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MEDi talk

MEDIHEAL GROUP OF HOSPITALS
QUARTERLY NEWSLETTER

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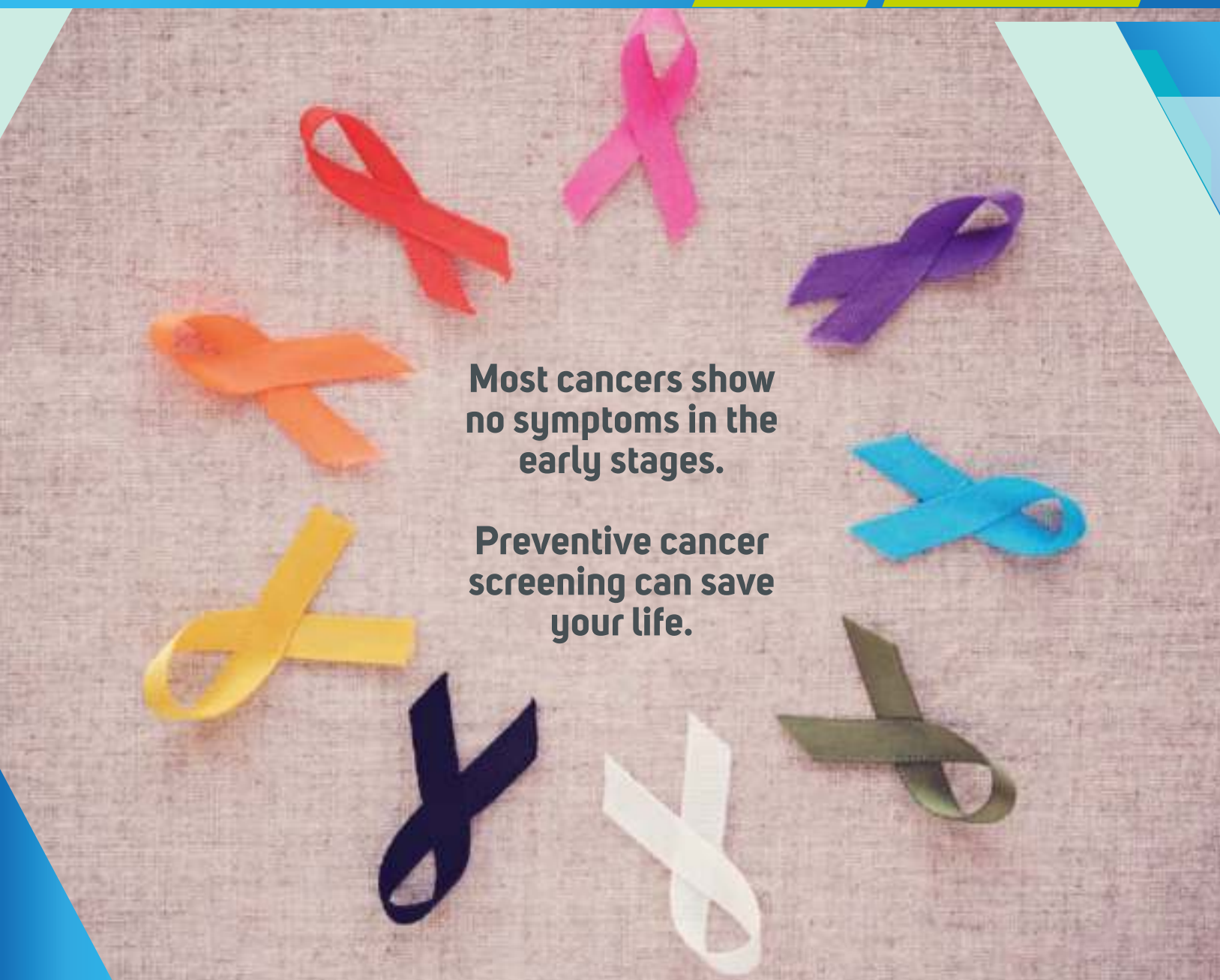

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A BRIEF OVERVIEW OF 100 KIDNEY TRANSPLANT RECIPIENTS

CR 1

Total No. of Transplants (Nov. 2018 - Oct. 2020): 100
Age Group: 60+ (10 patients)
(Oldest: 70 & Youngest: 12)

HIGH-RISK PATIENTS

Surgical:
5 (1 vascular anomaly, 3 simultaneous/Pre-transplant native kidney Nephrectomy) + transplant multiple renal arteries 10, lower urinary tract abnormalities requiring perioperative repair 2)

Anesthetic:
4 1 obesity OSA, PAH 2 Thymo induced ARDS done under epidural anesthesia 2 OSA with SVC syndrome all recovered with delayed extubation and ICU care.

Medical/Immunological:
Around 40% mild to moderate degree of sensitization requiring some form of desensitization including Plasma ex/IVIG depending on the degree of DSA levels. Around 40% of patients having uremic cardiomyopathy in the form of severe LVH/diastolic/systolic dysfunction/PAH and valvular leaks of varying grades requiring aggressive dialysis pretreatment with all the parameters improving following the transplant.

5 patients had severe secondary hyperparathyroidism requiring treatment before transplant and 3 patients needed partial Parathyroidectomy with intraoperative PTH monitoring, and/hemithyroidectomy (1 Patient) before the transplant for uncontrolled tertiary hyperparathyroidism with parathyroid adenoma/thyromegaly proven on Parathyroid Sestamibi nuclear scan/and FNAC

2 patients HBsAg +Ve, 3 patients HIV +Ve who underwent successful transplant after control of viral loads and continuing the antiviral drugs. 1 patient second transplant donor nephrectomy mostly → 95% Laparoscopic
All the patients received induction with Thymoglobulin and IV methylprednisolone

Average post-op recovery time in recipients 7 days (5-10) in 90% of patients. Incidence of delayed graft function /ATN 8 patients

Patients doing well as on date	89
Mortality	7
Morbidity 4 Patients back on dialysis (mostly due to drug noncompliance)	4
Infections major	6
Minor	15
Rejections Acute (Only 2 biopsy proven & 3 Suspected)	5
Chronic	1 biopsy proven

All the patients are doing well after the transplant and returned to work by 6-8 weeks post transplant.

Dr. A. S. Murthy
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& DM (Nephrology)

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MS, MCh (Urology),
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Dr. Vaijnath
Consultant
Anesthestist

KIDNEY TRANSPLANT IN PAEDIATRIC PATIENT - CHALLENGES AND LEANINGS FROM THE FIRST SUCCESSFUL CASE

CR 2

The mother of a small boy (aged 10 years but looking like 5 years) cried with overwhelming joy while narrating to me her story on this boy on the day of discharge from our KTP Unit, Mediheal Hospital, Eldoret. She told, she is emotionally attached to this child the most (out of 3 children she has), not only because the boy is her first child, very obedient, talented, and peaceful, but also because she has spent more time caring for his ailments last 5 years.

The boy was diagnosed with CRF (basic disease/ CIN / FSGS) during the evaluation of stunted growth, weakness and fatigue (anemia), recurrent seizure episodes, bone pain and abnormalities, and failure to thrive. After ESRD developed, hemodialysis was started 1 year back and is continued till the transplant. Getting a reference from some of our previous post-transplant patients, they came here for a kidney transplant, the mother decided to donate a kidney (giving him birth for a second time).

After the overwhelming success of the Mediheal Renal Transplant Program (about 100 successful cases in a year) more and more complex, high-risk cases are being referred to us.

He weighed 19Kg (half the appropriate for his age), stunted growth, features of full-blown renal osteodystrophy, severe anemia (Hb 7-8gm), cardiomegaly, LVH with low EF due to long-standing volume overload.

After all preparations, PAC, and legal formalities kidney transplant in this child was done. Donor's (mother) left kidney was retrieved by laparoscopy, who recovered well and discharged on POD4. Stringent peri-operative monitoring, intravenous fluid, and electrolytes balance due to prolonged ileus (transperitoneal surgery) was required - he recovered otherwise uneventfully and was discharged on POD10 with a creatinine of 0.4mg/dl.

At 9 months follow up he is doing well, normal renal function (creatinine 0.75; Hb 14.1) and gaining weight (5kg), no bone pain, started growth spurt. No seizure, MRI brain was normal – Levipil is stopped. This is the first successful KTP in small children (<10 years), the smallest of all in Kenya.

CHALLENGES

Preoperative Preparations - Special pediatric nephrology expertise required to deliver wholesome care focussed on growth and metabolism, nutrition, bone disorders, infection & vaccination, fluid-electrolytes management, medications dosing, etc in addition to dialysis / RRT. Dialysis in children itself is cumbersome, technically difficult, different from adults, access problems, machinery configuration and blood volume related cardiac complications as well as long term dialysis-related complications. Thus, small children are not prepared well to cope-up with high-risk operations and the stress of fluid shift, changing internal milieu - leading to high perioperative mortality and morbidity.

Surgical techniques: Small iliac vessels of recipients disproportionate to the size of adult renal vessels, make anastomosis technically demanding. Usually, the graft renal vein is anastomosed to the recipient's common iliac vein / IVC and renal artery to the common iliac artery. There are high chances of vascular thrombosis, bleed, and pseudoaneurysm.

Lack of space in iliac fossa to keep the adult kidney – midline transperitoneal incision is preferred to approach adequate feeder vessels and to keep kidney higher up. A long Ureter stump with compromised vascularity may be associated with high ureteral anastomosis complications.

Anaesthesia, ventilatory management, intra-op medications, fluid management are also challenging in view of prolonged surgery; a slight amount of blood loss can cause hemodynamic instability leading to renal dysfunction (ATN).

Postoperative fluid management – profuse diuresis >500ml/hour replaces the whole plasma volume every few hours with dyselectrolytemia which needs frequent checking and replacement.

Children are **immunologically strong, have a high risk of rejection** as well as recurrence of basic diseases in transplant kidney and graft dysfunction. Induction and high immunosuppression can lead to many infective complications (CMV, Tuberculosis, UTI)

CONCLUSIONS

Kidney transplantation is the treatment of choice for children with End-Stage Renal disease (ESRD).
Children with well-functioning graft have a better quality of life, improved cognitive development, and near-normal growth in comparison with dialysis.

Furthermore, KTx is more cost-effective than dialysis.
Despite advances in improved immunosuppressive regimes, surgical technique, and peri and post-operative management over the last decade, KTx remains a challenging procedure in small children.

Dr. Sanand Bag
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Sr. Consultant Urologist & Transplant Surgeon
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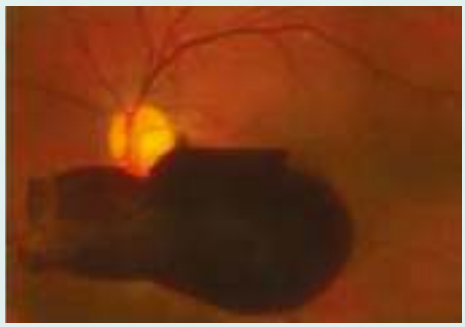
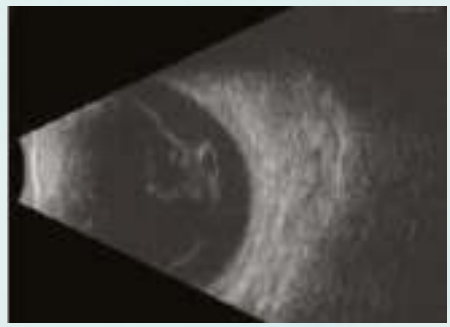
ROLE OF INTRAVITREAL INJECTION OF RANIBIZUMAB IN VITREOUS HAEMORRHAGE

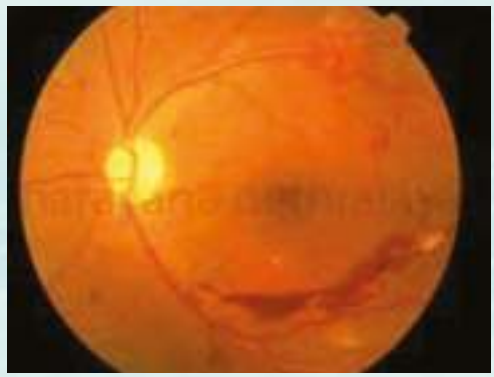
CR 3

A 67-year old male patient reported with chief complaints of sudden diminution of vision in the left eye for four days. The patient is a known diabetic for the past 11 years and was on insulin for the last 2 years. On examination, his vision in the right eye and left eye was 6/18 and 3/60 respectively. His intraocular pressure was within the normal limit. Fundus Foto and B scan also done.





Blood tests and fundus Foto were suggestive of vitreous hemorrhage, secondary to diabetic retinopathy in the left eye.



Follow-up was done after 4 weeks and 8 weeks. After 8 weeks, the vision has improved from 3/60 to 6/24 in the left eye.

PROCEDURE DONE

Intravitreal injection of Ranibizumab (anti-VEGF) given in the left eye 0.5 mg in 0.05 ml into the vitreous cavity 3.5 mm from the limbus.

CONCLUSION

Ranibizumab is anti –VEGF, FDA approved molecule, better than Bevacizumab (off-label in the eye). It gives promising results in controlling vitreous hemorrhage following one or sometimes two intravitreal injections. If presented very late or in refractive cases patients may need green laser plus vitrectomy.

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ABERRANT THYROID - OUR EXPERIENCE

CR 4

INTRODUCTION

Thyroid swellings (Goitre) incidence is high in Kenya. However, exact data is unavailable. High incidence in the country can be attributed to relative iodine deficiency in the hilly regions of rift valley together with a staple diet made up of foods rich in goitrogens like cabbage, kale, cauliflower, etc.

Goiters tend to be large at presentation due to a lack of awareness and difficult access to the health care facility.

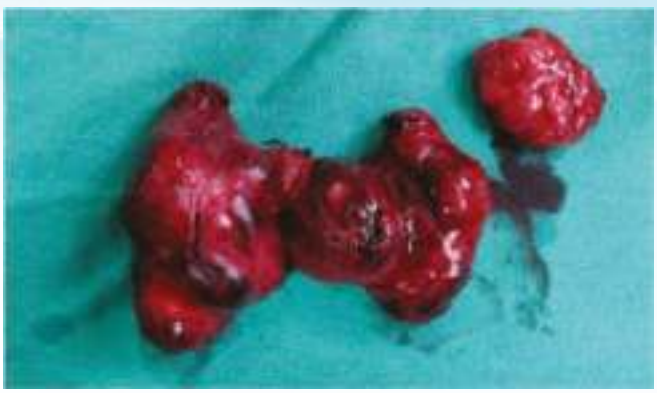
ABERRANT THYROID

Aberrant thyroid is a mass of tissue having the structure of a normal or pathological thyroid gland but situated at some definite distance from the normal thyroid.
Prevalence in the normal population is estimated to be 1 in 100,000-300,000 people.

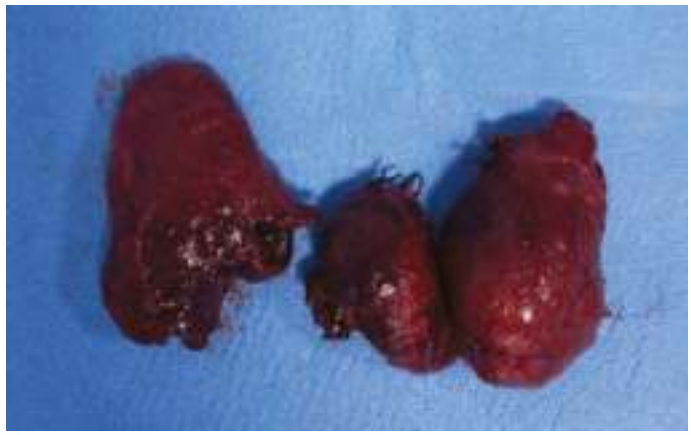
Imaging of thyroid in population with thyroid disease shows an incidence of 2%.

OUR EXPERIENCE

Here we present a short series of cases spanning 16 months from July 2019 to October 2020.
In 16 consecutive patients of Goitre operated by a single surgeon (10 Total Thyroidectomy & 6 Hemithyroidectomy; 13 Euthyroid & 3 Hyperthyroid), we found aberrant thyroid tissue situated in the lateral neck in 2 cases and intramuscular in Sternohyoid muscle in 1 case.
All 3 aberrant thyroids were found in total Thyroidectomy cases.



Pic 1: Lateral aberrant thyroid found on left side (Euthyroid patient)



Pic 2: Aberrant thyroid found in right sternohyoid muscle (Hyperthyroid patient)

TAKE-HOME MESSAGE

At our center, we have found the incidence of aberrant thyroid tissue to be 18.75% in operated cases.

However, we accept the limitations of this case series due to low volume size and originating from a single center and single surgeon. Hence, we recommend collaboration by surgeons performing thyroid cases in Kenya and form a registry to find out the true incidence of aberrant thyroid in the Kenyan population.

We also recommend being vigilant during Thyroidectomy and carefully look for aberrant thyroid, especially in cases of Hyperthyroidism to avoid treatment failure and recurrence.

Dr. Dhaval Mistry
Consultant Laparoscopic
& General Surgeon
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ILEOCECAL RESECTION WITH PRIMARY ILEOCOLIC ANASTOMOSIS IN ELDERLY WOMAN WITH MULTIPLE MEDICAL COMORBIDITIES

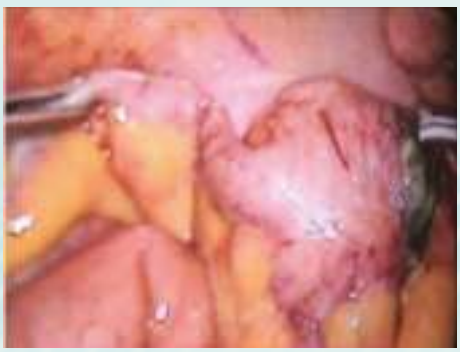
CR 5

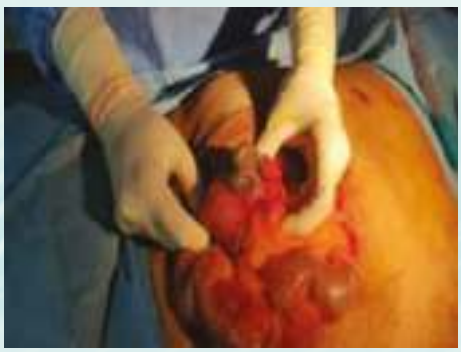
A 70 year old Indian lady reported with complaints of acute abdominal pain for 2 days. She was found to have tachycardia tenderness with guarding and rigidity in the right lower abdomen. A clinical diagnosis of acute appendicitis was made and it was confirmed on ultrasound. The patient required an urgent appendectomy. However; she was having multiple medical conditions like Obesity, Hypothyroidism, Diabetes Mellitus, Hypertension, Pulmonary Hypertension, and Chronic Kidney Disease.

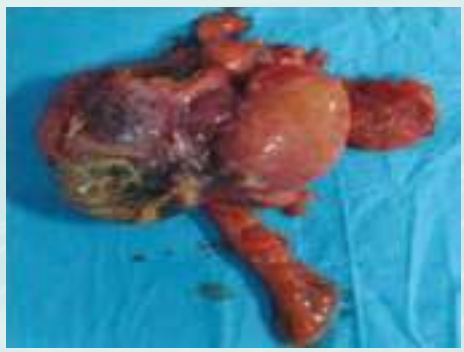
INTRA OPERATIVE MANAGEMENT

During laparoscopy, the patient was found to have not only acute appendicitis but also had gangrene of part of her caecum.

A quick decision was made to extend the scope of surgery and ileocecal resection was performed with primary ileocolic anastomosis and peritoneal wash was given.
Surgery was concluded within a reasonable time because of old age and multiple medical comorbidities and the patient was shifted to HDU care.







POST-OPERATIVE MANAGEMENT

Management of the patient does not end with surgery. A multidisciplinary approach is needed in comorbid conditions. She was started on orals from day 2 and was discharged on POD 6.

Old aged patients with multiple medical comorbidities can undergo complex surgeries with a well-coordinated multidisciplinary approach safely.

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Nairobi

Dr. Ramakrishna
Sr. Consultant Anaesthetist
Mediheal Hospitals Parklands,
Nairobi

CEREBELLAR HAEMANGIOBLASTOMA

CR 6

Cerebellar hemangioblastomas are rare neoplasms of cerebellum with uncertain histogenesis classified under WHO grade I category. Most of these lesions are sporadic and few of them, though rare, are associated with Von Hippel-Lindau disease (VHL).

A 57 year old wheelchair bound male facing speech difficulty presented with headache, vomiting and loss of balance since 6 months. MRI revealed a large well circumscribed cystic lesion in the left cerebellar hemisphere and vermis with a nodular densely enhancing component along its inferior part with mass effect and cerebellar tonsillar herniation with hydrocephalous (fig 1).

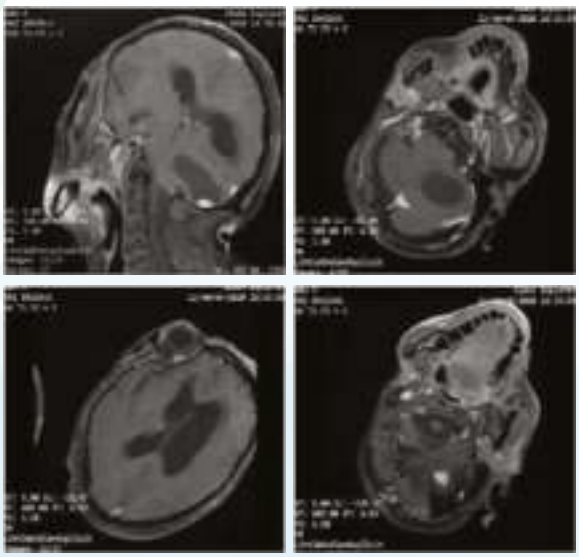


Fig. 1 – pre operative MRI showing cystic lesion with mural nodule

Posterior fossa decompressive craniotomy with gross total excision of cyst and mural nodule was done. Patient had hypertension during immediate post-operative period and progressively became drowsy over period of 3 to 4 hours after surgery. Repeat CT scan showed bleed in tumor bed with hydrocephalous (fig 2).

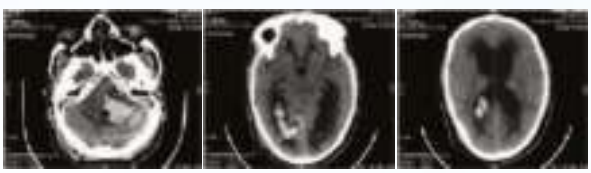


Fig 2 – Immediate post-operative Tumor bed bleed with hydrocephalous

The external ventricular drain which was placed intra operatively was blocked, hence patient was immediately taken for re-exploration and clot evacuated (fig 3). The following morning, patient regained consciousness, improved neurologically and was discharged after 7 days.

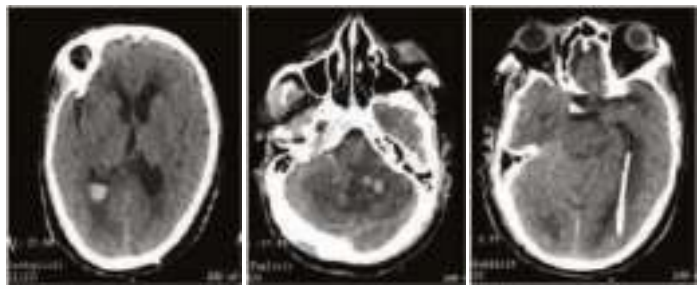


Fig. 3 – First post-operative day after evacuation of clot

The excised tumor was sent for histopathological examination. The tumor consisted of multiple gray brown soft tissue bits approximately measuring 3cc in volume. Histopathological examination revealed a highly vascular tumor with stromal cells arranged in nests and islands (fig 4).

Fig. 4 – Histopathological slides

Individual tumor cells were large with abundant vacuolated cytoplasm and centrally placed nucleus along with vascular channels of various caliber which were lined by endothelial cells. Areas of hemorrhage were noted. A diagnosis of cerebellar Hemangioblastoma was given. Patient is on regular follow – up for 3 months with significant improvement in neurological status. Three months post-operative MRI is awaited.

Dr. Tanay Sholapurkar
MBBS, MS, M.Ch. (Neurosurgery)
Consultant Neurosurgeon
Mediheal Group of Hospitals, Nakuru

torrent PHARMA

Feliz S
Escitalopram 5 mg / 10 mg / 20 mg Tablets

Nebicard
Nebivolol 2.5 mg / 5 mg Tablets

torleva
Levetiracetam 250 mg / 500 mg / 750 mg / 1000 mg Tablets

Angiopril
Captopril 25 mg tablet

Torpezil
Donepezil 5 mg / 10 mg Tablets

Nexpro
Esomeprazole 20 mg / 40 mg Tablets

Tozaar
Losartan 25 mg / 50 mg Tablets

Asthator
Montelukast 4 mg / 10 mg Tablets

Tozaar-H
Losartan 50 mg +Hydrochlorothiazide 12.5 mg Tablets

Lefra
Leflunomide 20 mg Tablets

Valparin CHRONO 300 / 500
Sodium Valproate 200 mg + Valproic Acid 87 mg
Controlled Release Tablets

Pantor
Pantoprazole 20 mg / 40 mg Tablets

Lamitor
Lamotrigine 25 mg / 100 mg Tablets

Ramipex
Pramipexole Hcl 0.25 mg / 1 mg Tablets

Tolanz
Olanzapine 5 mg / 10 mg Orodispersible Tablets

Torrent Pharma wishes Mediheal Hospital good luck in their endeavours.

SEGMENTAL MANDIBULECTOMY

CR 7

A 68-year-old female reported with complaints of a mass left cheek for 3 months. Biopsy revealed squamous cell carcinoma. CT scan was done which showed tumor left buccal mucosa without distant metastasis. MRI showed no Lymphadenopathy.

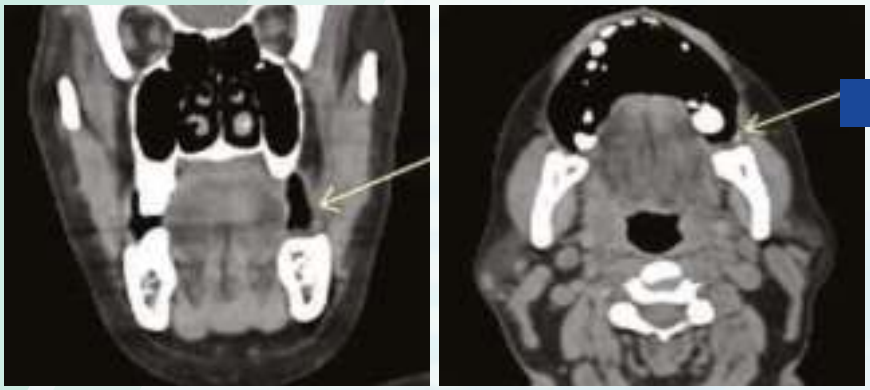
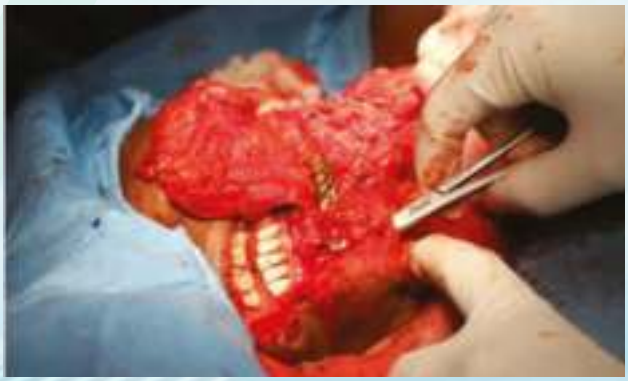
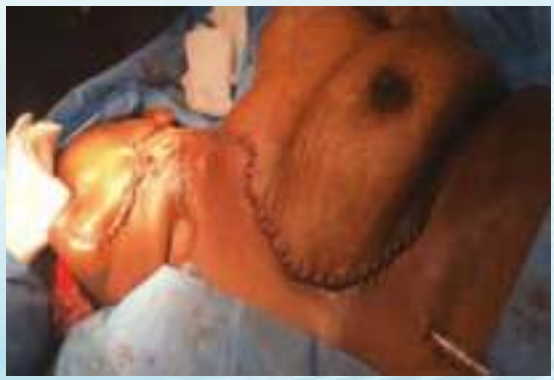


Image showing tumour left cheek

Segmental Mandibulectomy with selective neck dissection was done. A mandibular prosthesis and PMMC flap was used for reconstruction of the mandibular and soft tissue defect.



Titanium Prosthesis



Pectoralis Major Myocutaneous Flap

The epidemiology of oral cancer in Kenya is still uncertain. Earlier, reports suggested a relatively low incidence of oral cancer. However, there have been recent reports of an upward trend in the incidence of oral cancers in developing countries as a consequence of changes in lifestyle and the emergence of new diseases. It is, therefore, reasonable to expect changes in the pattern of oral cancer in Kenya given these changes.

"A team of dedicated cancer care specialists comprising Medical Oncologist, Surgical Oncologist, Radiologist and Plastic surgeons is necessary for best surgical outcomes to all cancer patients. At Mediheal Group of Hospitals, we have such a team to deliver optimal results".

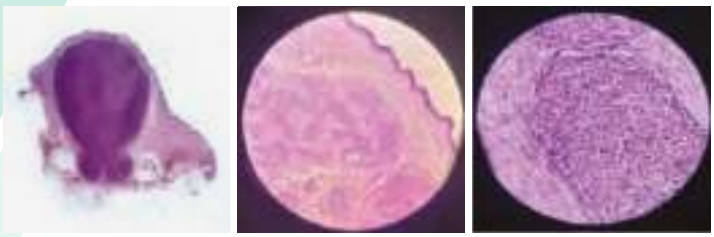
Dr. Ashraf Emarah
Consultant Plastic Surgeon
Mediheal Group of Hospitals,
Eldoret

Dr. Chandra Mohan V.
Consultant General Surgeon
Mediheal Group of Hospitals,
Eldoret

CASE NO. 1

A 45 year old male presented with painless, slow-growing swelling over the thigh in the last 1 year. On examination, firm, non-tender cutaneous swelling measuring 2x1cm over the posterior aspect of right thigh was noted.

DERMATOFIBROMA



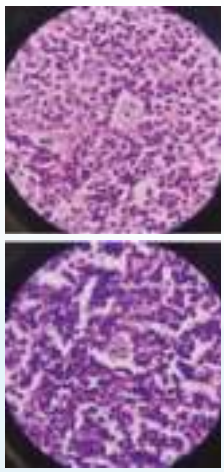
FINAL DIAGNOSIS: NODULAR HIDRADENOMA

Discussion: Nodular Hidradenoma also called clear cell hidradenoma and eccrine spiradenoma, found mainly in adult females, is a benign skin adnexal tumor that arises from the sweat gland distal excretory duct, usually solitary, on the scalp, axillae. This case presented with a solitary lesion on the thigh of a male patient. The differential diagnosis of clear cell tumors in the dermis includes metastatic disease and primary skin tumors with follicular differentiation, sebaceous differentiation, or sweat gland differentiation.

CASE NO. 2

A 14 year old female reported with multiple enlarged cervical lymph nodes since 6 months associated with low-grade fever and generalized weakness. On examination, firm, non-tender, matted, multiple level cervical lymph nodes largest measuring 3.5x2.0cm was noted.

Immunohistochemistry: Positive-CD30, CD20, PAX5, MUM-1. Negative-CD3, CD15, CD45, EBV-LMP-1, ALK-1, EMA.



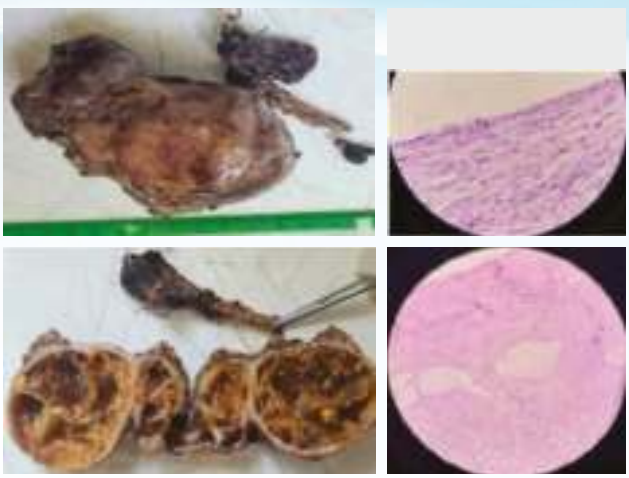
DIAGNOSIS: CLASSIC HODGKIN LYMPHOMA-LYMPHOCYTE RICH

This is a rare case with:

1. Classic history, age group of the patient, and location of the lesion. (Peak age at childhood and 75% cervical presentation).
2. Classic fish flesh and rubbery appearance on gross examination.
3. Histology slides show typical owls-eye, multinucleated Hodgkin Reed-Sternberg cells (as seen in the above photos).
4. EBV negative -lymphocyte rich; as EBV positive will have a mixed type of lymphocyte depleted.
5. Presence of B symptoms (up to 40% of patients).

CASE NO. 3

A 3 year old male child came with abdominal fullness since 2 years, associated with anorexia and failure to thrive. Intra-op findings were solid cystic mass (Thin wall cyst with clear fluid arising from omentum) occupying the lower half of the abdomen which was adherent to the sigmoid colon and anterior abdominal wall.



DIAGNOSIS: LYMPHATIC CYST/ CYSTIC LYMPHANGIOMA

Discussion: Lymphangiomas are benign congenital malformations characterized by an abnormal dilatation and proliferation of lymphatic spaces, found predominantly in children. Symptomatic mesenteric cyst accounts for only 1 in 20,000 in pediatric admission. We hereby present a case of 3 year old boy who presented with chronic abdominal distension and failure to thrive. Two huge irregular and multi-lobulated mass measuring 10x7x5 and 9x5x4 cm located in the mesentery were surgically resected. Pathological features of the lesion were consistent with cystic lymphangioma.

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MEDIAN ARCUATE LIGAMENT SYNDROME - EVALUATION WITH CT ANGIOGRAPHY

CR 9

INTRODUCTION

Median Arcuate Ligament (MLA) syndrome is also known as celiac artery compression syndrome, Dunbar syndrome, or Harjola-Marable syndrome. It is a rare condition characterized by upper abdominal pain in the setting of compression of the celiac artery by a median arcuate ligament.

ANATOMY

The median arcuate ligament is a fibrous arch that unites the diaphragmatic crura on either side of the aortic hiatus. The ligament usually passes superior to the origin of the celiac axis. In 10%- 24% of people, however, the ligament may cross anterior to the artery; in some of these individuals, the ligament may compress the celiac axis (Fig.1), compromising blood flow and causing symptoms.

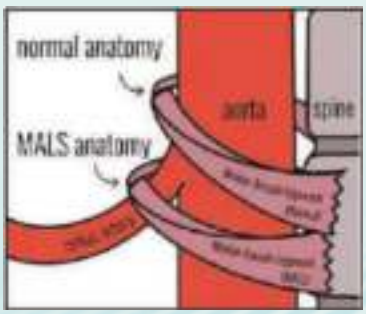

Fig.1: Normal and abnormal position of Median Arcuate Ligament

CLINICAL PRESENTATION

MALS typically occur in thin young patients (20-40 years) and is more common in female (4:1 female/male ratio). Patients usually present with chronic abdominal pain, especially postprandial. The symptoms can be relieved by the change in a position like standing and aggravated by a supine position. Patients may present with nausea, vomiting, and weight loss.

CT ANGIOGRAPHY FINDINGS

CT angiography and conventional angiography are considered to be the gold standard imaging modalities for the detection of the proximal celiac stenosis with classic hooking configuration. It is important to note that the narrowing of the celiac trunk at the diaphragm is non-specific and most commonly seen in asymptomatic patients. As always, imaging findings should be correlated with clinical history. We detected celiac trunk compression by median arcuate ligament as an incidental finding in renal donor patient. CT angiography shows focal narrowing of the superior aspect of the proximal celiac trunk forming a hooked or "J" appearance (Fig.2a,b) which can help distinguish this condition from other causes of celiac artery narrowing, such as atherosclerotic disease. The phase of respiration often has a significant impact on the degree of celiac narrowing. Most commonly, the celiac arterial narrowing is accentuated during end-expiration and lessens during end-inspiration. CT scan is typically performed during inspiration; therefore, if the focal narrowing is observed during inspiratory CT, it may be clinically significant, since the transient compression seen only during expiration in some patients would not be manifested at inspiratory CT. Also, associated post stenotic dilatation or collateral vessels may suggest actual pathologic conditions and warrant clinical correlation.

Figures (2a): Sagittal abdominal aorta angiography image and (2b) 3D volume-rendered sagittal image showing focal narrowing of the superior aspect of the proximal celiac trunk forming a hooked or "J" appearance.

TREATMENT

The surgical management of median arcuate ligament syndrome is controversial. Many more patients have the anatomic abnormality of low insertion of the median arcuate ligament than have symptoms caused by the abnormality. Surgical treatment is more likely to relieve symptoms in patients of 40–60 years of age with postprandial pain, greater than 20-lb weight loss, and post stenotic dilatation and collateral vessels. In the rare patients who indeed have such symptoms, some will experience relief when the ligament is divided surgically, a task that can now be accomplished laparoscopically. In others, the ligamentous constriction of the celiac axis causes vascular damage, which may require vascular reconstruction.

CONCLUSION

Median Arcuate Ligament syndrome is a controversial entity. The abnormally low insertion of the median arcuate ligament can be found in normal asymptomatic people. In a small subset of patients, however, the compression of the celiac axis can cause symptoms that may be relieved after surgical decompression. CT Angiography plays important role in the diagnosis of this condition by demonstrating the characteristic focal narrowing of the celiac artery in patients presenting with the appropriate clinical symptoms.

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ANAPLASTIC MENINGIOMA

CR
10

Intracranial meningiomas continue to challenge our best clinical efforts to eliminate them once discovered and deemed appropriate for treatment.

Malignant meningiomas constitute 10% to 15% of all meningiomas and limited information exists regarding adjuvant treatment. The external whole-brain irradiation is recommended. Traditional chemotherapy has proven ineffective; thus, new chemotherapeutic agents and new methods of delivery should be developed.

This 66-year-old man presented with headache, behavior disorder, vomiting, urinary incontinence, and speech disturbances. The neurological examination revealed mild mental confusion and bilateral papilledema. There was right-sided hemiparesis to the extent that the patient was bed and chair bound for a period of 3 months. A Magnetic Resonance Image (MRI) obtained with and without contrast showed an enhancing lesion in the left frontal parafalcine area with extensive surrounding edema and a midline shift. The falcine dura adjacent to the lesion was strongly enhancing.

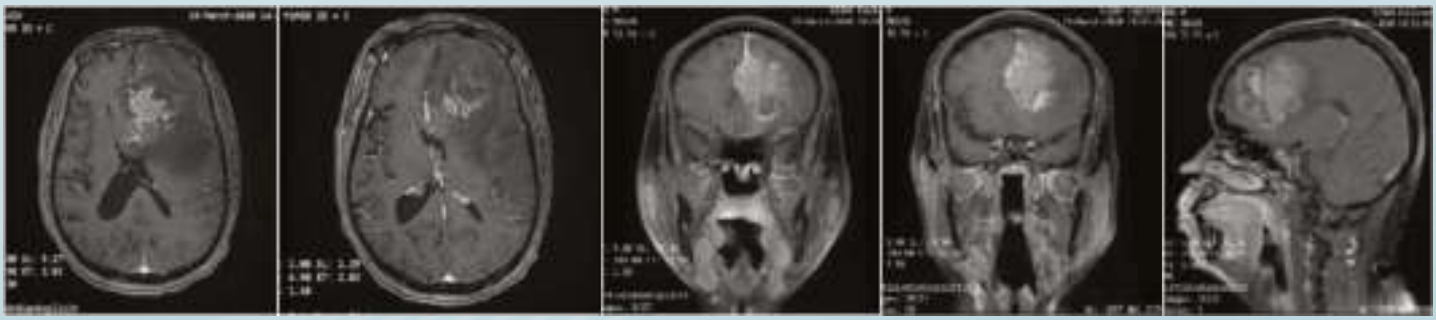

Figure 1: pre operative MRI

A bicoronal flap with bifrontal craniotomy was performed. The tumor was breaching Pia in some areas. The tumor was highly vascularized. The dural attachment was removed. The tumor was completely excised (Fig 2). Postoperatively, the patient remained neurologically intact. He stayed in ICU for 48 hours with intracranial pressure monitoring which was within the normal range. The patient was discharged after one week. The histopathologic exam showed malignant meningioma with vascular channels surrounded by neoplastic meningothelial cells with fibroblasts and highly cellular areas with mitoses (Fig 3).

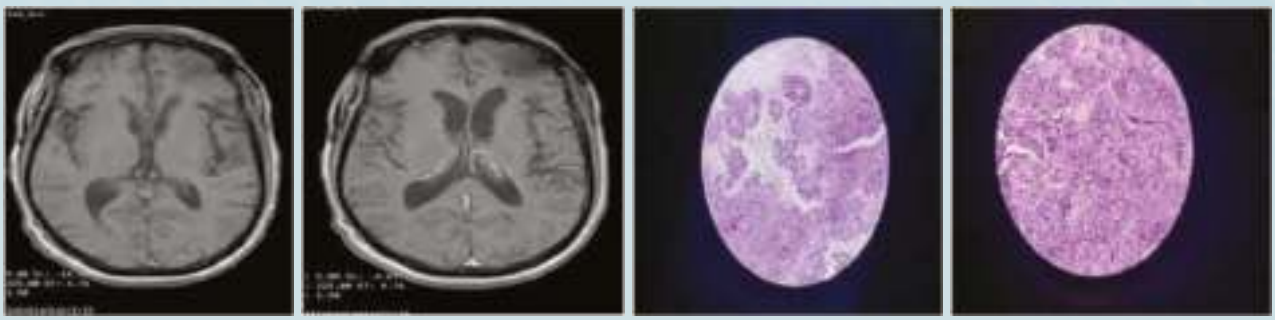

Figure 2: 3 months post-operative MRI

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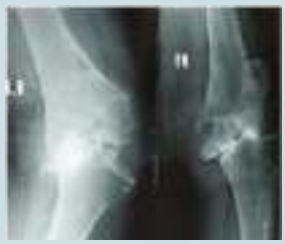
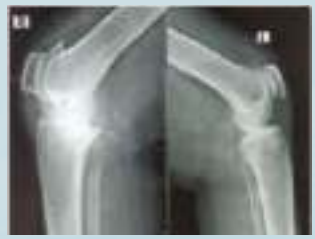
VALGUS DEFORMITY CORRECTION IN TOTAL KNEE ARTHROPLASTY

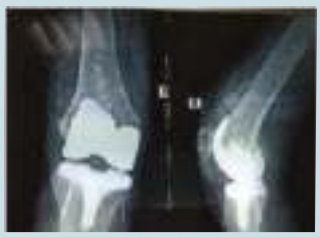
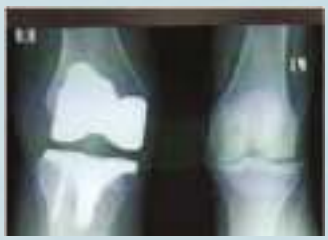
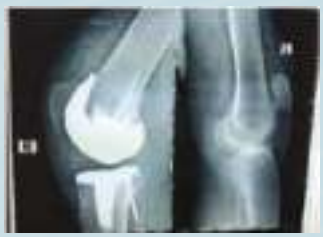
CR 11

Valgus deformity (knock knee) is a very rare deformity affecting the knee, (approximating 15%). Varus (bow knee) is more common. The valgus deformity is most common in rheumatoid with female dominance and aged above 60 yrs. Typically, defect is due to hypoplasia (underdevelopment) of lateral femur condyle along with posterolateral tibia in valgus deformity, tissues on the lateral side of the knee are contracted while medial soft tissues are stretched. The majority of valgus knees are associated with hip and ankle deformities secondarily. Correction of deformity involves releasing/lengthening of lateral contracted soft tissues (LCL, popliteus, PCL) and balancing gaps between medial and lateral joint spaces, getting a normal mechanical alignment. Difficulty in valgus knee correction is due to the proximity of the common peroneal nerve at the posterolateral knee corner along with a thin lateral soft tissue sleeve. In the varus knee, there is no dangerous structure medially or posteriorly and medial soft tissue is thick and robust.



We perform correction by limited bone resection of tibia and femur, limited soft tissue releases, and external rotational alignment of femur component thus achieving rectangular flexion and extension gaps. Soft tissue releases involve posterolateral capsule release at the joint line, pie crusting of popliteus, and PCL excision achieving rectangular extension gap. Pie crusting of popliteus and LCL leading to rectangular flexion gap. This procedure is very safe and easily reproducible in our hands. In rare cases where there is extensive medial soft tissue stretching, we prefer to lift the lateral ligamentous complex off from the lateral femur epicondyle, as a single unit. We never had to perform lateral retinacular release for mal tracking of the patella by this technique.



Immediate post-op image on the left
6 weeks post-op image on the right

We did 86 joint replacements at Mediheal from August 2019 to date, out of which 41 are TKR. In 41 cases, we had 18 Valgus knee corrections.

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PUFFED CHEEK TECHNIQUE TO EVALUATE ORAL VESTIBULE

CR 12

INTRODUCTION

Clinical examination often "understates" the deep spread of oral cavity tumors. Computed Tomography (CT) provides additional staging information that helps determine more precisely the exact local extent of a tumor. Moreover, CT helps in nodal staging at the same time. However, because the mucosal surfaces, the muscle tissues, and the surrounding facial planes in the oral cavity are in close relationship with each other, it is usually difficult to delineate anatomic structures by conventional CT alone.

For example, small mucosal tumors of the oral cavity are usually not visible on conventional CT. Although large, bulky tumors are apparent. CT cannot always identify their surface of origin. Distension of the oral cavity during CT has been shown to facilitate the detection of small tumors and to provide information on their extent (Fig 1a and 1b). Distension of the oral cavity for CT is indicated when the opposition of the surface of the buccal mucosa and the surface of the gingival mucosa hinders localization and demonstration of tumor extent. It may also be useful when the mucosal surfaces of the tongue and the gingival mucosa are opposed.

TECHNIQUE

Ask the patient to inflate their cheeks, pursed their lips, and held their breath, and scan the oral cavity and neck in axial thickness with and without contrast.

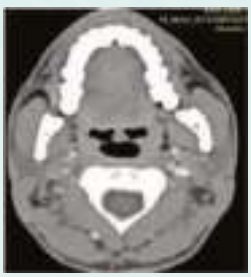

Fig. 1a: Without Puffed Cheek technique

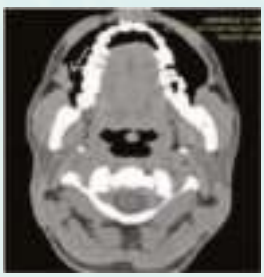

Fig. 1b: With Puffed Cheek technique showing buccal mucosa-buccinator complex mass (arrow)

DISCUSSION

The oral vestibule separates the teeth and gingival mucosa from the lip and cheek. On conventional CT images, the buccal and gingival mucosa is not separated and hence separate involvement is difficult to opine and define (Fig. 1a & b). Also, lesions involving the gingival mucosa can involve the buccal mucosa and vice versa. This imaging protocol is supported by various studies mentioned in the literature. Images taken with the puffed cheek technique are useful as

1. Air acts as a negative contrast medium and separates the buccal and gingival mucosa and the extent of the tumor is better defined
2. Separate involvement of the buccal and gingival mucosa can be commented
3. Distensibility of both the cheeks as well as buccal mucosa can be assessed
4. Retromolar trigone involvement can be better assessed.

The success of the puffed cheek technique depends on the co-operation of the patient, distensibility of the cheeks and buccal mucosa, and the extent of submucosal oral fibrosis which commonly coexists in these cases. This maneuver is easily taught and patients' compliance is not a problem.

Puffed cheek CT scans provide a clearer and more detailed evaluation of the gingival and buccal mucosa of the oral cavity. It can be used as a routine protocol in the pathologies of the oral vestibule. For evaluation of lesions involving the oral vestibule puffed cheek technique is recommended.

CONCLUSION

Puffed cheek CT scans provide a clearer and more detailed evaluation of mucosal surfaces of the oral cavity than do conventional (non-puffed) images. It should be included in the routine protocol to define the lesions of the oral vestibule.

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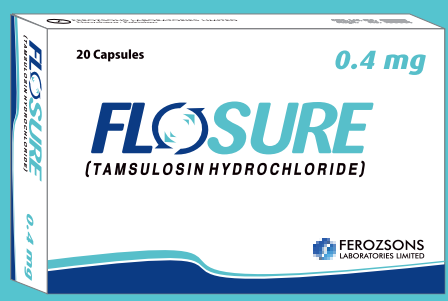


Approved for The Treatment of LUTS

TWO UNUSUAL RECURRENT DURA-BASED TUMORS OF THE BRAIN - CASE REPORTS

CR 13

CASE NO. 1

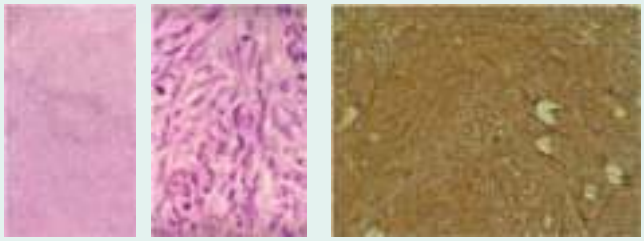
A 60 year old male presented with headache, altered sensorium, left hemiplegia with palpable mass under the scalp at the old craniotomy site. He was operated in the year 2016 outside for right parieto-occipital meningioma.

MRI showed well defined heterogeneously enhancing solid cystic mass in the right parieto- occipital region measuring 8.7 x 7.1 x 7.0 cm with bone lysis. A neoplastic tumor (Residual or Recurrence). Another lesion 3 x 2.2 x 2.7 cm in right occipital lobe adjacent to above lesion -? Meningioma. (Figure 1 and 2).

Intra-operative findings: A large tumor involving the skull bone, firm to hard consistency. Total excision was done.

Gross examination: Multiple greyish white solid soft tissue and bony bits aggregating to 9 x 7 x 4 cm (Figure 3).

Microscopic examination: Spindle cell tumor arranged in fascicles and storiform pattern with brisk mitosis (Mitotic rate 4 - 5 per HPF), moderate nuclear atypia, and extensive tumor cell necrosis. (Figure 4 and 5).



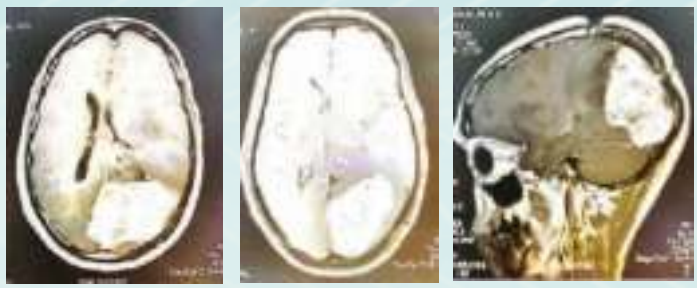
On Immunohistochemistry (IHC), tumor cells are immunoreactive for CK, Vimentin (Figure 6), focal S-100, and show a high Ki67 proliferation index (>20%). Tumor cells are non-reactive for LCA, Desmin, SMA, TLE, BCL2, STAT6, CD34, and EMA.

Final diagnosis was **Anaplastic (Malignant) Meningioma, WHO Grade III.**

CASE NO. 2

A 29 year old male presented with headache and convulsions. He was operated upon in the year 2016 for craniotomy and histopathology reported as suggestive of meningioma.

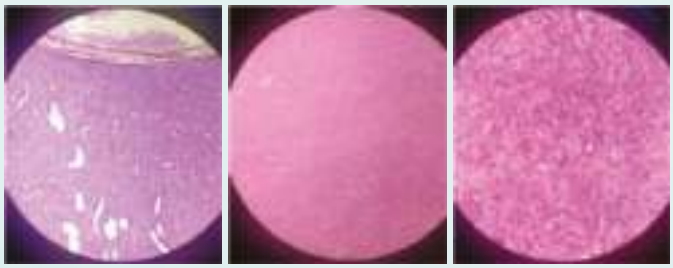
MRI showed a large left parieto-occipital dural based tumor with enhancement on contrast measuring 7.7 x 5.5 x 7.8 cm with mass effect. (Figure 1, 2).



Intra-operative findings: Large extra-axial mass attached to dura with fibrosis. Gross total excision was done.

Gross examination showed greyish white, firm, nodular, solid tumor masses with attached dura aggregating to 10 x 8 x 3 cm (Figure 3).

Microscopic examination showed a well-circumscribed, moderately hypercellular tumor arranged in solid sheets, fascicles, and vague storiform pattern. The tumor cells are spindle-shaped with a homogenous moderate amount of eosinophilic cytoplasm, round to oval nuclei with prominent nucleoli. Stromal ropey collagen and intratumoral hemangiopericytoma like staghorn blood vessels seen. Mitotic activity is 1-3 / 10 HPF. No evidence of increased mitosis, nuclear atypia, or palisading type tumor cell necrosis. (Figure 4, 5, 6).



Histology diagnosis was **Solitary Fibrous Tumor / Hemangiopericytoma, WHO Grade II.**

DISCUSSION

Anaplastic (Malignant) Meningioma is a rare subtype of meningioma accounting for less than 5 % of all meningiomas with malignant morphological characteristics and a WHO grade of III. The histologic criteria for diagnosis include either a) 20 or more mitotic figures per 10 HPF or b) regions with malignant anaplastic cytology, resembling sarcoma, carcinoma, or melanoma. This subtype of meningioma can be secondary to WHO grade I meningioma after a long quiescent period. The median survival of the patients is 2 years.

Solitary fibrous tumor/hemangiopericytoma (SFT/HPC) is a rare tumor arising from various organs, such as soft tissue, bone, dura, and pleura. It accounts for less than 1 % of all primary brain tumors.

It was reported that both SFT and HPC had the same driver mutation; fusing the NAB2 and STAT6 gene derived from inversions at 12q13. Therefore, the 2016 CNS WHO classification has created the combined terminology of SFT/HPC for the same disease as these tumor types are histologic variants of a single entity. Recently, the STAT6 antibody has been used to diagnose SFT/HPC because STAT6 staining in the nucleus is pathognomonic for SFT/HPC.

The 2016 CNS WHO has broken with the typical WHO CNS tradition and assigns three grades within the entity of solitary fibrous tumor/hemangiopericytoma:

Grade I corresponds most often to the highly collagenous, relatively low cellularity, spindle cell lesion previously diagnosed as a solitary fibrous tumor.

Grade II corresponds typically to the more cellular, less collagenous tumor with plump cells and "staghorn" vasculature that was previously diagnosed in the CNS as hemangiopericytoma.

Grade III that most often corresponds to what was termed anaplastic hemangiopericytoma in the past, diagnosed based on 5 or more mitoses per 10 high-power fields.

CONCLUSION

For patients with a history of meningioma, including benign cases, regular follow-up and physical examination are important for early detection of tumor recurrence and malignant transformation. Immunohistochemistry is very helpful in the final diagnosis of these rare dura based brain tumors.

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TORSION OF SCLEROSING STROMAL TUMOR OF OVARY CAUSING DIAGNOSTIC DILEMMA

CR 14

A 22 year old female presented with lower abdominal pain and swelling. CECT abdomen and pelvis showed a lobulated cystic mass with nodular enhancing wall measure 7 x 12 x 7 cm anterosuperior to uterus predominantly on the right side with mild ascites, most likely represents malignant ovarian mass with differentials of the hemorrhagic endometriotic cyst (Figure 1). Serum tumor markers (AFP, CA125, beta HCG) were within normal limits.

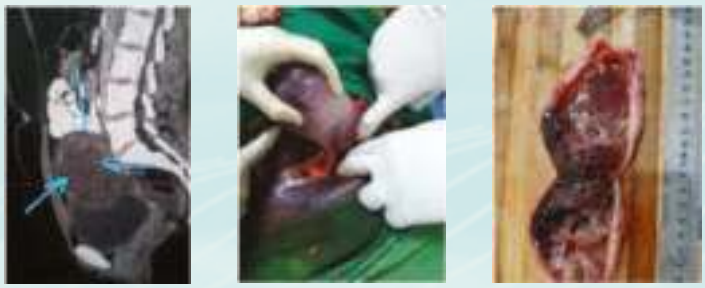
On exploratory laparotomy, there were two twists at the pedicel of the right ovarian mass with an attached ovary (Figure 2). Release of torsion and enucleation of ovarian mass done along with reconstructive preservation of right ovary done. There were no intra-operative signs of malignancy so only enucleation was performed. The left side ovary was normal.

Gross examination showed a 9 x 7.5 x 6 cm smooth congested ovarian mass with an intact capsule. Cut section showed loculated cyst filled with hemorrhagic fluid (Figure 3). The cyst wall was 2 to 3 cm thick and showed 1-2 cm round solid greyish tan nodules separated by soft loose and hemorrhagic areas. Microscopic examination showed a well-encapsulated tumor composed of hypercellular circumscribed solid nodules separated by hypocellular edematous areas (Figure 4). Areas of hemorrhages and congestion were identified due to torsion. Cellular areas were vasculocentric and comprised of spindle, ovoid, epithelioid, and polygonal cells having moderate eosinophilic cytoplasm and vesicular nuclei. A network of thin-walled capillaries giving hemangiopericytomatous like patterns, few signet ring-like cells, and RBC containing intracytoplasmic vacuoles gave a histological picture of a vascular tumor-like Epithelioid Hemangioendothelioma (EHE) (Figure 5). No necrosis increased mitosis or nuclear atypia seen. No germ cell tumor or surface epithelial tumor components seen. Histology differentials were vascular tumor (EHE) and Sex cord-stromal tumor of the ovary. Immunohistochemistry was performed and showed Inhibin (Figure 6) and Calretinine positivity in tumor cells. Tumor cells were negative for CD34, CD31, EMA, CK, and WT-1. So the final diagnosis was Sclerosing Stromal Tumor of the Ovary.

DISCUSSION

Ovarian sex cord-stromal tumors are relatively infrequent neoplasms that account for approximately 6 to 8% of all primary ovarian neoplasm. Sclerosing Stromal Tumor (SST) is a distinctive, rare, benign, sex cord-stromal tumor of the ovary and accounts for 2% to 6% of ovarian stromal tumors.

It predominantly affects females of second and third decades (Mean age is 30 years) and presents with menstrual irregularity, pelvic pain, and are mostly hormonally inactive. Pre-operative clinical-radiology and routine histology diagnostic difficulty were because of torsion of ovarian mass causing engorgement and congestion of small vessels making them prominent on histology even though serum tumor markers were normal. Mild ascites also raised the possibility of malignancy. The definite diagnosis was made only with the help of ancillary immunohistochemistry tests. Conclusion: The possibility of SST of ovary should always be kept in mind in young females with normal serum tumor markers and borderline to malignant radiology features complicated by torsion. Immunohistochemistry is essential for the final definitive diagnosis as it is a benign tumor treated by enucleation / unilateral ovariotomy with preservation of fertility in a young female patient.



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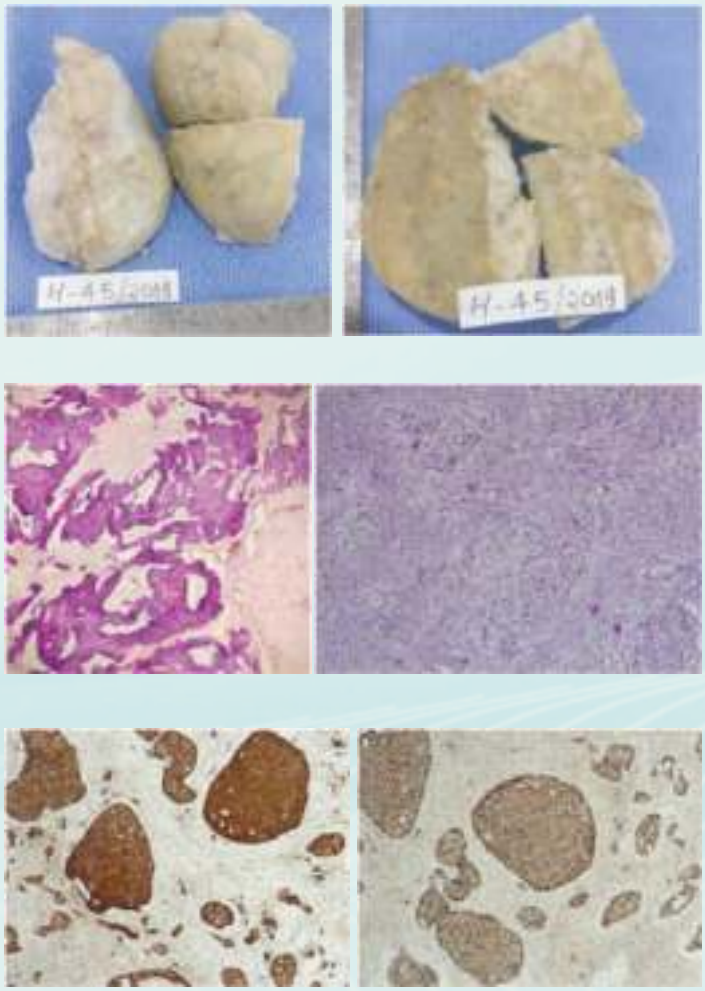
OSSIFIED ADULT GRANULOSA CELL TUMOR OF OVARY (OVARIAN STONE) - AN INCIDENTAL FINDING DURING CESAREAN SECTION

CR 15

A 42 year old female, during an elective cesarean section, was found to have the right ovarian mass involving the entire ovary. Right, salpingo-oophorectomy was done and the specimen was sent for a histopathology examination.

Gross examination showed a 6.5 x 6.5 x 4.5 cm well encapsulated, intact, smooth ovarian mass with an intact capsule and stretched 5 cm long normal fallopian tube (Figure 1). The cut section showed a solid stony hard greyish-white mass with a peripheral thin rim of soft greyish-white tissue (Figure 2).

Microscopic examination of decalcified sections showed a well-encapsulated tumor composed of central extensive ossification, hyalinization, sclerosis, and calcification (Figure 3). The peripheral rim of ovarian cortical stroma showed solid nests of granulosa cells against fibromatous stroma (Figure 4). No Psammoma bodies, germ cell tumor components, mitosis, nuclear atypia, or necrosis seen.
These cells were immunoreactive for Inhibin, Melan A (Figure 5 and 6), Calretinin, CD56, and CD99. These tumor cells were non-immunoreactive for CK and EMA. The final histopathological diagnosis was Ossified Adult Granulosa Cell Tumor of Ovary.



DISCUSSION

The bone formation has been described in various ovarian tumors like 1) Sex-cord stromal tumors – Luteinized thecoma, Fibroma, Sertoli-Leydig cell tumor, 2) Germ cell tumors – Mature cystic teratoma, 3) Surface epithelial tumors – Serous, Mucinous, Endometrioid carcinoma, MMMT (carcinosarcoma) with heterologous elements and even benign tumors like cystadenomas and chocolate cysts of the ovary. The most plausible explanation for bone formation is dystrophic calcification and osseous metaplasia.

CONCLUSION

Approximately one-fourth of the ovarian neoplasms and cysts are diagnosed incidentally during cesarean section, despite the routine prenatal ultra-sonogram. This underlines the importance of inculcating the habit of examining the ovaries at operation. To the best of our knowledge, ossified adult granulosa cell tumor of ovary found incidentally during cesarean section has not been reported in the literature and probably this is the first case worldwide.

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CASE SUMMARY - PRE ECLAMPSIA

CS 16

A para 1+1, gravida 3, presented to our Antenatal clinic at 26 weeks 4 days with a history of generalized swelling all over the body including the face for the last 2 weeks.

She had started her clinic at a peripheral center at 20 weeks, where she underwent routine tests and was given tetanus toxoid vaccine, malaria prophylaxis, and iron tablets. She was informed of her blood pressure of 132/96mm of mercury but was not given any medication.

Past obstetric history- She had a cesarean section in her first pregnancy at 37 weeks due to hypertension and intrauterine growth restriction, delivered a live male infant 2.0kg, in the year 2009. In the 2nd pregnancy, she had an intrauterine fetal death at 17 weeks, 2014. Medical history - she has been diagnosed with hypertension but has not been on any medication as it was not disturbing her.

Her examination revealed a very high blood pressure of 188/112mm of mercury. Further testing also revealed proteinuria of 4+ on the dipstick, hence the diagnosis of Pre-eclampsia with severe features was made and was admitted to our maternity.

Other investigations were within normal range hence she was put on anti-hypertensives and dexamethasone for fetal lung maturity. She was done an obstetric ultrasound scan which revealed a live fetus at 26 weeks with an abnormal Doppler waveform i.e. Absence of End-Diastolic Velocities (AEDV) in the umbilical artery and redistribution or brain sparing wave form in the middle cerebral artery and expected fetal weight of 690 gms.

Her ultrasound scan put her fetus at an increased risk of intrauterine death hence fetal monitoring was done with fetal kick charts non-stress test.

The plan was to repeat ultrasound doppler after 48 hours which revealed now Reversed End-Diastolic Flow (REDV), with altered Ductus venous waveform. She was counselled about the high risk for the baby and she accepted an emergency cesarean section. She was started on magnesium sulfate for neuro-protection of the baby and done cesarean section after 5 hours. The outcome was a live female fetus weighing 590 gms. The baby was received by our Neonatologist Dr. Chepkemoi and admitted to NICU.

She was given surfactant and put on a neonatal ventilator. She stayed on the vent for 5 days and was stepped down to c-pap.

Today she is 790 gms, on oxygen only, and accepting feeds. The mother recovered well post-operative and was discharged on anti-hypertensive medications.

THIS IS NOT A SUCCESS STORY

Can PRE-ECLAMPSIA be prevented?
Pre-eclampsia is one of the very common complications of pregnancy and affects almost abut 8-9% of pregnant women. It is one of the 5 major causes of maternal mortality. For years it was diagnosed on routine pregnancy visits by measuring blood pressure when it could have been just treated by controlling blood pressure and delivering mother when the fetus is mature, which is what is done for most women attending antenatal clinics. This does not always lead to a successful outcome in many women. Pregnant women with pre-eclampsia are at high risk of maternal complications like renal failure, liver dysfunction, DIC, pulmonary edema, Cerebrovascular accidents
But now it can be PREVENTED!!

A woman who is at high risk of pre-eclampsia can be screened at 10 -14 weeks of gestation by Mean Arterial Pressure, Laboratory tests and ultrasound scan for Uterine Artery Doppler which can reliably predict early-onset pre-eclampsia and woman can be started on medication low dose Asprin to prevent the development of pre-eclampsia and intrauterine growth restriction.

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CASE SUMMARY - GESTATIONAL DIABETES WITH PROM

CS 17

Mrs. BNW, a 38-year-old lady presented to our Antenatal clinic at 20 Weeks pregnancy with a history of recurrent pregnancy losses. She was Para 1+ 27, this being her 29th pregnancy.

Obstetric History- She had a series of almost 11 miscarriages at 8-10 weeks. After herbal treatment. she got her first child in the year 2011. She had a normal delivery. Thereafter she had 16 more spontaneous pregnancy losses at 3-6 months of the gestation period

She has put a cervical cerclage also in the last 3 pregnancy despite which she still had a preterm delivery, where the fetus was born alive but succumbed due to prematurity
On routine history, she did not have any chronic medical condition and was normotensive. We ordered routine investigations including random blood sugar, thyroid function tests, screening for Brucella, toxoplasma. We also ordered an obstetric ultrasound scan to see the fetal development, rule out fetal anomalies, and cervical length measurement.

Her ultrasound revealed a normal intrauterine pregnancy at 20 weeks 3 days, no fetal anomalies, and a cervical length of 4cms, which effectively ruled out cervical incompetence.

All her blood reports came out normal except glycosylated hemoglobin which was 6.7%. She was advised to go for an Oral Glucose Tolerance Test to rule out gestational diabetes. She got worried and was lost to follow up and failed to respond to telephonic contact too.

She presented to maternity 9 weeks with a history of draining clear fluid per vaginum. She was not having any contraction.

The examination confirmed the Breech presentation at 28 weeks with PROM.

Her Fasting blood sugars were 7.7 mmol/lit and postprandial sugars were 14.2 mmol/lit. Ultrasound scan showed a single live intrauterine pregnancy at 28.4 weeks with oligohydramnios, a BPP score of 6/8.

Hence a diagnosis of gestational diabetes with PROM AT 28.4 weeks, with BOH was made. Looking at the clinical presentation conservative approach was planned to allow pregnancy to continue. She was started on Insulin, Injection Lantas along with Metformin, Dexamethasone to mature the lungs, antibiotics to prevent infection and Tocolysis for two days for preventing the onset of labor, also Magnesium sulfate for neuro-protection.

She started uterine contractions despite these medications hence emergency cesarean delivery was undertaken as it was Breech presentation. The outcome was a live female infant, 950 gms, APGAR score of 9,10,10 at 1, 5, and 10 minutes. Neonate was handed over to our neonatologist Dr. Chepkemoi, and was admitted to NICU.

The baby received Surfactant to prevent respiratory distress syndrome, was put on ventilator as it was not able to maintain respiration. In the nursery, the baby was diagnosed with PDA and pulmonary hypertension which was managed successfully with Sildenafil.

She was discharged from NICU after 38 days at a weight of 1650 gms.

Today Mrs. BNW is a happy lady. She promised us that she will come to the clinic early in her next pregnancy and will follow instructions to avoid a poor outcome.

Dr. Pallavi Mishra
MD
Consultant Gynecologist & Obstetrician
Mediheal Group of Hospitals, Eldoret

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INTERNATIONAL DESK

My condition was so bad, I had a kidney problem. I went to many places and hospitals in Nigeria for lab tests and many assessments but I could not get any assistance. My right kidney was blocked with stones (kidney stones) and for more than 3 months I could not get any assistance I needed. But a friend of mine advised me to seek for treatment abroad and oriented to Mediheal Group of Hospitals in Kenya. When I landed in Kenya, the hospital hand already arranged for my transportation from the airport to the hospital. The care and attention I got from Mediheal was extremely at another level; in fact I found that there is haven of earth where people are passionate, concerned and sympathetic towards someone else's sickness. The nurses and the medical team were very devoted and dedicated to their duties; the level of care in Mediheal was unbelievable. Dr Sanand Bag handled me like his son from the preparations to the theater. He advised me and was very concerned about my wellbeing, for once I felt as if I healed even before surgery. After surgery my wife told me that my procedure took long but the doctor really tried their best and got me through this. I never knew such good equipment existed in Africa and being handled by experienced specialists. May God bless Mediheal Group of Hospitals for saving my life.

Mr. Uche Alexander Uwakwe
Nigeria (Lagos)

I have had many complaints for the past few years. I visited many facilities and hospitals across my country but I didn't find a proper treatment to my condition. I was then referred to Mediheal Group of Hospitals for a proper diagnostic and a potential treatment. Dr G.B. Mahapatra has been my treating doctor ever since I landed in Kenya. He ruled out so many things and discovered many ailments that I never knew I had before. A treatment was initiated and after a proper diagnostic, my gallbladder was also found with some problems. Dr Mistry (General and Laparoscopic Surgeon) attended to me and the surgery was successful. I came back for my review and Dr Mahapatra said that I have nothing to worry about, I have been completely healed. I could have been dead by now if my problems were not diagnosed earlier but I thank the doctors at Mediheal for saving my life once again.

Ms. Jeanette Misengabo
D. R. Congo

I was diagnosed with Meningioma this year. A local consultant Neurosurgeon recommended me to travel abroad for treatment and recommended several hospitals including Mediheal Group of Hospitals. Following discussions between a local consultant and consultant Neurosurgeon at Mediheal about my condition, I decided to seek treatment at Mediheal. The customer care experience was great from the time of arrival at the airport to the travel to the facility. I was picked up from the Airport and accommodation was arranged for me at one of the nearby hotels. The following day I was taken to the hospital to consult with the specialist and registered for treatment. All the necessary investigation were done very fast within the facility and I was admitted. The surgery was successful, all went well and I was in the ICU for three days. My main challenge that I battled with was anxiety but I was guided through the process meeting with the psychiatrist very often. During admission and after surgery the nurses were so kind, patient and checked on me every time and again to see how am doing and do the necessary tests to monitor my progress. The food was great too. The level of professionalism and care given cannot be matched with any I have ever experienced anywhere. Even when I was discharged am still able to communicate with my doctors about my progress and they keep guiding me through the process. It's a great telemedicine experience. I thank the Mediheal fraternity for the care and treatment they have given me and most importantly giving me a second chance to life. Thank you.

Mr. John Dikhonte
Uganda

Overall, we very much appreciate the services of Mediheal Hospital. From the reception, orientation, consultations and even laboratory services are all excellent. All the staff are welcoming and are up to the job. Doctors give themselves body and soul to satisfy their patients. For sure the services we received were commendable and to a higher standard.

Marie-Chantal Mukandori
Burundi

Distribution of Bibles by Gideons International through Mr. Ashish Raman, Vice President Operations, Nairobi Cluster

LCM Marks World Diabetes Day, Diwali

BY CORRESPONDENT

On 14 November, the Lions Club of Nairobi (LCM) visited the Aims Old age Home to share happiness and health in tandem with the festival of Diwali and World Diabetes Day (as shown below). "We were able to check their blood pressure, blood sugar, weight and temperature courtesy of Medheal Hospital. The hospital staff also gave them some medication while the doctor advised them on diabetes management and general nutrition. Following the theme 'Nurses: Make a difference' set by the International Diabetes Foundation, we gave the nurses and doctors bouquets of flowers and Diwali sweets. Additionally, we took flowers, sweets and food baskets for the elderly people. This activity was conducted in the presence of President Lion Rishi and Lion Tonia. We were glad to be able to give them validation once again. LCM brought smiles to another set of people," read a press statement.

World Diabetes Day & Diwali celebration at LCM.

MEDIHEAL IN THE NEWS

Dr. Sanand Bag, Consultant Urologist, being interviewed on KTN for Prostate Cancer Management.

https://youtu.be/2layz8ttfxk

Dr. Lalit, Medical Oncologist, being interviewed on the awareness of Breast Cancer.

https://youtu.be/cQQI_5alTEY

Dr. Khandwala discussing various topics related to infertility issues and treatment modalities.

https://youtu.be/UDDd-Es6Ahk

Mr. Gokul Prem, VP - Business Relations, discussing the impact of COVID-19 on BCC (Healthcare Segment)

https://www.facebook.com/BBCnewsafrica/videos/330483998372489/?sfnsn=wa&extid=tPRoZDlNafNOACvi

The Standard (18th Sept.): Article on how COVID-19 affected elective and mandatory surgeries - Dr. K. Pramod Joshi, Orthopaedic Surgeon, Mediheal Hospitals.

The Standard (18th Oct.): Article on how IVF can be a solution for childless couples - Dr. Shaunak Khandwala Group IVF Director, Mediheal Hospitals.


Cancer that plagues 1 in 7 African men

The Standard (16th Nov.): Article on cancer that plagues men in Africa - Dr. Sanand Bag, Transplant Surgeon, Mediheal Hospitals.

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MEDICAL QUIZ

1. What is Ecchymosis?
A. Bruise
B. Snoring
C. Wart
D. Chest Acne

2. What is Varicella?
A. Chicken Pox
B. Mumps
C. Scarlet Fever
D. Measles

3. What is Nulligravida?
A. Duodenal Leakage
B. Heart Murmur
C. Never Pregnant
D. Iron Deficiency

4, What is Hematuria?
A. Blood in Urine
B. Bleeding Brain
C. White Blood Cell Deficiency
D. Blood in Stool

5. What is Epistaxis?
A. Abdominal Distension
B. Tooth Decay
C. Back Strain
D. Nose Bleed

6. What is Scoliosis?
A. Deep Thigh Bruise
B. Pelvis Rupture
C. Spine Curvature
D. Rib Curvature

7. What is Cephalalgia?
A. Ear Infection
B. Nose Bleed
C. Concussion
D. Headache

8. What is Podobromhidrosis?
A. Runny Nose
B. Bow Legs
C. Stinky Feet
D. Bad Breath

9. What is Pandiculation?
A. Anxiety
B. Heartburn
C. Yawn Stretch
D. Nail Biting

10. What is Aphagia?
A. Unable to Swallow
B. Unable to See
C. Unable to Breathe
D. Unable to Hear

E-mail your answers to medtalk@medihealgroup.com

Answers of the Medical Quiz from MedTalk Vol. 1:
1-A, 2-A, 3-A, 4-A, 5-A, 6-A, 7-A, 9-A, 10-A,11-A,12-A,13-A

COMIC TONIC

Patient: Doctor,
I have swallowed a spoon.
Doctor: Sit down
and don't stir!

Q. Does an apple keep
the doctor away?
A. Only if you aim
it well enough.

**Human-beings
get rich as they grow old:**
Silver in Hair, Gold in Teeth,
Sugar in Blood, Precious
Stones in Kidney and a
never ending supply
of gas!

"Doctor, doctor, will I be able
to play the violin after the
operation?"
"Yes, of course..."
"Great! I never could before!!"

Did you hear about
the Optometrist who fell
into his lens grinding
machine?
He made a spectacle
of himself!!!

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