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Royal Care

- **Editor & Publisher**

Dr. K. Madeswaran

Chairman - Consultant Neuro & Spine Surgeon

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PATIENT SAFETY & QUALITY OF CARE
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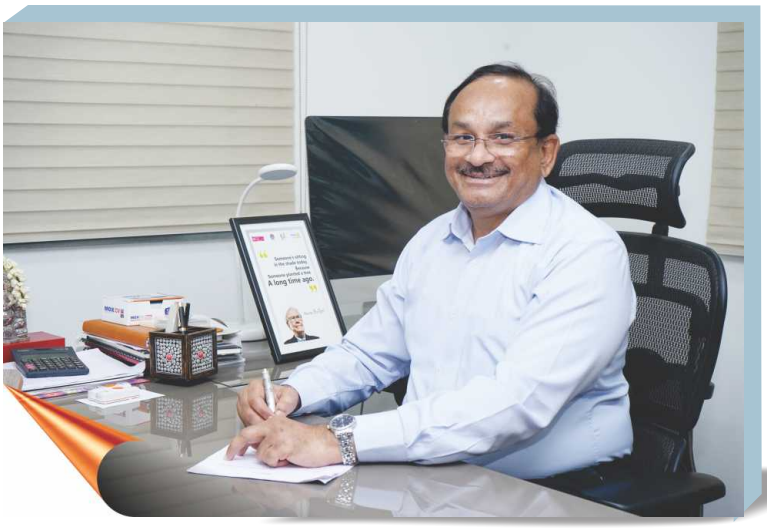
CHAIRMAN'S COLUMN



Warm greetings to all !

COVID-19 has struck the world in multiple variants and will leave a lasting imprint on the world economy, causing permanent changes and teaching important lessons. Developing countries like us are adapting to the change and performing stronger than expected as evident from the GST collections month on month this year.

We have always been focussing on the new healthcare technology and we are pioneers in introducing the new healthcare associated tech at Royalcare for the benefit of the general public. One such thing is the new innovative technology called Exablate Neuro, soon to be introduced for the first time in Indian Subcontinent at Royalcare.

From patient-specific planning to sub-millimeter precision, this incision-free treatment often results in an immediate therapeutic effect. The treatment is guided in real-time by a state-of-the-art new 3T MRI, focused ultrasound is an innovative tech to treat Essential Tremor and Tremor-dominant Parkinson's Disease.

Regards

Dr. K. Madeswaran

Founder Chairman

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From The EDITOR'S DESK

"Success lies in the joy of achievement and thrill of creative effort "..

Franklin D Roosevelt

Our hospital completed 5 years since our inception and it was celebrated with great fervor and was attended by important people from our society. For a hospital to attain such heights within 5 years of inception is, indeed a great achievement.

It is also noteworthy that our hospital has managed to get the NABH award within this period itself at the highest level. This is another added feather to the cap of our hospital. We thank all our doctors and employees who worked tirelessly to achieve this feat and will continue to work hard to maintain this prestigious award.

Education never ends in medicine and Royal care always strives to improve and impart education to the medical fraternity, we are proud to announce that our hospital is now approved to conduct the DNB for Internal medicine, critical care medicine, and Radiodiagnosis.

The country is gradually recovering from the negative impact of COVID and getting back on our feet. We have started to conduct awareness rallies, educational meetings, and camps for the public. This year has been nominated by our chairman to create cancer awareness in our patients with each month focusing on different cancer.

We congratulate Dr.N.Premalatha on being awarded the coveted FRCOG from the Royal College of Obstetricians and Gynecologists and also Dr.D.Gandhiraj for the successful completion of his Ph.D. in Microbiology.

In this edition, we have an interesting write-up on cosmetic surgery, Cardiothoracic surgery, internal medicine, and Rheumatology.

Welcome the new consultants who have joined Royal Care Hospital and wish them success in their endeavors. We also welcome our new chief operating officer, Dr.Vasudevan, to our fold and we wish him the very best.

PARAPHARYNGEAL MYOEPITHELIOMA - CASE REPORT

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Parapharyngeal space (PPS) tumours are rare, accounting for only 0.5% of neoplasms of the head and neck.

A variant of pleomorphic adenoma called myoepithelioma was first described by Sheldon in 1943. Myoepitheliomas of salivary glands is extremely rare, comprising approximately only 1–1.5% of all salivary gland tumours.

The most common site of origin of Myoepitheliomas are the salivary glands and rarely other sites in the head and neck have been described in the literature.

A 38 years old male was admitted with complaints of pain over the right side of the head and neck for the past 1 month and otherwise a normal neurological examination. Video-laryngoscopy showed a smooth bulge involving the right side tonsil.

Magnetic Resonance Imaging (MRI) of the neck showed a well-defined bi-lobed soft tissue lesion noted epicenter in the right pre styloid parapharyngeal space measuring 4.4 cm in the craniocaudal direction, 4.2 (Width), and 1.9 cm the anteroposterior direction.

The lesion is completely obliterating the fat space displacing the right medial pterygoid laterally and the pharyngeal mucosa medially up to the midline narrowing the nasopharyngeal [at the level of the soft palate] and part of oropharyngeal space. The lesion is Mildly displacing a part of the external carotid artery and the Distal cervical segment of the right internal carotid artery is also displaced posterolaterally.

The lesion shows mild internal heterogeneity but predominantly hyperintense on T2 with heterogeneous postcontrast enhancement And nodular internal components with a well-defined capsule. the deep part of the right parotid gland is seen separate from the lesion.

Routine blood investigations were within normal limits.

A diagnosis of parapharyngeal lesion? schwannoma was made. A transcervical approach was planned. Under general anesthesia (GA) with the patient in the supine position, head turned towards left side 45degree, placed in the extended position. A curvilinear incision was made two cm below the mandible from the angle of the mandible to the body of the mandible region and curved downwards along the medial border of the sternomastoid muscle. Platysma was incised. dissection was started along the medial border of the sternomastoid near the angle of the mandible. Hypoglossal nerve, posterior belly of digastric and external carotid artery branch was identified. Tumour was identified beneath the posterior belly of the digastric, dissected along with its capsule, the entire lesion was enucleated after separating from the pterygoid muscle.

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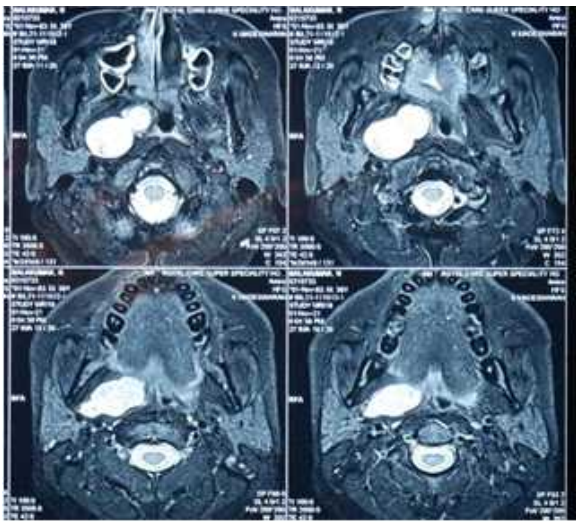

Fig 1 T1 gadolinium-enhanced sagittal, axial, MRI scan showing a mass in right pre-styloid space pushing pharyngeal wall medially.

Postoperatively, there was no facial paralysis. There was no evidence of recurrence at three months follow-up.

Macroscopically, the tumor was solid and well-circumscribed.

Histopathologic examination showed tumour composed of medium-sized epithelioid to spindle cells having eosinophilic cytoplasm and oblong nuclei arranged as cord nests and sheets with interspersed tubular structures. The epithelioid cells are separated by large areas of a loose matrix composed of spindle stromal cells in a myxoid matrix. There is no evidence of significant cellular atypia.

Postoperative Contrast-enhanced CT neck showed post-operative changes with mild fat plane haziness are noted in right prestyloid parapharyngeal region and insitu drain tube.

No obvious evidence of residual enhancing mass lesion, collection/hematoma seen.

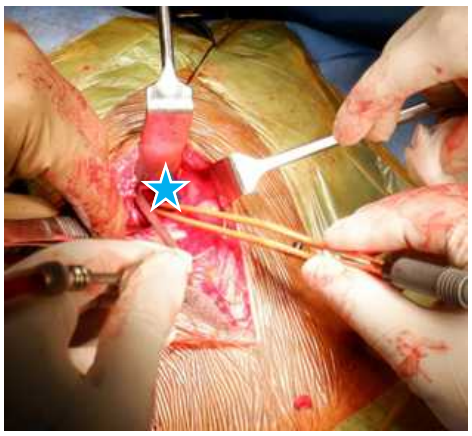

Fig 2 Intra-operative picture showing tumour cavity during resection (★)

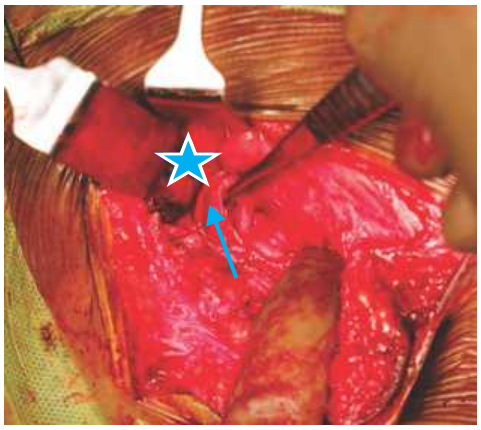

Fig 3 intraoperative picture showing tomour cavity after completion excision (★), posterior belly of digastric muscle (↖)

Figure 4. Macroscopic appearance of the resected tumor.

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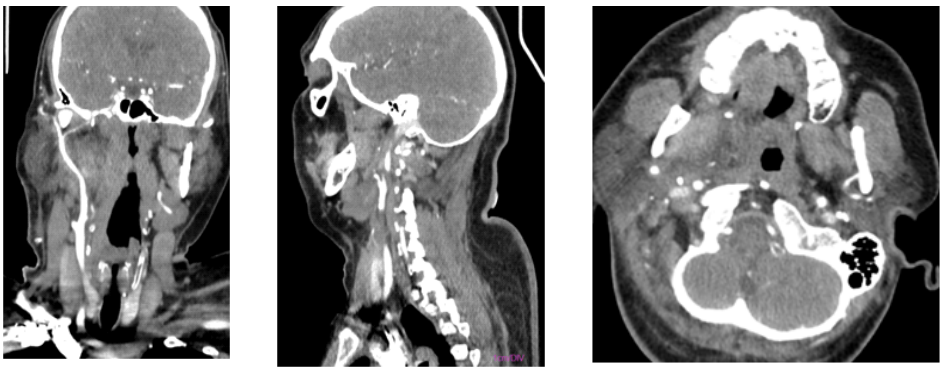

Fig 5 Coronal, Sagittal, Axial contrast CT scan showing complete excision of the lesion

Discussion

Classical Symptoms of benign parapharyngeal swelling are otalgia, neuralgia, palsies of 9th, 10th, or 11th cranial nerves or trismus and findings are submucosal swellings in the lateral pharyngeal wall with or without extension to retromandibular fossa or the submandibular trigone and bimanual ballet ability.

Some authors consider it a variation of the pleomorphic adenoma. Others define it as a tumour composed solely of myoepithelial cells. However, there are no definite criteria for the inclusion of a tumour in this category yet. There is no gender preponderance and the average age is 40 years. Diagnosis is mainly through histopathology examination that will show either a plasmacytoid or a spindle cell appearance or a mixture of both. The recommended management of myoepithelioma is surgical excision with adequate clear margins. A recurrence rate of 15–18% is observed

Myoepithelioma should be differentiated from its malignant counterpart that is, malignant myoepithelioma which is more aggressive and show recurrence even after adequate treatment. Histopathologically presence of cellular atypia, cellular pleomorphism, cellular necrosis, increased mitotic figures, invasive growth pattern, or a combination of these favor the diagnosis of malignant myoepithelioma.

The parapharyngeal space is, however, a complex anatomic region located between the mandibular ramus and lateral pharynx and extending as an inverted pyramid from the skull base superiorly to hyoid bone inferiorly. Within this potential space are cranial nerves IX, X, XI, and XII, the sympathetic chain, carotid artery, the jugular vein, and lymph nodes. Due to the PPS's anatomic complexity, location, and surrounding vital structures, resection of tumours from this space can prove challenging to the head and neck surgeon.

CT scan and MRI help in determining the extent of disease, local spread, and the type of tumour. Contrast enhancement suggests vascular and neurogenic tumours. The presence of an intact fat plane is important in distinguishing benign tumours from malignant ones.

The approach of choice to the parapharyngeal space to allow adequate removal of the tumour should meet two criteria: wide intra-operative visibility for safe radical dissection and minimal functional and or cosmetic after-effects. As far as treatment of myoepitheliomas is concerned, there is limited experience but complete surgical excision is the mainstay of therapy. Several surgical approaches for the management of para-pharyngeal mass have been described included such as transcervical, submaxillary, transmandibular, transparotid, transoral and infratemporal.

In our patient, we adopted the transcervical approach. It enabled complete resection of the tumourSimple surgical excision is the treatment of choice for benign myoepithelioma. Recurrence is very rare in benign myoepithelioma. Our case did not show any signs of recurrence during 3 months follow-up.

Conclusion

Myoepithelioma occurs in most major and minor salivary gland tissues, and it is generally a biologically benign lesion.

Treatment should be designed for a benign salivary gland tumor with a margin of normal uninvolved tissue being included within the surgical excision. The recurrence rate is similar to that of the pleomorphic adenoma (15–18%).

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DENGUE in PREGNANCY

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The incidence of dengue is high in India in the recent years. Evidence suggests that dengue fever in pregnancy is associated with adverse maternal and foetal outcome.

Dengue has wide clinical presentation from being asymptomatic, uncomplicated fever, dengue haemorrhagic fever and dengue shock syndrome. There is an increased incidence of pre-term birth, low birth weight and still birth ranging between 6.7 to 44%.

We present two pregnant women who were referred to our hospital with dengue in the third trimester, became quite unwell but eventually made a good recovery with good maternal and fetal outcome.

Case1

Mrs S was a 24 year old lady 35+4 weeks in to her second pregnancy presented with a 4 day history of fever associated with myalgia and chills. She reported of good foetal movements, no abdominal pain or vaginal loss on admission.Her pregnancy was largely uneventful until then.

This was her second pregnancy and she had an emergency caesarean section first time around. She was treated elsewhere and the platelet count had dropped serially from 1,00,000 to 19,000 and therefore referred here. On arrival she was afebrile with a mild tachycardia and tachypnoea.

Investigations revealed a platelet count of 19,000, APTT OF 45.1 seconds and AST OF 63. The rest of her bloods were normal. Dengue rapid NS 1 test was positive.Her covid test was negative. She was transferred to the ICU. Initially her blood gases revealed metabolic acidosis which was corrected. Platelet transfusion was commenced. She gradually became hypoxic and was started on NIV support. Her Ultrasound revealed that the estimated foetal weight was above the 95 th centile with a reduced AFI of 7.9. Doppler s were normal. Fetal heart was regularly monitored and it was satisfactory.She was diagnosed with late onset gestational diabetes which was appropriately managed. She gradually improved and her platelets started to improve in 2 days. She was subsequently weaned off NIV and then transferred to ward following three days of her admission. Close maternal and fetal monitoring continued in the ward, Ultrasound revealed progressively reducing liquor volume. At this point

the platelet count has risen to 2,34,000. She was then delivered by Caesarean section AT 36+4 weeks of gestation. Postoperative period was uneventful and the baby did well. Both mother and baby were discharged in good condition.

Case 2

Mrs S was a 22 year old Primi. She was 35 +3 weeks, was a known PCOS, has developed gestational diabetes and was on Insulin. She had a four day history of fever, Dengue NS1 was positive. She was treated outside with IV fluids, and other supportive measures. In view of dropping platelet count, she was transferred here.

On admission she had a temperature of 101 F, PR of 120/mt and respiratory rate of 22/mt.Her platelet count was 36,000 on admission and her blood gases revealed metabolic acidosis.Her liver enzymes were elevated with a SGPT of 62, APTT was 43 seconds whilst the other bloods were normal.She was transferred to ICU and appropriate treatment was commenced. She was started on NIV, the platelet count dropped up to 14,000. Platelet transfusion was undertaken.Her LFTs worsened initially and ALT was 368, AST 659 at its worst. Her platelet count started improving following 4 days of admission, Liver enzymes showed an improving trend from day 7 and her NIV was weaned off on the 5th day of admission.Foetal well being scan and electronic foetal heart monitoring was satisfactory.

She was transferred to the ward on day 7 of admission. She was closely monitored in the ward. She was then delivered by Caesarean section at 36+4 weeks of gestation. Platelet count was 1,32,000 at delivery. Blood loss was normal and baby was delivered in good condition. The postoperative period was uneventful and mother and baby were discharged home in good condition.

Discussion

Dengue in pregnancy is associated with both maternal and foetal risks. The maternal risks are mainly, Pre term labour, increased risk of pre-eclampsia and haemorrhage. Rarely ARDS, acute liver injury and kidney injury can occur. Dengue can often mimic HELLP syndrome as low platelets and elevated liver enzymes are associated with both conditions. Foetal risks include prematurity, Increased risk of In utero foetal hypoxia and operative delivery and low birth weight. Evidence suggests that vertical transmission can occur and protective antibodies are present in the baby for up-to 6 months.

Preventative measures should be taken by pregnant women in areas where dengue is prevalent.

Treatment is mainly supportive depending on the presentation. Close maternal and foetal monitoring is indicated and delivery should be done in the appropriate time.

Management of dengue during pregnancy requires a multidisciplinary team including intensivists, physicians, and gynecologists. Patients can develop moderate to severe pleural effusion as a part of capillary leak syndrome which will further increase the work of breathing. Also, thrombocytopenia increases the risk of postpartum hemorrhage and patients may need multiple single donor platelets especially if the bleeding is during the post febrile phase of illness. Both of the patients in this case report presented to us during the critical phase of dengue and required ICU care and Non-invasive ventilation. Both the patients developed significant metabolic acidosis and compensated shock during their ICU stay and were managed with IV fluids conservatively. Platelets improved with conservative measures and thrombocytopenia improved following which they underwent cesarean section.

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INTERNATIONAL Infection Prevention Week

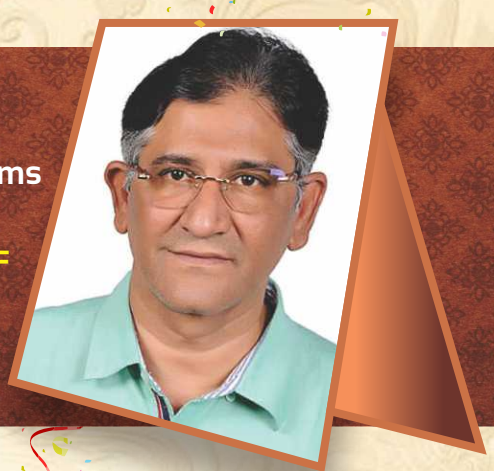
The International Infection Prevention Week (IIPW) has been celebrated globally every year. The theme of the year 2021 was "Make Your Intention Infection Prevention". On behalf of this, the Royal Care Super Speciality hospital's Infection Prevention and Control Committee (HIPC) has conducted many training, awareness, and brainstorming activities throughout the week from October 18th to 22nd. The motto of the program was focused on Train the Trainers, to make their intentions for the prevention of Hospital Acquired Infections. The five day of awareness program ends up with the Best hand-hygiene performance award and prize distribution for the winners by our beloved chairman.

Congrats

Dr. D.Gandhiraj

MSc, Microbiology (Faculty of Medicine), MBA (NYSIC), Ph.D.,
Chief Microbiologist, Infection Control Officer & Head-Quality systems

Completed Ph.D. and awarded Doctorate degree for his work on "ANTIBACTERIAL ACTIVITY AND PHYTOCHEMICAL ANALYSIS OF CITRUS HYSTRIX (DC) LEAF EXTRACTS AGAINST METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)".
Awarded by, PERIYAR UNIVERSITY Salem dated 09.03.2022.



GLIMPSE

National Organ Donation Day Signature Campaign at Royal Care Premises on 27.11.2021

Breast Cancer Awareness Campaign at Coimbatore Railway Station on 20.10.2021

Launch of New CT Scan Machine at Royal Care on 28.10.2021

New Technology Introduced Frozen Section Machine in Microbiology on 13.10.2021

Mental Health Program at Royal Care Premises on 09.10.2021

Breast Cancer Awareness Campaign at Co-operative Hospital_ Palakkad on 26.10.2021

Breast Cancer Awareness Campaign at Sri Shakthi College On 09.10.2021

Inauguration of New PMR Department with Robotic Equipment at Royal Care on 28.10.2021

Eye Camp held at Senjerimalai Sultanpet on 08.10.2021

CHRONIC NON-BACTERIAL OSTEOMYELITIS (CNO)/ CHRONIC MULTIFOCAL OSTEOMYELITIS (CRMO)

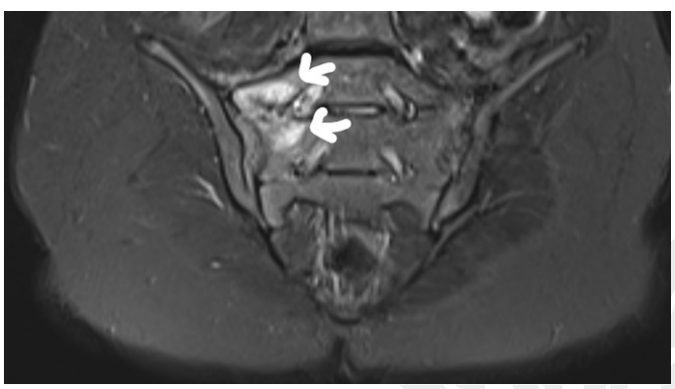
Dr. Madeshwaran Mani
MD.,DM (Rheumatology),
Consultant Rheumatologist

Case 1: Miss. XY, a 14 year girl was referred for pain in both knees lasting for two months. She reported with difficulty in climbing stairs. There were no history of fever, skin rash, backache, red eyes, bladder/ bowel disturbances. Musculoskeletal examination revealed tenderness in 10'O clock position in left knee. No swelling/loss of range of movements noted in both knee. There was no muscle weakness in extremities. Other systems were unremarkable. Her inflammatory markers were high (ESR=33 mm/hr, CRP=16 mg/L). Plain radiographs of both knees were normal. MR Imaging of both knee with pelvis screening showed diffuse bone marrow edema in distal part of both femur with small pockets of fluid near the physis (A & B). Mild sub-periosteal fluid collection noted around both distal femur on anterior and posterior aspects predominantly around the metaphyseal region. Significant paraosseous soft tissue edema was seen. Significant marrow edema in right proximal fibula and body of right sacrum at S1-S2 level with paraosseous soft tissue edema was seen (C). These findings are suggestive of multifocal osteomyelitis.

She improved significantly with NSAID mono therapy. She needs long-term follow-up and treatment for CNO. Antibiotic(s) has no role in this condition.

Picture A. Diffuse marrow edema in right proximal fibula seen

Picture B. Pockets of fluid near physis with surrounding marrow edema seen in left distal femur



Picture C. Marrow edema in body of sacrum-right side

- CNO/CRMO is an autoinflammatory bone disorder mostly affecting children and adolescents.
- Dysregulated cytokine expression and pathological activation of inflammasomes play a central role.
- Treatment is based on experience from case series and expert consensus treatment plans.

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Case 2 : SARCOIDOSIS

52 year old gentleman reported to Rheumatology clinic with history of fever for three months associated with weight loss and multiple joint pain. He had past history of sarcoidosis five years ago (diagnosis based on mediastinal lympadenopathy and high ACE), for which he took steroids for short-term and lost to follow-up with his previous doctor. In Royal Care Hospital he was evaluated this time for above symptoms. Clinical examination revealed bilateral parotidomegaly, cervical-,and inguinal lymphadenopathy. Complete blood count, peripheral blood smear and LDH was normal. ESR(75 mm/hr) and CRP (12 mg/l) was high. ENA profile and viral markers were negative. Serum ACE was high (171u/l). Whole body FDG PET/CT revealed FDG avid multiple lymphnodes involving bilateral intraparotid, cervical, axillary, mediastinal, celiac, retroperitoneal, iliac and inguinal nodes. Low heterogeneous FDG avid multiple nodules in bilateral lungs were seen.

Image 1

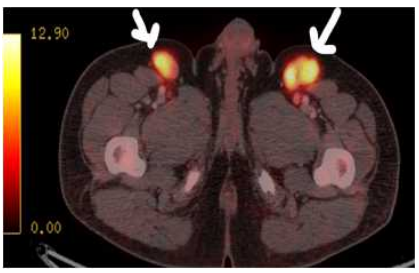
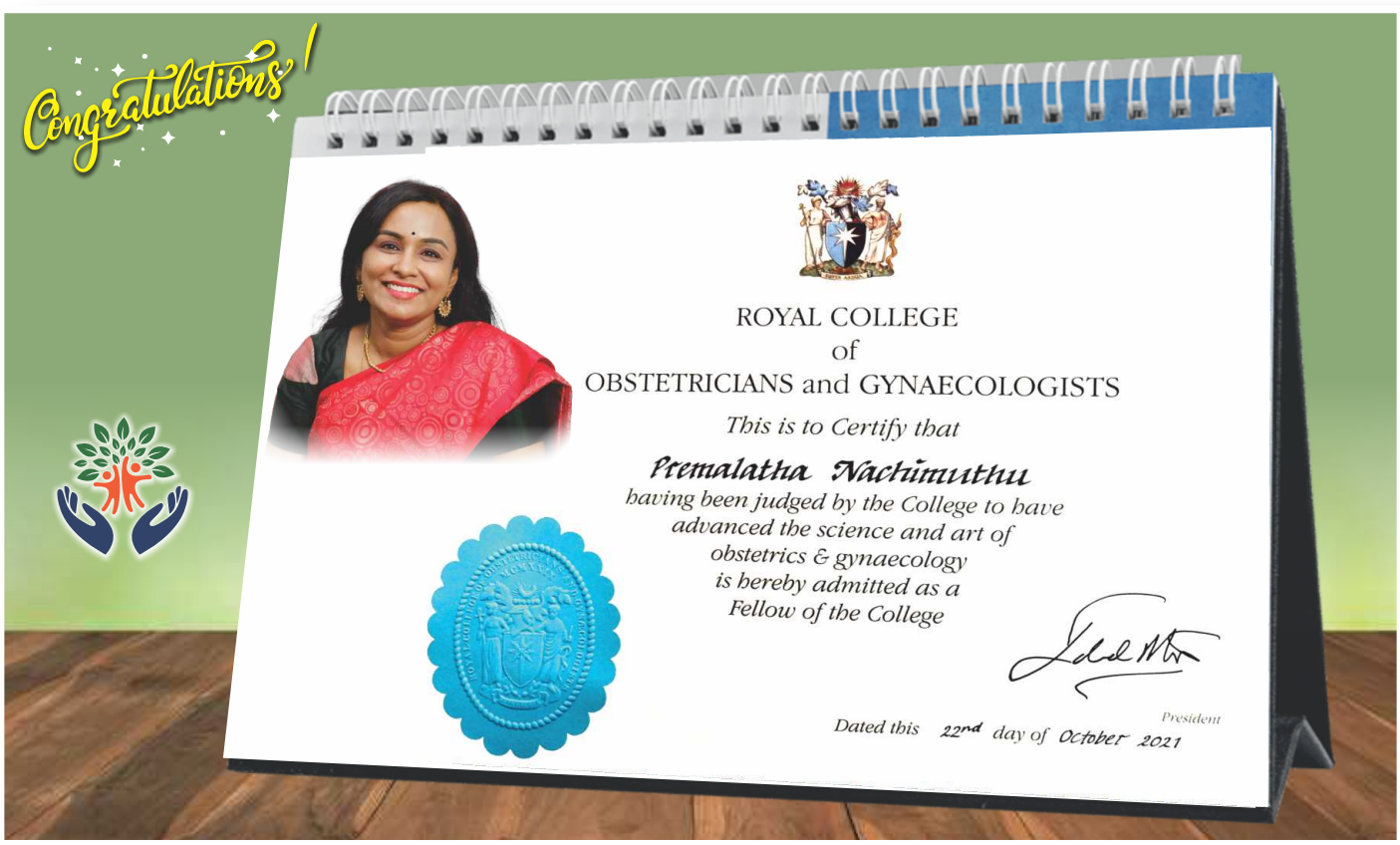


Image 2

Image 1 : Whole body PET/CT shows FDG avid bilateral cervical, mediastinal and celiac lymphnodes

Image 2 : PET/CT reveals FDG avid bilateral inguinal lymphnodes

Left inguinal lumphnode was biopsied and HPE revealed non-necrotising granuloma. No features of lymphoma. AFB stain and Genexpert were negative. He was treated for relapse of sarcoidosis with oral steroid and methotrexate for which he responded well. His recent ACE was 52 (12-68 normal range), during follow up.



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MULTI VESSEL CORONARY ENDARTERECTOMY IN DIFFUSE CAD

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Dr. Abraham Gerald Henry
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Abstract : Coronary endarterectomy (CE) assures complete revascularization of the myocardium in case of diffusely diseased vessels and prevents residual ischemia. There is a controversy regarding coronary endarterectomy. CE is criticized for its higher rate of morbidity and mortality. At present, the available evidence supports the CE in off-pump CABG and along with valvular procedures. Graft patency is better with the open technique. There, it is important to focus on the current results to accept the CE as a routine procedure like CABG.

Introduction : Coronary endarterectomy was first performed in the late 50s, and subsequently it was combined with coronary revascularisation. In the current era presentation of diffuse coronary artery disease is on the rise associated with systolic dysfunction. This subset of patients is either managed medically or deemed inoperable. Initially many cardiac surgeons were reluctant to perform this procedure because the patients who underwent CE were at higher risk of surgical morbidities, such as perioperative myocardial infarction (POMI), and mortality

CE has shown to benefit patients with advanced coronary atheroma by providing complete revascularization. The main indication for CE is the presence of diffusely diseased calcified coronary arteries that is not suitable for distal grafting. The basic principle of coronary endarterectomy is to extract the plaque completely.

European Society of Cardiology/European Association for Cardio-Thoracic Surgery Guidelines on myocardial revascularization recommends CABG over PCI for highly complex CADs, such as left main or triple-vessel diseases with intermediate or high SYNTAX scores.

Off-pump Vs on-pump CABG: Off-pump CE is considered a technique of choice in high-risk patients to avoid Cardiopulmonary bypass-related

inflammation and global ischemia. However, if multivessel endarterectomy is planned the procedure of choice is on-pump CABG which ensures stable hemodynamics and complete revascularization with minimal myocardial ischemia. A myocardial perfusion scan/viability is mandatory.

Technique: Coronary endarterectomy is a risky and time-consuming procedure, which has to be done completely. Partial atherectomy or vessel injury leads to the jeopardy of a large area of perfusion. Two techniques are described, Open and closed. Open technique CE is performed by opening the native artery longitudinally and not too long. Then the plaque is gently lifted off the vessel and a circumferential clearance is obtained. The atheroma is grabbed securely and gentle traction and countertraction are applied to retrieve the entire length of occlusion. Later patch closure of native artery (i.e. LAD) is done if needed, followed by bypass grafting. With this technique complete relief of obstruction is assured, and intimal flaps are prevented. Choice of conduits would be predominantly arterial conduits, however competitive flow situations have to be borne in mind. Postoperatively they are started on Ticagrelor 90mg B.D, Asprin 75mg O.D, Warfarin according to the prothrombin time to maintain an INR Of 1.5 – 2

At 3 months Warfarin is discontinued and they are on dual antiplatelet drugs for 1 year.

We at Royal Care have performed more than 65 multivessel endarterectomies and concomitant CABG. Three of them had diffuse disease associated with severe LV dysfunction <30% EF. All 3 were deemed to be inoperable due to poor target vessels and were on medical management. All 3 of them have multiple vessels endarterectomy and grafting. Post of LVEF improved to 45%. The majority of them had a LIMA to LAD over a vein patch reconstruction of the LAD. Post-operative IABP was needed in 7 patients. The average ICU stay was 3 days, and the hospital stay of 7 days.

On follow -up we noticed one mortality after 3 months and the rest of them in NYHA class II

Conclusion :

CE remains an effective and safe procedure when done in completion despite the risk of high morbidity, offering surgical revascularization in patients with diffuse calcific atheromatous vessels.

Figure: 1

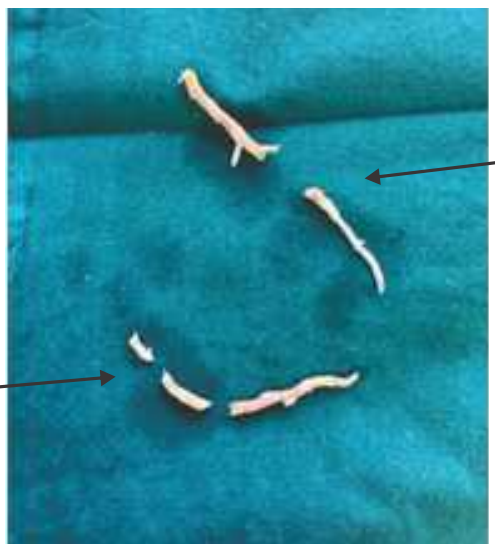

Illustration showing the excised atheromatous plaque from LAD and RCA.

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THE MOMMY MAKE OVER

RESTORING YOUR BODY AFTER CHILDBIRTH

Dr.K.Preetha Rani
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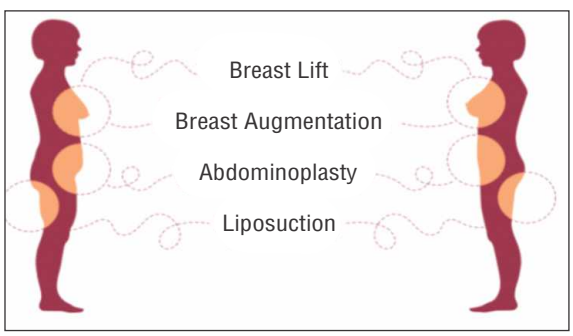
Consultant Plastic and Cosmetic Surgeon

Moms sacrifice many things for their children, especially their health, physical outlook and external appearance. Pregnancy, childbirth and nursing can all change the female body in ways that make you feel less like yourself. Many women notice changes in their bodies post-pregnancy. There are many areas of the body that can be addressed, most commonly the breasts, abdomen, waist, genitalia and buttocks.



The body changes after pregnancy that concern them the most are:

- Breast deflation
- Drooping and sagging in the abdominal area
- Bulging in the stomach area
- Abdominal stretch marks
- Vaginal laxity
- Separation of abdominal muscles
- Stubborn and extra fat in new areas.

Pregnancy and Breastfeeding leads to looseness of the breast, loss of volume and leads to sagging or ptotic breasts. Many women feel self-conscious and are unable to lead an active athletic life.

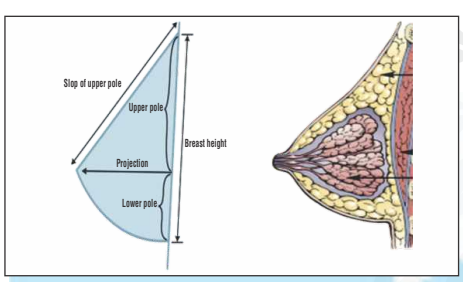
Normal breast shape has a beautiful slope on top and lovely rounded lower half with the nipple and areola situated in the centre.

Mother hood is an amazing experience; but it also comes with significant dramatic changes occurring both during and after pregnancy in a women's body which cause many women lose confidence in their appearance and have a negative impact on their self esteem.

The goal of a mommy makeover is to restore the shape and appearance of a woman's body after childbearing and boost her self-esteem and confidence. When you go through surgery, as a result, you get the desired looks which increase the positivity in you and also improves your mental health.

Candidates for mommy makeover surgery :

- You may be a candidate for mommy makeover surgery if:
- You are in good medical health
- You are at or near your target body weight
- You have a positive outlook and realistic expectations
- You are finished with child bearing



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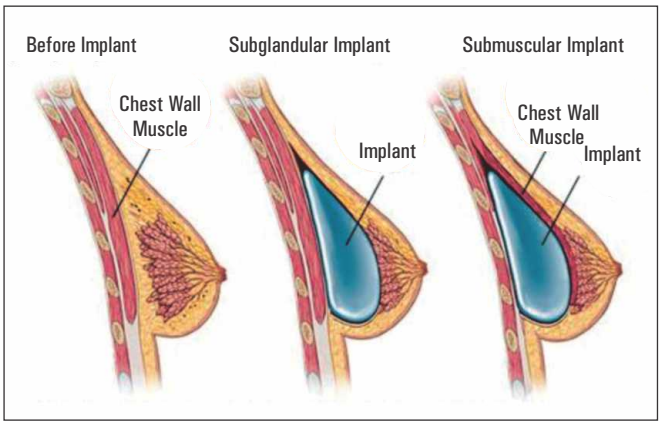


Breast augmentation can fill out breast volume that may have been lost after pregnancy or weight loss. Breast augmentation restores the volume and projection of the breast.

Breast Lift surgery involves removal of excess skin, repositioning of the breast gland tissue along with uplifting of the nipple areola complex to reverse the sagging and restore a youthful and uplifted look to the breasts.

Mastopexy is a parenchymal reshaping that may or may not require a small parenchymal reduction.

Typically, the ptotic breast has a paucity of breast parenchyma in relation to a lax, excessive skin envelope. Mastopexy (Breast Lift) not only makes the breasts look younger but also helps you to lead a more active life

Liposuction :

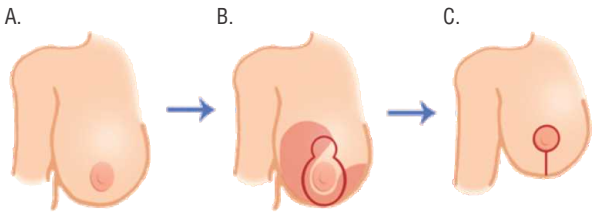
The abdomen, back, hips, thighs and arms may gain bulges of fat during pregnancy. Some of this goes away when you lose weight and get back to your pre-pregnancy weight. Even extremely fit people can have areas of fat on their bodies which are resistant to exercise. So liposuction for women is aimed at these specific stubborn areas of fat to get the perfect contour.

Recovery after mommy makeover :

Recovery can range from two to four weeks in most cases. The amount of time it will take to recover will vary from patient to patient and what procedures were included in their makeover.

Breast Reduction :

For some women, breasts can tremendously increase in size during pregnancy. Women with large heavy breasts suffer from back pain, shoulder pain, poor posture and limited clothing options. Reduction Mammoplasty or breast reduction involves removing excess breast tissue, skin and reshaping the breast mound. Breast reduction surgery makes breast lighter and more proportional to their body size and gives relief from the above symptoms.



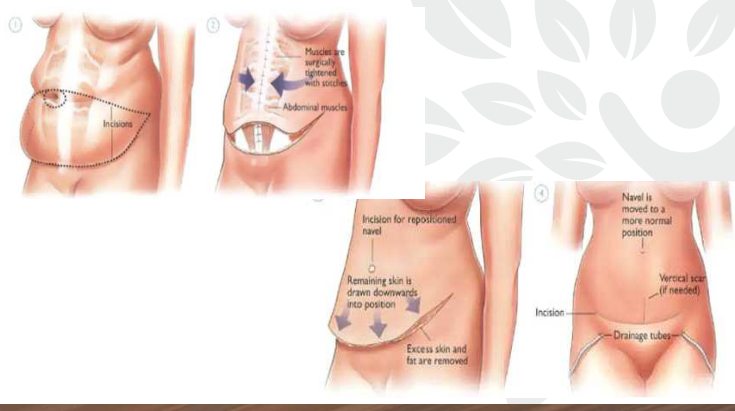
The surgery basically entails the reduction of the skin envelope and the breast parenchyma.

Techniques (periareolar, lollipop or anchor shaped) vary according to the skin excess, and parenchymal shaping can be done using various pedicles (superior, superomedial, inferior, bipedicled) to maintain blood supply. The incisions are usually well concealed.

The nipple and areola move with the pedicle or may be removed completely and reattached as a free graft, depending on the blood supply.

Tummy Tuck :

During pregnancy and childbirth, there is fat accumulation and stretching of the abdominal skin, along with thinning and separation of the muscles. After delivery, some changes reverse but there is residual loose hanging skin and muscle weakness. Tummy Tuck removes excess skin, tightens the abdominal muscles and also provides contouring for post weight loss patients.



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Dr. Atul Mohan Kochhar
Chief Executive Officer

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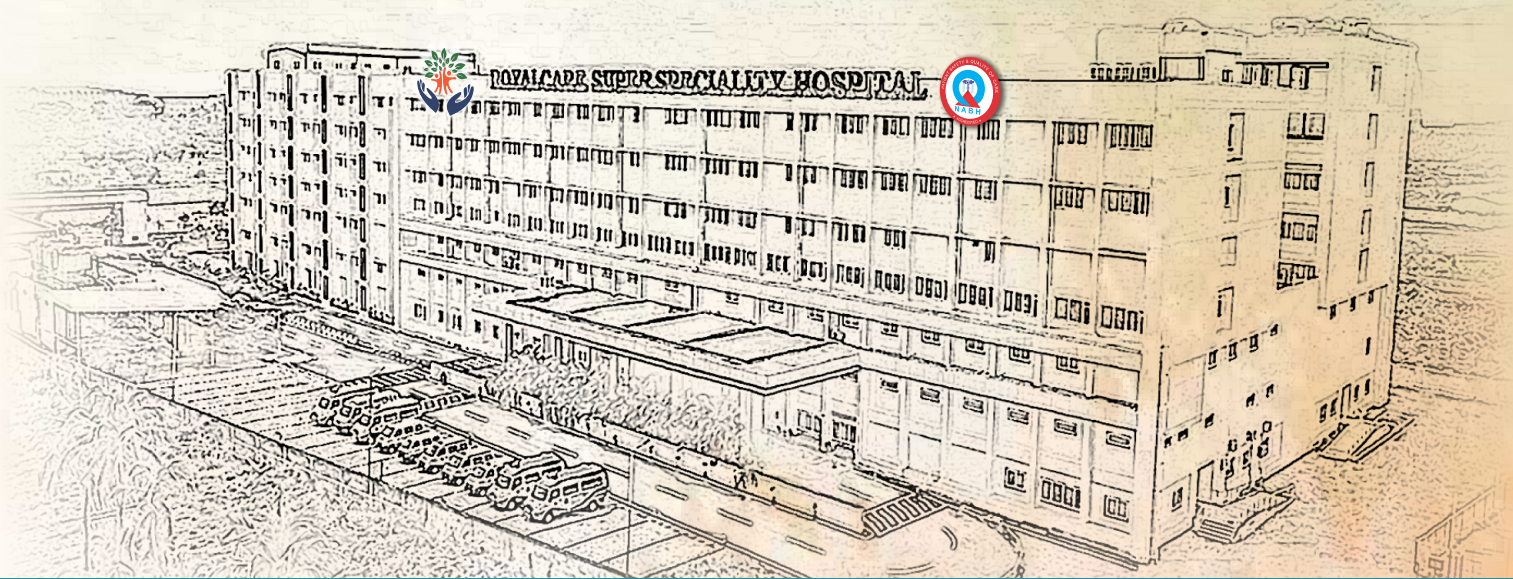

Welcomes...

Dr. Vasudevan. S

MBBS., PGDHM (UK), MBA (HA), PGDMLS (Medico Legal), PGDHIM (Medico Insurance), MBA (HM).,

Chief Operating Officer

Dr.S.Vasudevan has completed his MBBS from Sri Balaji Medical College & Hospitals, Chennai, and he has achieved PGDHML (Health Management in Strategic Management and Leadership) from City of London University, London, United Kingdom. Also, he achieved MBA (Hospital Administration) from The Institute of Chartered Financial Analysts of India (ICFAI) University, Hyderabad, India in 2018. Subsequently, he has achieved PGDIP-MLS (Medico-Legal Systems) and PGDIP-HIM (Health Insurance Management) from Symbiosis Centre of Health Care, Pune. He worked as a Chief Medical Officer at KIMS Group of Hospitals, Hyderabad, India before joining our Royal Care.

Dr. R. Eniyavel

MD, (PGI, Chandigarh), DNB.,

Consultant Radiologist

Completed MBBS from Madras medical college, Chennai in 2013 and he has achieved MD radio diagnosis from PGIMER Chandigarh in 2016. Subsequently, he completed one year of senior residency in PGIMER Chandigarh in 2017 and also achieved DNB radiodiagnosis in the same year. Later, he worked as a consultant Radiologist in Metro scans Trivandrum from 2018, before joining our Royal care.

Dr. Jaswanth Muppalla

MBBS, DNB (CVTS).,

Consultant Cardiovascular and Thoracic Surgeon

Completed MBBS from Dr. NTR University of health sciences Vijayawada in 2010. Worked as a medical officer in the republic of the Maldives for one year. Joined in surgical residency in Kilimanjaro Cristian medical center 2011-2013. Worked as registrar in vascular, cardiothoracic surgery in Manipal hospital Bangalore in 2013-2015. completed DNB cardiovascular and thoracic surgery in 2021 from Narayana hrudayalaya Bangalore. Worked as Junior consultant in cardiac surgery in Asian heart institute, Mumbai.

Dr. Sathish Kandasamy

MBBS, MD, DNB (Radiology), DM.,

Consultant Interventional Radiologist

Completed his MBBS in Tirunelveli Medical College, Tirunelveli in the year 2012. and he has achieved MD Radio-Diagnosis from JIPMER, Puducherry in 2016. Subsequently, he did DNB Radio-Diagnosis, NBE, New Delhi. also, he achieved DM Interventional Neuro-radiology from Sree Chitra Tirunal Institute for Medical Sciences and Technology (SCTIMST), Trivandrum in 2019. He worked as a Consultant Interventional Radiologist at GKNM hospital, Coimbatore before joining our Royal Care.

Dr. Peeyush Maniyambath

MBBS, DA, MD (anaesthesia), DA (London), FRCA (London).,

Visiting Consultant in Anaesthesiologist

Completed MBBS, DA, and M.D from JIPMER. Worked in N.E Thames group of hospitals in London and obtained D.A (London) and F.R.C.A, also worked as a locum consultant in pain and palliative care at Whipps Cross hospital London. Returned to join KMCH as a senior consultant in anesthesia before setting up own pain management, joined Royal Care hospital as visiting consultant.

Dr. T. Y. Brithika

MBBS, DNB (Nuclear Medicine).,

Junior Consultant, Nuclear Medicine & PET - CT

She has completed her MBBS from Rajah Muthiah Medical College, Annamalai University, Chidambaram in 2015. she has achieved DNB Nuclear medicine at Apollo Hospitals, Chennai in 2021. She worked as a Registrar in Nuclear Medicine and PET/CT in Apollo hospitals, Chennai before Joining our Royal care.

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