-60 years. Risk Factors include Multiparity, Obesity, Family history and Hypertension. Fibroids frequently cause lower abdominal pain, a history of heavy menstrual flow and infertility, and clinical features depend on the number, size and location of the Fibroids. Symptomatic fibroids may be managed Medically or Surgically. However, hysterectomy by different routes is the most common operation performed for the fibroid uterus. Hysterectomy may not be the desired modality of treatment where the uterus needs to be retained for future childbearing, menstrual function or her strong will to retain the uterus. Removal of Fibroid Surgery is called Myomectomy, followed by reconstruction of the uterus, which is the correct and desired mode of management in such cases. It can be removed by different routes like abdominally, laparoscopically or hysteroscopically. Myomectomy aims to reconstruct a functional uterus, but if reconstruction is not feasible, it becomes a contraindication, and hysterectomy is the only remedy. The patients should be counselled about the possibility of a Hysterectomy before taking for Myomectomy. Here we prevent one such case where almost 20 fibroids of varying sizes were removed abdominally and the uterus reconstructed.

Case Report:

A 45-Year-old married lady reported to OPD with complaints of infertility, Pain abdomen, a History of heaviness in the lower abdomen, History of heavy menstrual flow associated with the passage of clots max size measuring about 3x3cm. There were no bladder or

bowel symptoms. The patient was referred from the infertility centre, stating that there is a single fibroid for Myomectomy. All necessary investigations were done. On repeat, USG shows Multiple fibroids, Intramural and Subserous. So we have advised the patient to get MRI Pelvis done for fibroid mapping. It shows Multiple Fibroids, Intramural, and sub-serous, on General and Systemic examination was regular. Per abdomen examination showed an Abdominopelvic mass which was irregular and bosselated and was of size 18 to 20 weeks gravid uterus. Mobility was restricted.

The patient was planned for Myomectomy. After the pre-anaesthetic check-up, Patients and Patient attendants were explained the risk of surgery, the possibility of ending up in an emergency hysterectomy and multiple blood transfusions, and informed consent was obtained. Preoperative bowel preparation was done as the difficulties of the surgery could not be predicted. Under spinal anesthesia and the abdomen was opened by Pfannenstiel incision abdomen opened in layers.

Intra-op findings:

Multiple fibroids occupied the whole fundus and body, and some seedling fibroids were noted on the lower uterine segment. A total of 3-4 incisions were taken on the most prominent part of the Fibroid, the Largest measuring about 7x6cm to various sizes with multiple seedling fibroids noted. They were removed carefully. Infiltration of vasopressin diluted in NS was done before incising one ampoule containing 20 units was diluted into 50-60ml NS. Approximately 130ml of such fluid was used throughout the procedure. 20 Fibroids were removed by using cautery blunt and sharp dissection, ensuring that the raw bed stopped bleeding. Uterus shape and size





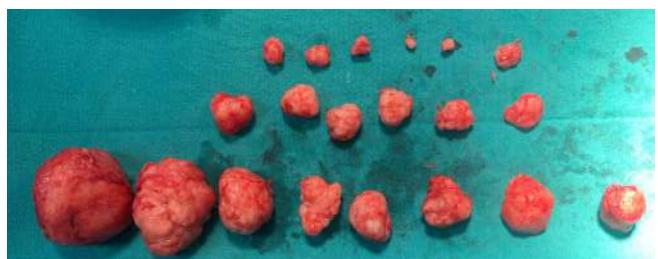
were regained, total blood loss was up to 800ml, the Total duration of the surgery was approximately 1 hour 40 minutes, and the surgery went uneventful. The Patient was discharged in good condition and referred to the Infertility centre for further treatment.

Discussion:

Benign muscular growths in the wall of the uterus, the majority of them are small and asymptomatic. They can cause a lump, abdominal or pelvic pain, abnormal uterine bleeding (usually menorrhagia), and are sometimes linked with infertility, which may manifest as pressure symptoms depending on their location and size. Most fibroids can be diagnosed by clinical examination and ultrasonography; very rarely, other imaging modalities like MRI are required primarily to differentiate fibroid from local or focal adenomyosis. It is well known that these fibroids are hormone-dependent, and they all regress after menopause. Due to hormonal influence, many medications like Danazol, GnRH agonist, and Mifepristone have been used to reduce the size of the fibroids preoperatively or primarily as medical management. Treatment of fibroid with Mifepristone

Definitive treatment of fibroids is surgical; hysterectomy in patients who have finished their childbearing or myomectomy where the uterus needs to be retained either for childbearing or for the patient's desire. Myomectomy has traditionally been performed abdominally but lately, the same procedure can be performed laparoscopically. Patients undergoing laparoscopic myomectomy should give informed consent for the possibility of converting to laparotomy or emergency hysterectomy. Laparoscopic surgery reduces pain, morbidity, hospital stay, and adhesions.

Abdominal myomectomy should be performed through an incision with adequate exposure, and fever is an uncommon postoperative event. The main concerns are the recurrence of fibroids, fertility, and rupture of the scarred uterus. Anti-progesterones like RU 486 are effective in reducing the size and recurrence of fibroids.



Conclusion:

Advanced technology and minimally invasive surgery may not be available everywhere and feasible in every case. However, there is still a place for open myomectomy where fibroids are multiple.

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Ruptured Sinus Of Valsalva Aneurysm

Medicover Hospitals - Karimnagar

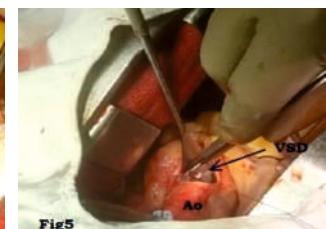
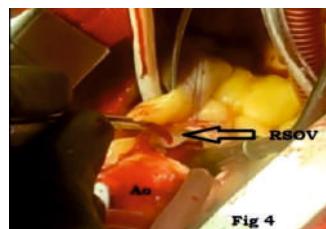
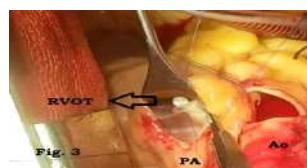
RSOV aneurysm is a rare but potential cause of high output heart failure, with the reported incidence of 1-5% and male to female ratio of 4:1. It commonly originates in right coronary sinus followed by non-coronary sinus and ruptures into the right ventricle followed by right atrium. The most common coexisting cardiac anomaly with RSOV is Ventricular septal defect in 75% of cases and Aortic Regurgitation in 25% of cases. We are presenting here a case of RSOV aneurysm associated with VSD and ruptured into the right ventricle.

A 43yr old male patient came with complaints of chest pain in the past 6 months associated with shortness of breath on exertion NYHA CLASS II. Known case of chronic calcific pancreatitis. On General examination the patient is moderately built, nourished, pedal edema and Icterus present. On Systemic examination CVS -pan systolic murmur present, RS -NVBS, P/A soft, CNS-NAD. 2Decho revealed -5.7MM RSOV and RV with left to right shunt, gradients-115mm of HG. EF:60%, coronary angiogram revealed normal coronaries. LFT -raised bilirubin (TB-2.9, DB-1.8), serum albumin 2.5. Based on the examination and investigations patient was diagnosed as RSOV aneurysm.



Patient was taken up for RSOV repair Surgery. Under General Anaesthesia on cardiopulmonary bypass. RSOV And Subaortic VSD were identified and closed with

separate piece of pericardial patch with 5-0 prolene. RVOT part of RSOV is closed with 5-0 Prolene continuous stitch.



Post operatively patient was on inotropic supports which was weaned off gradually. Post OP 2D Echo suggestive of no residual shunt across the patch on 5th post op day patient was discharged with stable hemodynamics. Patient is doing good and on regular follow up.



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Surgical Decision Making In A Patient with Concomitant Cervical & Lumbar Spinal Canal Stenosis

Medicover Hospitals - Nizamabad

Introduction:

Very frequently we come across cases where the patient has coexisting spinal pathologies. Cervical and Dorsal, or more frequently Cervical and Lumbar. The presenting complaints of the patient may not match the clinical scenario after examination, and the expectations of the patients may not be realistic given the circumstances of his/her ailments. So how do we convince the patient about the treatment plan and what is the ideal course of action in such patients is what we are going to discuss henceforth. In this particular issue, we are going to present a case where the patient has both Cervical and Lumbar Canal stenoses.

Case Presentation:

A 55 year old male patient, walked into the OPD with the support of a stick. His chief complaints were low back ache radiating to both lower limbs, difficulty in walking, claudication pain, tingling and numbness in all 4 limbs. The first question I asked after listening to his brief history is whether he could walk without a stick. He said it's not possible to walk without support and kept reiterating the fact that he has back ache and he needs support to walk. On further questioning he said that he had frequent falls, especially at the wash basin and of late he brushes his teeth or washes his face sitting down, fearing that he may fall.

On a quick examination, Romberg's test was positive, tone was increased in all 4 limbs, Deep Tendon Reflexes were exaggerated. An MRI of the whole spine revealed Lumbar Canal and foraminal Stenosis and T2 Hyperintensity at C3/C4 level. Clinically his current symptoms correlated with the cervical spine pathology.

But the patient was adamant on getting operated at the lumbar level as he felt his back ache and radicular pain were the cause of his condition. After thorough counselling we were able to convince the patient and his family that he needs cervical spine decompression at the moment and Lumbar spine surgery at a later date.

Under GA C3/C4 anterior cervical decompression and fusion was done using a standalone cage. Surgery was uneventful and the patient gradually improved. 2 weeks post surgery patient reviewed in the OPD. He was walking without support and was feeling comfortable. The low back ache and radicular pain still persists for which a lumbar laminectomy with fixation will be done at a later date.

Conclusion:

Cases like these are frequently seen by many surgeons and there is always a dilemma in approach. In such scenarios a careful clinical examination is essential but convincing the patient to go ahead with a cervical spine surgery which is traditionally considered to be a riskier procedure in comparison to lumbar spine surgery is a bigger challenge. Most of the times we may end up doing both surgeries but the cervical spine surgery should take precedence over other procedures.





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Iron Deficiency Anemia Presenting as Restless Legs Syndrome

Medicover Hospitals - Kakinada

Introduction:

Restless legs syndrome (RLS) is a common sensorimotor disorder of the central nervous system. It is characterized by an irresistible urge or need to move the limbs that occurs as a result of uncomfortable limb sensations. These symptoms may be present all day, but usually worsen during periods of inactivity and in the evening.

The prevalence of RLS is twice as high in women as in men. While the precise etiology of RLS is not clear, there is a familial and genetic component. Brain iron deficiency may be a potential causative factor.

Case Report:

A 56yr old male presented with complaints of nocturnal leg pains with disturbed sleep for 4 yrs, and symptoms have been worsening in the last two months. He feels more of discomfort in his legs with unpleasant sensations rather pain, which on walking gets relief. He suffered this for the last 4yrs leading to disturbed sleep and anxiousness sometimes. He often experiences cramp-like pain and occasionally deep pain in his legs. These prolonged symptoms have led to poor sleep quality, walking asleep (somnambulism) and experienced falls often. Due to this problem, he couldn't concentrate on his work, impacting his life and getting depressed. His history is significant for having Psoriasis vulgaris and occasional episodes of bleeding PR from haemorrhoids, for which he is taking symptomatic medication on and off. History of similar complaints seen in his mother and younger sister. His symptoms fit the 2012 Revised ILRSSG Diagnostic criteria of Restless Legs Syndrome. On the IRLS rating scale, score is 24 out of 40, coming under the severe category. On lab evaluation – Hemogram is s/o microcytic hypochromic anemia of moderate degree with reactive thrombocytosis. RFTs, LFTs, Electrolytes, Thyroid profile, Serum Calcium and Magnesium, were WNL. The stool for occult blood is negative. Nerve conduction studies of both lower limbs

were WNL. Serum Iron is 17.2 µg/dl (N-59-148). Serum UIBC is 401 µg/dl (N- 125-345). TIBC is 418.2 µg/dl (N- 228-428). Transferrin saturation index is 4.1 (N-16-45). On the whole Iron studies confirms Iron deficiency anemia. He is treated with Ferric carboxy maltose 1gm injection, Iron supplements and other supportive measures. On Follow up his leg pain subsided and quality of sleep improved.

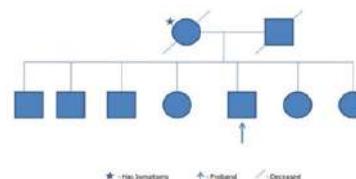


Fig.1
Pedigree chart

Name:		Restless Legs Syndrome Rating Scale	
From the patient's own history, respond to the following ten questions. The answers will help your doctor make the diagnosis, but the examiner should be available to clarify any questions the patient may have about the questions.			
In the past week:		In the past week:	
(1) Overall, how much trouble do you feel you have because of your RLS symptoms?		(2) How often do you get RLS symptoms?	
<input checked="" type="checkbox"/> (1) Very severe <input type="checkbox"/> (2) Severe <input type="checkbox"/> (3) Moderate <input type="checkbox"/> (4) Mild <input type="checkbox"/> (5) None		<input checked="" type="checkbox"/> (1) Very often (more than 5 days in 1 week) <input type="checkbox"/> (2) Sometimes (2 to 5 days in 1 week) <input type="checkbox"/> (3) Occasionally (2 days in 1 week) <input type="checkbox"/> (4) Rarely	
In the past week:		In the past week:	
(3) Overall, how much relief do you get from moving when?		(4) When you have RLS symptoms, how severe were they on average?	
<input type="checkbox"/> (1) No relief <input type="checkbox"/> (2) Slight relief <input checked="" type="checkbox"/> (3) Moderate relief <input type="checkbox"/> (4) Good relief or almost complete relief <input type="checkbox"/> (5) Full relief, symptoms do not return		<input type="checkbox"/> (1) Very severe (8 hours or more per 24 hour) <input type="checkbox"/> (2) Severe (4 to 8 hours per 24 hour) <input checked="" type="checkbox"/> (3) Moderate (1 to 2 hours per 24 hour) <input type="checkbox"/> (4) Mild (less than 1 hour per 24 hours)	
In the past week:		In the past week:	
(5) How severe was your RLS disturbance due to your RLS symptoms?		(6) When you had RLS symptoms, how severe were they on average?	
<input checked="" type="checkbox"/> (1) Very severe <input type="checkbox"/> (2) Severe <input type="checkbox"/> (3) Moderate <input type="checkbox"/> (4) Mild <input type="checkbox"/> (5) None		<input type="checkbox"/> (1) Very severe (8 hours or more per 24 hour) <input type="checkbox"/> (2) Severe (4 to 8 hours per 24 hour) <input checked="" type="checkbox"/> (3) Moderate (1 to 2 hours per 24 hour) <input type="checkbox"/> (4) Mild (less than 1 hour per 24 hours)	
In the past week:		In the past week:	
(7) How severe was your RLS disturbance due to your RLS symptoms - for example, difficulty carrying out a satisfactory family, home, social, school or work duty?		(8) How severe was your RLS disturbance due to your RLS symptoms - for example, difficulty carrying out a satisfactory family, home, social, school or work duty?	
<input checked="" type="checkbox"/> (1) Very severe <input type="checkbox"/> (2) Severe <input type="checkbox"/> (3) Moderate <input type="checkbox"/> (4) Mild <input type="checkbox"/> (5) None		<input type="checkbox"/> (1) Very severe <input type="checkbox"/> (2) Severe <input checked="" type="checkbox"/> (3) Moderate (1 to 2 hours per 24 hours) <input type="checkbox"/> (4) Mild (less than 1 hour per 24 hours)	
Sum of scores = 24			
<small>Scoring criteria are: Mild (scores 1-10); Moderate (scores 11-20); Severe (scores 21-30); Very severe (scores 31-40)</small>			
<small>1. Patients for this IRLS was assessed from 1 to 5 for the first three items (severely, very severe) to it for the last three (moderately, mild, none). All items are equally weighted. The International Restless Legs Syndrome Study Group holds the copyright for the scale.</small>			

Fig.2 Pt score on IRLS rating scale

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High-grade Spindle Cell Sarcoma of The Scrotum - A Rare Clinical Entity

Introduction:

The spermatic cord is responsible for the majority of malignant extratesticular tumors. Sarcomas are the most common type of malignant tumour, with rhabdomyosarcoma being the most common in children and liposarcoma being more common in adults. Pleomorphic sarcoma, leiomyosarcoma, mesothelioma, and lymphoma can all be found in the scrotum. High-grade pleomorphic sarcoma is an uncommon scrotal tumour.

Case report:

A 55 yrs old male presented with a history of left testicular swelling for which he underwent left orchidectomy (via scrotal approach) elsewhere 6 months back, followed by development of chronic non healing wound, which changed to an ulceroproliferative growth of scrotum. When he presented to our hospital, he had a large exophytic polypoid lesion of size around 15 x 25cm, occupying the entire scrotum, with bleeding and pus discharge. The initial orchidectomy biopsy report was granulomatous disease, no evidence of malignancy. Biopsy from the scrotal tumor at present revealed a malignant spindle cell tumor. After correcting anemia and controlling wound infection, the patient was evaluated with a Whole body PET CT scan. It revealed metabolically active, heterogeneous enhancing ill-defined irregular soft tissue density lesion with cystic areas and calcifications in left scrotal region extending to left inguinal region, abutting shaft of the Penis, measuring about 7 x 7x 12cm. Mild FDG avid left external iliac lymph nodes noted. No evidence of systemic metastases.

After evaluation and tumor board discussion, patient was planned for surgery. After discussing with urologist and

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plastic surgeon, the proposed plan of surgery is total emasculation i.e., total scrotectomy and orchidectomy, total penectomy, suprapubic cystostomy as perineal urethrostomy may not be feasible, left ilia inguinal lymph node dissection and reconstruction with a local flap or free flap based of the defect size. Patient and attendants were counselled for the same and proceeded. First Suprapubic cystostomy was done. Then while proceeding with total scrotectomy, we could preserve the penis as the tumor is just abutting the bucks fascia, but not infiltrating. After total scrotectomy, left ilioinguinal lymph node dissection was done and reconstruction of perineal defect was done with local rotational flap from thigh based on pudendal vessels. Final HPE with IHC markers reported as High-grade spindle cell sarcoma, of Grade 3, measuring 12cm in greatest dimension, resection margins negative, cut margin free of tumor, lymph nodes uninvolved, Stage: pT3N0. At present patient recovered well, the wound was completely healed and SPC removed and patient was further planned for Adjuvant Radiotherapy.

Discussion:

Soft tissue sarcomas, which arise from mesenchymal tissues and can develop anywhere in the body account for approximately 1% of all malignancies. Para testicular sarcomas are particularly very rare. Para testicular sarcomas are defined as tumors that arise within the scrotum and include the epididymis, spermatic cord, and tunica vaginalis. Similar to testicular cancer, intrascrotal sarcomas present clinically as painless, firm, intrascrotal swelling. Risk factors for intrascrotal sarcoma have been reported to include high doses of anabolic steroids, chronic inflammation and radiation and the present patient had chronic inflammation from





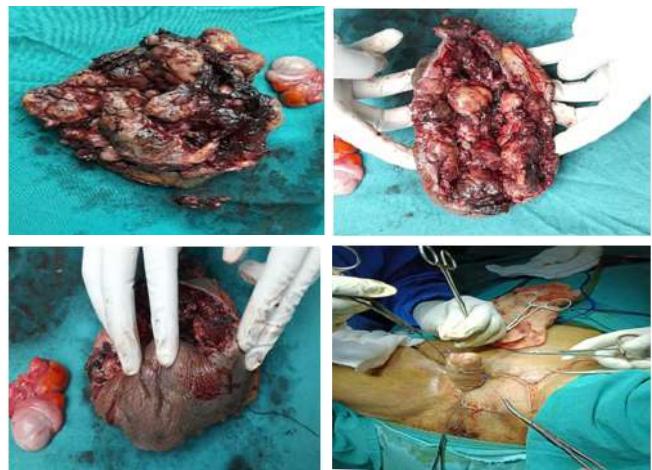
non-healing wound of previous surgery. Commonly, patients will undergo surgical resection without the clinical suspicion of sarcoma and thus, consideration is given to additional surgery, chemotherapy, and radiotherapy.

A diagnosis of spindle cell sarcoma is usually made by histological and immunohistochemical examinations. Spindle cell sarcoma shares the histological features of spindle-shaped cells. Spindle cell sarcoma is heterogeneous, including malignant fibrous histiocytomas (MFH), leiomyosarcomas, fibrosarcomas, angiosarcomas, and secondary sarcoma.

Surgical treatment of Para testicular sarcomas is challenging secondary to the close proximity to the reproductive organs, the abdominal wall/inguinal canal, and even the free intra-abdominal cavity. Also, the scrotal violation has been shown to result in inferior outcomes, unless adequately addressed. As with other soft tissue sarcomas, negative margin-wide resection is the potentially curative treatment.

Conclusion:

Patients with Para testicular sarcoma of all grades are at high risk for local failure, after limited local surgery. This requires aggressive treatment. Repeat wide local excision or radical excision are recommended for those initially treated with orchietomy. The experience with soft tissue sarcomas arising in other sites indicates that patients with narrow or positive margins after wide excision therapy are at an increased risk for local failure. Hence post operative radiation should be considered. Local failures occurred in patients who had initially undergone inadvertent intralesional surgery, and should be considered for radiation, followed by wide repeat excision. A systemic relapse of high-grade disease remains a significant problem, and improvements in survival will require effective systemic adjuvant therapy.



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MEDICOVER
HOSPITALS

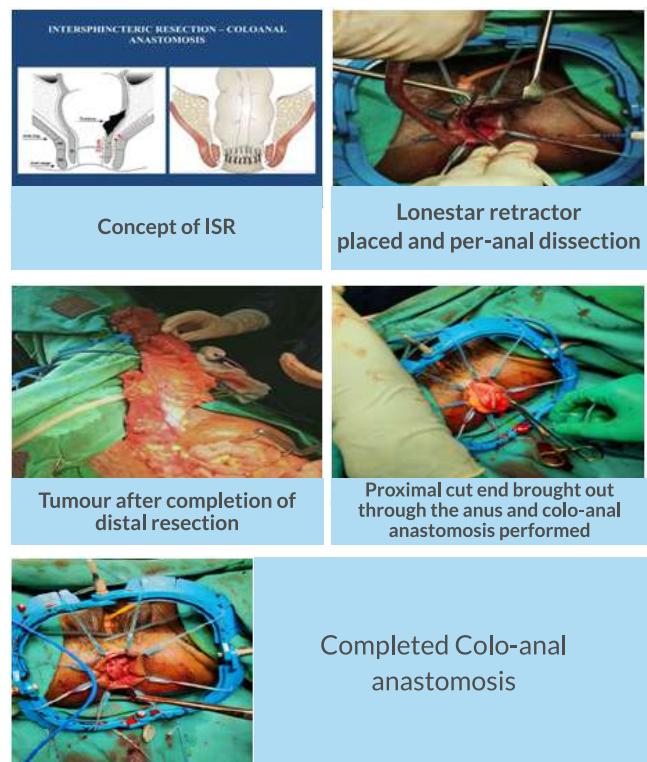
Sphincter Preservation For Rectal Cancers - ISR Technique

For rectal cancers, we perform ANTERIOR RESECTION surgery wherein the involved rectum is excised using the TME (Total mesorectal excision) technique and anastomosis of the proximal and distal segments of the bowel is performed. However, very low lying rectal cancers (where the distal margin of rectal cancer lies very close (within 1-3 cm) to the anal verge are a challenge for the surgeon because performing the anastomosis at such a low level is technically challenging. Most surgeons would prefer an APR - abdominoperineal resection wherein the entire anal canal is removed and proximal colon is brought out as a permanent end colostomy over the abdominal wall.

We have perfected a technique called the **INTERSPHINCTERIC RESECTION TECHNIQUE** wherein after complete dissection of the rectum and anal canal , a part of the internal anal sphincter is excised (as part of the distal margin clearance for the tumour) and a colo-anal anastomosis is performed - thereby **AVOIDING A PERMANENT COLOSTOMY** for the patient. Usually - only young patients and patients with good pre-operative anal sphincter tone are selected for these procedures. It is a technically challenging surgery which has two parts - the abdominal dissection first followed by perineal dissection. During the abdominal part which can be done either by open or minimally invasive technique - we perform a complete mobilization of the rectum in the TME plane ensuring complete excision of the mesorectum upto the levator and muscles which have to be exposed. Complete splenic flexure mobilization is essential to ensure reach of the proximal sigmoid colon to the anus. The perineal component of the surgery requires a special (Lonestar retractor) which enables proper retraction and exposure of the anorectal mucosa. The intersphincteric groove is identified, saline with adrenaline is injected to decrease bleeding and mucosal incision is taken. The dissection plane is deepened to excise the full thickness of the rectum and this plane is connected to the previously dissected intra-abdominal plane. A protective diversion ileostomy (temporary) is performed. If the patient selection is improper/external sphincter is damaged, patients will have fecal incontinence. The specimen is delivered and resected with adequate proximal margins. The proximal

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colon is sutured to the remnant anal mucosa. At Medicover, Vizag we have performed ISR in 3 patients (all 3 received neo-adjuvant chemoradiation therapy before surgery). We have done reversal of stoma in the 1st patient who is a 36 year old male. He has good continence post-surgery.



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Minimally Invasive Management of An Aortic Ticking Time Bomb TEVAR (Thoracic Endovascular Aortic Repair)

Medicover Hospitals - Vizag MVP

Clinical presentation:

A 75yr old female who is a known diabetic and hypertensive since 15 years who was on regular medication, presented to the ER department with complaints of Expectorant cough since 1month associated with an episode of massive hemoptysis (600 ml) on the day of admission. She was advised blood and imaging investigations.

Investigations:

- Blood picture showed a low haemoglobin (HB-7%) with normal serum electrolytes,RFT,LFT and coagulation parameters.
- Cardiac: S1,S2 heard,ECG-normal, Echo cone LVH,EF-64%Grade1 diastolic dysfunction
- Respiratory:B/L NVBS,B/L wheeze.
- CT thoracic aortogram showed a large complex multilobulated wide necked saccular aneurysm of size 4.6 x 3.8 x 2.3 cm arising from anterior aspect of descending thoracic aorta with contained rupture into the left main bronchus.

Through a multidisciplinary team approach meeting, owing to her age and associated co-morbid condition - TEVAR (Thoracic endovascular aortic repair) was sought as the best possible option under general anesthesia (GA). Patient and the attendees were explained regarding the procedure, its merits and risks. After obtaining the required permissions and consent , basic pre procedural workup and PAC(pre-anesthetic checkup) was done. Prior to procedure HB was corrected with 4 units of blood and peri-procedural antibiotic coverage was administered.

Procedure:

Under safety aseptic precautions and general anesthesia, 2 intra-arterial access were obtained (radial and femoral routes) on the right side of which radial was used for angiography and the later for technical deployment. Angiogram showed a large wide neck saccular aneurysm arising from the descending thoracic aorta .Aneurysm was crossed using catheter-wire (VERT-terumo) combination from the femoral access .The terumo wire was later exchanged to a stiff Iunderquist wire, with its floppy tip in right atrium. A cut down was made at the right femoral access site by the surgical team ,A 24F covered stent system (Valiant captivia stent graft system-34-30x150cm) was inserted over the stiff wire ,positioning of stent at the desired location was performed and deployed across the aneurysm in a graded manner .Post stenting angiogram from the radial access showed complete exclusion of aneurysm with no evident endo-leaks. Post successful deployment of endograft, the delivery sheath system was removed and the femoral cut down was sutured back, followed by application of sterile pressure dressing at the access sites.

Post procedure ,the patient was retained in ICU for observation .She was shifted to room on day 2 with stable vitals and was discharged on the following day with advice to be on regular medications and follow up with the multidisciplinary team at 1 week ,1,2,3 months ,and every 3months thereafter.

Followup:

At 1 month follow up - she has stable vitals with normal blood parameters ,no added complaints and is able to do her daily chores.

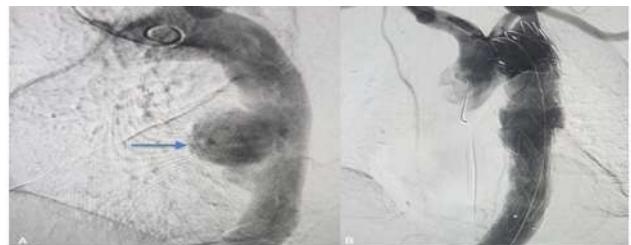


Discussion:

The development of thoracic endovascular aortic repair (TEVAR) has allowed a minimally invasive approach for management of an array of thoracic aortic pathologies. Initially developed specifically for exclusion of thoracic aortic aneurysms, as advances in endograft technology continue to broaden, this technique is now used as an alternative to open surgery for a variety of disease pathologies such as traumatic aortic transection, management of uncomplicated type B dissection or complicated by rupture/malperfusion, penetrating aortic ulcer/intramural hematoma. Although there are no randomized controlled trials directly comparing TEVAR to open surgery, numerous studies suggest that TEVAR is associated with decreased morbidity compared with open repair. Benefits of the endovascular approach include avoidance of thoracotomy or sternotomy incision, avoidance of aortic cross-clamping, decreased blood loss and decreased end-organ ischemia. Unfavorable anatomy is the major contraindication to TEVAR, hence Preoperative planning is important for optimal outcomes. Adequate preoperative measurements are critical for the correct sizing of thoracic endografts and are best facilitated by computed tomography angiography (CTA) with three dimensional reformatting. This provides various information about the seal zones, coverage length, tortuosity, angulation of the aorta, intraluminal thrombus or wall calcification that may have implications for graft placement. Complications such as stroke, paraplegia, visceral ischemia, post implantation syndrome, device migration, endoleaks and access site complications can occur. TEVAR has an excellent technical success rate of up to 98%. There is low perioperative mortality compared with open repair, with endovascular repair mortality rates of 1.9 to 2.1%, compared with 5.7 to 11.7% with open repair. Perioperative stroke may occur in 4 to 8% and spinal cord ischemia in 3 to 5.6% of patients.

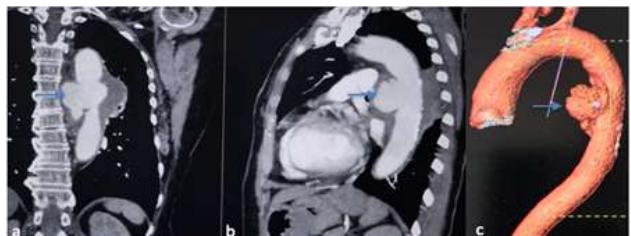
Conclusion:

Minimally invasive interventional radiology procedure such TEVAR (Thoracic endovascular aneurysm repair) can be life saving in patients with co-morbidities. Careful preoperative planning, Proper device sizing and its deployment are critical to obtain a good result and limit Complications.



DSA aortogram from the radial access showing A) wide necked saccular aneurysm (blue arrow); B) Post stenting angiogram showing complete exclusion of aneurysm with no evident endo-leaks.

and its deployment are critical to obtain a good result and limit complications.



CT aortogram (coronal) (a) sagittal (b), VR image (c) showing large complex multilobulated wide necked saccular aneurysm (blue arrow) arising from anterior aspect of descending thoracic aorta with contained rupture.

Multidisciplinary team / Treating doctors

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A Rare Occurrence Of Hydatid Cyst Over The Abdominal Wall (Muscular Hydatid)

Medicover Hospitals - Vizianagaram

Introduction:

Hydatid disease is a parasitic tapeworm infection that usually involves the liver and lungs. Primary skeletal muscle hydatid cyst without liver and lung involvement is rare, even in endemic districts. Muscular hydatidosis has been well documented in the literature but the involvement of the abdominal wall is a rare entity, with about 5 cases reported to date. It is interesting to note that in all 5 cases, the cyst location has been in the right Para umbilical and iliac fossa. We report a case of abdominal wall hydatid with an attempt to explain the mechanism for this unusual location.

Case Report:

A 22 Year Male Came To The Surgery Opd Of Tirumala Medicover Hospitals Vizianagaram With A Complaint Of Swelling Over The Right Upper Abdomen For 3 Months. He Was Refereed By A Practicing Surgeon.

The Patient Was Suffering From Mild Pain Abdomen And Swelling Over The Right Hypochondrial Region Of The Abdomen. There Were No Other Constitutional Symptoms. O/e, There Was A Palpable Mass Over The Right Hypochondrial Region, Firm Inconsistency And Immobile, As Shown In Fig.1 . Routine Blood Investigations Were Within Normal Limits. The CECT Abdomen Revealed Possibilities Of

Hepatic Cyst, Duplex Cyst, And Mesenteric Cyst. Initially, Diagnostic Laparoscopy Was Performed On 4th Feb 2023, It Showed A Cyst Hanging From The Abdominal Wall Without Any Connection With Intra-abdominal Structures Fig.2 And Immediately, A Laparotomy Was Performed. The Findings Were A Large Cyst Measuring 8 Cm X 7 Cm Over The Parietal Wall Of The Abdomen Between The Rectus Abdominis And Posterior Rectus Sheath Diagnosed As A Muscular

Hydatid Cyst. The Cyst Was Excised (fig.3) And Sent For Histopathology For Accurate Diagnosis. Post Op Period Was Smooth, And The Patient Was Later Treated With Albendazole And Praziquantel And Discharged On The 5th Post-op Day. On Histopathology, It Is Confirmed As Hydatid Cyst.





Discussion

Hydatidosis is a zoonotic infection caused by tapeworm. Primary skeletal muscle infection with *E. granulosus* accounts for 1%-4% of reported hydatid cases. It may be postulated that the low prevalence of this form of the disease is potentially due to the physical barriers to the hematogenous dissemination of cysts created by hepatic sinusoids and pulmonary capillaries. Only a few cases of primary subcutaneous hydatidosis have been reported. Solitary abdominal parietal wall hydatid is a rare finding with only 5 cases reported it is interesting that all five cases reported have hydatid cysts presenting in the right iliac region or right paraumbilical region. Muscular hydatidosis resembles a benign neoplasm in many ways. In order to prevent serious complications, the diagnosis should be made before any therapeutic intervention.

Endovesicular daughter cysts that are commonly seen in hepatic hydatid disease imaging are not usually seen on ultrasound or CT of skeletal muscle cysts, and calcification is rare. Therefore, Imaging evaluation may not be specific and accurate and can also indicate other pathological processes, such as malignancy, including sarcoma or infection. MRI is the examination of choice in case of suspicion of hydatid disease. The classic MRI findings include a multivesicular cyst, a low-intensity rim "rim sign" on T2-weighted images or a detached membrane. The treatment of choice in muscular hydatid disease is the excision of the intact cyst and surrounding tissue. Albendazole therapy after percutaneous aspiration-injection-reaspiration (PAIR) or surgery is to inactivate viable scoleces in the residual cyst and prevent a recurrence. But the cure rate was higher in combination therapy. Therefore, combination therapy may result in a more rapid response than therapy with albendazole alone.

Conclusion

This case illustrates that echinococcal disease should be considered in the differential diagnosis of every cystic mass in any anatomic location, especially when they occur in areas where the disease is endemic. Surgical excision is the treatment of choice with postoperative combined treatment with Albendazole and Praziquantel to prevent a recurrence.

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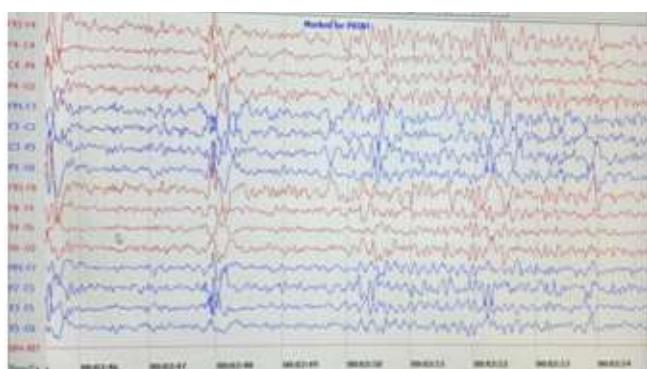
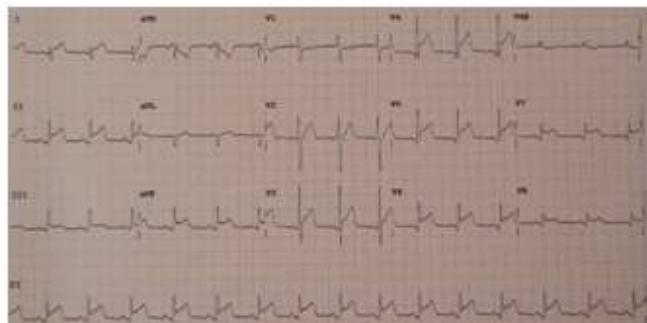


Enrofloxacin Poisioning-a Veterinary Floroquinolone Toxicity

Case Report:

A 25 year female patient with past history of TB lymphadenitis got admitted into critical care unit after stabilization in Emergency ward ,who has intentional consumption of 25 ml of Enrofloxacin 10% with complaints of headache, 2 episodes of vomiting and 3 episodes of seizures,unconscious.

In view of low GCS(6/15) and high risk of aspiration patient got intubated and managed on ventilator ,CT brain is normal. Initial ABG showing lactic acidosis. Patient was managed supportively, patient had refractory status epilepticus confirmed by EEG for which she was managed with benzodiazepine and propofol infusion as per neurologist advice. On Day 2 of ICU stay she developed new onset shock-cold peripheries, hypotension and worsening lactates ,ECG showing diffuse ST-T changes ,2D echo showed global hypokinesia, dilated LV, for which anti cardiac failure treatment was given as per cardiologist advice.



Medicover Hospitals - Srikakulam

Slowly patient conscious level improved and no further episodes of seizures after weaning off from anaesthetic drugs,inotrope requirement came down. Patient got extubated by day 3 after meeting extubation criteria. With all multidisciplinary efforts patient got discharged by day 6 with normal neurological status.

Conclusion:

Enrofloxacin is a fluoroquinolone antibiotic frequently used in veterinary medicine. It is highly bioavailable, has a quick absorption irrespective of the route administered, and is eliminated via kidneys . Its manifestations include nausea, vomiting, headache, Dizziness, Seizures, QT prolongation, ST-T segment changes, polymorphic ventricular tachycardia, and liver dysfunction. Cardiovascular manifestations occur due to sodium channel blockade, and seizures occur due to increased GABA antagonistic action. As per the literature based on internet and other sources there are no adult patients who are survived from this poisoning.

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The Baffling Ammonia !!

Ashoka Medicover Hospital - Nashik

Introduction

Hyperammonemia is a recognized cause of hepatic encephalopathy characterized by episodic confusion and coma in a patient with chronic liver disease. However, there are a number of non-hepatic reasons for hyperammonemia severe enough to cause confusion and coma. We describe a case of non-cirrhotic

Case description:

A 54-year-old male patient was admitted to AMH NASHIK ICU with altered sensorium, fever, lethargy, confusion and irritability for the last two days and unconsciousness since the day of admission. He was admitted three months back for polytrauma with pelvic ring injury, long bone fractures, rib fractures, and fat embolism. He had a prolonged stay in ICU for over two months, was stabilized with traction and orthopedic manipulations and was discharged with an external fixator. One week before admission, he started draining pus from the surgical site. Culture revealed MDR Klebsiella, and antibiotics were given accordingly on an outpatient basis.

The clinical evaluation on this admission revealed a hemodynamically stable patient with severe encephalopathy. Urethral catheterization revealed turbid urine, and urine cultures were sent. Investigations revealed normal WBC and normal sepsis biomarkers. His renal and liver functions, including coagulation parameters, were within normal limits. Other workups for encephalopathy in the form of CT brain, thyroid function tests, and calcium were all within normal range.

His serum ammonia was 700 micrograms /dL (Normal range in our lab: 27-102 micrograms/dL). A diagnosis of non-hepatic hyperammonemia due to UTI was

considered. He responded dramatically to antibiotics, lactulose enema and other supportive treatments for hyperammonemia encephalopathy.

His urine culture grew Klebsiella pneumoniae which was sensitive to ongoing antibiotics. Ultrasonography of the abdomen revealed normal liver, and he was discharged home after three days in a stable condition with serum ammonia of 53 on discharge.

Discussion:

Hyperammonemia encephalopathy occurs when hyperammonemia causes glutamine-mediated effects on the brain, such as astrocytic swelling, cerebral edema, and raised intracranial pressure. Increased ammonia levels in blood have been described in different clinical conditions, such as hepatic failure, urea cycle disorders, and, rarely, after therapeutic procedures on the urinary tract. In fact, hyperammonemia may be provoked by either a loss of the ammonia metabolism by the hepatic mitochondria, with consequent impairment of the urea cycle, or an increase in the amount of ammonia produced by urease-positive pathogens. Since urease catalyzes the hydrolysis of urea to produce ammonia,

the action of urea-splitting organisms results in an increased production of ammonia and its absorption in circulation.

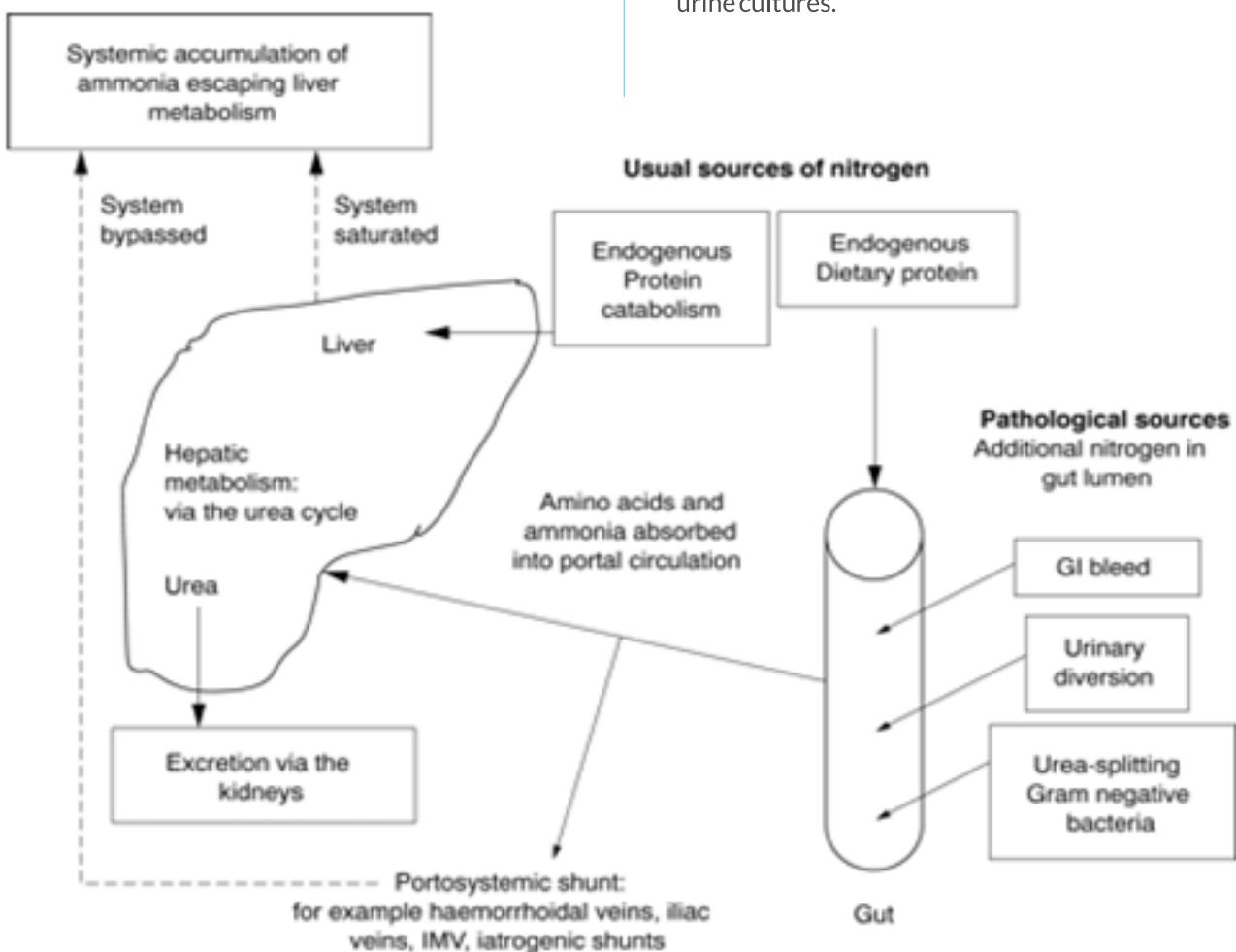
Urinary tract infection by Klebsiella oxytoca, Klebsiella pneumoniae, Proteus sp, Corynebacterium sp and Staphylococcus aureus (known as urease-positive bacteria) have been reported to be involved in hyperammonemia encephalopathy in children and adults. These urease-positive bacteria in the urinary tract produce an alkaline environment, which increases



the proportion of NH₃ compared with ammonium (NH₄⁺). The venous drainage of the bladder flows directly to the systemic circulation, bypassing the liver's attempt to detoxify. Predisposing conditions such as a neurogenic bladder or urinary retention can increase urinary tract infection and urine stagnation.

Conclusion:

The present case focuses on urinary tract infection as a potential cause of hyperammonemia, which can lead to metabolic encephalopathy. A low threshold of suspicion must be kept to confirm UTI and to check for ammonia levels in patients with metabolic encephalopathy, particularly in patients with gram-negative bacteria in urine cultures.



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Neurogenic Scoliosis with Diastomatomyelia

Ashoka Medicover Hospital - Nashik

Abstract:

Neurogenic scoliosis is not a very uncommon condition in the clinical practice of pediatric orthopedics. However, if not diagnosed in time, the curve progresses very rapidly and can create permanent disability if untreated.

Diastomatomyelia is the splitting of the spinal cord by a fibrous or bony band. If not released in time, it can tether the spinal cord leading to a progressive neurological deficit in the form of urinary incontinence, bowel incontinence, and motor deficit in the lower limb in the near future of the child. Hence, the release of Diastomatomyelia, also known as de-tethering of the spinal cord, is an essential procedure to be carried out before the adolescent growth spurt.

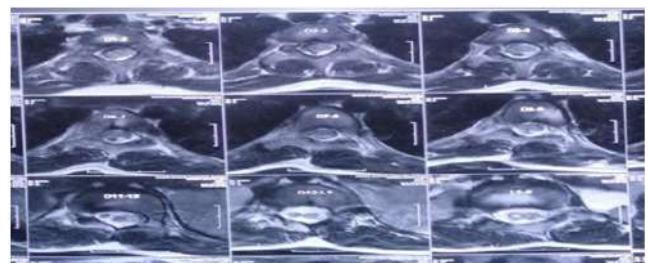
Hence, timely diagnosis with timely intervention will help prevent this deformity in adulthood. The deformity is notorious to progress at a rapid pace during the development of secondary sexual characters. Ideally, such a deformity requires surgical correction. Such deformity correction has a risk of paraplegia (Paraparesis). The risk is very much high if the correction is overzealous without intraoperative monitoring. Such risk can be mitigated by a technology called neuro monitoring which is used intraoperatively in surgical theatre. A reduction in the amplitude of action potential indicates that the spinal cord is at risk, and the deformity correction should be stopped at that level.

Case history:

This 12-year-old child with poor socio-economic background presented with a progressive curve of the spine. Clinical examination did not reveal any

neurological deficit. However, MRI screening detected diastomatomyelia at the D12-L1 level (splitting of the spinal cord by the fibrous band).

MRI:



MRI Showing Diastomatomyelia at D12-L1 level



(Pre-op Image)



(Post-Op Image)



(Pre-Op X-ray)



(Post-Op X-ray)





Hence, the case required a surgical correction of deformity and necessitated de-tethering of the spinal cord to prevent any neurological deficit shortly. Therefore, this surgery is not only a cosmetic correction of the spine but also a prophylactic surgery in the prevention of any neurological handicap in future.

Discussion: Many patients are reluctant to undergo surgery as only a few centres provide infrastructure for such a major case. The complication of paraparesis is very grave and rightfully unacceptable for correcting of cosmetic deformity. This risk can largely be negated by the use of this technique.

Take home message

1. Neurogenic scoliosis is a treatable condition.
2. Scoliosis advances rapidly with the onset of adolescence.
3. Surgical correction under neurological monitoring reduces the risk of paraparesis and gives good function along with good cosmesis.
4. Screening of scoliosis for spinal cord tethering prevents future handicaps.

Note: This case was performed at Ashoka Medicover Hospital, Nashik, as CSR activity at a very optimum cost as the patient belongs to very poor socio-economic conditions.

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Idiopathic Epidural Lipomatosis - A Rare Case

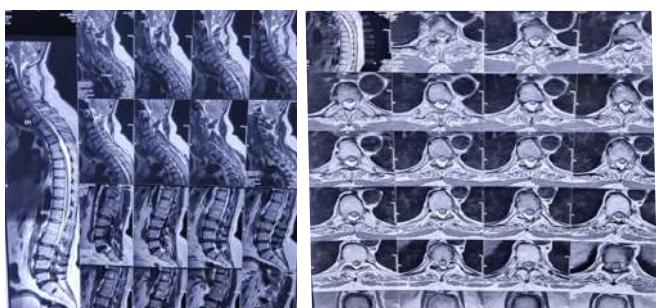
Medicover Hospitals - Aurangabad

Introduction:

Epidural lipomatosis is a rare entity to cause spinal cord compression and neurological deficits. Spinal epidural lipomatosis is a pathological overgrowth of the normally presented extradural fat and often causes dural impingement. Symptomatic epidural lipomatosis was first described by Lee et al. in 1975 in a patient after renal transplantation.

Case Report:

A 50-year-old male patient who's obese, non-diabetic, non-hypertensive, and has a history of progressive Paraparesis. He has consulted neurologists, neurosurgeons, spine surgeons from three major cities in Maharashtra. On examination, spasticity in both lower limbs grade 3, power both ul 4/5, both II 3/5 able to walk with support, sensation decreased below d5, joint, and vibration affected in both II, knee jerk +++ bil ankle ++ plantar up going.; based on the examination laminectomy was suggested from D2 to D7 and lipoma excision was successful. On the Post OP day-3, the patient started walking with minimal support, and presently he can do his daily activities independently.



D2-D7 LAMINECTOMY
AND EXCISION OF LIPOMA

Discussion:

Spinal epidural lipomatosis is characterised by abnormal deposition of unencapsulated fat in epidural space. The pathogenesis is probably multifactorial; venous stasis with thrombosis has been suggested as precipitin syndrome. Myelopathy is because of mechanical compression of the spinal cord and the vascular dysfunction caused by compression of the epidural blood vessels with venous engorgement. Males are affected more than females, with 75% of reported cases being males. The thoracic spine is affected more, followed by the lumbar region, while cervical epidural lipomatosis has not been reported till now. MRI spine is the diagnostic choice of imaging. It shows uniformly hyperintense fat collection in epidural space on both T1W1 and T2W1 sequences. Epidural fat thickness greater than 7 mm is diagnostic of spinal epidural lipomatosis. Circumferential compression of the thecal sac is referred to as "Y-sign" and is pathognomonic in lumbar axial imaging.

Conclusion:

It may be present even without endocrinopathies or in non-obese patients. MRI spine with contrast is diagnostic and early diagnosis is essential as minor symptoms may be relieved on conservative treatment while advanced and progressive disease requires surgical intervention.

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Modified Martius Flap Ventral Onlay Urethroplasty For Recurrent Stricture Urethra

Medicover Hospitals - Sangamner

Introduction:

Stricture urethra in females is rare disease and further rare is the recurrence of the stricture after primary urethroplasty is done. The literature is limited over this and only few cases and small case series are reported. The surgical treatment for the recurrent stricture is extrapolated from the techniques used for male urethral reconstruction though, female urethroplasty is complicated and much different from the urethroplasty done for the male urethra. We, here describe the technique of modified Martius flap ventral onlay urethral reconstruction in a patient who already underwent vaginal graft dorsal onlay urethroplasty few years back.

Case Presentation:

A 64 years old female presented to our emergency room with acute retention of urine. She had a history of vaginal graft dorsal onlay urethroplasty 3 years back. She was a chronic tobacco chewer for more than 30 years. Her bladder was palpable on per abdominal examination. We tried to catheterise her but we were not able to do so because her meatal opening was not visible. So, we did suprapubic catheterisation under local anaesthesia. Her micturating cystourethrogram (MCU) done later, suggested trabeculated and sacculated. Her bladder neck was also not visible properly in the films (Fig 1). She was then planned for surgery after proper work up and was explained about the complicated nature of the surgery. Pros and cons as well as the chances of success were explained. Prior to planned urethroplasty, we did supra-pubic antegrade cystoscopy with 6/7.1 Fr ureteroscope, which suggested wide open bladder neck. We were able to slide the glidewire through the

ureteroscope into the urethra and through the meatus. Once glidewire came out, we dilated the urethra upto 16 Fr to pass a 14 Fr Foley catheter. We then, did modified Martius flap ventral onlay urethroplasty (Fig 2-5). Foley catheter was removed after 21 days and she voided well with good satisfaction and without any residual urine. Follow-up MCU (Fig 6) suggested minimal residual urine and uroflowmetry (Fig.7) suggested a classical bell-shaped curve of normal urinary flow. Her maximum urinary flow rate was 14 ml/sec, which could be attributed to the poor detrusor contractions due to chronic urinary obstruction. She maintained a good urinary flow and satisfactory voiding till her last follow-up at four months.

Conclusion:

Modified Martius flap ventral onlay urethroplasty adds to the armamentarium of the modern reconstructive surgeons. It is a good and reproducible technique and can be used for recurrent and full length female urethral strictures.





Figure 1



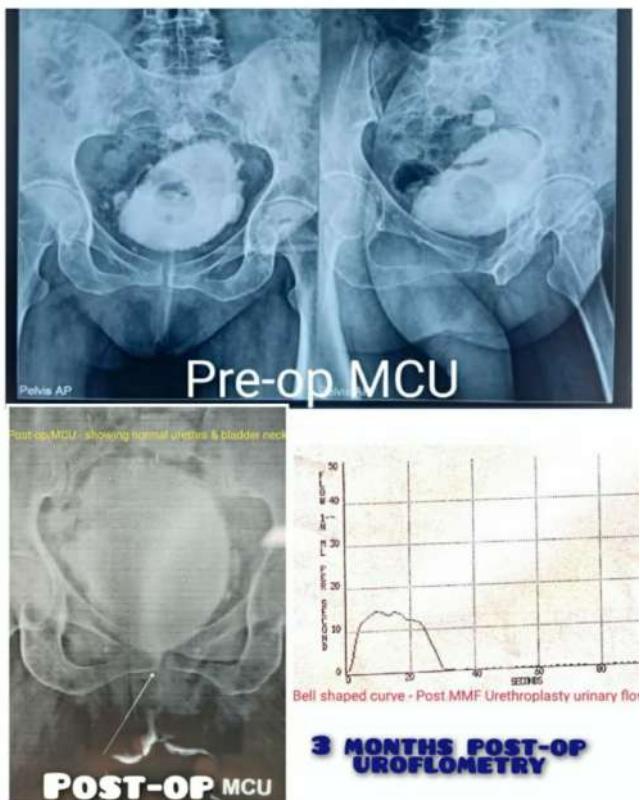
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Figure 2





Angioedema as Initial Presentation of SLE

Introduction:

Angioedema is a well demarcated localized edema involving deeper layers of skin and subcutaneous tissues. It can be hereditary or acquired. Reports of acquired angioedema secondary to SLE have been rare. So here in this case we present angioedema as initial presentation that led to the diagnosis of SLE.

Case Summary -

45 years old female known case of hypothyroid on thyroxine treatment admitted with history of swelling around eyes, lips and around neck for one day slowly increasing in severity. She had similar 2-3 episodes in past 2 months. On examination she had periorbital edema with left eye subconjunctival haemorrhage and mild fullness around neck. There was no skin rash elsewhere. She had aphthous ulcer in oral cavity examination. Systemic examination was otherwise unremarkable. On clinical examination, provisional diagnosis of angioneurotic edema was made. She was administered with IV dexamethasone and she was stabilized. After asking leading questions, she gave history of mild recurrent joints pains involving small joints of hands for which she was taking some ayurvedic treatment. She also had history of recurrent oral ulcers. Investigations were done for her evaluation. C1 esterase inhibitor level was done which was normal. ANA was strongly positive, ds DNA was positive, C3, C4 levels were low, ANA blot assay was positive for Scl70/Sm/SSA. She was also complaining of tingling numbness in both upper limbs for which NCV was done which showed features suggestive of carpal tunnel syndrome. Renal function test and urine routine was normal but 24 hours urinary protein were raised. It suggests that she also had renal involvement. Based on clinical presentation and investigations, final diagnosis was Acquired angioneurotic edema with SLE with subclinical renal involvement. She was given pulse therapy with IV methylprednisolone.

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Fig1 : On Admission



Fig2:After initial stabilization



Fig 3: At the time of discharge

She responded well to the treatment. Symptoms resolved significantly. She was discharged in hemodynamically stable condition with immunosuppressive therapy and was asked for regular follow up. Possibility of acquired angioedema was concluded based on age of onset and with negative family history of angioedema.

Conclusion

Acquired angioedema can be associated with secondary causes like autoimmune conditions, lymphoproliferative disorders or monoclonal gammopathies. Once patient is stabilized, the cause of angioedema should be determined. In our case initial presentation of angioedema could lead to a very important diagnosis of SLE

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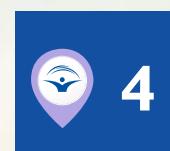
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