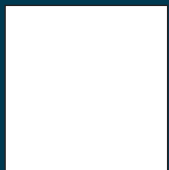




• **Editor & Publisher**

Dr. K. Madeswaran

Chairman - Consultant Neuro & Spine Surgeon



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CHAIRMAN'S COLUMN



Warm greetings from Royallcare

Hoped for a better start of the new year 2021, but the second wave that started in April has already caused havoc in many parts of our country and it is more deadly than the first wave. We have already increased our Covid ICU / HDU and general beds to serve more number of cases in the western region. Our entire healthcare team has been vaccinated. Our wonderful physicians, Pulmonology and critical care team along with their selfless support staff are doing a fantastic job and they have meticulously planned and strategised treatment protocols. Each and every Covid patient parameters are individually taken into consideration and personalised care is given. Drive through Covid screening facility which is first of its kind is being appreciated and actively utilised by the general public. Hopefully we will be able to overcome this pandemic situation in the coming months.

As part of our organic growth strategy, we will be starting our next phase of expansion in the near future.

Stay safe and alert.

Regards

Dr. K. Madeswaran

Founder Chairman



From The EDITOR'S DESK



"Great difficulties may be surmounted by patience and perseverance"..

Abigail Adams

The Covid pandemic has taken a huge toll on mankind and health infrastructure. It is purely perseverance that enables everyone to muster their strength and plough on. With the able guidance of our chairman we have seen off the first wave and hopefully we shall prevail over the second wave of this pandemic.

We congratulate our neurosurgery team for performing awake craniotomy - an innovative procedure that helped the patient receive maximum tumour excision. Carotid endarterectomy was done successfully by our CTVS and Neuro team enabling the patient to be free of stroke risk in the future.

Royal care 24 x 7, a new peripheral facility was opened in Senjeri pirivu to cater to the immediate emergency needs of the needy public. The COVID vaccination programme was also conducted with great success in our hospital with thousands of people benefitting from it. We are proud to be a part of the biggest vaccination drive in the world.

We have started a new ray of hope for rehabilitation with help of robotics in our hospital, incorporating advanced technology to help patients with various disabilities. Some of the equipments are first of its kind in the region. Hydro therapy shall soon be incorporated into the rehabilitation center.

Women's day health awareness programmes were conducted in various centres by our Gynecology consultants and was a huge success amongst the younger population. Our hospital also opened the Neutropenic ICU which is exclusive ICU for cancer patients with low blood cell counts. Oncology day care unit was also inaugurated with new facilities.

In this issue, we have articles on Arthroscopy, OBG, Cardiothoracic surgery. We welcome the new consultants who have joined Royal care Hospital and wish them success in their endeavours.

Editorial Board

Dr. B. Paranthaman Sethupathi

Medical Director & Consultant Psychiatrist

Dr. N. Senthil Kumar

Consultant Radiologist

Mr. T. Soundharrajan

Marketing Executive

ROYAL CARE 24x7

*New facility at
Senjeri Pirivu (Sultanpet)*

Royal Care 24/7 Peripheral Medical Centre was inaugurated by Thiru.S.P.Anbarasu, Chairman, Nallaram Trust and Thiru.V.P.Kandasamy, MLA, Sulur Taluk on 15th Feb 2021 in the presence of Dr.K.Madeswaran, Chairman and Consultant Spine and Neuro Surgeon. This facility will cater to the Medical needs of people living in and around Sultanpet. About 400 participants including the General public, Doctors and Staff of Royal Care participated in the inauguration.

The Royal Care 24x7 is offering the following facilities:

- Accident and Emergency Care
- Fully equipped Ambulance
- Doctors Consultation
- Daycare Service
- Specialities Consultation (weekly visit)
- Pharmacy services will be offered to the public



98542 99999



Uyirin Suvasam Trust's 15th Nursery Unit Inauguration :

Thiru.S.P.Anbarasu inaugurated the 15th Nursery unit of Uyirin Suvasam Trust on the 15th February of 2021. Uyirin Suvasam Trust has planned to plant 2 Crore Trees in Erode, Coimbatore and Tiruppur districts and till now, has planted 15 lakh saplings free of cost. Farmer and General public who need saplings can get the saplings from the Uyirin Suvasam Trust.





ROBOTIC REHABILITATION - A NEW HOPE

The aim of neurorehabilitation is to improve outcome of function after damage to the CNS, such as stroke, TBI, SCI etc through retraining. Recovery of sensorimotor function after CNS damage is based on the exploitation of neuroplasticity. This requires a physiological limb muscle activation that can be achieved through functional arm/hand and leg movement exercises and the activation of appropriate peripheral receptors. These therapies are usually done manually by Physiotherapists, Occupational therapists etc.



Inauguration of Robotic Rehabilitation Equipments

We can expect better functional outcome when therapies are given intensively, function specific, with adequate no. of repetitions. However, certain times in conventional therapies neuroplasticity is limited, with most patients reaching a plateau after sometime, especially when the intensity or repetition of therapies are reduced. Sometimes when recovery is incomplete, compensatory movement strategies are also an important contributor to the mitigation of motor deficits.

The extent of recovery depends on the severity of CNS damage and the individual neural capacity of a patient to regain a function. The current evidence suggests that recovery requires active physical participation of patients during therapy. Additionally, intensity, repetitions and duration of therapies given are also thought to have a positive effect on outcome. Active cognitive engagements also boosts recovery.

It may not be possible fully to restore the normal movement performance after a CNS injury. Therefore, the goal of rehabilitation is not primarily to re-establish the normal movement patterns, but to enable simpler, less complex, well-organized movements to achieve optimal outcome in mobility and independence during activities of daily living (ADL) for the individual patient.

Robotic equipments have emerged in the field of rehabilitation from the above needs. This technology can provide adaptive assistance through cognitive challenge, automated task difficulty adaptation and motivating feedback. Feedback about movement performance can not only enhance motivation, but also facilitate neuroplasticity in the motor cortex if it arrives synchronously with motor output. Rehabilitation robots are thus an ideal means to complement conventional therapy. These new generation of devices, allows for more advanced interaction control, ranging from passive movements for the most severely impaired patients, to active-assisted and active-resisted movements in moderately impaired patients. Furthermore, assistance could be automatically adapted to the patient's performance. In a conventional setting, hemiparetic patients typically perform about 30 movement repetitions with their affected upper limb in a 45-min session, whereas robot-assisted therapy has achieved over 1000 repetitions per session.

The Department of Physical Medicine & Rehabilitation at Royalcare Super Specialty Hospital introduces the full range of Upperlimb Robotics Equipments and Advanced Gait trainer for rehabilitation services.

1. AMADEO

This is specific for improving finger function, providing both visual and haptic feedback. Training includes games and tasks which are functionally relevant for ADL, such as grasping and releasing objects using virtual dynamics to train somatosensory function. Indications are Stroke, TBI, SCI, Parkinsonism, post tendon repair and post traumatic rehab.

2. DIEGO

This equipment is used for shoulder rehabilitation. It can serve in patients with nil power to full power. It can help in unilateral or bilateral hand functions. Interactive games can help in improving motivation. It has additional Virtual Reality module which also has significant training effects. It is indicated in patients with stroke, TBI, Orthopedic Rehab, SCI, GBS, etc

3. PABLO

This is a sensor based technology which can help in training of hand grip, wrist and elbow movements. It can improve power, ROM and coordination of hand. The interactive games improves involvement from patients. It is useful in Stroke, TBI, SCI, pediatric rehab etc

4. TYMO

This also sensor based platform for balance training. It can be used for sitting as well as standing training. The interactive gaming helps in improving training. Useful in Stroke, TBI, Parkinsons, Ataxia, Peripheral neuropathy, pediatric rehabilitation etc.

5. ROBOWALK GAIT TRAINER

This is an advanced gait trainer which can give visual, tactile, auditory feedback to improve balance and gait parameters. This can give intensive gait training with interactive visual feedback making the training more enjoyable. It is extremely useful for patients with Stroke, TBI, Parkinsonism, Ataxia, SCI, Orthopedic rehab etc. It can be used for sports persons for intensive training. This can be used for gait assessments and foot pressure analysis

With a multidisciplinary team for Rehabilitation consisting of Rehabilitation Physicians, Physiotherapists, Occupational therapists, Speech Therapists, Neuropsychologists, Prosthetic & Orthotic technicians etc, it is possible to cater the needs of patients with any impairment in a holistic way. Adding advanced technology to this boosts up the quality of services. This helps patients recover faster and improve their quality of life.



AMADEO



DIEGO



PABLO



TYMO



ROBOWALK GAIT TRAINER

To know more, please contact :
0422-2227152, 2227182

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CAROTID ENDARTERECTOMY AND STROKE PREVENTION



Dr. S. Krishna Kishor

MS, DNB (CTVS),
Consultant Cardiothoracic Surgeon



Dr. K. Madeswaran

M.Ch.,
Consultant Neuro & Spine Surgeon



Dr. K. Vijayan

MBBS, MD (General Medicine),
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DM (Neurology), ASN (USA),
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Dr. K. Chockalingam

MD., DM (Cardio),
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Dr. R. Chandramohan

MD, DM (Cardio),
Consultant Interventional Cardiologist



Dr. Abraham Gerald Henry

MBBS., MD.,
Consultant Cardiac Anaesthesiologist

Introduction

Carotid stenosis is a common atherosclerotic lesion seen in 5.2% of people, it is mostly associated with coronary artery disease. Mild to moderate disease is often managed medically. Severe grade stenosis needs to be addressed surgically.

The objective of carotid endarterectomy (CEA) is to prevent strokes. In the United States, stroke is the fifth leading cause of death overall, and women have a higher lifetime risk of stroke than men do. Among patients suffering a stroke, 50-75% had carotid artery disease that would have been amenable to surgical treatment.

Several prospective randomized trials have compared the safety and efficacy of CEA with those of medical therapy in symptomatic and asymptomatic patients. Data from these prospective trials have confirmed that CEA offers better protection from ipsilateral strokes than medical therapy alone in patients presenting with either symptomatic or asymptomatic carotid artery disease.

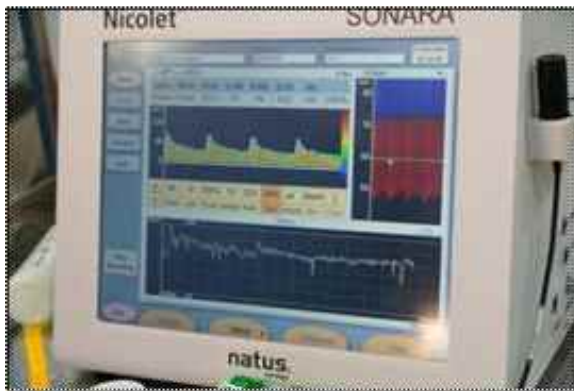
It is well enunciated in multiple meta analysis that CEA is a far superior procedure with less morbidity and mortality and also the procedure of choice for carotid stenosis irrespective of the age and comorbidity.



Indications

CEA should be considered for any patient with carotid artery stenosis in whom surgery will improve the natural history of the disease to a greater degree than the corresponding medical treatment would.

Carotid artery disease may be either symptomatic or asymptomatic. Symptoms include transient ischemic attack (TIA), stroke, stroke in evolution, or crescendo TIA. In symptomatic patients, imaging should begin with carotid duplex ultrasonography (US). Carotid duplex imaging uses qualitative and quantitative information to determine the severity



Transcranial doppler

of carotid artery stenosis with an overall accuracy of 80-97%. All patients undergo cardiac evaluation followed by CT cerebral angiogram or MR angiogram

Transcranial doppler-Transcranial Doppler (TCD) ultrasonography provides a relatively inexpensive, noninvasive real-time measurement of blood flow characteristics and cerebrovascular hemodynamics within the basal arteries of the brain. The physiologic data obtained from these measurements are complementary to structural data obtained from various modes of currently available vascular imaging.

Procedure

Monitoring – CVP, Invasive arterial pressure line, Transcranial doppler

A cervical incision is made parallel and anterior to the sternocleidomastoid and centered over the carotid bifurcation. This incision can be extended proximally to the sternal notch for more proximal lesions of the common carotid artery (CCA) and distally to the mastoid process for higher exposure. Its upper end should be angled posterior to the earlobe to avoid the parotid gland and the greater auricular nerve. The incision is carried down through the platysma, and the sternocleidomastoid is retracted laterally with self-retaining retractors.

The internal jugular vein is visualized, and the carotid sheath is opened along the anterior border

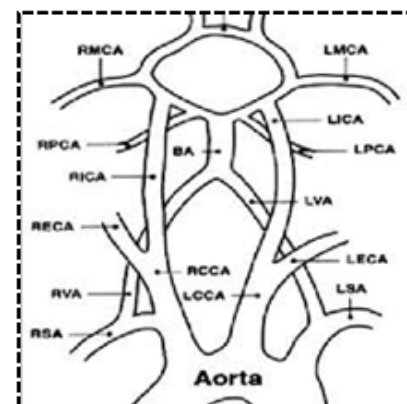


Illustration showing branches of Internal carotid artery

of the vein. The internal jugular vein is retracted laterally, and the common facial vein is ligated. Dissection is continued anterior to the CCA to keep from injuring the vagus nerve. The vagus nerve usually lies in a posterior lateral position within the carotid sheath but occasionally may spiral anteriorly, particularly in the lower end of the incision.

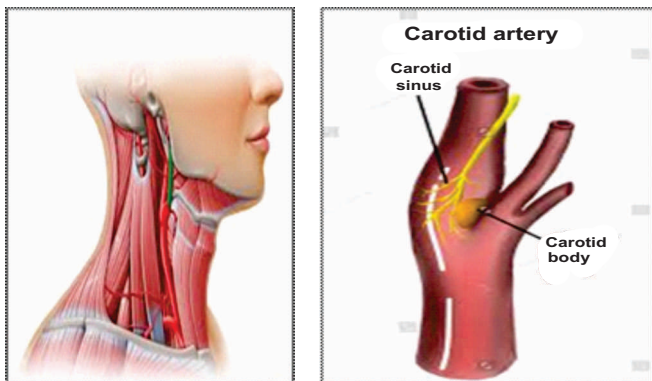
Attention should be paid to cranial nerves IX (glossopharyngeal nerve), X (vagus nerve), XI (accessory nerve), and XII (hypoglossal nerve), as well as the marginal mandibular branch of VII (facial nerve) and the rare nonrecurrent laryngeal nerve that comes directly off the vagus to innervate the vocal cords.

The CCA is mobilized proximal to the carotid lesion. Dissection is continued upward to isolate the external carotid artery (ECA). The internal carotid artery (ICA) is mobilized up to a point where the vessel is completely normal.

Excessive or prolonged retraction of the upper aspect of the incision may cause temporary compression injuries either to the greater auricular nerve laterally or to the marginal mandibular branch of the facial nerve medially.

In patients with a high carotid bifurcation or an extensive lesion, mobilizing the ICA distally can be achieved through several maneuvers, as follows:

- The skin incision can be extended up to the mastoid process, with complete mobilization of



Illustrations showing anatomy of carotid artery

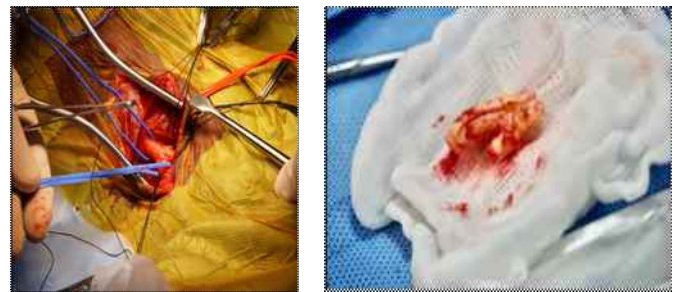
the sternocleidomastoid toward its tendinous insertion on the mastoid process; care must be taken not to injure the accessory nerve, which enters the substance of the sternocleidomastoid at that level

- The digastric muscle can be mobilized anteriorly or, if necessary, divided
- If further exposure is needed, the styloid process can be transected, and the mandible can be subluxated anteriorly

Control of the CCA is obtained proximal to the level of disease by surrounding the vessel with an umbilical tape. If sinus bradycardia develops, 1-2 mL of 1% lidocaine is injected into the tissues of the carotid bifurcation to correct reflex sympathetic bradycardia.

Follow up

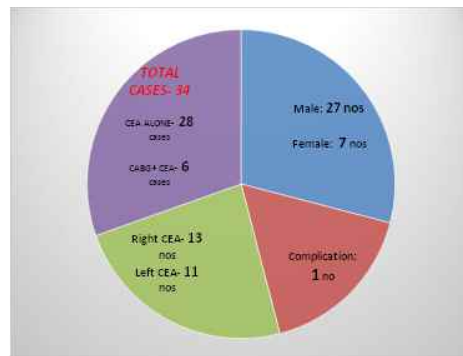
At 2-6 weeks after CEA, carotid duplex US should be performed. If the findings from duplex imaging are satisfactory, another duplex study should be done 6 months to 1 year later, then every year thereafter. If there is evidence of moderate contralateral disease or recurrent carotid artery stenosis, scanning may be performed at intervals of 6-12 months.



Illustrations showing Surgical exposure of Carotid artery & Excised plaque

Our data

Total cases – 34



- ❖ CABG + CEA – 6
- ❖ CEA alone- 28
- ❖ Male 27
- ❖ Female 7
- ❖ Right side 21
- ❖ Left side 13

Complications :

One patient had a major haemorrhagic stroke and improved over 3 months with minimal residual paralysis. Rest of the patients are doing well on follow up.



GLIMPSE

**Women's Health Awareness
Talk Program** conducted by
Dr. N. Premalatha on
15.12.2020 at Royal Care
premises



Inauguration of
Oncology
Day Care Unit &
Neutropenic ICU
on 04.02.2021



**Road Safety Awareness
campaign and special
Medical Camp** was held
in Kaniyur on 25.02.2021
in view of the
32nd Road Safety Week



**International Women's Day
Health Talk Program** by
Dr.S.Kalyanakumari at
Shanthi Gears company
on 08.03.2021



International Women's Day
Health Talk Program by
Dr.N.Premalatha at Sri Shakthi
College of Engineering and
Technology on 08.03.2021



International Women's Day
Health Talk Program by
Dr.S.Kalaivani at Kathir
College of Arts and Science
on 08.03.2021



Covid 19 Vaccine
for
senior citizens..

General Medical Camp held
at
Senjerimalai on
24.03.2021



"AWAKE CRANIOTOMY"



Dr. K. Madeswaran

M.Ch.,
Consultant Neuro and
Spine Surgeon



Dr. R. SenthilKumar

MBBS, MS (Gen Surg),
M.Ch (Neuro Surgery), DNB, MNAMS.,
Consultant Neuro surgeon

Introduction

Awake craniotomy can be defined as an intracranial surgical procedure where the patient is deliberately awake for a portion of the surgery, usually for mapping and resection of the lesion. It has a long history that pre-dates general anesthesia (GA) as there are many examples of paintings and descriptions of such procedures, especially trephination, dating back over a thousand years. During the last several decades, this procedure has become increasingly popular with wider indications prompted by accumulating evidence that patients receiving awake craniotomy have better outcomes in many aspects.

Awake craniotomy is used for any intra-axial mass lesion residing adjacent to or in eloquent brain based on pre-operative imaging, including motor,

and language cortex. The lesions are primarily gliomas, cortical, and subcortical, both high and low-grade, as the survival rate is related to the extent of resection.

This Patient..

42 year male, a bus conductor was having seizures involving right upper limb and face on and off for the past five years, he was on antiepileptics but still he had few breakthrough seizures. MR imaging of brain showed a lesion in broca's area. Removal by routine surgical methods could affect his ability to speak, therefore awake craniotomy was planned.

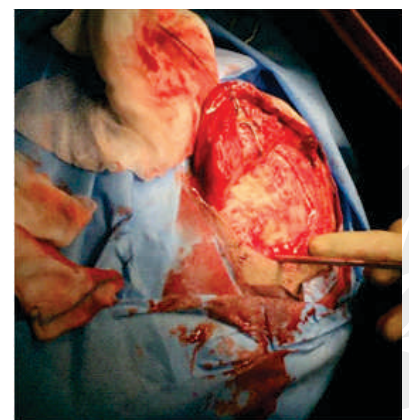
The patient was conversing, answering the questions, he was watched for any speech disturbances while removing the tumour. Near total resection was achieved without any speech disturbances.



Under scalp block, Patient positioned in supine position with head turned towards right and fixed with mayfield fixator.



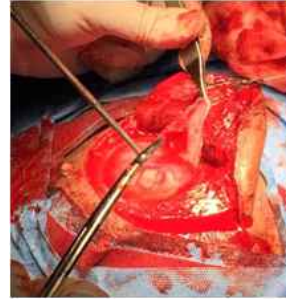
Draping is made in such a way that the patient will be monitored and assessment can be done.



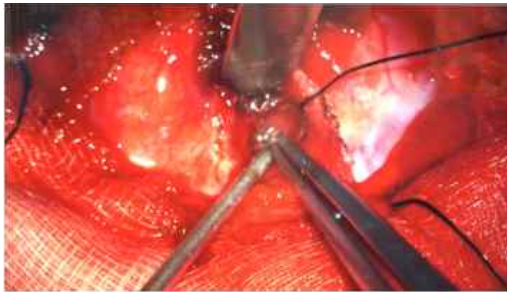
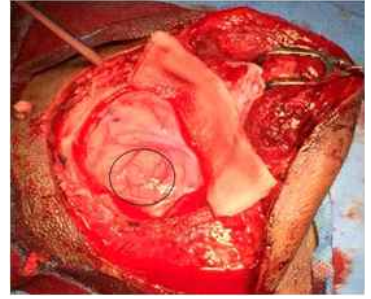
Incision was made over left fronto-temporal region above the hairline and flap was raised



A burr hole was made. Craniotome was used to complete the craniotomy.



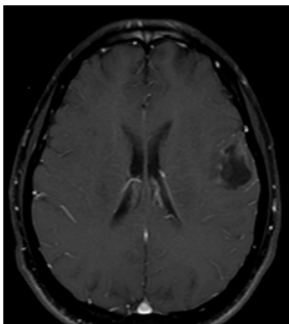
Free bone flap was removed, Dura opened flapping over temporal region. Slight difference in texture and colour can be appreciated over inferior frontal gyrus.



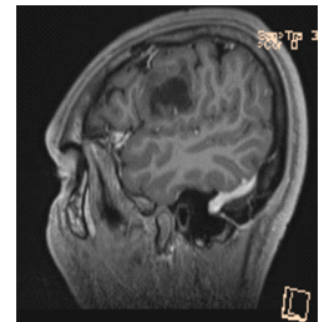
Microsurgeal excision of the lesion carried out with constant interaction with the patient.



Postoperative CT showing post operative cavity with air pocket and minimal hemorrhage.



Pre operative contrast MR imaging (axial and sagittal section) showing a well defined predominantly necrotic intraaxial lesion involving inferior frontal gyrus (Broca's area).



BENEFITS

The goal of awake craniotomy is to maximize tumor resection while preserving neurological function. With language and sensorimotor mapping functional aspects of the brain can be more accurately delineated so that patients can have more extensive tumor resection, reduced need for postoperative intensive care monitoring and less cost, fewer neurological deficits, shorter hospital stay, longer survival.

As awake craniotomy with light-moderate sedation doesn't require mechanical ventilation, it avoids physiological disturbance associated with GA.

"Saving The MENISCUS" SportsMed @ Royal Care



Dr. C. Karthikeyan M.S. Ortho., DNB Ortho., MRCS (Ed),
Fellowship in Arthroscopy (Shoulder and Knee),
Dip In Sports Medicine (UK).
Consultant Arthroscopy & Sports Medicine.

Introduction

Meniscus a fibrocartilagenous structure made up of Type 1 collagen, is an important component of the knee joint. It has some crucial functions like transmission of load from femur to tibia, acts as a shock absorber of the knee, provides stability and proprioception to the knee, as well as nutrition to the articular cartilage.

Blood supply to the meniscus is from its periphery, thereby dividing it into three zones, red-red, red - white and white - white zones, with the central white zone being relatively avascular.

Meniscal Tears

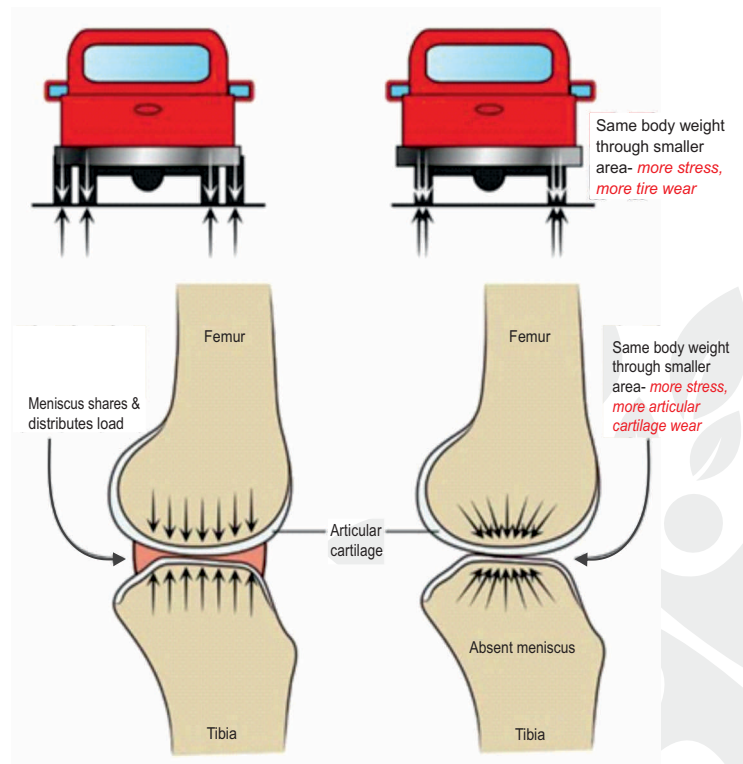
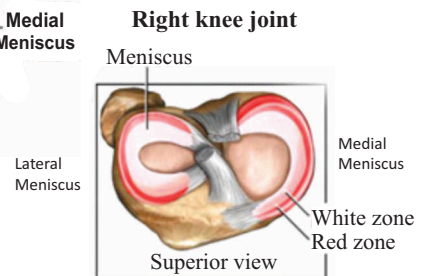
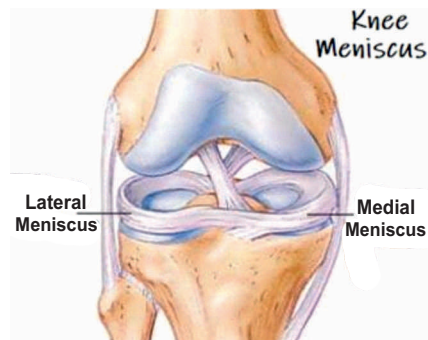
Meniscal tears are one of the most common injuries of the knee joint. In young people it occurs after a traumatic injury, where as in the elderly degenerative tears are common.

Arthroscopic Partial Meniscectomy (removal of torn portion) was the standard treatment performed for Meniscal tears. This surgery gives excellent short term outcomes, but long term results have shown that upto 53% to 89 % of patients develop Osteoarthritic changes of the knee and almost 46% of patients had to give up sports following meniscectomy. The reason for this is because the load sharing function of meniscus is lost and there is a high contact stresses following meniscectomy.

Meniscal Repair

To overcome the shortcomings of Meniscectomy, current recommendations are to preserve the meniscus by MENISCAL REPAIR whenever possible in traumatic meniscal tears.

Here I would like to showcase few cases in which Meniscus has been preserved by doing Arthroscopic Meniscal Repair.





Case 1:

16 Year old boy - had a Bucket handle tear of medial meniscus while playing volleyball



He underwent Arthroscopic Meniscal repair using "ALL INSIDE, INSIDE OUT and OUTSIDE IN TECHNIQUE".



Bucket handle tear of Medial Meniscus



Images after Arthroscopic Repair

Case 2:

36 year old male - post ACL Reconstruction developed pain in his knee. MRI - Showed complex tear in body and posterior horn of Lateral Meniscus

Patient Underwent Arthroscopic repair of the Horizontal component of the tear



Complex Tear Body of Lateral Meniscus



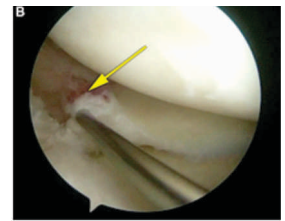
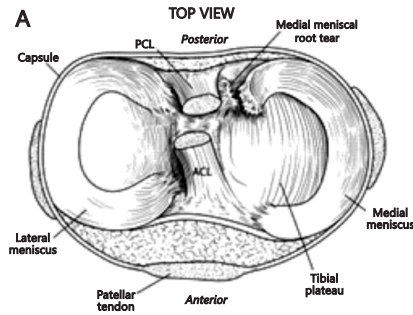
Arthroscopic Images after Meniscal Repair





Root of the meniscus is the region where the meniscal tissue gets attached to the bone. Meniscal root tears are problematic because they disrupt the transmission of the forces across the joint thereby leading to rapid degenerative changes.

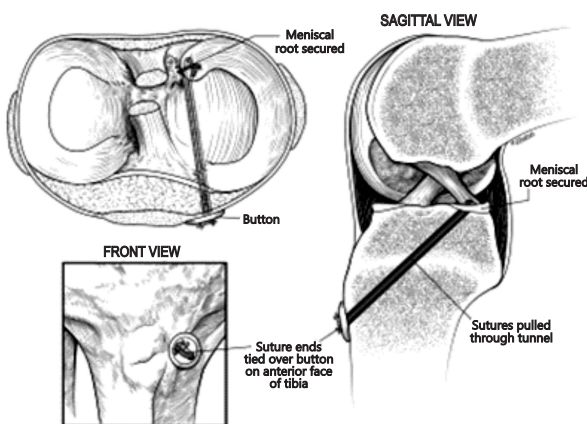
Hence the current recommendation is to repair these root tears to prevent arthritic changes in the joint.



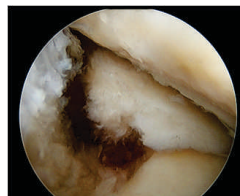
Medical Meniscus Posterior Root Tear

Case 3 :

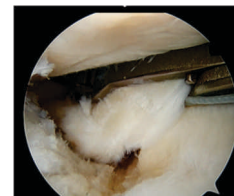
Illustration of Medial meniscus posterior root tear and its Transosseous Repair



I present an example of a 45 year female with Medial Meniscus Posterior Root tear, she underwent Arthroscopic Root Repair by Transosseous technique.



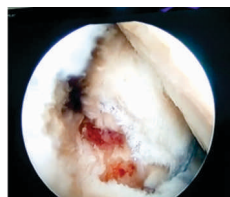
Posterior Root Tear



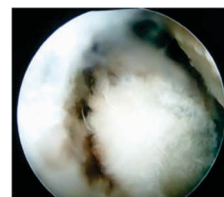
Suture passed through the Root



Transosseous Tunnel



Suture Pull Out



Final Radiological And Arthroscopic Picture



Discussion :

"Meniscus is not the Appendix of the KNEE"

The menisci perform many essential biomechanical functions and also serve to decrease contact stress and increase contact area and joint congruency. Therefore, in the knees without the meniscus, the impact and load are three times higher.

Hence in the current era of joint preservation with increasing life expectancy of people, surgeons must strive to save the meniscus whenever possible. Meniscal repair provides improved long-term outcomes, better clinical outcome scores, and less severe degenerative changes seen radiographically compared with partial meniscectomy.

Here at Royal care Hospital in the Department of Arthroscopy and Sports Medicine, I follow the strategy of meniscal repair for all repairable meniscal tears. Combined with a good post operative rehabilitation we make sure the patients return to pre injury levels at the earliest.

In conclusion it is time for a paradigm shift in the management of meniscal tears. Meniscectomy should no longer be the first-line option. Meniscal Repair, should whenever feasible be proposed for traumatic tears, thereby SAVING THE MENISCUS.





SUCCESSFUL PREGNANCY outcomes following a previous mid trimester loss and an acquired thrombophilia



Dr. N. Premalatha

MBBS, DGO, MRCOG (UK), DIUI (France),
Consultant Obstetrician and Gynaecologist

Mrs M a 26 Year old lady booked with us in August 2018 at 7 weeks into her third pregnancy. She was married for 3 years with an eventful Obstetric history.

Her first pregnancy ended in a missed miscarriage at 8 weeks for which a suction evacuation was undertaken. Her second pregnancy proceeded normally until 20 weeks. She then presented with painless cervical dilatation and a rescue encirclage was placed. She was an inpatient for 2 weeks but unfortunately miscarried. The first 2 pregnancies were managed in a different hospital.

Her subsequent investigations revealed that she had an abnormal b2 glycoprotein antibody levels. The rest of the thrombophilia screening was within normal limits. The acquired haemophilias that can potentially lead to adverse pregnancy outcomes are Anticardiolipin, Antiphospholipid and b2 glycoprotein antibodies. These conditions can predispose the women to micro-vascular and macro-vascular thrombosis on the background hypercoagulable state of pregnancy. They can potentially lead to recurrent pregnancy loss and placenta mediated adverse outcomes like pre-eclampsia, IUGR, abruption and stillbirth. The role of Aspirin in reducing the risk of adverse pregnancy outcomes in certain circumstances has been proven by many clinical trials, however there is no robust evidence for the use of heparin. Nonetheless it is being used in clinical practice for 2 factors. The emotionally charged patient who would do anything to prevent an adverse pregnancy outcome and the willingness of the

clinician to try an appropriate intervention in that context.

We have 2 issues here. A positive thrombophilia test combined with an increased risk of pre-term labour due to the previous mid trimester loss.

At her booking visit ,BMI was 23.9, the other routine investigations were normal and an Ultrasound showed a single live intrauterine pregnancy of approximately 7 weeks. She was started on Folic acid, Aspirin 150mg, Enoxaparin 40 micrograms and 400 micrograms of micronised progesterone daily. Her First Trimester combined screening revealed that she was low risk for Trisomies. The cervical length was 3 cm. The intervention required to predict the risk of pre-term labour in our set up is serial cervical length screening from 12 weeks. Subsequent scan 2 weeks later revealed a progressive shortening of the cervix, therefore decision was made to place a cervical encirclage at 14 weeks. Her anomaly scan and glucose tolerance test at 20 weeks were normal. She was followed up with 4 weekly growth scans in the third trimester and they were all normal. The cervical stitch was removed at 37 weeks. She went into spontaneous labour at 39 weeks, had an epidural for pain relief and had a normal vaginal delivery of an alive male baby weighing 3.6kgs in March 2019. Postnatal period was uneventful.

She subsequently booked with us for her next pregnancy in June 2020. She was on prolonged lactational amenorrhoea and had 3 cycles before falling pregnant again.



Her basic bloods were normal and an Ultrasound revealed a gestational age of 7 weeks. The same management was initiated for this pregnancy also. She was low risk on her first trimester combined screening. However the serial cervical length screening did not reveal shortening this time and the cervical length remained between 3-4 cm. Therefore a cervical encircage was deferred this time. Anomaly scan and a GTT at 20 weeks was normal. However a growth scan at 28 weeks revealed an increased amniotic fluid index of 27.1. A repeat GTT Showed normal blood sugar levels, but there was 1 plus of sugar in the urine. As there was a possibility of a potential occult gestational diabetes, She was initiated on a low glycaemic diet and advised physical exercises for a minimum of 30 minutes per day. Blood sugars were monitored regularly and they remained normal. The Polyhydramnios gradually improved and AFI was 14 a month later. The estimated foetal weight consistently remained at the 50th centile. The foetus was in unstable lie throughout the third trimester until term. She was admitted with regular contractions without cervical changes at 37 weeks which settled following an inpatient observation of 48 hours. The lie of the foetus was initially oblique

and then become longitudinal with the head presenting. She then presented 10 days later in spontaneous labour and had a normal vaginal delivery of an alive male baby weighing 3.6kg.

Discussion

We had this lady with a background obstetric history posing different challenges in her two pregnancies. Her booking BMI was 23.9 during her first pregnancy and 26.1 during her second pregnancy. The booking HbA1c was 4.94 and 5.52 during the first and second pregnancies. This would perhaps explain the potential GDM during the second pregnancy. The management was tailored to the current needs and appropriate interventions were undertaken at the right time leading to a good outcome in both her pregnancies. No unnecessary interventions or procedures were done. We didn't rush to do a Caesarean when she presented at 37 weeks with contractions and an oblique lie. We decided to wait as there was no cervical changes. As expected the lie reverted to longitudinal paving way for a vaginal delivery ten days later. Masterly inactivity with watchful expectancy holds true for obstetric practice in certain circumstances.

Breast milk Donation

Royalcare mum Mrs. Sruthi Nandhini Sandeep created a record for donating 32 litres of breast milk in the Asia book of records.



Breast milk donation is a very noble deed. Mothers can donate the excessive milk over and above their baby's requirements to the breast milk bank at the Coimbatore medical college Hospital. Breast milk is also called liquid gold.

There are so many sick and needy babies in the Neonatal Intensive Care Unit (NICU) at Coimbatore Medical College Hospital who depend on this bank. There may be numerous reasons due to which the biological mothers may not be able to produce enough milk. In such circumstances the alternative is formula feed. Here is when the donated breast milk comes in. Breast milk being natural is the perfect feed for the newborns being nutritious and rich in antibodies. It

helps in avoiding the potential problems associated with formula and babies thrive on donated breast milk.

We encourage and support our women who are motivated for this noble cause and alleviate their fears if any.

Congrats



Dr. AK. Jaleel
Consultant in Pediatrics

**Awarded as a Senior pediatrician by
IAP 2020 Tamil Nadu**



Welcomes...



Dr. J. Gerard Vinodh

MBBS., DNB (General Medicine), DNB (Nephrology), FICM.,
Consultant Nephrologist

Completed MBBS from Dr. M.G.R Medical University - Govt. Medical College at Thoothukudi in 2008. Subsequently he completed FICM – Fellowship in Intensive Care Medicine at Apollo Hospitals Educational & Research Foundation in 2015. He had achieved DNB - General Medicine in 2015 and DNB - Nephrology in 2020 at National Board of Examinations, New Delhi. He was working as a DNB Registrar (Nephrology) in Apollo Hospitals, Bengaluru before joining Royal Care.



Dr. Sithantha Seelan

MBBS, DMRD, DNB.,
Consultant Radiologist

Completed his MBBS at PSG Medical college in the year 2012. He finished DMRD at Patna Medical college hospital, Bihar in 2018. Also he completed DNB at Sir H. N. Reliance Foundation Hospital and Research Centre, Mumbai in 2020. He has joined as a Consultant Radiologist at Royal Care.



Dr. S. Senthilkumaran

M.D (Radio Diagnosis),
Chief Consultant Radiologist

Completed MBBS at Coimbatore Medical College in 1997 and MD Radiodiagnosis at Madras Medical College in 2001. Has worked as consultant and head in G.K.N.M hospital for the past 16 years. Special interest in Oncology, breast and cardiac imaging. Now he has joined as a Chief Consultant Radiologist at Royal Care.



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