Dear Associates,

Another quarter has gone by and it is work as usual at Wockhardt Hospitals. Even as this edition goes to print our North Mumbai Unit has successfully performed its first cadaver Liver transplant case. At Wockhardt hospitals our mission is to provide quality high end Medical treatment with excellent clinical outcomes to all our patients and this edition highlights some of the complex work our associates are doing towards fulfilling our mission.

Our South Mumbai hospital recently underwent survey by Joint Commission International and has become the first hospital in South Mumbai to be JCI accredited. My heartiest congratulations to the entire team who have worked relentlessly to ensure a successful completion of this audit. I am sure the experience has been very enriching for all our associates and you will continue with the same dedication and commitment.

I would like to wish all our Nursing associates on the occasion of Nursing day that is celebrated internationally on 12th May. At Wockhardt hospitals Nurses play a very important role in delivering quality, compassionate and safe patient care. Our Nursing associates are also at the fore front leading many projects.

I am extremely proud of our associates and would like to congratulate all group hospitals for participating in the different healthcare forums showcasing some of the excellent operational and patient safety initiatives we have implemented, competing with the best healthcare organizations and winning awards. Your dedication and hard work is commendable and your efforts ensure that at Wockhardt Hospitals, Life Wins.

Zahabiya Khorakiwala
Managing Director,
Wockhardt Hospitals
Did you know that Vitamin B 12 deficiency can be associated with coronary artery disease

A 32-year-old male presented to Wockhardt Hospital, North Mumbai emergency department in a gasping state. The patient had sudden onset of crushing chest pain. He was taken to a private nursing home where ECG was done. ECG showed hyperactive anterior wall myocardial infarct. He was referred to Wockhardt Hospital. While getting shifted, the patient had 2 to 3 episodes of unresponsiveness.

Patient was intubated immediately. ECG showed multiple episodes of ventricular tachycardia/ventricular fibrillation. DC cardioversion was done at regular intervals to revive the patient.

Coronary angiography was suggestive of LAD flush occlusion from ostium. Immediate thrombosis with direct stenting to LAD was done with a drug eluting stent. Ventricular tachycardia/ventricular flutter storm subsided after the stenting. Patient had good TIMI3 flow with grade 3 myocardial blush. He was extubated after 24hrs and had a complete neurological recovery. He was discharged on day 4 in a stable condition and was asked to follow life style modifications along with medications.

On history and investigations, he had no family history, no addictions with regular job schedule. He was a pure vegetarian with normal lipids and HbA1C.

Serum Homocysteine was more than 100 (Normal Value- 15) secondary to severe Vit B12 and folate deficiency. Hyper homocysteinemia is one of the correctable risk factor for premature Coronary Artery Disease. It is secondary to severe Vit B12 and folate deficiency common in pure vegetarians.

**General Information:**

Pure vegetarians with B12 deficiency are at equal/high risk risk for premature Acute Coronary Syndrome and Coronary Artery disease. Urgent PAMI with door to balloon time < 30 mins salvaged this patient with complete neurological recovery.

**Dr. Anup Taksande**
Consultant- Cardiology
Wockhardt Hospital, North Mumbai
Relief from hyperhidrosis - side effect used as a treatment

A 28-year-old male patient came with the complaint of excessive sweating in both palms and both soles since last 15 years. He had a high profile job and was very embarrassed because of his sweating problem. He had visited many doctors and taken many medicines for the same with no relief. He was then advised by a surgeon to go to a Pain Physician and he came to Wockhardt hospital, Nagpur. All investigations were done to rule out secondary hyperhidrosis. He was also referred to Intensivist and Physician of Wockhardt to rule out any other medically treatable problem.

Basic investigations were normal. His labs revealed Sr.calcium were low and 25-[OH] Vitamin D value of 16.4ng/ml. for which he was given calcium and vitamin D3 supplements for over a month. He was also given oral cyclopam. 24hrs VMA [Vanillyl Mandelic acid] was 2.54.

There are various conservative methods to treat the disease like Physiotherapy (Iontophoresis) which are time consuming and require regular follow ups. Patient wanted immediate relief to the condition so he was scheduled for stellate ganglion block. Initially it was done only for the right hand, as it was troubling him more. After informed high risk consent, a diagnostic stellate ganglion block was performed. Patient had signs of Horner’s syndrome meiosis, rise in temperature of 3 degrees celcius and his hand felt dry.

He had a 40% reduction in sweating on second day. After a gap of 2 days second ganglion block was done. Follow up after a month and patient is happy with the improvement.

General Information:

Incidence of focal hyperhidrosis is 2.8% involving population between 25-65yrs. and has a genetic predisposition.
Stellate ganglion block is a safe effective alternative giving the patient relief for 6mths to a year. One of the side effects of stellate ganglion block is anhydrosis (complete loss of sweat) which was used in this case to relieve the hyperhidrosis (excessive sweating).

Dr. Kiran Vyawahare
Sr. Consultant: Anaesthesia and Pain Management
Wockhardt Hospital, Nagpur
Pharmacomechanical catheter directed therapy in a patient of massive pulmonary embolism

A 50 years old gentleman, a known case of systemic hypertension, chronic smoker presented to Wockhardt Heart Hospital, Nagpur with history of dyspnea and cough since 4 days. He was referred with the diagnosis of acute pulmonary embolism, pulmonary hypertension, right ventricular dysfunction with right heart failure. Earlier the patient was admitted in a private hospital and received Inj. Streptokinase infusion for 24 hrs, but patient's condition did not improve and hence he was transferred to Wockhardt.

After admission to our hospital Inj. Streptokinase infusion was continued for another 24 hours. However the patient's condition did not show improvement and he required noninvasive ventilatory support.

His 2 D echocardiogram was done which was suggestive of right atrium, right ventricle dilated and severe pulmonary hypertension with pulmonary artery systolic pressure of 76 mm Hg (Normal value: 120mmHg). His D-Dimer was high (4293 ng/ml). Venous doppler both lower limbs was done which revealed no evidence of deep vein thrombosis. The biochemical report was suggestive of acute kidney injury on chronic kidney disease (Sr. Creatinine – 2.37 mg/dl).

Patient and relatives were given the options of pulmonary angiogram with local thrombolysis and surgical pulmonary thrombectomy. They opted for local thrombolysis with Inj. Actylase. The thrombus was masserated with Terumo wire and 20 mg of Actylase was injected over 20 minutes.

The patient showed dramatic improvement on table as his saturation improved. Antegrade flow in right pulmonary artery was established. Gradually his condition improved and repeat 2 D echocardiogram showed fall in pulmonary artery systolic pressure (46 mm of Hg). Patient was put on unfractionated heparin 5000 IU bolus then 1000 IU/hr infusion with regular monitoring of activated partial thromboplastin time (APTT). Patient's condition showed gradual improvement and he was subsequently discharged in stable condition.

He is advised for follow up after 2 weeks. His kidney function test and 2 D echocardiogram will be repeated during next visit and CT pulmonary angiogram will be done to assess pulmonary artery vasculature.
General Information:

The 1% greater rate of intracranial haemorrhage in patients with pulmonary embolism receiving systemic thrombolysis has dampened enthusiasm for this potential life saving therapy. Pharmacomechanical catheter-directed reperfusion, however, holds the promise of good efficacy, with lower rates of major bleeding owing to lower dose of thrombolytic agent. The typical dose of tissue plasminogen activator in a pharmacomechanical catheter-based procedure, for example, is 25 mg or less as compared with 100 mg for systemic administration.

Interventional mechanical techniques usually performed in conjunction with low dose thrombolysis include mechanical fragmentation and aspiration of thrombus through a standard pulmonary catheter, clot pulverization with a rotating basket catheter, rheolytic thrombectomy and pigtail rotational catheter embolectomy. After the thrombus burden has been reduced, pulmonary artery balloon dilation and stenting can be undertaken to treat residual vessel stenosis. Successful catheter embolectomy rapidly restores normal blood pressure and decreases hypoxemia. Low intensity ultrasound–facilitated fibrinolysis is a novel approach. Ultrasound disaggregates fibrine strands, increases clot permeability, and disperses infused fibrinolytic drug into clot through acoustic microstreaming effects.

Did you Know

Medical Facts

- The human brain is capable of creating more ideas equivalent to that of the atoms of the universe.
- A sneeze leaves your body at 40 miles per hour.
- Your skull is made up of 22 different bones.
- Human blood travels 60,000 miles (96,540 km) per day on its journey through the body.
- Laugh and you will burn up three and a half calories.
A 37-year-old female presented to Wockhardt Hospital, North Mumbai with sudden onset of severe headache, nausea, vomiting and left eye diplopia since 3 days.

MRI brain revealed a solid cystic lesion in the sellar region with left parasellar extension. The lesion appeared iso to hyperintense on T1 weighted imaging and iso to hyperintense on T2 weighted imaging along with fluid-fluid level suggestive of hemorrhagic transformation of sellar lesion. Superiorly the lesion was compressing the optic chiasm and laterally the tumor was encasing the internal carotid artery. Tumor showed homogenous enhancement on post contrast injection. Imaging features were suggestive of pituitary tumor with apoplexy.

Ophthalmological evaluation did not reveal any field defects. Pituitary hormonal profile was normal.

The patient was stabilized with adequate analgesics, corticosteroid supplements and electrolyte correction. Endonasal Endoscopic Transsphenoidal decompression of pituitary tumor was done. This is purely an endoscopic binostri approach. The first part of the surgery included access to the sphenoid sinus and sellar floor and the second part included opening of the sellar floor and tumor decompression. There was no evidence of CSF leak after tumor decompression as confirmed with intraoperative valsalva maneuver. First part of the surgery was done by the ENT surgeon who is specialized in endoscopic skull base surgery and the second part by the neurosurgeon. Patient was then extubated after the procedure. Post operatively nasal packs were removed after 72 hrs. Left eye diplopia completely resolved postoperatively. There was no CSF rhinorrhea or no electrolyte imbalance, no diabetes insipidus in the postoperative period. Histopathology report was suggestive of pituitary adenoma. As the pituitary hormonal profile was normal, corticosteroid supplements were given only in perioperative period and the patient was discharged on 5th post operative day on analgesics, antacids, and nasal drops.

Follow up post contrast brain MRI done 2 months after the surgery showed near complete excision of tumor.
General Information:

Pituitary apoplexy (PA) is a relatively uncommon yet potentially life-threatening clinical syndrome caused by the rapid enlargement of a pituitary adenoma because of hemorrhage or infarction.

Classically, symptoms evolve from hours to two days after the onset of apoplexy, although a subacute course is described. Most patients complain of headache, visual defects and ophthalmoplegia. A high degree of suspicion is needed to make the clinical diagnosis as most patients do not have a previous history of known pituitary adenoma.

It is important to stress that pituitary adenomas co-exist with cerebral aneurysms at a rate of 7.4%.

Answers to Quiz  Wocksynapse 7

**Answer 1:** Lyme disease

**Answer 2:** Absent voluntary saccades

**Answer 3:** Neurotoxic cerebral oedema

**Answer 4:** Maternal serum

**Answer 5:** Bluish discoloration of the vaginal mucosa

**Answer 6:** Low dose aspirin + heparin
A 48 year old male met with road traffic accident due to unusual hailstorm which blindfolded him and as a result he collided with a tree. He suffered a wooden stick high velocity penetrating injury to his right eye ball.

Through the right eye ball the stick entered the skull. Patient became unconscious on the spot, immediately he was moved to a local hospital, where the doctor tried to take out the stick. But the stick was badly impacted in the eye ball and was not moving at all on manipulation. Gradually the patient landed up in hypotensive shock. Looking at the extend of injury the treating doctor immediately referred him to Wockhardt hospital Nagpur.

CT scan of the head was done which revealed that the stick had penetrated the eyeball and entered the skull.

Along with that the patient had bleeding in the medial temporal lobe and intraventricular bleed. Patient was taken for emergency surgery. Orbital and cranial exploration were done. The stick was badly impacted hence the lateral wall orbitotomy was done and stick taken out. It was a 15cm long stick which has damaged the eyeball completely.

In view of the injury the patient was electively ventilated. An opthalmologist opinion was done. B scan revealed choroidal and retinal detachment along with the bleed.

VEP (Visual Evoked Potential) was also done which showed no vision in right eye. Retinal expert opinion was also taken and patient was advised conservative management and regular follow up for the eye injury. Post operatively the patient became conscious following command with complete vision loss in the right eye. Patient was extubated on 2nd post-operative day. Patient had no motor deficit; head injury part was managed conservatively. Patient was discharged on post op day 11, except vision loss he was intact neurologically.

**Challenges:**

- Grievous penetrating eye ball injury a single miss would have made him paralyzed for whole life.
- Severe head injury leading to paralysis.
- Hypotensive shock.
- Prevention of eye ball infection.

**Dr. Ajay Kurve**  
Consultant- Neurosurgery  
Wockhardt Hospital, Nagpur

**Dr. Ajay Sakhare**  
Consultant - Critical Care & Internal Medicine  
Wockhardt Hospital, Nagpur

**Dr. Pravin Thakur**  
Consultant-Anesthesia  
Wockhardt Hospital, Nagpur
Timely intervention in Brain Hemorrhage saves a life

A 26 year old male, a road traffic accident case was referred to Wockhardt Hospital, North Mumbai emergency department in a state of drowsiness, paucity of movement of left upper arm (power Grade 1/5) and left lower limb (power Grade 2/5). His Glasgow Coma Score on admission was E1M5V1. Pupils were bilaterally equal and reacting to light.

CT brain revealed a fairly large right frontal extradural hematoma with compression over the ipsilateral motor cortex and lateral ventricle. The hematoma was measuring approx. 3.7 cm in maximum thickness with subfalcine herniation to the left measuring 1.5 cm.

The patient was immediately shifted to ICU where he was resuscitated and hydrated with IV fluids and intubated in view of poor GCS score. Arterial line access was taken and he was shifted to the operation theatre.

Right frontal craniotomy was done and the hematoma was evacuated. There was extensive oozing from the anterior part of superior sagittal sinus which was controlled with hemostatic agents. Multiple dural hitch sutures were taken and thorough hemostais achieved. Bone flap was replaced back and fixed. Wound was closed in layers after placing subgaleal drain. Patient was then shifted to ICU on ventilatory support.

Within 24 hours after surgery he was conscious and obeying commands and subsequently extubated. His left side hemiparesis also significantly improved (power Grade > 3/5). Subgaleal drain was removed after 48 hours. Follow up CT scan of brain did not show any residual hematoma.

He was transferred to the wards and subsequently discharged on 3rd postoperative day. At the time of discharge, he was conscious, oriented with a GCS score of E4M6V5 and without any neurological deficit. Sutures were removed on 8th postoperative day in OPD.

General information:

Extradural hematoma is an emergency and if treated promptly and efficiently can save the patients life and prevent morbidity as well. In this particular case, due to collective efforts of the emergency department staff, ICU team, anesthetist and operation theater staff, we could do the surgery early and this has given a new life to this patient.

Dr. Pandurang Reddy M
Consultant Endovascular Neurosurgeon
Wockhardt Hospital, North Mumbai

Dr. Neepa Vellimuttam
Consultant ENT & Endoscopic Skull base surgeon
Wockhardt Hospital, North Mumbai
World Health & Wellness Congress and Awards Best design hospital- Feb 2017

50 outstanding women in healthcare
Ms. Zahabiya Khorakiwala

100 most impactful Healthcare leaders
Dr. Clive Fernandes

Wockhardt Group Hospitals, won award for “Innovation in Quality of Service Delivery”

Wockhardt Hospital, South Mumbai award for “Best design hospital”

Wockhardt Hospital, Nashik won award for “Best Multispecialty Hospital in respective regions”

Wockhardt Hospital, Rajkot won award for “Best Multispecialty Hospital in respective regions”
Wockhardt Hospital, Nagpur won award for “Best Multispecialty Hospital in respective regions”

Wockhardt Hospital, Surat won award for “Best Single Speciality Hospital”

Wockhardt Hospital, North Mumbai won award for “Best CSR activity”

AHPI Awards for Excellence in Healthcare- Feb 2017

Wockhardt Hospital, Nagpur won award for “Quality beyond Accreditation”

3D Printing World Award 2017 - Medical & Health Care “Hospital of the Year” 7th March 2017

Wockhardt Hospital, North Mumbai won award for “Hospital of the Year”
Accreditations (March-June 2017)

South Mumbai unit accredited with JCI on – 29th April, 2017

Surat unit accredited with NABL on - 20th March, 2017
Complicated case of cardiac rupture and MI

A 63 year old male presented to Wockhardt Hospital, Surat with chest pain on mild physical exertion with perspiration and giddiness. The patient had taken primary treatment from a private hospital and was referred to Wockhardt hospital, Surat for further management.

Echo revealed pericardial collection with suspected free wall rupture. As in such cases surgery is not a viable option so the patient was admitted and conservative management was started.

Next day early morning the patient became drowsy followed by cardiac arrest. Immediately CPR was done and echo was performed which revealed free wall rupture of LV( Left Ventricular ) with pericardial collection. Patient was shifted to OT for surgery. On opening the chest it was observed that there was a 5-6 cm tear of cardiac muscle in posterolateral wall of MI( Myocardial Infaction). There was large collection of blood and clot in pericardial cavity.

The rupture was repaired with dacron patch and teflon using 2 -0 centibond interrupted mattress sutures followed by 3 – 0 prolene continuous suture as a 2nd layer. After proper hemostasis, chest was closed and patient was shifted to ICCU in stable condition.

During OT and after OT, blood transfusion was done. Patient was keep in the ICCU for 4 days and shifted to the ward for further management. There was no neurological or cardiac event after surgery and patient was discharged with improved EF (Ejection Fraction)

Uniqueness of case:

- Post MI ruptures are most of time managed conservatively as it is difficult to repair a fragile tissue.
- High mortality rate but this case survived without any complication.
- Chances of brain damage during cardiac arrest are there but this patient had no neurological defect.
- Chances for re exploration are present in case of more oozing of blood. But in this case no requirement of re exploration.
- Less than 15 days stay inside hospital stay even after such a major operation.
An interesting case by interventional cardiologist related to aortoplasty with use of self-expandable stent.

A 20 year old female presented to Wockhardt Hospital, Surat with complain of recurrent headache and numbness of limb associated with chest pain. Her BP was 250/100 mmHg on upper limb and 100/60 mm Hg on right lower limb.

2 D Echo suggested interrupted aortic arch type A with LVH (Left ventricular hypertrophy). Aortogram was suggestive of occlusion of the descending thoracic aorta distal to the origin of sub clavian artery and distal aorta. Subclavian artery was normal which was suggestive of interrupted aortic arch type A.

Patient being a young lady, surgical option was ruled out. Angioplasty was the only option left but it had risk of complication related to rupture or aneurysm or guide wire not being able to pass or emergency cardiac surgery.

After various thought processes patient was scheduled for angioplasty by self-expandable stent.

Post aortoplasty patient was shifted to ICU with stable hemodynamic and difference of BP in upper and lower limb was regularized.

Echo was done again which was suggestive of Stunting of Type-A Interrupted Aortic Arch with Gradient across stent, Moderate LVH (LVID= 51/32 mm, IVS/PW= 8/8mm) Good biventricular function. (EF: 68 %, FS: 38 %) without PAH.

Patient was discharged without any complication with antiplatelet drug and anti hypertensive drug.

General Information:

Interrupted aortic arch (IAA) is an uncommon congenital anomaly representing approximately 1% of congenital heart disease. More than 97% of the cases also have associated cardiac anomalies complicating their treatment.
Please send your answers for puzzle to wocksynapse@wockhardthospitals.com

ACROSS

1. Conducting nerve impulses in a direction opposite to normal. (10)
2. Located outside the alimentary tract. (10)
3. Filled with vascular sinuses and capable of becoming distended and rigid as the result of being filled with blood. (9)
4. Make a great effort at a mental or physical task. (5)
5. Capable of responding to stimuli. (9)
6. Especially of muscles; drawing away from the midline of the body or from an adjacent part. (9)
7. A medicine that strengthens and invigorates. (5)
8. Moving of a body part away from the central axis of the body. (9)
9. Not supplied with oxygen. (9)
10. Of two or more muscles; having equal tension. (8)
11. The effect of a stimulus (on nerves or organs etc.). (11)
12. Without volition or conscious control. (6)
13. Regulation or maintenance of a function or action or reflex etc. (7)
14. Of sexual organs; stiff and rigid. (5)

DOWN

1. Drawing a limb towards the body. (9)
2. Maintaining a generally constant physiological state in a cell or organism. (14)
3. Supplied with oxygen by respiration. (7)
4. Controlled by individual volition. (9)
5. Controlled by the autonomic nervous system; without conscious control. (11)
6. Located outside the alimentary tract. (10)
7. Filled with vascular sinuses and capable of becoming distended and rigid as the result of being filled with blood. (8)
The year 2017, bringing a paradigm shift in the health care industry. The healthcare industry seeing so many Government interventions on various facets of Healthcare operations. Stents covered under DPCO, prescription in generics, implementation of GST and almost every week’s Chinese whispers suggesting many more items coming under DPCO, literally disturbed our quiet and easy life of many years. In most of the cases, decisions came first and we waited for what process and methodology to follow for implementation. Healthcare was never shaken up for many years and that made all healthcare professionals complacent, easy going and never trying to think differently. We always believed the decision makers are Doctors and the CEO of the company and HIS (Hospital Information System) is our way of life. We never looked beyond this ambit and never tried to venture different things.

The changed scenario created initial panic. Overnight implementation of new much lowered sales price of all the stents reduced hospital margins to zero. Suddenly the local FDA gets in action, randomly visiting hospitals and behaving like class monitors. There was utter confusion amongst the materials fraternity of healthcare. Should we charge at MRP? My purchase price and selling price is same, then, where is my margin? Stents company wants to take back inventory, should I give or not? My purchase price was higher than new DPCO MRP. What I should do? Only 8% margin for supply chain and hospital will not have any margins. Then why do I invest in Stents because the TPA companies pay me after 6 months? All sorts of questions.

After the initial shock and ascertaining estimation of loss, the brain starts working and looking for opportunities. We must find out the ways to enjoy at least 8% of supply chain margin. Take a retail drug licence to sell the product to patient. Bill the patient from Pharmacy instead of Medical Store. Negotiate with suppliers on vendor payment. Promote a particular stent by insisting and perusing with Doctors. Increase tariff innovatively. Implementation of increased tariff for cash patient immediately and renegotiate with Insurance companies, which are unlikely to accept but let us claim our stake for future negotiations. Explore the possibility of getting our own stent on contract manufacturing and retain a very high margin. Float a separate own supply chain company, retain all the margins, and share with the individual unit hospitals depending their share. Own supply chain company will supply hospitals on MRP and that will be easier to give purchase bills to Insurance companies who pay as per their cap or actual supplier bill whichever is lower. All margins can be parked at own supply chain companies.

Doctors got the shock on the news that MCI have issued guidelines to prescribe medicines by generic names only. Their entire relationship with companies and brand was at stake. They were unable to cope up this. In this, the opportunity lies with the hospital for enforcing its own hospital formulary, which will be in generic, and gives advantage in purchasing. The focus of pharma companies shifts from doctors to hospital management and it’s pharmacy. The commercial equations changes for hospitals. It is an opportunity to push pure generic products, which are not so critical.
Deadline for being GST compliant created an opportunity for our colleagues in supply chain to learn what tax structure current is and GST. Its impact on the cost of materials. Some will be costlier or in some cases, it will be cheaper. Renegotiate all the items. Rework on vendor registration with additional information. Make changes in HIS for capturing HSN Codes in item master. Revising PO and GRN formats for Capturing the HSN code and checking it for correct HSN codes while receiving the materials for claiming credits for product sold in OP and for Cosmetic surgeries. Most of the hospital materials colleagues have lesser knowledge about excise tariff, HSN codes, Input Tax Credit. Now, the Materials function needs to be more agile and alert.

Practically all the above situations nobody ever thought off in healthcare. These situations made the Materials function think differently and rise above their comfort levels, cross-functional exposure and the areas like which they never wanted to venture has to learn. This paradigm shift is nothing but change management. Whosoever accepts and act quickly is a winner.

Mr. Anil Sahasrabudhe
Head – Materials
Wockhardt Hospitals

New consultants who joined
The Wockhardt Family

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<td>Dr. Arpitha J.</td>
<td>DA, DNB (Anaesthesia)</td>
<td>Anaesthesiology</td>
<td>North Mumbai</td>
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<tr>
<td>Dr. Anita Karande</td>
<td>MD DA (Anaesthesia)</td>
<td>Anaesthesiology</td>
<td>North Mumbai</td>
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<tr>
<td>Dr. Radheshyam Chaudhari</td>
<td>MCh(Urosurgery, DNB Genito urinary surgery)</td>
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<td>Dr. Gopal Thakre</td>
<td>MD Anaesthesia</td>
<td>Cardiac Anaesthesiology</td>
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<td>Dr. Manish Torne</td>
<td>MD Anaesthesia</td>
<td>Anaesthesiology</td>
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<tr>
<td>Dr. Bargavi Raval</td>
<td>Dch Fellowship Neonatology (FNNF)</td>
<td>Neonatology</td>
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World international Nurses Day
celebration at Wockhardt Group Hospitals -
12 May 2017

Wockhardt Group Hospitals celebrated nursing week from 8th - 12th May 2017 to commemorate nursing day on 12th May 2017. The programme was inaugurated by Mr. Anupam Verma, President, Wockhardt Hospitals and Dr. Clive Fernandes, Group Clinical Director, Wockhardt Hospitals via video conference with all Wockhardt Hospitals.

During the week the nursing staff were involved in various activities like poster competitions, one minute games, health talks were conducted on various topics like stress management & healthy living and other interactive events.

The nurses who have completed 5 and 10 years of association with Wockhardt hospitals were felicitated at their individual units by the respective centre heads.

ICU on ventilatory support.

Nagpur
Ratheesh Kumar
Nidheesh Karunakaran

Rajkot
Sarath S
Amit Kumar Vaghasiya
Veer Bhadra Yadav

Nashik
Prashant Sunil Uplekar
Tarachand Arun Shelke
Jaya Bhagchand Salve
Aashish K. Patanwala

Vashi
Sibin George
War and Medicine

Many key developments in healthcare have had their origins in the battlefield where the treatment of injured troops has led to innovations throughout history which continue today. The Indian teenager pried from a twisted wreck on a Friday night and sped to a hospital owes a debt of gratitude to the horse-drawn wagons (known as “flying ambulances”) that Dominique Jean Larrey, MD, invented to carry injured soldiers in Napoleon’s army. What are the other instances where military experience has helped us to improve our medical services?

- Ultrasound that we use in our hospitals so much was itself a product of war, first used by tank engineers in World War II to detect cracks in armour. Today it has become a fantastic medical tool, used for everything from scanning pregnant women to looking for cancers.

- Modern infection control borrows much from the work of Florence Nightingale during the Crimean War in the mid-19th century. She ensured hospital wards were cleaned and ventilated leading to a dramatic drop in mortality rates.

- In World War I, french doctors first formalized the system of triage to treat mass casualties. Patients were split into three categories to allow prioritization. Those who were most likely to benefit from treatment were selected ahead of those likely to live and those likely to die regardless.

- Fleming's discovery of penicillin in 1928 was initially over-looked and was only made into an effective drug in World War II, when medical researchers were seeking a method of infection control in troops.

- Another technique developed by the military, hand in hand with civilian medics is the use of portable ultrasound. This is used not only for scans but also for pain control by allowing surgeons to locate and anaesthetise individual nerves.

- Blood loss has always been the biggest killer in any accident or mass casualty. A big turning point came, in 1537, when a French barber called Ambroise Pare was sent as a surgeon to the Siege of Turin. He was so horrified by what he saw, that he came up with an incredibly simple alternative, the ligature. He would identify bleeding arteries, clamp them, and then tie the ends with silk threads. Ligatures were used by the Romans and the Arabs, but the skills had been lost and it took time for Pare's work to change people's attitudes.
Dear Readers,

The last 3-4 months have seen a number of decisions being rolled out by the Healthcare authorities that will impact the way healthcare will be delivered going forward, be it the cap on stent pricing or the directive on generic prescribing and last but not the least implementation of GST. The article by Mr Anil Sahasrabuddhe provides excellent insights into some of these changes and the operational impact it will have on healthcare organizations.

Nursing day was celebrated globally on 12th May in honor of Florence Nightingale to acknowledge the efforts of nursing associates in delivering quality and compassionate patient care. This edition showcases our “Nursing Day” celebrations across all group hospitals. Nurses are the backbone of a healthcare organization and we at Wockhardt hospitals have always recognised the role our nursing associates play in delivering safe quality care.

As always our hospitals participated and won awards in numerous Health care forums, I am extremely proud of each of our associates for continuously striving and doing their best for each of our patients. Congratulations to our South Mumbai team on getting JCI accredited.

Wocksynapse is our medium wherein we showcase some of the very complex tertiary healthcare work that we are providing at our Units and I hope you find it an interesting read.

Looking forward to your views, inputs and feedback about this edition at wocksynapse@wockhardthospitals.com

Dr. Clive Fernandes
Group Clinical Director
Wockhardt Group Hospitals