

Managing Director's Message



**Dear Associates,**

Wishing you and your family a very Happy New Year!

A tertiary care healthcare organization is differentiated from healthcare providers and its peers not only by the clinical outcomes of its services but more importantly by the complexity of services provided. Organ transplantation is a speciality that is the need of the hour but has still a long way to go to meet the needs of our community. At Wockhardt Hospitals our philosophy has been to provide clinical care across the spectrum. This edition of Wocksynapse highlights the amazing clinical work being done across our group hospitals as part of our Organ Transplant program. At our South Mumbai hospital, the transplant program is just over a month old and the transplant team conducted a rare simultaneous live kidney and liver transplant on the same recipient, which is a testimony of the skill, dedication and commitment of the entire team.

Our 4<sup>th</sup> Infection Prevention & Control Conclave had over 450 registered participants from across the country and is our endeavour of sharing the latest evidence-based infection prevention practices with our community hospitals.

I am extremely proud of all the hard work being done by our associates across all our hospitals as these published cases demonstrate. Standardised care with defined protocols and efficient teamwork ensures that at Wockhardt Hospitals, Life Wins.

**Zahabiya Khorakiwala**

Managing Director,  
Wockhardt Hospitals

## Table of Contents

## Page No.

From the Managing Director's desk	1
<b>Wockhardt Hospital's Transplant Programme</b> The team performs a very complex transplant surgery: South Mumbai Another complex case: South Mumbai <i>Dr. Anurag Shrimal, Dr. Gaurav Gupta</i>	2-3
Case of Bone Marrow Transplantation: North Mumbai <i>Dr. Dipanjan Halder</i>	4
Wockhardt Hospital's Transplant Programme	5
Woman's skull preserved in her abdomen to conduct lifesaving surgery <i>Dr. Ajay Bajaj</i>	6
Did You Know <i>Dr. Prashant Mehta</i>	6
Critical case with Post-Partum Haemorrhage (PPH) <i>Dr. Vikas Jain, Dr. Jigna R. Ganatra</i>	7
Two interesting cases of accidental ingestion of foreign bodies <i>Dr. Mrudul Dharod</i>	8
Anaesthetic management of a rare case of pulmonary alveolar proteinosis <i>Dr. Jayesh Dobriya, Dr. Ketan Hirani</i>	9
Wockhardt Group Hospitals conducted its 4 <sup>th</sup> Infection prevention and conclave 3 <sup>rd</sup> & 4 <sup>th</sup> Dec, 2016	10
Complicated fracture femur treated successfully <i>Dr. Yogesh Chaudhari</i>	11
Answers to Quiz – Wocksynapse 6	11
A stitch in time saves nine <i>Dr. Brijesh Dube</i>	12
Team effort treats an aggressive cancer in an elderly gentleman <i>South Mumbai Team</i>	13
Medical Quiz <i>Dr. Sadaf Khan</i>	14
New consultants who joined The Wockhardt Family	15
Editorial Page	16

# WOCKHARDT HOSPITAL'S TRANSPLANT PROGRAM THE TEAM PERFORMS A VERY COMPLEX TRANSPLANT SURGERY: SOUTH MUMBAI

1st  
Article

This case marks the beginning of the Multi-Organ Transplantation Unit at Wockhardt Hospitals, South Mumbai. India's first specialized Liver, Kidney, Pancreas and Small Intestine transplant unit under one roof.

The team successfully performed one of the most complex transplant operation 'A Living Related Simultaneous Liver & Kidney Transplant'. Mr. X an ex-MLA was suffering from Liver and Kidney failure due to Hepatitis B. Over the past one year, his condition deteriorated and he was started on thrice weekly dialysis.

Dr. Anurag Shrimal and Dr. Gaurav Gupta, led a team of 15 doctors to successfully carry out this transplant. Three surgeries were carried out

simultaneously lasting over 20 hours. The patient received only 4 units of blood during the surgery. Both the transplanted liver and kidney started working immediately as soon as the blood supply was re-established. He was taken off the ventilator 4 hours after the surgery, and was shifted out of the ICU within 2 days. He had an uneventful recovery and got discharged in less than three weeks after undergoing transplant. The liver donor donated 65% of his liver and the kidney donor donated his left kidney. Both of them recovered very well and were discharged within 5 days after the transplant.

Dr. M M Bahadur, an eminent nephrologist, was instrumental in the medical management of this patient and guided the team for perioperative dialysis. Dr Anjali Patki & Dr Meenakshi Puranik led the anesthesia team for all three surgeries.

Less than 5% of all patients who need liver transplant, develop kidney failure also and need a simultaneous kidney transplant. Simultaneous Liver and Kidney Transplant not only increases the quality of life (freedom from dialysis) but also increases the quantity by more than 30%. The rule of organ allocation by ZTCC makes it difficult for these patients to get both these organs together.

## Some of the key points about the case:

- First in Western India to perform Living donor Simultaneous Liver and kidney transplant by a Mumbai based team.
- Two healthy related family members donated the organs.
- Three simultaneous operations lasting for 20 hours.
- Minimal blood loss in all three operations.
- Team of more than 30 Doctors, Nurses, Physiotherapist and Nutritionist ensured a speedy and uneventful recovery of all three (recipient and two donors).
- Both donors were discharged on the fifth day after surgery and the recipient discharged within 3 weeks of surgery.

# WOCKHARDT HOSPITAL'S TRANSPLANT PROGRAM, ANOTHER COMPLEX CASE: SOUTH MUMBAI

Mr. X a 51-year-old gentleman presented to our hospital after undergoing two surgeries at outside hospitals. First surgery was a Laparoscopic Cholecystectomy, usually a straight forward operation, which in his case got complicated leading to biliary and vascular injury. The second surgery was an exploratory laparotomy. After this surgery, the patient developed massive intraabdominal bleeding with shock requiring life support with intubation



**Dr. Anurag Shrimal**

Consultant - Abdominal Organ  
Transplant & HPB surgeon  
Wockhardt Hospital, South Mumbai



**Dr. Gaurav Gupta**

Consultant - Abdominal Organ  
Transplant & HPB surgeon  
Wockhardt Hospital, South Mumbai

and mechanical ventilation, multiple transfusions with blood and blood products and higher antibiotics. He also developed intraabdominal infection with MDR *Klebsiella*. He had an ERCP and biliary stenting for control of the biliary leak.

After initial stabilization, the CT scan showed a suspected injury to the Right Hepatic Artery, with a surgical clip in close proximity being an indirect marker for the site of injury. We did a third surgery for this patient, evacuated 6 liters of old blood clots from his abdomen, and after meticulous portal dissection, we identified the site of arterial injury to be the Right Hepatic Artery. We ligated the RHA for control of bleeding. On post operative Day 2, the patient developed a bile leak requiring a second surgery with ligation of cystic duct stump.

The patient then had an uneventful recovery after the surgery. His liver function tests (LFTs) were elevated transiently. A follow-up CT scan after 6 weeks showed a completely normal liver with restitution of arterial supply from the left hepatic artery to the entire liver and absence of any cholangiopathy. The biliary stent was removed subsequently and the cholangiogram showed normal bile ducts. The patient is now three months post-surgery with normal LFTs.

The key learning point from this case is to correctly identify post-cholecystectomy injury, if it happens and most importantly, to identify and treat vascular injuries.



# CASE OF BONE MARROW TRANSPLANTATION: NORTH MUMBAI

2nd  
Article

A 36-year-old male patient presented to Wockhardt Hospital, North Mumbai with expansile bony lesion of the S2 vertebra with diffuse abnormal marrow signals involving all visualized bones with bilateral compression of sciatic nerves (Rt.> Left) and fish mouth deformity of vertebral bodies.

He was diagnosed with Multiple myeloma in May 2016 at Kenya. His bone marrow aspiration showed marked plasmacytosis (90%) and his serum protein electrophoresis showed M band (78g/L). A diagnosis of Multiple myeloma was made and was started on chemotherapy with Melphalan, Prednisolone and Thalidomide in Kenya probably for 3 months. His radiotherapy spine & back showed expansile lytic lesion at S2 vertebra.

For further chemotherapy he came to India. He underwent Autologous Bone Marrow Transplantation. Chemotherapy was given with Cyclophosphamide, bortezomib and dexamethasone with monthly zoledronic acid for 5 cycles. His FISH panel for multiple myeloma was also performed and it revealed normal karyotype. Following his chemotherapy, he achieved Very good

partial response with Serum Protein electrophoresis showing M Band of 0.76g/dl. His bone marrow aspiration revealed occasional plasma cells. His other pre transplant work up was well within acceptable limits.

He was mobilized using GCSF and Plerixafor protocol (in view of prior history of Melphalan chemotherapy and pelvic irradiation). GCSF was started and his peripheral blood CD 34 Count after 3 days was 14.4 cells/micro lit. Subsequently, he was administered Inj Melphalan 235 mg IV Bolus (140mg/m<sup>2</sup>). Then he was infused stem cells and was put on antibiotic prophylaxis with levofloxacin, acyclovir and posaconazole.

He developed mild (Grade 1) mucositis for which he was started on Inj GCSF from day +4. He developed mild throat pain and tachycardia for which blood cultures were done and he was started on Inj Magnex Forte. His blood culture did not grow any organisms. During his stay he was transfused with 1 Unit of Irradiated Packed cell and 3 units of irradiated single donor platelets. His serum protein electrophoresis was repeated 2 weeks after bone marrow transplantation and showed a decreasing M protein value of 0.45g/dl.

The patient is now being discharged in stable condition with detailed advice regarding medications to be taken and precautions to be followed at home.



**Dr. Dipanjan Haldar**

Consultant - Haematology  
Wockhardt Hospital, North Mumbai

## GENERAL INFORMATION

Bone marrow is the soft, spongy area in the center of some of the larger bones of the body. The marrow produces all of the different cells that make up the blood, such as red blood cells, white blood cells (of many different types), and platelets. All of these cells develop from a type of precursor cell found in the bone marrow, called a “hematopoietic stem cell.”

Autologous Bone Marrow Transplantation is a stem cell transplantation (also called bone marrow transplantation, hematopoietic stem cell transplant, or hematopoietic cell transplant), is a type of treatment for cancer (and a few other conditions as well.)

# WOCKHARDT HOSPITAL'S TRANSPLANT PROGRAMME

Particulars	Nagpur	Nashik	South Mumbai	North Mumbai
<b>Licence obtained</b>	2011	2010	July 2016	June 2016
<b>KTP's (Kidney Transplant) Done</b>	87	27	5	2
<b>Transplant Team</b>	<b>Nephrologists</b> Dr. Sameer Choubey, Dr. Suryashree Pandey	<b>Nephrologists</b> Dr. Nagesh Aghor, Dr. Deodatta Chafekar	<b>Nephrologists</b> Dr. Mustafa Khokkhawala, Dr. Arun Doshi, Dr. M. M. Bahadur, Dr. Aaseem Thamba	<b>Nephrologist</b> Dr. Mahesh Prasad
	<b>Transplant Surgeon</b> Dr. Sanjay Kolte, <b>Associated Surgeons</b> Dr. Jitendra Hazare & Dr. Surojit Hazra	<b>Transplant Surgeon</b> Dr. Kishore Wani, Dr. Nanadan Vilekar, Dr. G. B. Singh, Dr. Rahul Kaiche, Dr. Anurag Srimal, Dr. Gaurav Gupta	<b>Transplant Surgeon</b> Dr. Mukund Andankar, Dr. Hemant Pathak, Dr. Ashiq Raval, Dr. Nayan Sanghvi, Dr. Prashant Pattanaik, Dr. Mohd. Ayub Siddiqui, Dr. Anurag Shrimal, Dr. Gaurav Gupta	<b>Transplant Surgeon</b> Dr. Anurag Shrimal, Dr. Gaurav Gupta
	<b>Anaesthetists</b> Dr. Bhau Rajurkar, Dr. Sarita joglekar, Dr. Swanand Melag, Dr. Avantika Jaiswal & Dr. Das	<b>Anaesthetists</b> Dr. Kirandeep Sandhu, Dr. Rupinder Kaiche, Dr. Sandeep Bhangale	<b>Anaesthetists</b> Dr. Meenakshi Puranik, Dr. Anjali Patki	<b>Anaesthetists</b> Dr. Anjali Patki, Dr. Mangesh Rayban, Dr. Vasudeo Utpat, Dr. Satish Suryavanshi
	<b>Transplant co-ordinators</b> Dr. Rajesh Gade & Preeti Jain	<b>Transplant co-ordinator</b> Dr. Sachin S. Mane	<b>Transplant co-ordinator</b> Bhavana Shah	<b>Transplant co-ordinator</b> Dr. Manisha Pathak

**Rajkot has applied for licence of KTP, Inspection done. Awaiting licence**

# WOMAN'S SKULL PRESERVED IN HER ABDOMEN TO CONDUCT A LIFESAVING SURGERY

The surgery was going to be complicated as there was an injury to the brain tissue. Even though there was no major blood clotting, but the swelling



**Dr. Ajay Bajaj**

Consultant - Neuro-Spine Surgeon  
Wockhardt Hospital, South Mumbai

was extensive. She was administered medications to reduce the swelling, but her condition kept deteriorating. Therefore, it was decided to remove the top half of the skull to allow the swelling of the brain to occupy the cavity and reduce the pressure. It was then preserved in the abdomen. The purpose being that once the swelling is reduced, the part of the skull preserved in the abdomen would be put back in the brain. The brain was then covered with a thin layer of skin. She had suffered diffuse brain injury, which resulted in multiple parts of the brain being affected by the extent of the trauma.

This process of preserving it within the patient's body was to ensure that no external elements affect the skull. Rather than using a prosthesis for reconstruction, it was thought to preserve the original part of the skull. It could have been preserved by refrigerating it at a temperature lower than 8 degrees Celsius. But, as the duration of recovery was hard to predict, it was decided to store the skull naturally. This was the most efficient and natural way to preserve it.

The patient is stable now and has been discharged from the hospital. She will take around 3 months to recover completely following which 2<sup>nd</sup> part of the surgery will be planned.

## DID YOU KNOW:



- Ears and Nose never stop growing
- Similar to fingerprints, everyone also has a Unique tongue print
- When awake, the human brain produces enough electricity to power a small light bulb
- We spend about 10% of our waking hours with our eyes closed, blinking
- If the human eye was a digital camera, it would have 576 megapixels



**Dr. Prashant Mehta**

Medical Administrator  
Wockhardt Hospital, South Mumbai

# CRITICAL CASE WITH POST-PARTUM HAEMORRHAGE (PPH)

A 38-Year-old female, Primigravida with history of IVF (In Vitro Fertilization) pregnancy. Patient was posted for Lower Segment Cesarean Section (LSCS) with Pregnancy introduced hypertension (PIH). She was pregnant with twins at Adipur Private Hospital. LSCS was performed by a Gynaecologist, 1 male and 1 female child. After LSCS, patient had Postpartum haemorrhage (PPH). Well known gynecologists gathered at Adipur Hospital and they took decision of obstetric hysterectomy. The procedure was carried out in which 7 units of whole blood and 2 units of Fresh Frozen Plasma

(FFP) was given. As the drain output was 1500 cc of frank blood, patient was referred to Wockhardt Hospital, Rajkot for further treatment.

On admission, as the patient was in DIC (Disseminated Intravascular Coagulation) with Hb 7.6, Platelet count 56000 and Plasma fibrinogen 225, 10 units of cryoprecipitate and 6 units of fresh frozen plasma were given. Overnight, the patient was observed. But the patient's Hb dropped to 5.4 and she had increased drain out with tachycardia and her Ultrasonography (USG) findings suggested mild to moderate Haemoperitoneum with intra-abdominal hematoma extending from perisplenic region to left iliac fossa and few hematomas in pelvis. An Interventional Radiologist was consulted. Uterine artery and anterior division of internal iliac artery were embolized. Tachycardia was still present with increased drain output. Patient had respiratory acidosis. Endotracheal intubation was done and patient was kept on ventilator.



**Dr. Vikas Jain**

Consultant - Interventional Radiologist  
Wockhardt Hospital, Rajkot



**Dr. Jigna R. Ganatra**

Consultant - Obstetrician & Gynaecologist  
Wockhardt Hospital, Rajkot



Angiography was done. There was active bleeding from the left ovarian artery which was embolised. After that, gradually the patient was stabilized.

Total 15 units of Red Cell concentrate, 10 units of Platelet concentrates, 12 units of Fresh Frozen Plasma, 10 units of Cryoprecipitate and 1 single Donor Platelets were given. When the patient stabilised, she was shifted to the ward. All hematomas gradually got resolved. Patient had episodes of frequent stools for which a gastroenterologist was referred. This case highlights importance of tertiary care centre in managing high risk and critical cases like PPH.

# TWO INTERESTING CASES OF ACCIDENTAL INGESTION OF FOREIGN BODIES

5th  
Article

Foreign body ingestion occurs commonly, with the majority of foreign bodies passing off spontaneously. Most cases occur in pediatric population. In adults, true foreign body ingestion i.e. non food objects occurs more commonly in those with psychiatric disorders, developmental delay, alcohol intoxication and in incarcerated individuals. Edentulous adults are also at greater risk of ingesting foreign bodies, including their dental prosthesis. Impaction, perforation or obstruction often occurs at GI angulation or narrowing. Ingestion of sharp and pointed objects, animal or fish bones, magnets increase the risk of perforation. Once through the esophagus, most foreign bodies including sharp objects, pass uneventfully.

Here we present 2 cases of impacted foreign bodies in esophagus, which were missed initially at first point of contact with medical care, and were subsequently removed by us endoscopically.

## Case 1:

A 59-year-old diabetic male, visited Wockhardt hospitals, North Mumbai with a history of retrosternal chest pain since 3 days. He had consulted 2 physicians and a tertiary care hospital prior to visiting us, and was considered to have acute coronary syndrome and was being treated for it. On detailed inquiry, he gave a history of having



**Dr. Mrudul Dharod**

Consultant - Gastroenterology,  
Hepatology and Endoscopy  
Wockhardt Hospital, North Mumbai

accidentally swallowing a large mutton piece while talking on the phone, followed by onset of chest pain a few hours later. We got a chest and upper neck CT scan done, suspecting a foreign body. CT revealed a triangular bone piece, impacted in the upper esophagus, just below the cricopharynx), with surrounding mucosal edema. Patient was subjected to the upper GI endoscopy, after intubation, which revealed the said bone piece in upper esophagus, lying laterally, with its sharp edges impacted in lateral esophageal walls. The edges were dislodged carefully, and the bone piece was removed with a Rat-tooth forceps. A subsequent tomography revealed mild peri-esophageal mediastinitis, and few air pockets within the wall of esophagus, without any overt perforation. Above findings were probably due to bone piece lying impacted for 3 days and subsequent instrumentation. Patient was kept Nil by mouth (NPO) for few days and maintained on parenteral nutrition. He gradually improved, was started on liquids and discharged on 7<sup>th</sup> day.

CT scan Coronal view showing Triangular bone piece in the esophageal lumen, just below the cricopharynx



## Case 2:

A 60-year-old lady presented to the emergency department with complaints of throat pain of 12 hours duration. She gave a history of foreign body sensation since the previous night, after having gulped a large capsule without water. She had initially gone to the emergency department of a different hospital with the same complaint, wherein she was considered to have a impacted pill, and was discharged after without further evaluation. At home, she found her dental prosthesis of 3 teeth of lower jaw was missing and suspected it had been swallowed with the pill. We got her CT evaluation, which showed a similar shaped foreign body in the upper esophagus with hyperintensity at one end, possibly due to dental cap. Subsequent upper GI ENDOSCOPY under sedation revealed the said dental prosthesis impacted in her upper esophagus. Attempts were made to retrieve it directly, which failed. Subsequently, we pushed it into the stomach gently, maneuvered into the general gastric cavity and retrieved it with an endoscopic snare. Follow up tomography didn't reveal any perforation. She was started on an oral diet the following day and discharged, without any untoward complications.

Denture pushed into the stomach



# ANAESTHETIC MANAGEMENT OF A RARE CASE OF PULMONARY ALVEOLAR PROTEINOSIS (PAP)

A 21-year-old male, chronic tobacco chewer, presented with a complaint of breathlessness since the last 6 months increasing in severity in the last one month from NYHA Grade I to III. Patient was on nebulization, mucolytics & antibiotics medication.

On examination, his vitals were normal except the respiratory rate - 22/min in sitting position with baseline SpO<sub>2</sub> 72% on room air & 83% with O<sub>2</sub>. Bilateral extensive crepitations were present on chest auscultation. No other abnormality was detected on systemic examination.



**Dr. Jayesh Dobriya**

Consultant - Chest Physician & Intensivist  
Wockhardt Hospital, Rajkot



**Dr. Ketan Hirani**

Consultant - Anaesthesia  
Wockhardt Hospital, Rajkot

On investigation, Hb was 17g/dL, chest X-ray s/o bilaterally coarse infiltrates in both lung fields which was confirmed by CT scan chest.

Finally, diagnosis of Bilateral Pulmonary Alveolar proteinosis with type I respiratory Failure was confirmed and patient was posted for Left Bronchoscopic Alveolar lavage under general anaesthesia.

Lavage procedure was started with flooding of left lung with normal saline drip put at 60 cm height from patient. Yellowish white colour effluent suggestive of protein flakes were removed after chest percussion and head down position till clear effluent came from lung lavage. Around 1 litre of lavage was performed during 1st cycle and 9 cycles were performed to achieve a clear effluent. After the end of procedure, DLT was replaced with 8.5 no. cuffed ET tube.

Patient was shifted to MICU for overnight ventilation in a haemodynamically stable condition. Ventilator setting was FiO<sub>2</sub>-60%, Tidal Volume-8ml/kg, RR-18/min, PEEP- 5cm of H<sub>2</sub>O to achieve SpO<sub>2</sub>>94%. Patient was extubated next morning in a haemodynamic stable condition. Postoperatively, SpO<sub>2</sub> was maintained 85% with an O<sub>2</sub> mask and the patient shifted to ward on same day.

Same procedure was performed on right lung after 1 week with same postoperative course to achieve room air SpO<sub>2</sub> >85%.

After one month, second sitting of bilateral lung lavage procedure was done to achieve room air SpO<sub>2</sub>>90% & NYHA Grade I symptoms present on discharge. On follow-up patient was non-symptomatic free & maintaining room air SpO<sub>2</sub>>94% after 4 months.

## GENERAL INFORMATION

Pulmonary Alveolar Proteinosis, is a rare lung disease in which abnormal accumulation of pulmonary surfactant occurs within alveoli, interfering with gas exchange. PAP occurs in primary form i.e. genetic component or rarely secondarily in malignancy, pulmonary infection or environmental exposure to dust or chemicals. Anaesthetic management of such a rare form of lung disease is really challenging, especially one lung ventilation.

# WOCKHARDT GROUP OF HOSPITALS CONDUCTED ITS 4<sup>th</sup> INFECTION PREVENTION & CONTROL CONCLAVE ON 3<sup>rd</sup> & 4<sup>th</sup> DEC 2016

## Participants:

Wockhardt Group of Hospitals conducted its 4<sup>th</sup> Annual Conclave on Infection Control in Mumbai on 3<sup>rd</sup> and 4<sup>th</sup> December, 2016. During the 2-day conclave conducted in association with Indian Medical Association (IMA) - Mira Road, Bhayandar and Association of Medical Consultants (AMC), industry experts from across the country delivered lectures on the importance of hospital infection prevention and control initiatives.



The event saw participation from over 450 clinicians, nurses and hospital administrators from various hospitals of Mumbai region & other cities like Nagpur, Indore, Pondicherry, Surat, Rajkot, Ahmedabad, Chennai, Hyderabad, Nashik etc. The conclave focused on a range of topics on infection prevention which will be useful to clinicians, nurses and hospital administrators.

The conclave was inaugurated by Zahabiya Khorakiwala, Managing Director, Wockhardt Hospitals, Anupam Verma, President Wockhardt Hospitals and Dr. Clive Fernandes, Group Clinical Director Wockhardt Hospitals along with Dr. B K Rana, CEO, NABH, Quality Council of India (QCI) and Dr. Girdhar Gyani, Director General, Association of Healthcare Providers (India) and the IMA - Mira Road Bhayandar President Dr. Rajiv Agarwal.



Sessions were delivered by industry experts in infection control from across the country, that included speakers from Breach Candy Hospital, Mumbai, Columbia Asia Hospital, Pune; DM Aster Hospital Bangalore; Global Hospital, Chennai; Kokilaben Dhirubhai Ambani Hospital; Manipal Hospital, Bangalore; Orange City Hospital, Nagpur; Shalby Hospital, Ahmedabad and Wockhardt Hospitals.

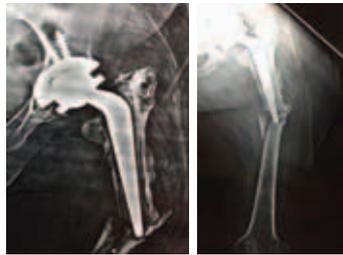
# COMPLICATED FRACTURE FEMUR TREATED SUCCESSFULLY

A 35-year-old, female patient with a history of avascular necrosis (AVN) of the left hip since the last 4 year back with left sciatic nerve palsy and a known case of Post Polio Residual Paralysis (PPRP) of the right lower limb was operated in Wockhardt Hospital with Total Hip Replacement (THR) with uncemented constrained acetabulum. Recently, she tripped over a carpet at home and fell down.



**Dr. Yogesh Chaudhari**

Consultant - Joint replacement surgery  
Wockhardt hospital, Nashik



She presented to Wockhardt Hospital, Nashik with pain in the left hip with swelling and inability to weight bear on left lower limb. X-rays were done which showed a peri-prosthetic fracture of the left femur with loosening of the femur stem and proximal stress shielding. She was planned for revision THR with distal fixation stem (Wagner) while retaining the acetabular component and the liner. During surgery, it was difficult to dislocate the stem due to a constrained liner. So, we had to extract the liner itself to dislocate the stem. The stem being loose came out easily. After taking off the cement completely, distal femur reaming was done and Wagner stem was put to give additional rotational stability. We did an encirclage wiring over a DCP which was applied over a lateral femoral surface spanning the fracture site. Constrained liner was put back into the cup and locked. We also put the bone graft substitute at the fracture site to enhance bone healing.



Post-op, the patient has been kept non-weight bearing. 1<sup>st</sup> follow-up X-ray has been convening and we hope the fracture to heal over a period of few months.

## ANSWERS TO QUIZ – WOCKSYNAPSE 6

### Answer 1

#### Periungual telangiectasia

- Seen in upto 49% diabetics
- Megacapillaries and irregularly elongated loops
- Often associated with nail fold erythema, accompanied by fingertip tenderness and “ragged” cuticles
- Functional microangiopathy (engorgement of venular limbs), tortuosity indicates structural changes

### Answer 3

Grave’s dermopathy or Pretibial myxedema (PTM) or thyroid dermopathy is a term used to describe localized lesions of the skin resulting from the deposition of hyaluronic acid, usually as a component of thyroid disease. Although it is most often confined to the pretibial area, it may occur anywhere on the skin, especially the ankle, dorsum of the foot, knees, shoulders, elbows, upper back, pinnae, nose, and neck. It is nearly always associated with autoimmune thyroid disease.

### Answer 4

Peutz–Jeghers syndrome: a familial polyposis inherited as an autosomal dominant trait and characterized by numerous polyps in the stomach, small intestine, and colon and by melanin-containing spots on the skin and mucous membranes especially of the lips and gums.

### Answer 5

Yellow nail syndrome, is associated with yellow dystrophic nails, pleural effusion and lymphedema (due to under development of the lymphatic vessels).

### Answer 2

#### Acanthosis nigricans

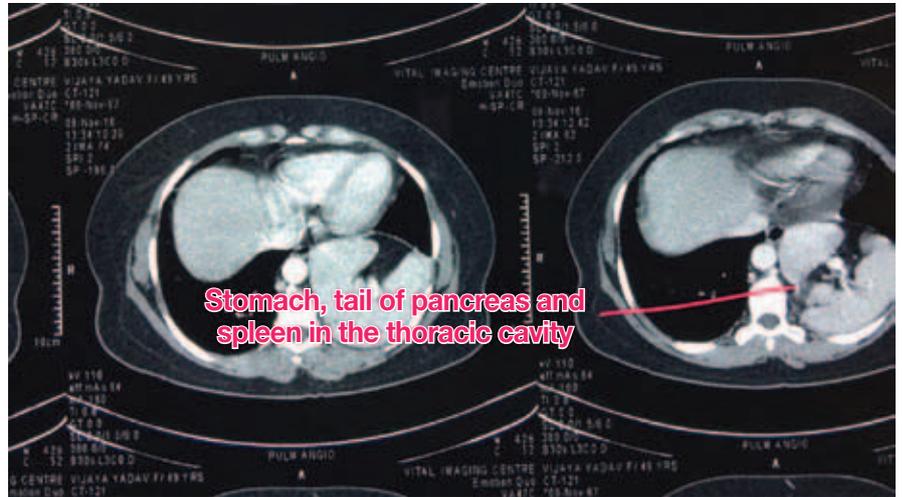
- Symmetrical
- Velvety- verrucous hyperpigmented plaques
- Associated with papillomatous skin tags
- Axilla, nape of the neck
- Occasionally hands & feet, mucous membranes
- Hyperinsulinaemia- stimulate IGF receptor on KC+dermal fibroblasts

# A STITCH IN TIME SAVES NINE

A 49-year-old female was suffering from chest discomfort and breathlessness since 3-4 years. She did not have any co-morbidities like hypertension or diabetes. For the past 6 months the intensity of her complaints went on increasing. With the same complaints she went to various tertiary care hospitals across Mumbai, but there was no diagnosis and outcome. She was very tired of her problems and her life had become a misery.

She then came to Wockhardt Hospitals, North Mumbai. At the time of presentation, she was breathless with severe chest discomfort. Her Electrocardiogram (ECG) was showing non-specific changes and even the other investigations were within normal limit.

CT scan done in view of chest discomfort showed left-sided diaphragmatic hernia through the foramen of Bochdalek with a part of stomach, tail of pancreas and whole of spleen inside the left thorax. The heart was displaced to the right side and the left lung was compressed in the lower and middle zone. In view of massive



diaphragmatic hernia, a laparotomy was performed through left subcostal incision. The hernia defect was identified. All the abdominal organs were brought down to the abdomen and the defect was approximated and reinforced with a mesh.

Post-operative ultrasound showed adequate lung expansion. Patient was discharged on the 4<sup>th</sup> post-operative day with a big smile. Patient is comfortable and thankful for the accurate diagnosis and timely treatment.

North American Journal of Medical Sciences 2016 published the fact that such cases of Bochdalek hernia are very rare.



**Dr. Brijesh Dube**

Consultant - General Surgery  
Wockhardt Hospital, North Mumbai

## Patient's testimonial

My wife was suffering from this problem since long. We had shown her to various doctors but she couldn't get any relief. Then we approached Wockhardt Hospital, North Mumbai. Dr. Brijesh is a very good doctor. He explained things very nicely and with his timely operation and treatment, my wife was relieved of her problems which had persist for long. My wife is very happy with the treatment and recovery.

**- Narayan Yadav**

# TEAM EFFORT TREATS AN AGGRESSIVE CANCER IN AN ELDERLY GENTLEMAN

A 71-year-old gentleman, known case of hypertension and bronchial asthma presented with jaundice, itching, abdominal pain and fever for 3 weeks.

On work up, the jaundice was cholestatic in nature and bilirubin was 19 mg/dL.



**Dr. Amit Gupte**

Consultant - Gastroenterology  
Wockhardt Hospital, South Mumbai



**Dr. Akash Shukla**

Director - Gastroenterology &  
Hepatology, Maharashtra  
Wockhardt Hospital, South Mumbai



**Dr. Boman Dabhar**

Consultant - Medical Oncology  
Wockhardt Hospital, South Mumbai



**Dr. Gaurav Gupta**

Consultant - Abdominal Organ  
Transplant & General Surgery  
Wockhardt Hospital, South Mumbai



**Dr. Anurag Shrimal**

Consultant - Abdominal Organ  
Transplant & General Surgery  
Wockhardt Hospital, South Mumbai

Ultrasound of the abdomen showed dilated intrahepatic radicals with a mass in the proximal common bile duct (CBD). CT abdomen revealed a hilar mass with total occlusion of the CBD, the mass extending into the right biliary system with preserved communication of the right and left system. The mass was abutting the right portal vein and right hepatic artery. Radiologically, vessel involvement was not ruled out. In view of cholangitis, the patient was taken up for Endoscopic Retrograde Cholangio Pancreatogram (ERCP) first which showed a tight hilar stricture and communicating right and left system. The left system was drained with a 10 Fr plastic stent. Brush cytology confirmed hilar cholangiocarcinoma. The patient's cholangitis improved initially with resolving hyperbilirubinemia, but after a week he developed fever with leukocytosis without a rise in bilirubin. Segmental cholangitis was suspected. Repeat CT showed an undrained right posterior system. PTBD (Percutaneous Biliary Drainage) was done to drain the right posterior system. Subsequently, his cholangitis settled.

Hilar cholangiocarcinoma being a very aggressive tumour, its curative treatment can be achieved only by surgical resection. Most of the patients presenting with this cancer are already beyond curative stage. Our patient presented at a stage where the mass had probably involved the right hilar structures but his main vessels (portal vein and hepatic artery) were free. For curative surgery, a right major open liver lobe resection had to be done to resect all the cancer. Although he was 71-year-old, he was physically fit and quite active. Hence, we decided to be aggressive and offered him surgery as an option. CT volumetry for liver showed a remnant of almost 40%. He was taken up for surgery. Intraoperatively, CBD was resected at the retropancreatic area. Frozen section from the distal end was negative for malignancy. Left bile duct margin was negative for malignancy in frozen section. Right hepatectomy with complete excision of extrahepatic biliary apparatus along with hepaticojejunostomy was done. The patient tolerated the surgery very well and was discharged in 5 days without any complication. The biopsy showed cholangiocarcinoma with perineural invasion. No macrovascular invasion was seen and resection margins were negative.

**He is currently on adjuvant chemotherapy and is doing very well.**

# MEDICAL QUIZ

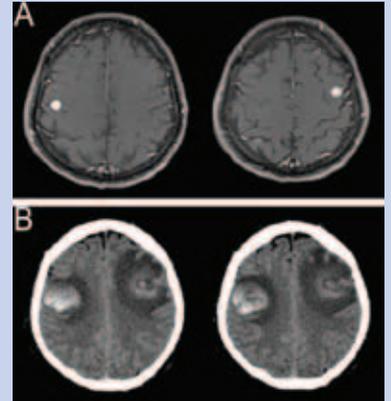
Q1. These type of lesions are characteristics of which disease?



Q2. A 52-year-old man with metastatic melanoma deposits in the frontal lobes bilaterally presents with an acute onset of headache. CT brain shows haemorrhages at the sites of the metastases.

Which of the following eye movement disorders is most likely?

- Absent quick phases of nystagmus
- Absent voluntary saccades
- Bilateral sixth nerve palsy
- Bilateral third nerve palsy
- Nystagmus

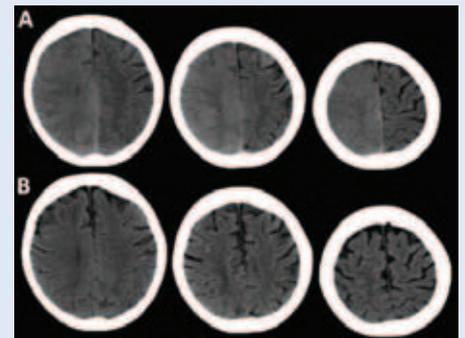


Q3. A 60-year-old woman was found unconscious in her hospital bed approximately two hours after routine coronary angiography.

Cerebral CT-scan revealed the following:

What is your diagnosis?

- Decompensated glioblastoma multiforme
- Diffuse subarachnoid haemorrhage
- Malignant ischaemic infarct of the right middle cerebral artery
- Neurotoxic cerebral oedema
- Status epilepticus



Q4. The highest levels of HPL (human placental lactogen) can be found in which of the following?

- Fetal urine
- Fetal serum
- Amniotic fluid
- Maternal serum

Q5. In pregnancy, what is the Chadwick sign?

- Bluish discoloration of the vaginal mucosa
- Lower uterine segment softening
- Tenderness of breasts with enlargement
- Uterus palpable above the pubic symphysis

Q6. Your patient has had two first trimester and one second trimester spontaneous abortions. Her screen for anticardiolipin antibodies is positive. The most appropriate treatment option for this patient during her next pregnancy includes which of the following?

- Low dose aspirin + heparin
- Low dose aspirin + plaquenil sulphate
- Low dose aspirin + steroids
- Reassurance



**Dr. Sadaf Khan**

Medical Administrator

Wockhardt Hospital, North Mumbai

Please send your answers for quiz to  
[wocksynapse@wockhardthospitals.com](mailto:wocksynapse@wockhardthospitals.com)

# NEW CONSULTANTS WHO JOINED THE WOCKHARDT FAMILY

Name of the Consultant	Qualification	Specialty	Location
Dr. Dipen Patel	MS MCh (Oncosurgery)	Oncology	Rajkot
Dr. Falguni Jani	MD (Pathology)	Histopathology	Rajkot
Dr. Jignesh Usdadia	MD DM (Clinical Immunology & Rheumatology)	Rheumatology	Rajkot
Dr. Akshay Jain	MD, FACE, CCD, ECNU, D.ABOM	Endocrinology	South Mumbai
Dr. Bhagyam Nagarajan	DNB (Radiology)	Radiology	South Mumbai
Dr. Bhadra Trivedi	MD (Paediatrics), Fellowship in Paediatric Cardiology	Paediatric Cardiologist	South Mumbai
Dr. Soham Doshi	MBBS, MD (Medicine), DNB (Gastrohepatology)	Gastroenterology	Nashik
Dr. Rahul Baste	MBBS, MD (Medicine)	Critical Care	Nashik
Dr. Sandeep Aware	MBBS, MS (Ortho)	Orthopaedics	Nashik
Dr. Swapnil Sakhala	MBBS, DNB (Tuberculosis & Respiratory Disease), DTCD	Chest Medicine	Nashik
Dr. Pankaj Gupta	MBBS, MD (Anesthesia)	Anaesthesia	Nashik
Dr. Babulal Agrawal	MBBS, MS (Paed. Surgery)	Paediatric Surgery	Nashik
Dr. Bindu Mulakavalupil	DNB Anesthesia	Critical Care	North Mumbai
Dr. Riya Ballikar	MD (Medicine), DM Clinical	Haematology	Nagpur
Dr. Sourabh Shirguppe	DNB, MCh Orthopaedic Surgery	Orthopaedics	Nagpur
Dr. Rishikesh Awode	MD (Anaesthesia)	Anaesthesiology	Nagpur
Dr. Prasad Panbude	MD, DM (Anaesthesia)	Anaesthesiology	Nagpur

# EDITORIAL PAGE



Dear Readers,

Wishing each one of you a very happy, joyous and prosperous New Year 2017.

I hope you have found the published articles an interesting read, just the way I have. This edition of Wocksynapse highlights the Organ transplant program across our group hospitals and showcases how in our South Mumbai Unit within a span of just over a month of obtaining all statutory clearances our team has got down to performing some very complex transplants. Wishing the team all the very best going forward!

At Wockhardt Hospitals in addition to clinical excellence we place great importance to academics and sharing of good practices with our community hospitals. Our Annual Infection Prevention and Control Conclave is a one of the ways in which we meet this objective. The sheer magnitude of growth of this conclave is a testimony to this. Our first conclave in 2013 was an internal event and had 14 participants. Subsequently, every year we started involving community hospitals and IMA which granted the program CME points. Our 4<sup>th</sup> All India Infection Prevention and Control conclave in Dec 2016 in Mumbai in association with IMA & AMC had over 450 registered participants from across the country. The faculty included Infection control doyens from across reputed healthcare organizations in the country. It was a great learning experience for all participants.

Looking forward to your feedback and views about this edition at [wocksynapse@wockhardthospitals.com](mailto:wocksynapse@wockhardthospitals.com)

**Dr. Clive Fernandes**  
Group Clinical Director,  
Wockhardt Group Hospitals

<b>Dr. Clive Fernandes</b>	<b>Editor</b>
<b>EDITORIAL BOARD</b>	
<b>Ms. Ieshu Razdan</b>	<b>BKC</b>
<b>Dr. Chintan Shanishwara</b>	<b>Rajkot</b>
<b>Dr. Sachin Mane</b>	<b>Nashik</b>
<b>Dr. Rajesh Gade</b>	<b>Nagpur</b>
<b>Dr. Manisha Pathak</b>	<b>NOBO</b>
<b>Dr. Prashant Mehta</b>	<b>SOBO</b>
<b>Mr. Santosh Dasgupta</b>	<b>BKC</b>
<b>Dr. Vikas Chaudhari</b>	<b>Nagpur</b>



Contact Us  
[wocksynapse@wockhardthospitals.com](mailto:wocksynapse@wockhardthospitals.com)  
Ph. No. (+91)-22-7159 6537/6509

Disclaimer: "It is to be noted that the treatments being discussed above are informative in nature and case to case specific. Hence it should not be treated as medical advice. Readers are advised to consult clinicians before making any informed view or decision in this regard."