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ROYAL CARE HOSPITALS

making life better

- **Editor & Publisher**

Dr. K. Madeswaran

Chairman - Consultant Neuro & Spine Surgeon

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CHAIRMAN'S COLUMN

Greetings to all of you as we step into a new quarter, filled with promise and dedication to the well-being of our patients and the advancement of healthcare excellence.

As we continue our journey, our unwavering commitment to providing exceptional care remains our top priority. Our dedicated medical professionals and support staff have demonstrated extraordinary resilience and determination, ensuring that each patient receives the highest level of attention and compassion.

In the realm of medical innovation, we are proud to report significant strides in the implementation of cutting-edge technologies. These advancements empower our medical teams to make more accurate diagnoses, develop personalized treatment plans, and achieve better patient outcomes. Our investment in state-of-the-art equipment underscores our dedication to remaining at the forefront of medical progress.

It's been almost one year since launching India's first and only Magnetic Resonance guided Focused Ultrasound (MRgFUS) at Royalcare for treating Parkinson's disease and Essential tremors and we have successfully treated close to 50 patients.

We have started the next phase of our capacity expansion with additional 550 beds being built up in a new block of 7 lakh square feet.

The wellness and job satisfaction of our esteemed staff members are of paramount importance to us. We are continuously working to enhance our work environment, promote professional growth, and foster a culture of collaboration and mutual respect. Our staff's dedication and expertise are integral to the seamless functioning of our hospital, and we are committed to providing them with the support they need to thrive.

I want to express my gratitude to every member of our hospital family-our patients, staff, partners, and community for your unwavering support and trust. Together, we are creating a brighter future for healthcare, one characterized by compassion, innovation, and a shared commitment to excellence.

Wishing you all good health and success in the coming months.

Regards

Dr. K. Madeswaran

Founder Chairman

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From The EDITOR'S DESK

"The growth and development of people is the highest calling of leadership "...

- Harvey Firestone

Many changes have been brought in the infrastructure of the hospital in the last few months aiding treatment and diagnosis very evidence-based and accurate for the patients. The Kongu region has been going through a big financial strain and we have taken multiple steps to curtail the medical expenditure so as to ensure that patients and caregivers don't suffer.

The hospital, under the able guidance of our Chairman Dr.K.Madeswaran, has been growing rapidly and due to the repeated requests from the public and to keep in touch with the growing needs of our patients, we have started the new project of constructing 11 lakh square feet of the next phase of our hospital in full speed and we hope to dedicate it to the usage of high-end technology and the benefit of the people of this region within 24 months.

Royalcare Interventional pulmonology team conducted a pleura workshop under Trends in Interventional Pulmonology (TIP) and it was a grand success with hands-on training for many of the doctors from across the country. The ICU team also conducted CRITICIMA, a program in conjunction with the IMA to disseminate knowledge for doctors about critical care in the peripheral setting. The monthly program was concluded last month with over 50 doctors benefitting from it.

As always, we try to make the public aware of our programs and camps which were conducted in the fields of road safety, head injury, BLS, MRgFUS, and laboratory diseases. Many dignitaries like the commissioner of police Mr.Balakrishnan IPS were part of the programs. Labor welfare meet and the fire and safety drill was also conducted to ensure that patient safety shall always be our top priority.

In this edition, we have articles on shoulder arthroplasty, Meniscus repair, Aqua therapy, and Melioidosis. Aqua therapy is a unique treatment in the department of PMR where patients are suspended from harnesses and exercises are done in water reducing the strain of gravity.

We welcome the new consultants who have joined the ever-growing Royal Care Hospital team and wish them success in their endeavors.

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MRg FUS

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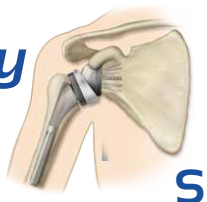
Arthroplasty



SHOULDER

Dr. Dinesh Chidambaram
MS Ortho, DNB., FoTs(Trauma fellow),
FASM (Arthroscopy), Shoulder Fellow (Japan).,
Consultant Arthroscopy & Trauma Surgeon

Lesions of the shoulder requiring arthroplasty are much less common than lesions involving the weight-bearing joints of the body such as the hip and knee.

Shoulder joint - Unique

Most mobile joint

No inherent bony stability
(little glenoid bone stock)

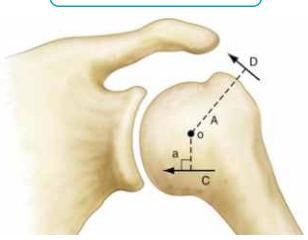
Relies on soft tissues

Injuries - cuff / labrum(quite common)

Biomechanics:

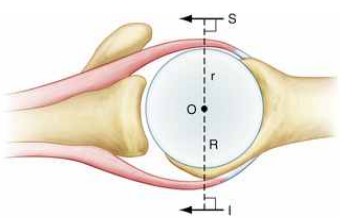
The main function of the Rotator Cuff muscle is to balance the force couples across the shoulder joint (Stable fulcrum)

Coronal plane



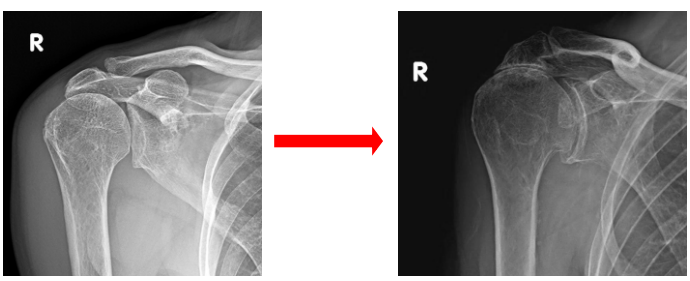
The inferior rotator cuff must balance the moment created by the deltoid

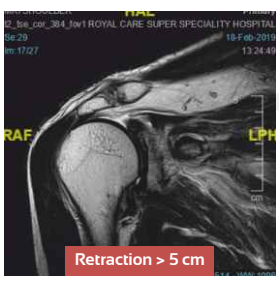
Transverse plane

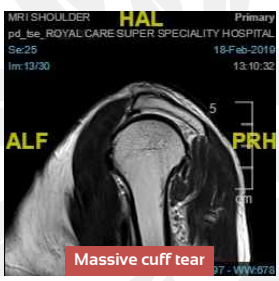


The anterior rotator cuff must balance the moment created by the posterior rotator cuff

In massive rotator cuff tears, this balanced force couple is lost resulting in proximal migration of the humeral head due to unopposed activity of the Deltoid, resulting in Cuff tear arthropathy







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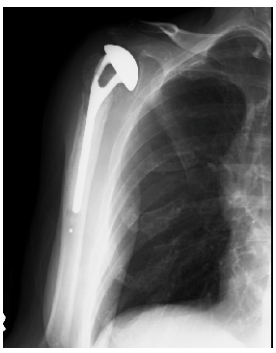
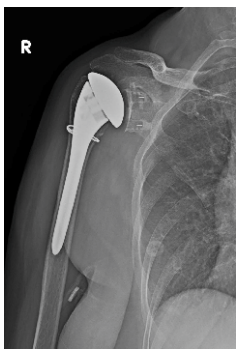
Treatment Options :

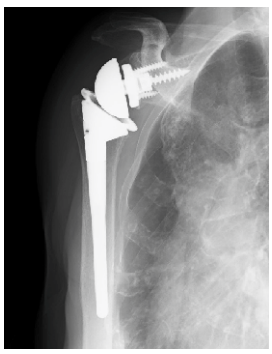
Hemiarthroplasty



Total Shoulder Arthroplasty



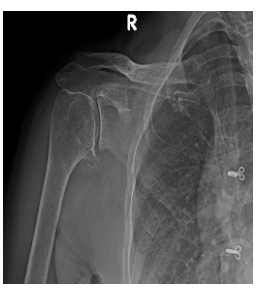
Reverse Shoulder Arthroplasty



Case example :

66 years female came to the outpatient department with complaints of pain and stiffness over her Right shoulder for the past 3 years with restrictions in activities of daily living. She had multiple consultations elsewhere and is being managed as a "Frozen shoulder".

Arthritis



X-ray - Rt Shoulder: Primary Glenohumeral

Common indications for Shoulder joint replacement :

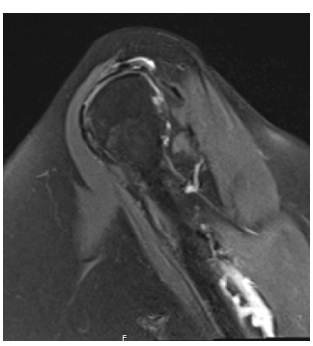
- Cuff tear Arthropathy
- Complex proximal humerus fractures in elderly patients
- Osteoarthritis
- Rheumatoid Arthritis
- Avascular necrosis
- Post-traumatic arthritis

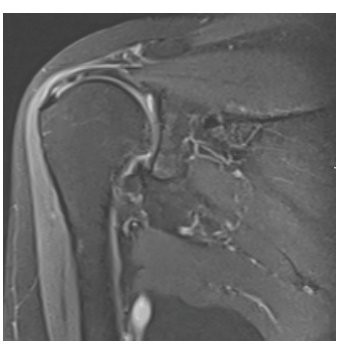
Clinical Examination:

ROM	RIGHT	LEFT
Flexion	45°	120°
IR	L 5	T 12
ER	10°	45°
Abd	45°	120°
Ext	30°	60°

SPECIAL TESTS	RIGHT	LEFT
NEERS & HAWKINs	+	-
FULL CAN	+	-
EMPTY CAN	+	-
HORN BLOWERS	-	-
ER LAG SIGN	+	-

MRI - No cuff tear





Operative details :

As the patient's age was below 70 years with intact rotator cuff muscles and symptomatic she underwent Total Shoulder replacement where both the humeral head (ball) and glenoid (socket) were replaced with a Humeral stem and Glenoid cup.

The humeral component consists of the artificial metal humeral head attached to a metaphyseal stem that is either fully cemented or proximally cemented, of press-fit into the humeral shaft and the components of the glenoid are either a pegged or keeled high-molecular-weight polyethylene cemented component.

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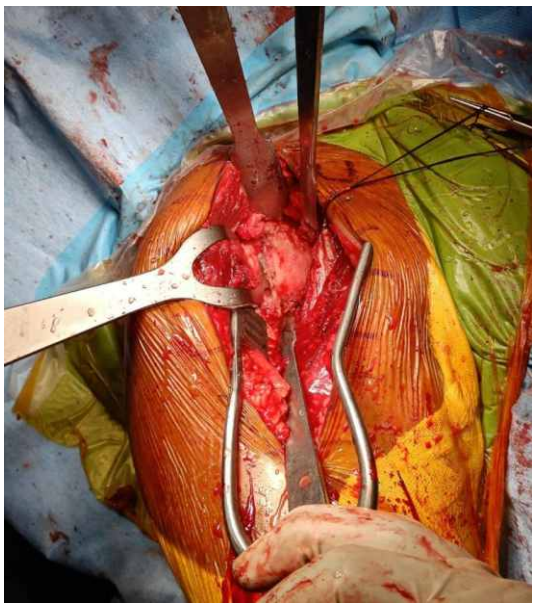
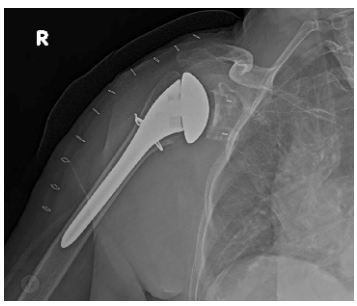
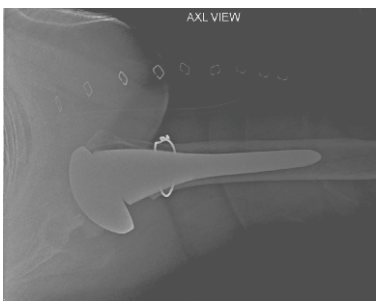
Intraoperative image - 360° Glenoid exposure (a key step in surgery)

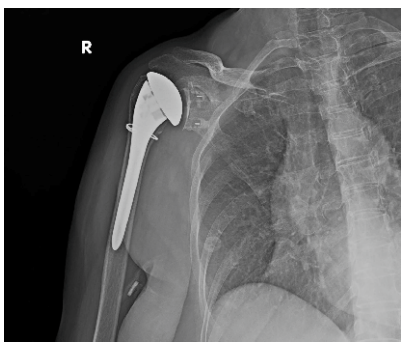


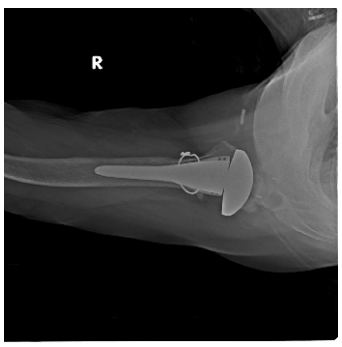
Postop Xray:





At 3 months follow-up, the patient is doing fine and doing her routine activities of daily living. She had greater pain relief and gained her movements.





Patient education before and after the surgery is vital as patients must know to expect differing levels of postoperative function depending on many factors such as the type of surgical implant, status of the remaining rotator cuff, and bone stock of the glenoid and humeral head.

Conclusion:

Total Shoulder Arthroplasty has become a viable option for patients with advanced shoulder dysfunction due to a variety of different etiologies. This procedure, along with the newer Reverse Total Shoulder Arthroplasty, can help relieve pain and increase function in patients when indicated. Postsurgical rehabilitation for these patients is key to obtaining successful outcomes.

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INNOVATIVE & COST EFFECTIVE TECHNIQUE FOR MENISCUS REPAIR

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Consultant Arthroscopy & Sports Medicine

Background : Meniscus tears of the knee joint are the most common indications which require arthroscopic surgery. We describe a new technique for the repair of the meniscus which is both biological and cost-effective.

Operative technique :

Inside-out Meniscal repair with fibrin clot augmentation

After Diagnostic arthroscopy identified horizontal meniscal tears. Meniscal flaps were freshened. Loose flaps were debrided. Horizontal meniscal tears were repaired with circumferential compression stitches using an inside-out technique. One needle was passed along the superior surface of the meniscus with a suture threaded into it and the second needle was passed along the inferior surface of the meniscus which carried the other end of the suture. The two ends of the thread were retrieved from the posteromedial skin incision and tied over the capsule. This provided a stable repair of the horizontal meniscal flaps.

Fibrin clot was prepared from autologous blood and was packed between the flaps before tying the threads.

STEPS:

Complex meniscal tear

Debridement of flaps

MEDIAL PIE CRUSTING TO OPEN UP THE JOINT

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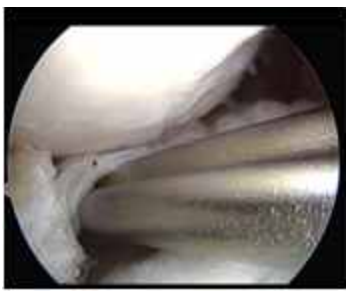
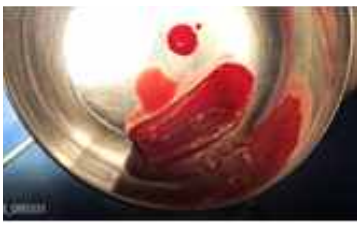
SUTURES PASSED ALONG THE SUPERIOR AND INFERIOR SURFACE



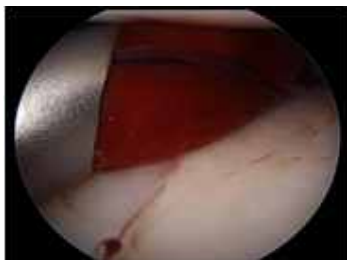



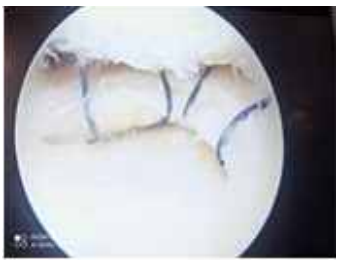
Preparation of Fibrin clot


Autologous blood withdrawn and stirred on rough surface to retrieve a clot




Clot introduced into the joint and packed at the repair site






Innovation & Cost Effectiveness

In this procedure, by using an inside-out technique for repair we minimize the cost of surgery by avoiding costly All Inside Implants. The implant cost is only a fraction of the cost incurred while using all inside devices. Fibrin clot acts like a scaffold on which mesenchymal stem cells can imbibe and differentiate into native meniscal tissue. Growth factors derived from the fibrin clot are chemotactic and mitogenic. Fibrin clot preparation is autogenous and cheap.

Conclusion

In our series of five patients, with medial meniscus tears who underwent the above procedure, all patients had good to excellent clinical outcomes with no major complications. We conclude that fibrin clot augmentation is a good cost-effective modality of treatment for repairable meniscus tears to preserve the meniscus and decrease the point contact pressure on the condyles which may prevent the early occurrence of osteoarthritis.

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GLIMPSE

MRgFUS CME Programme held at Namakkal IMA on 26.02.2023

Labour Welfare meet held at Royal Care on 10.03.2023. Special lecture by Officials of Dept. of Labour Commission Coimbatore.

Road Safety Awareness Program held at Royal Care on 24.03.2023

Head Injury Awareness Walkathon on 26.03.2023

MRgFUS CME Programme at Karur on 27.03.2023

Basic Life Support Program (BLS) conducted for Le Meridien Hotel staff on 28.03.2023

Fire and Safety Mock Drill held at Royal Care on 06.04.2023

Royal Care 24x7 Hospital Inauguration at Senjeri 15.04.2023

CME Programme Laboratory Diseases at Hotel Gokulam Park Coimbatore on 29.04.2023

International Nurses Day Celebration 20.05.2023

AQUATHERAPY

Dr. R. Priyavadhana
MD, DNB, DPMR .,
Consultant Physiatrist & Rehabilitation Incharge
Institute of Physical Medicine & Rehabilitation

Aquatherapy is an Evidence-Based field of Rehabilitation Medicine that involves the use of water. It refers to the usage of therapeutic techniques in an aquatic environment. It uses the unique properties of water for sensory, motor, psychological, social, and other therapeutic benefits.

HOW AQUATHERAPY WORKS

The buoyancy of the water reduces gravity and allows easier, safer, and less painful movements. The therapeutic temperature of 90-94 degrees F relaxes sore or tight muscles. The water's resistance can also be used to strengthen muscles and improve cardiovascular fitness. Aquatherapy can help improve balance, coordination, range of motion, and flexibility. The hydrostatic pressure exerted by the water assists with upright support to improve balance. Water exerts hydrostatic pressure on the body, which can help reduce swelling and improve circulation. This pressure can also provide a calming and soothing effect, promoting relaxation and stress reduction. The water adds resistance in all directions, enabling patients to work at various intensity levels to strengthen weak muscles. Activities in water promotes deep breathing, cardiovascular and muscular endurance. Warm water immersion increases circulation, flexibility & balance & promotes healing & relaxation.

WHY AQUATHERAPY - THE BENEFITS

- Reduced Pain
- Improves circulation
- Better relaxation and sleep
- Improves Joint Range
- Re-educate paralyzed muscles
- Increased aerobic activity
- Improves balance and coordination
- Improved sensory processing
- Decreases stress on the joint
- Improves fun and makes therapy enjoyable

FOR WHOM

1. Neck pain, back pain, knee pain, ankle pain etc
2. Arthritis (OA, RA, AS)
3. Shoulder pain (Post-op rehab + persistent MSD)
4. Sports Injuries
5. Lymphoedema
6. Fibromyalgia
7. Mobility and balance retraining
8. Chronic pain & fatigue
9. Parkinson's Disease
10. Neurorehabilitation including Stroke, TBI etc
11. Spinal cord injury
12. General fitness
13. Anxiety and depression patients
14. Osteoporosis

TECHNIQUES

Aquatherapy sessions are typically supervised by a trained therapist (Aquatherapist) who guides patients through specific exercises and movements. Various techniques may be employed, including stretching, joint mobilization, water resistance exercises, water aerobics, and relaxation exercises. Some of the various techniques used are the Watsu method, Bad Ragaz ring method, Aquastretch, Burdenko method, and Jacuzzi treatment.

Aquatherapy remains a valuable addition to the comprehensive rehabilitation program. It can improve compliance and add more fun to therapies thereby improving the rehabilitation outcomes.

TRENDS IN INTERVENTIONAL PULMONOLOGY(TIP)

PLEURA WORKSHOP 2023

Trends in interventional pulmonology is a state-of-the-art training course organized by the Department of interventional pulmonology and sleep medicine which offers interactive training and workshop on various interventions in pulmonology such as bronchoscopy, EBUS (Endobronchial ultrasound), rigid bronchoscopy, and thoracoscopy. The TIP course is held on a periodic basis at the Centre for advanced pulmonary interventions(CAPI) in Royal Care Super Speciality hospital, Coimbatore, and attracts pulmonologists from across India. The course provides an opportunity for the participants to enhance their skills in interventional pulmonology through hands-on training and knowledge sharing.

The TIP course has gained recognition and popularity in recent years. Last year, this course was first held between the 29th to 31st of July and then on the 11th of December 2022 which has been a roaring success with participants from all regions of India. The limited number of participants, more personalized and focused learning experience, interactive sessions, live streaming of demonstrative cases, and dedication of faculty and hospital staff support contribute to the overall success of the course.

The recent TIP course focused on pleural interventions, took place on June 25th, 2023. It covered topics such as flexi-rigid and rigid thoracoscopy, indwelling pleural catheter placement, management of malignant pleural effusion, and surgical aspects of the pleura. The course was facilitated by renowned experts in the field of interventional pulmonology and received positive feedback, indicating its success.

Due to the positive response, a second pleura workshop has been scheduled for August 22nd, 2023. This upcoming workshop will likely continue to provide detailed teaching and practical sessions on various aspects of pleural interventions. It's a valuable opportunity for pulmonologists to enhance their knowledge and skills in this specialized area.

AN UNUSUAL CAUSE OF EMPYEMA : MELIOIDOSIS

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Dr. S. Mahadevan
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Dr. Arjun Srinivasan
MD, DM (Pulm & Crit. Care).,
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Dr. Pravin Hanumant Taware
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Fellowship in Interventional Pulmonology

Melioidosis is a rare bacterial infection caused by gram-negative aerobic bacillus Burkholderia pseudomallei. This is also considered a potential bioterrorism agent. Melioidosis is an endemic infection in Southeast Asia and Northern Australia and is now expanding rapidly to other regions of the world. It has been predominantly reported in Southern India. It is known as a "great mimicker" as it has a wide range of clinical manifestations ranging from no symptoms, mild localized infection, a subclinical disease with indolent course, and an acute fulminant disease with widespread bacterial dissemination and septicemia which has high mortality.

Patients with diabetes are most susceptible to this infection and other risk factors include renal disease, chronic lung disease, exposure to the soil, and stagnant water. Most cases go unnoticed and unreported due to a lack of clinical awareness and an inability to establish a diagnosis at the right time. Burkholderia is often misclassified as Pseudomonas or other aerobic spore-baring bacteria. It is often confused with tuberculosis, other bacterial and fungal diseases due to its clinical presentation making diagnosis exceptionally challenging. We present two unusual cases of melioidosis with predominant pleural where thoracoscopy played a role in both establishing the diagnosis and reducing the burden of infection.

Case 1: A 61 years old diabetic gentleman, presented to pulmonology opd with a history of cough, fever, and chest pain for 2 weeks. Initial evaluation revealed right multiloculated pleural effusion (Image 1) which was managed with intercostal tube drainage and antibiotics. He was referred to our center because of incomplete drainage and worsening breathlessness. Initial assessment revealed severe toxemia with a persistent focus in the right pleural cavity.

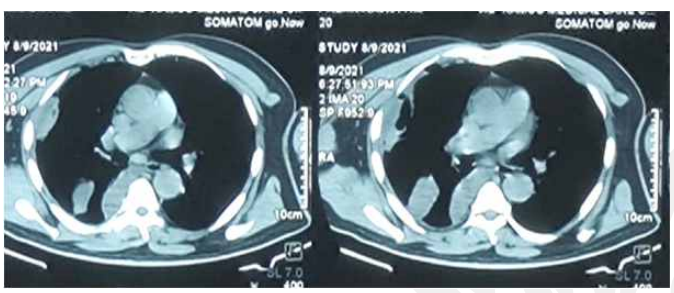

Image 1: CT thorax showing right multi-loculated pleural effusion

He was taken up for medical thoracoscopic adhesiolysis and fluid drainage under general anesthesia. Thick parietal and visceral pleural peel was removed (Image 2,3,4). All adhesions and pus pockets were evacuated thoroughly.

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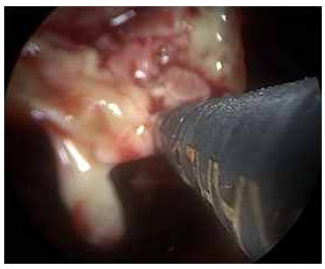

Image 2: Thickened parietal pleura peel removal

Image 3: Thickened visceral pleura peel

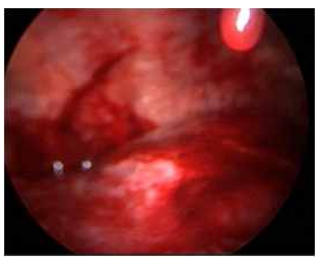

Image 4: Post thoracoscopy clean pleural cavity

Post-procedure, the patient had a high-grade fever with severe tachypnea requiring a critical care shift and reintubation. The patient continued to have a fever despite an escalation of antibiotics. 72 hours post-procedure cultures from pleural tissue finally turned positive for Burkholderia pseudomallei (Image 5) and antibiotics were changed appropriately to ceftazidime.

Image 5: Pleural biopsy culture

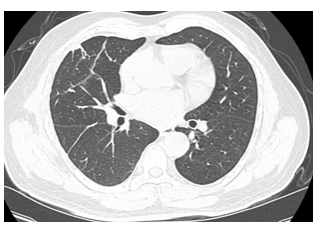

Image 6: Follow up CT chest showing complete resolution

He gradually improved and was extubated 5 days later. He was treated with 4 months of oral antibiotics as per sensitivity after initial 3 weeks of intravenous therapy. Follow-up chest imaging (Image 6) showed complete resolution of the disease.

Case 2: A 29 years old female with no prior comorbidity presented to the emergency department with symptoms of cough with sputum production for the past 1 year which worsened in 2 months. She had worsening dyspnea and left pleuritic pain of 2 days duration at presentation showed severe leucocytosis, she was started on broad-spectrum antibiotics. She was referred to our center because of non-improvement. A Sonogram of the thorax showed left loculated pleural effusion with internal echoes suggestive of empyema. CT showed evidence of underlying bilateral bronchiectasis. Pleural fluid analysis showed glucose of 2 mg/dl, LDH of 8385 U/L, proteins of 4.305 g/dl, TC of 25000 cells/cumm, Neutrophils of 98 %, Lymphocytes of 2%, gram stain - many pus cells, gram-positive cocci. Blood and urine cultures were sterile.

Image 7 : Thoracscopy adhesiolysis

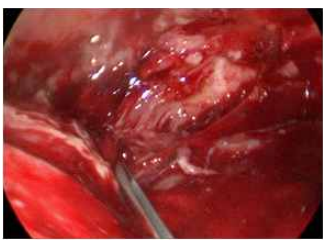

Image 8: Post Thoracscopy pleural cavity

Image 9 : Chest xray on follow up after 3 month

She underwent thoracoscopic adhesiolysis under general anesthesia. All adhesions and pus pockets were completely cleared. Pleural biopsy culture grew Burkholderia pseudomallei for which antibiotics (Ceftazidime & Septran) were initiated according to sensitivity.

The patient improved symptomatically, Repeat Chest xray after 3 months showed significant resolution (Image 9), and oral antibiotics were continued for 4 months.

Discussion: Melioidosis can have an acute fulminant presentation, which is life-threatening. It has a tendency for hematogenous spread with seeding to multiple organs. Blood culture is often positive in patients who present with sepsis and an earnest attempt to look for the focus of infection is mandatory. Pulmonary parenchymal involvement

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is a frequent manifestation of this infection, pleural involvement is uncommon. Isolated pleural involvement is extremely rare. Of the two patients, one had isolated pleural involvement and the other had pleuropulmonary involvement. Pleural effusion could be due to a syn-pneumonic reaction or an invasion of pleura by the organism. In both our cases pleural involvement was secondary to bacterial invasion that was evidenced by the presence of frank pus and complicated nature of pleural effusion. In non-endemic situations like in India, clinical suspicion of this unusual infection is low. Primary thoracoscopic adhesiolysis in this scenario serves a dual purpose of obtaining adequate tissue for cultures as well as decreasing the infection burden as was seen in our cases. These patients may have a brief period of worsening post-procedure as was seen in one of our cases due to a probable shower of bacteria during adhesiolysis. With these cases, we propose a novel minimally invasive technique to establish the diagnosis as well as manage the focus of infection in pleural melioidosis.

Conclusion:

Melioidosis is an emerging infection, especially among immunocompromised patients in south India. The clinical picture is often similar to tuberculosis which is seen commonly in the same subset of patients. It is important to consider this uncommon infection in our differential diagnosis when faced with an appropriate clinical scenario. Tissue and blood cultures, a well-equipped department of microbiology, and an open channel of communication between departments with an emphasis on keeping an eye out for unusual organisms are essential to establish timely diagnosis. Treatment involves debridement of involved areas whenever possible, appropriate antibiotics for induction, and then a prolonged course of oral antibiotics for eradication of infection. With these measures, complete recovery is possible as we have seen in both of our cases.

CRITICIMA

IMA AMS TNSB CRITICAL CARE WORKSHOP

Royal Care Institute of Critical Care Medicine and the Academy of Medical Specialities (AMS) wing of the Indian Medical Association conducted a workshop on the basics of Critical Care for General practitioners. A structured programme was conceived and planned on the basics of managing the critically ill.

5 sessions were held, each session on the last sunday of every month, as a whole day programme including lectures and workstations. The programme was coordinated by Dr. M. N. Sivakumar, Head - Institute of Critical Care Medicine, Royal Care Super Speciality Hospital and Dr.P.Vivekananthan - Consultant Intensivist, Royal Care Super Speciality Hospital with the guidance of Dr.R.Kannan - IMA AMS Chairman, Dr.V.Rajeshbabu - IMA AMS Secretary and Dr. Arul Jothi - IMA AMS Joint Secretary. The course was framed in a way to help Clinicians in their day-to-day patient management. Participants included General physicians, Emergency physicians, Anesthetists, Surgeons, Nursing home owners, Postgraduates from different specialities and post-MBBS doctors. To facilitate individual attention and one-to-one interaction in workshops total participants were restricted to 30.

The first session was inaugurated on 29.01.2023, in the presence of Dr.Paranthaman Sethupathi - Medical Director of Royalcare Super Speciality Hospitals and Dr.Rajeshbabu - IMA AMS Secretary. Basics of critical care including recognition, assessment and optimization of critically ill, Basic Life Support and Advanced Cardiac Life Support were dealt with in it.

The second session was conducted on 26.02.2023, covering various types of trauma, basics of fluid resuscitation and transport of critically ill, with hands-on workshop on ICD placement and log rolling.

The third session was conducted on 26.03.2023, which dealt with various aspects of poisoning and airway management. A hands-on workshop on securing and maintaining the airway including intubation and oxygen therapy was covered in it.

The fourth session was conducted on 30.04.2023, which covered areas like Management of Sepsis, Infection control and Mechanical ventilation. Workshops on non-invasive and invasive ventilation were conducted.

The fifth session was conducted on 25.06.2023, which covered the management of acute ill scenarios like burns, acute coronary syndrome, diabetic ketoacidosis, GI bleeding and detailed lectures/workshop on nutrition practices in critically ill.

All five sessions were taken by the Consultants of the Institute of Critical Care Medicine, Royalcare and the last session on acute scenarios was dealt by Dr.R.Chandramohan - Consultant Cardiologist, Dr.P.Velayutham - Consultant Endocrinologist and Dr.P.Karthikeyan - Consultant Medical Gastroenterologist.

All the sessions were well attended by the delegates from all over Tamilnadu and sessions were well appreciated. Certificates of attendance and TNM Credit points were given to all the delegates. IMA AMS has requested to conduct such courses in future for the benefit of practitioners.

GLIMPSES OF IMA WORKSHOP

29.01.2023

26.02.2023

26.03.2023

30.04.2023

25.06.2023

Welcomes...

Dr.S. Jeyakumar

MBBS, MS, DNB, MCh, FRCS (Edin).,

Consultant Vascular Surgeon

Completed his MBBS from Madurai Medical College, Madurai Kamaraj University, Madurai, in 1985 and MS. (General Surgery) at Madras Medical College, Chennai, Tamilnadu Dr. MGR Medical University, in 1991. Subsequently, he completed his DNB (General Surgery) National Board of Examinations, New Delhi, in 1991. He finished his M.Ch (Vascular Surgery) from Madras Medical College, Chennai, Tamilnadu Dr. MGR Medical University, Chennai, in 1995. Also, he got FRCS (General Surgery) Royal College of Surgeons of Edinburgh, Edinburgh, UK in 2000. He has had a rich experience of more than three decades domestically and internationally. He worked as a Professor & Consultant at Velammal Medical College & Research Institute, Velammal Speciality Hospital, Madurai before joining our Royal Care.

Dr. C. Anbu

MBBS, MD-RT.,

Consultant Radiation Oncologist

Completed his MBBS from Madras Medical College, Chennai in 2009 and M.D (Radiation Oncology) at Pandit Bhagwat Dayal Sharma, (PGIMS) Post Graduate Institute of Medical Sciences Rohtak, Haryana, in 2018. He worked as a Consultant in Radiation in Oncology at Ashwin Comprehensive Cancer Hospital, Gandhipuram, Coimbatore before joining our Royal Care.

Dr. Hariharaprakash. R

MD, DNB, EBIR, EDIR, DICR, DHHM, DMLS.,

Consultant Interventional Radiologist

Compeleted his MBBS from Madras Medical College, Chennai in 2013 and MD (RADIOLOGY) at SETH GSMC & KEM HOSPITAL, Mumbai in 2018. And DNB (RADIOLOGY) - National Board of Examination in 2020. He worked as a Consultant in Interventional Radiology at KG Hospital, Coimbatore before joining our Royal Care.

Dr. A.S. Naveen

MBBS, MD (General Medicine), FNB(I.D).,

Consultant Internal Medicine and Infectious Diseases

Completed MBBS from Tirunelveli Government Medical College, Palayamkottai in 2015. Subsequently, he did his MD (General Medicine) from Sri Ramachandra Medical College, Porur, Chennai in 2020. And he achieved his MRCP (UK) in 2020. Also, he Achieved FNB Infectious Diseases Apollo Main Hospitals, Chennai in 2023. He worked as a Freelancer - Associate ID Consultant in Corporate Hospitals before joining our Royal Care.

Dr. G. Praveen Prabu

MBBS, DNB (Gen Surgery), M.Ch, CVTS.,

Consultant Cardiovascular and Thoracic Surgeon

Completed his MBBS from TN Dr.MGR University, Madurai Medical College, Madurai in 2008. and subsequently, he completed his DNB in General Surgery from the National Board of Examinations at Sri Ramakrishna Hospital, Coimbatore in 2012. Also achieved M.Ch in Cardiothoracic Surgery from TN Dr.MGR University, Madras Medical College, Rajiv Gandhi Hospital Chennai in 2017. He worked as a Consultant Cardiothoracic Surgeon in Hindusthan Hospital, Coimbatore before joining our Royal Care.

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