

Vol. 5: June 2016

WOCK SYNAPSE

Managing Director's Desk



Dear Associates,

I would like to wish all our Nursing Associates a very Happy Nursing Day. I am extremely proud of each one of you and the work you do.

As is evident in the published cases which range from bizarre to extremely complicated requiring excellent skillsets, at Wockhard Hospitals our Consultants are doing some amazing work across specialities helping save lives and we are making a positive difference to the healthcare spectrum of our country.

It is important to show case the Clinical work we do from time to time to the community. Once again our Hospitals participated in various award categories across different forums competing with the best hospitals in the country and winning some awards thus demonstrating our commitment to Clinical Excellence. I would like to congratulate all associates who by their commitment have done us proud once again.

Zahabiya Khorakiwala
Managing Director,
Wockhard Hospitals

UNUSUAL CASE OF A SHARP METALLIC APPETITE

A 29 year male patient working as a laboratory technician presented to Wockhardt Hospital Nashik with a history of abdominal discomfort and passing black stool, since 8-10 days. He had no significant past history. On clinical examination, patient was well oriented and his general examination was normal. His abdomen was soft with mild epigastric tenderness. No rigidity and guarding present. Haematological and biochemistry reports were within normal range. X-ray of abdomen showed lumps of multiple metallic foreign bodies present in stomach & one surgical blade present in pelvis.



On further questioning the patient spoke of consuming scalpel blades, shaving blades, nails etc. for almost 1 month. He was taken up for surgery, first laparotomy followed by gastrotomy which revealed 29 Scalpel blades, 155 half Shaving blades, 15 Nails of various size, 2-3 small magnets present in the abdomen. One surgical blade was removed from the rectum. Some of the blades were corroded and partially digested as he had been consuming them for around a month.



Dr. G. B. Singh
Consultant - Laparoscopic Surgeon,
Wockhard Hospital, Nashik

He recovered well & was counselled & treated by a Psychiatrist.

8 MONTH OLD BABY'S LIMB SALVAGED

A one of its kind vascular reconstruction lower limb saving surgery

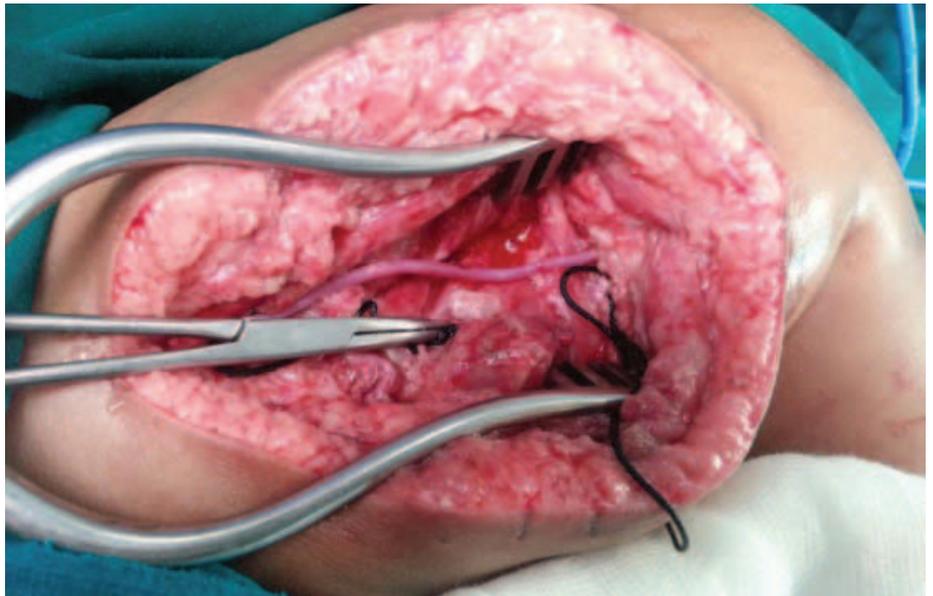
An 8 month old baby was undergoing major surgery for a large soft tissue tumor of the left thigh at a remote hospital. During this procedure the surgeon found that the tumor had completely engulfed the left femoral artery. So the doctors had no choice but to remove the whole tumor along with this artery. But this led to a major problem of restoring blood supply to the lower limb to prevent it from becoming gangrenous. As there was no facility available to salvage the limb, doctors at this hospital contacted Dr. Sameet Pathak who is a Cardio Vascular and Thoracic Surgeon at Wockhardt Multispeciality Hospital Nagpur and the baby was referred for further treatment. "It took few hours for the baby to reach Wockhardt hospital. Time is of prime importance in vascular reconstruction surgery as the only blood vessel which carries oxygenated blood to the limb was completely removed in this patient," said Dr. Pathak. The first six hour period is called the Golden period during which if blood supply is restored then the chances of limb survival is excellent but in few patients depending upon the situation it can be extended to 12 hours also.



Dr. Sameet Pathak

Consultant - Cardio Thoracic & Vascular Surgery,
Wockhardt Hospital, Nagpur

Dr. Pathak took up the baby for vascular reconstruction to restore blood supply without which the baby could have lost complete lower limb. There was a big surprise instore for him as he opened the wound. Almost 8-9 cms of vessel (Femoral Artery) was missing. Now the dilemma for the surgeon was, what to use as a replacement. Artificial tube grafts do not come in very small sizes and this baby's artery was only 1.5 mm in diameter and further these artificial grafts do not grow in size and baby would have to have a second surgery few years later and hence artificial tube graft was totally out of question according to Dr. Pathak. He therefore decided to use the patients own saphenous vein graft from the same thigh as it matched the size of the original vessel and has the potential to grow along with the patient. This saphenous vein is usually used for coronary artery bypass grafting surgery in adults but probably this is the first time that such a long vein graft was used in such a small patient for this purpose. The baby recovered very well after surgery and has now started walking when last seen at follow up.



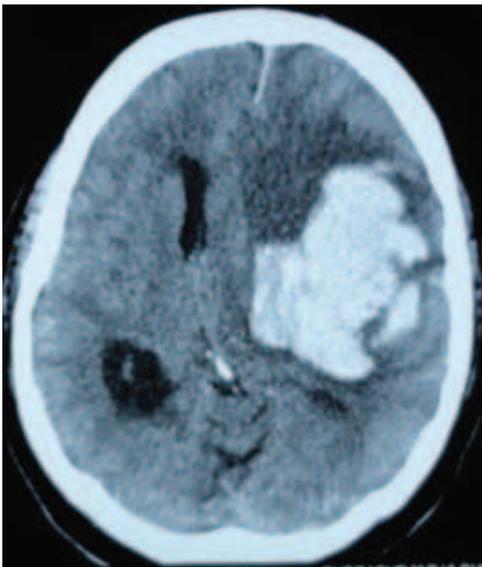
Dr. Pathak said "such vascular accidents are quiet rare and there were two challenges in front of me, one was to start the blood supply as soon as possible to the limb to avoid gangrene and amputation and secondly which tube graft to use for reconstruction because such a long length (9 cm) of patients own vein graft in such a small baby has not yet been reported to be used in world literature. The most important advantage of using the patients own vein graft is that it would grow along with patient and baby would hopefully not need a second operation."

According to Dr. Pathak, this technique of using patients own vein graft in small babies and young patients will soon become a standard treatment option if these patients are studied properly in future.

The baby is regularly coming for check-ups and is doing well.

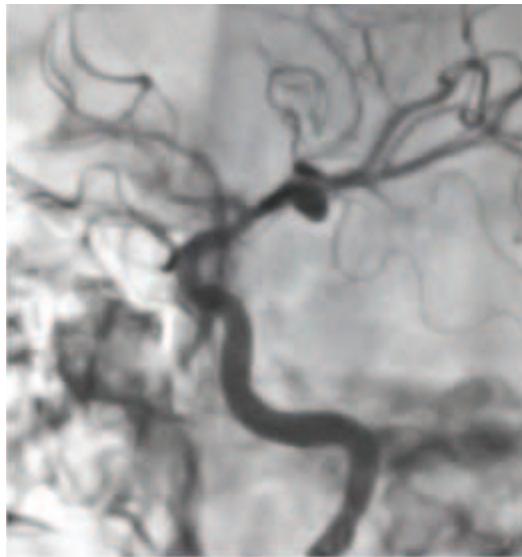
LEFT MIDDLE CEREBRAL ARTERY BIFURCATION ANEURYSM: CLIPPING

A 50 year old female presented to Wockhardt Hospital South Mumbai emergency department with a history of sudden onset of severe headache with vomiting one day back. She had loss of consciousness 6 hours prior to admission. On examination she was unconscious, with GCS (Glasgow Comma Scale) of E2V3M5 with right hemiparesis. Her pupils were bilateral equal size and reacting to light. She had neck rigidity. Her BP was 160/100 mmHg.



CT scan of the head was done which showed SAH (Sub Arachnoid Haemorrhage) in left sylvian fissure with adjacent ICH (Intra Cranial Haemorrhage) with mass effect.

Possibility of Left middle cerebral artery aneurysm was predicted. Urgent DSA (Digital Subtraction Angiography) of cerebral vessel was done which showed left MCA (Middle Cerebral Artery) bifurcation Aneurysm. In view of ICH with mass effect, patient was planned for Aneurysm clipping. Left pterional craniotomy and clipping of left MCA bifurcation aneurysm and evacuation ICH was done.



Patient was kept on ventilator support and showed signs of recovery. She was discharged within 20 days with mild hemiparesis but she was able to walk with support. After one month follow up she was fully independent and was doing her daily work without support.



Dr. Ajay Bajaj
Consultant - Neurosurgeon,
Wockhardt Hospital,
South Mumbai

ANOTHER REASON WHY WE SHOULD KEEP MEDICATIONS OUT OF THE REACH OF CHILDREN

A case of isolated benzodiazepine poisoning in a pediatric patient presenting with coma and respiratory arrest

A 10 year old male child presented to Wockhardt Hospital Rajkot with ET (Endotracheal) tube in situ with a history of 3-4 episodes of vomiting followed by loss of consciousness and respiratory arrest.

His general examination revealed hypothermia, tachycardia (HR-170/min), no spontaneous respiratory efforts, low peripheral pulse volume and low pulse oximetry saturation (85%) with bag and mask ventilation connected to free flow oxygen source.

His GCS (Glasgow Comma Score) was 3/15, E1V1M1, bilateral dilated and non light reacting fixed pupils, doll's eye movement absent, generalized hypotonia and areflexia.

Patient was immediately connected to the ventilator and started with IV fluids and all necessary medications. Laboratory investigations revealed severe RS acidosis with hypoxia, elevation of TLC with predominance of neutrophils.

Chest X-Ray indicated aspiration pneumonia. Brain imaging showed small non-specific focal lesion in right frontal lobe white matter suggestive of demyelization. EEG (Electroencephalography) showed features of diffuse encephalopathy.

Toxicology screening of urine was done which showed presence of BZDs (Benzodiazepine) in urine above the cut off value. So he was given a single dose of flumazenil. On discussion with parents, it was discovered that one of the member of the family was on BZDs and the child may have engulfed the same.

In the ward, he was given oral antibiotics, nutritional supplements, frequent inhaled steroid and mucolytics by nebulizer. Chest and limb physiotherapy was also given.

During his 4 weeks stay in hospital he remained comatose for first 7 days and then gradually improved. He was extubated after 18 days of exclusive ventilator care. His vitals, lab parameters and neuro-developmental assessment were normal at the time of discharge after total of 28 days.



Dr. Trupti Vaishnani
Consultant - Paediatrician &
Neonatologist,
Wockhardt Hospital,
Rajkot

GENERAL INFORMATION

BZD's (Benzodiazepine) should be used in persons older than 19 years; younger age groups are more susceptible to BZD overdose. BZD's overdose becomes fatal if it is taken with other substance like opioids. Isolated BZDs can rarely present with coma and respiratory arrest. But in pediatric age group, an isolated BZD poisoning can present with coma and respiratory arrest.

IMPORTANT PRECAUTION: We should always ensure that all medications /chemicals should be kept out of the reach of children.

MIRACLE BABY

A Primi gravida, 32 weeks of pregnancy, known case of Rheumatic Heart Disease having Severe Mitral Valve Regurgitation and Severe Aortic Regurgitation with Moderate Pulmonary Artery Hypertension and Severe Left Ventricular Dysfunction (Left Ventricular Ejection Fraction = 20 to 25%), presented to Wockhardt Hospital Rajkot, complaining of leaking of amniotic fluid since 6 hours. The patient was booked in the OPD for a routine check-up.



Dr. Madhulika R. Singh

Consulting - Obstetrics & Gynaecology,
Wockhardt Hospital, Rajkot

The patient had been operated for Mitral Valve Replacement at the age of 16 to 17 years with prosthetic Mitral Valve and she was taking anti-coagulant therapy since then. She had progressive aortic disease since the last 2-3 years. Cardiologist had advised her not to get pregnant considering serious consequences of pregnancy with co morbidities she had.

Patient was admitted to our hospital at 30th week of pregnancy for pre-term labor for which she was managed conservatively and discharged with steroid coverage.

On admission, the cardiologist reviewed the patient and all risks were explained to patient and her relative. On obstetric examination, patient had 32-34 week full term live cephalic presentation.

PV examination suggestive of internal OS closed and cervix with leak through vagina. FHS 120-126/minute. On USG examination, it was found that patient was having signs of oligohydramnios with loop of cord around the neck.

The team performed LSCS under General Anesthesia which was difficult in this case as the risk was very high. Post-operatively the patient stayed in the ICU for 24 hours then was shifted to the ward. At the time of discharge her coagulation profile was up to the mark.

Patient went off delighted as she was carrying her own baby for which she lost all hope.

PHOTO QUIZ

Case:

A 42 year old female came with a history of roadside accident at a village setting, 4 years ago. She developed a laceration at pre-auricular area on left side which was treated at a primary health centre (sutured).

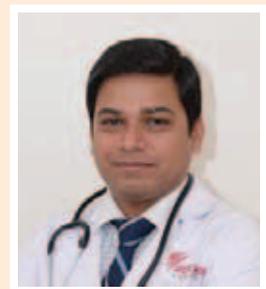
She developed pain and erythema on the same site after 2 months which gradually increased to current size. She had received multiple treatments including ATT but no response. Three biopsies done earlier had suggested chronic non specific inflammation.



What is the Diagnosis?

Please send in your responses to
wocksynapse@wockhardthospitals.com

Answer in the next issue

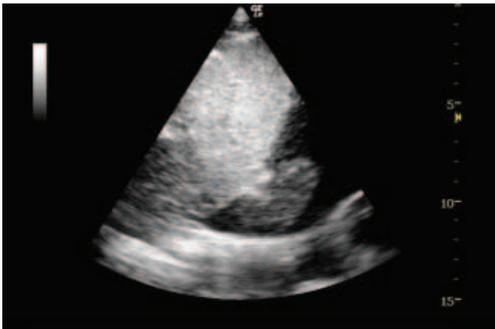
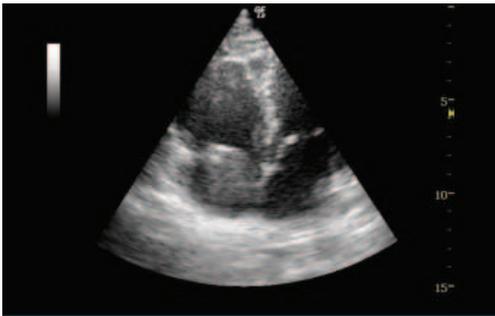


Dr. Nitin Shinde

Consultant - Infectious Disease &
Travel Medicine,
Wockhardt Hospital, Nagpur

CLOT IN TRANSIT: EARLY DIAGNOSIS AND TREATMENT SAVED THE YOUNG PATIENT'S LIFE

A 30 year old male patient presented to Wockhardt Hospital Nagpur emergency department with a history of right sided chest pain since last 6 hours. The clinical examination was unremarkable. The ECG, Chest X- Ray and cardiac enzymes were normal. Further workup HRCT (High resolution computed tomography) chest was done which showed pulmonary infarct in right lung with no thrombus in the pulmonary arteries.



Echocardiogram was done and the findings were surprising. There was a large thrombus in the right atrium extending from IVC (Inferior vena cava)-RA (Right atrium) junction to RV (Right ventricle) inlet. The thrombus was so large that if it would have embolized into the pulmonary arteries, it would have led to massive pulmonary embolism and risk of sudden death. Discussion with patient's relatives about patient's condition was done. The team decided to do thrombolysis. Patient was thrombolysed with Reteplase 20 units followed by low molecular weight heparin. The Echocardiogram was repeated after 2 hours which showed significant reduction in the thrombus burden by 60 % of its original size. Patient was observed for 4 days in critical care unit. The residual thrombus was resistant to the treatment. The team decided to remove the residual thrombus surgically. The total thrombus was removed surgically. The procedure was well tolerated.

Patient was kept on newer oral anticoagulants and was discharged after an excellent recovery.



Dr. D. R. Hore

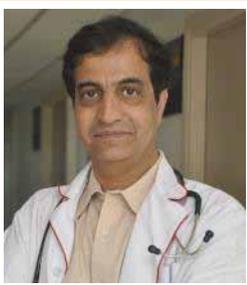
Consultant - Interventional Cardiology,
Wockhardt Hospital, Nagpur

GENERAL INFORMATION

Massive pulmonary embolism is a life threatening medical emergency. High index of suspicion, early diagnosis and treatment is critical to save life. It is a rare finding that documented large thrombus on the way of transit from IVC (Inferior vena cava) to right atrium. If it had dislodged, it would lead to sudden death.

"FIRM" DECISION MAKING IN "FLUCTUATING" STROKE

Thrombolysing an improving stroke patient is often a dicey situation. Neither can we predict whether he is going to certainly improve or is he going to fluctuate and worsen later. Here we present the case of a 67 year old male who was brought to the emergency by his relatives with acute onset of right hemiplegia with dysarthria. His weakness began at 7:45 pm, by 8:15 pm his right leg began to improve. By the time he reached the emergency department in Wockhardt Hospital at 9 pm, he only had a right sensory loss and persisting speech difficulty. His NIHSS at 9 pm was 3. His blood pressure was stable at 130mmHg Systolic and 90mmHg Diastolic. His sugar levels were normal. He was immediately rushed for MRI. His MRI showed an acute infarct in the left ganglio capsular region involving the posterior external capsule (Fig:1).



Dr. Shirish M. Hastak
Consultant - Neurologist,
Group Director Neurology & Stroke,
Wockhardt Hospitals



Dr. Philip Anemon
Junior Consultant - Stroke Medicine,
Wockhardt Hospital,
Mumbai Central

His angiogram showed an abrupt cut off at the junction of the M1 and M2 on the left side (Fig:2). On one hand, our patient was improving with only persisting speech deficits and sensory loss. On the other hand, we had a thrombus sitting in the Left MCA Distal M1. An initial thought was not to thrombolysate as patient was improving. In the same breath, the worry of deterioration loomed very strongly. We talked to the patient's relatives and explained the benefit and risks associated with thrombolysis and the possibility of deteriorating later and not being able to intervene if he deteriorates later. The relatives agreed for IV thrombolysis with Alteplase. At 45 minutes into IV thrombolysis, his speech became clear and the sensory loss improved. He was shifted to the ICU. At 24 hours post thrombolysis, his NIHSS remained at 0. His repeat MRA brain showed no increase in infarct size (Fig:3) and complete recanalization of the distal M1 (Fig:4). His work up was done, 2D Echo did not reveal any clots or vegetations. His exact etiology of stroke was unclear. He was discharged home on the 3rd day morning. At follow up he came alone to the OPD. His NIHSS on follow up was 0 and he could do all routine activities independently.

Learning Points:

- 1) Consider the clinical syndrome. Improvement though a positive phenomenon is not essentially permanent. It can be transient and may end in a deterioration. 1/3rd of patients who fluctuate may later deteriorate and be out of the window of thrombolysis.
- 2) Look for any acute thrombus, arterial block and the collaterals before making any decisions in acute stroke.
- 3) Consider early thrombolysis and endovascular therapy in case of larger strokes (NIHSS > 6)
- 4) Stroke with small infarcts are least likely to bleed.

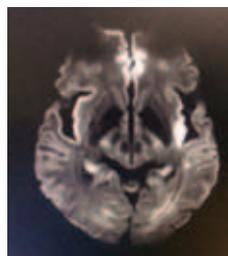


Fig 1-MRI showing acute infarct.



Fig 2- MRA showing abrupt cut off of distal M1

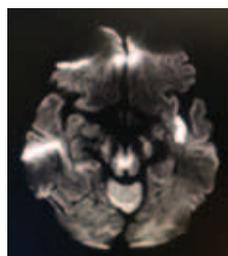


Fig 3- Repeat MRI showing no increase in infarct



Fig 4- MRA showing complete recanalization

RRT AWARENESS PROGRAMME 28th & 29th March, 2016

Opening Ceremony - BKC



Participation from units:



AWARDS 2016

Health & fitness leadership awards

Wockhardt Hospitals won the award for Innovation in Quality of Service Delivery at the group level



Wockhardt Hospital, North Mumbai won the Best Dialysis Service care provider

Wockhardt Hospital, Surat won the Best Marketing Campaign in Healthcare



Wockhardt Hospital, Rajkot won the Best Multispeciality Hospital, Saurashtra & Kutch region

AHPI

Dr. Clive Fernandes, Group Clinical Director presenting the award to Ms Zahabiya Khorakiwala, MD, Wockhardt Hospitals



Wockhardt Hospitals, South Mumbai won the AHPI award 2016 in the category of "Best place to work"

Wockhardt Hospitals, Nashik won the AHPI award 2016 in the category of "Nursing Excellence"



BIG RED BRAIN TUMOR IN A BIG BLUE HEART: “A VERY RARE CASE”

A 52 years old female patient presented to Wockhardt hospital Nagpur with headache, seizures and left sided body weakness for last 6 weeks. CT head showed a big tumor on the right side of brain (front parietal area) which was diagnosed as falcine Meningiomas (size 6.3 x 6.5).

Patient also turned out to be a case of congenital cyanotic heart disease i.e. tetralogy of fallot (TOF), (a complex cyanotic heart disease). Physiological changes that occur in TOF are arrhythmias (Irregular cardiac rhythm), hypoxia i.e. lack of adequate oxygenation, hyper viscosity (blood is very thick), infection in the heart and coagulation abnormalities. All these factors make these patients very challenging surgically and from anesthesia point of view.

This patient had poor oxygenation i.e. SpO₂ 75% with thick blood (hemoglobin more than 21 g/dL) big vascular brain tumor where tumor removal was the only treatment available and mandatory to save the life. It was a great challenge as the patient was a case of untreated cyanotic heart disease. Life risk i.e. patient dying on operation table or in the postoperative period was very high.

Challenges to the surgeons were:

- Thick blood, hence chances of postoperative brain stroke and heart attack was very high.
- Increased risk of bleeding which will precipitate hypotension & tachycardia. Both will complicate cyanotic spells and risk of vasodilatation with increase in intracranial pressure.
- Increased risk of infection, not only to brain but also to heart.

As the blood viscosity was very high, blood thinning was done twice before the surgery. The anesthetist played a very vital role in maintaining a smooth anesthesia period during tumor excision. Total duration of surgery was 3 hours. Complete tumor excision was achieved.



Intraoperative period went uneventfully the patient was mobilized from day 1 and started walking on the 3rd postoperative day. Postoperative CT was done which revealed complete tumor excision. Patient's cardiac status remained stable. Patient was discharged on 9th postoperative day without any cardiac and brain complication.

GENERAL INFORMATION

- Meningiomas are benign tumors (non cancerous) and are highly vascular (rich blood supply) and tend to bleed profusely during excision.
- Congenital cyanotic heart disease constitutes 10% of all congenital heart disease. If untreated 35% of patients die in the 1st year, 50% in 3 years and adults more than 21 years of age are very rare, less than 5% and hence this patient aged 52 years was itself very very rare and a successful outcome demonstrates excellent all round skill sets by all the surgical and other support teams.



Dr. Ajay Kurve

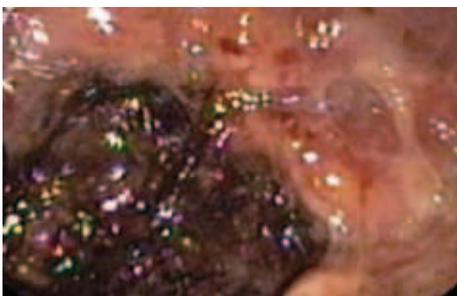
Senior Consultant - Neurosurgery,
Wockhardt Hospital, Nagpur

ACCIDENTAL BATTERY FLUID (SULPHURIC ACID) INGESTION BY A 4 YEAR OLD MALE CHILD

A 4 year old male child presented to our hospital with accidental ingestion of car battery fluid containing sulphuric acid. While taking history about the course of events it was revealed by the family that the father being a taxi driver had got the car battery fluid in a mineral water bottle home and kept on the table, as the child was unaware about the same and drank few ml. One of the family members witnessed the same and brought the baby to the hospital.

The child had abdominal pain and multiple episodes of blood tinged vomiting accompanied with stridor, hoarseness and respiratory distress. There was a drop in haemoglobin from 13 to 10, CRP (C Reactive proteins) was 10. Patient was kept NPO (NIL per mouth) and was started on IV fluids, PPI (Proton Pump Inhibitors) and antibiotics. Barium swallow test was negative. Chest X ray was normal.

Upper GI (Gastrointestinal) Scope which was performed 7 hours post-ingestion was suggestive of grade 3 injury involving body, antrum and a severely edematous peri-pyloric region. Most of esophagus was spared with grade 1-2 injury in distal esophagus.



The child was managed conservatively and reassessed at regular interval. Jejunal tube was placed on Day 3. Protein rich diet and medium chain triglyceride diet was started to meet caloric requirement.

Endoscopy was repeated which showed marked improvement and the child was discharged by end of second week. He was switched to oral diet before discharge.



Dr. Lalit Verma

Consultant - Paediatric Gastroenterologist,
Wockhardt Hospital,
North Mumbai

GENERAL INFORMATION

Caustic substances should be kept in labelled containers and away from the reach of children.

ZIKA VIRUS AN EXPLOSION HAPPENING

Zika virus is an arthropod-borne flavivirus transmitted by mosquitoes. The virus is related to other flaviviruses including dengue virus, yellow fever virus, and West Nile virus. Clinical manifestations of Zika virus infection occur in approximately 20 percent of patients and include acute onset of low-grade fever with maculopapular rash, arthralgia (notably small joints of hands and feet), or conjunctivitis (nonpurulent). Currently, there is an ongoing Zika virus outbreak in the Americas, the Caribbean, and the Pacific.

Zika virus is named after the Ugandan forest where it was first isolated in a rhesus monkey in 1947. The first human cases were detected in 1952 in Uganda and Tanzania.

Zika virus is transmitted to humans primarily via the bite of an infected *Aedes* mosquito; other modes of transmission can also occur. Zika virus RNA has been detected in blood, urine, semen, saliva, cerebrospinal fluid, amniotic fluid, and breast milk. The incubation period between mosquito bite and onset of clinical manifestations is typically 2 to 14 days. The illness is usually mild; symptoms resolve within two to seven days. Zika virus may be detectable in the blood of an infected person for a few days to a week. Once a person has been infected, he or she is likely to be protected from future infections. Severe disease requiring hospitalization is uncommon, and case-fatality rates are low.

Clinical manifestations of Zika virus infection occur in 20 to 25 percent of individuals who become infected with Zika virus. Symptoms and signs of Zika virus infection typically include acute onset of low-grade fever (37.8 to 38.5°C) with maculopapular rash, arthralgia (notably the small joints of hands and feet), and conjunctivitis (nonpurulent); clinical illness is consistent with Zika virus disease if two or more of these symptoms are present. Other commonly reported clinical manifestations include myalgia, headache, retro-orbital pain, and asthenia. More rarely observed symptoms and signs include abdominal pain, nausea, diarrhea, mucus membrane ulcerations, and pruritus. Thrombocytopenia has been described in case reports.

Zika virus infection has been associated with complications including congenital microcephaly and fetal losses among women infected during pregnancy and Guillain-Barré syndrome. Given an association between Zika virus exposure during pregnancy and congenital microcephaly, a number of authorities have advised that pregnant women avoid or consider postponing travel to areas below 6500 feet (2000 meters) where mosquito transmission of Zika virus is ongoing.

For individuals four or more days after the onset of symptoms, the diagnosis of Zika virus infection may be established by Zika virus serologic testing. Laboratory testing for Zika virus infection is not commercially available; testing is performed by the Pan American Health Organization/World Health Organization, the United States Centers for Disease Control and Prevention (CDC) Arboviral Diagnostic Laboratory. In India, National Institute of Virology is going to start testing.



Dr. Behram Pardiwalla
Consultant - Internal Medicine,
Coordinator Department of
Internal Medicine,
Wockhardt Hospital,
South Mumbai

NEW CONSULTANTS WHO JOINED THE WOCKHARDT FAMILY

| Name of the Consultant | Qualification | Specialty | Location |
|----------------------------|---|--|--------------|
| Dr. Amit Gupte | MBBS, MD (Int. Med), DM (Gastroenterology) | Gastroenterology | South Mumbai |
| Dr. Gaurav Gupta | MBBS, MS, Multi organ transplant fellowship American Society of Transplant Surgeons | Abdominal Organ Transplant & HPB Surgery | South Mumbai |
| Dr. Aaditya D Kashikar | DNB (Orthopaedics), Spine Foundation Fellowship (Mumbai) | Orthopaedics | North Mumbai |
| Dr Advait Ingole | MBBS, MD(Anaesthesia) | Critical Care | North Mumbai |
| Dr. Charudatt Vaity | MD (Med), DNB, MRCP (UK), EDIC, MFICM (UK) | Critical Care | North Mumbai |
| Dr. Disha Shah | MBBS, DNB (Anaesthesia) | Anaesthesia | North Mumbai |
| Dr. Neeraj Kasat | MBBS, MS (Orthopaedics), Spine Fellowship, (Korea University Medical Center;Seoul, South Korea) Adult Reconstruction Fellowship, (Tan Tock Seng Hospital, Singapore) | Orthopaedics | North Mumbai |
| Dr. Pandurang Reddy | DNB (Neurosurgery) Hinduja Hospital & MRC, Mumbai, Fellowship in Intervention in Neuro-radiology (University Hospital Zurich, Switzerland) | Neurosurgery | North Mumbai |
| Dr. Shalini Iyer Gonsalves | MBBS, MD (Internal Medicine) from GMC, Surat | Internal Medicine | North Mumbai |
| Dr. Siddharth Kharkar | MBBS, MD (Neurology) USA, Fellowship Epilepsy (UCSS, USA), Clinical Attachment in Movement Disorders (King's College London) MHS (John Hopkins) | Neurophysician | North Mumbai |
| Dr. Uma Dangi | MBBS, DNB (Medicine), DNB (Medical Oncology), ECMO (European Society of Medical Oncology) | Medical Oncology | North Mumbai |
| Dr. Vinayak Gudekar | MBBS, MD (Anaesthesia), IDCCM, FNB (Critical Care) | Critical Care | North Mumbai |
| Dr. Vipul Jethwa | DNB (Radiodiagnosis) K J Somiaya Hospital & Research Centre, Mumbai | Radiology | North Mumbai |
| Dr. Dhananjay Patil | MBBS, DNB (Medicine) | Critical Care | Nashik |
| Dr. Kedar Malwatkar | MBBS, MD (Paediatrics) | Paediatrics & Neonatology | Nashik |
| Dr. Paresh Alwani | MBBS, MD (Medicine) | Critical Care | Nashik |

NEW CONSULTANTS WHO JOINED THE WOCKHARDT FAMILY

| Name of the Consultant | Qualification | Specialty | Location |
|--------------------------------|---|--------------------|----------|
| Dr. Prashant Ubhale | MBBS, MD (Anaesthesia) | Critical Care | Nashik |
| Dr. Roma Saraf | MBBS, MD (Anaesthesia) | Anaesthesia | Nashik |
| Dr. Sandeep Bhangale | MBBS, DNB (Anaesthesia), PDCC (Pain & Palliative Medicine), FIACTA (Cardiac Anaesthesia) | Anaesthesia | Nashik |
| Dr. Sandeep Patil | MBBS, MD, DM (Gastroenterology) | Gastroenterology | Nashik |
| Dr. Vikesh Revdiwala | MBBS, MD, FIACTA (Cardiac Anaesthesia) | Cardiac Anesthesia | Surat |
| Dr. Sweta Lohiya | MBBS, MS (Otorhinolaryngology, Head and Neck Surgery) | ENT surgeon | Nagpur |
| Dr. Shreeram A Kamat Dhakankar | MBBS, MS (Orthopaedics), Fellowship in Adult Reconstructive Surgery & Fellowship in Sports & Joint Replacement Surgery (University of Heidelberg, Germany, ATOS Clinic) | Orthopaedics | Goa |



Dr. Zubin Pereira
Medical Administrator,
Wockhardt Hospital,
South Mumbai

Do you know:



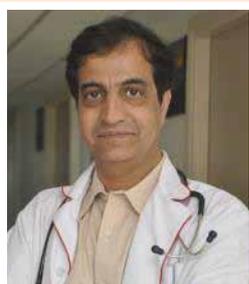
- 1 in 10,000 people have their internal organs reversed or "mirrored" from their normal positions. This condition is known as Situs Inversus.
- 80% of the brain is made up of water.
- A baby is born without kneecaps. They appear between age 2 and 6.
- A condition called synesthesia can cause senses to overlap. In other words, some people can taste words or hear colours.
- A heartbeat is the sound produced by the closure of valves of the heart when the blood is pushed through its chamber.

HEALTH TIPS TO PREVENT STROKE

A stroke occurs when the blood supply to part of your brain is interrupted or severely reduced, depriving brain tissue of oxygen and nutrients. Within minutes, brain cells begin to die.

A stroke is a medical emergency. Prompt treatment is crucial. Early action can minimize brain damage and potential complications.

- Check your blood pressure regularly. Maintain levels below 130 Systolic and 80 Diastolic
- Exercise regularly. Regular yoga or 45 minutes of walking could help keep you in good health
- Exercise your mind with meditation, Puzzles, Sudoku
- Restrict excess Salt and Sugar in your diet. "Moderation" in diet is the key to good health
- Eat bananas, they help protect your brain
- Fish / fish oils are excellent dietary sources for the brain
- Avoid smoking and alcohol. They could do so much of damage to the brain
- Do not ignore subtle weakness / sensory disturbances, they could be a precursor to a big stroke



Dr. Shirish M. Hastak
Consultant - Neurologist,
Group Director Neurology & Stroke,
Wockhardt Hospitals

MESSAGE FROM THE EDITOR



Medicine is advancing rapidly and as a Clinician it is extremely important to be on top of all the latest new developments. At Wockhardt hospitals we are well aware of this and it is our endeavour to support our Clinicians in whatever way we can. We have subscribed to “Up to date” a collection of all the important journals in each speciality. The response of our Clinicians to this has been excellent. During the Advisory Board meetings we have now introduced a session on discussion of cases from the latest journals too.

We celebrated International Nursing Day across all locations wherein we as a Group acknowledged the commitment and dedication of our nursing associates. At Wockhardt hospitals we believe Nursing has a very important role to play in the delivery of Quality healthcare and we have empowered our Nursing associates 365*24*7 through our various initiatives such as the Nursing Leadership Program, the Buddy system initiative, the FON audits etc. A small token of appreciation was presented to our Nursing associates who completed 10 years with Wockhardt Hospitals.

We celebrated the “The Rapid Response Team i.e. RRT” awareness week wherein we reinforced to all our Clinical associates the importance of recognising the early warning signs of a patients clinical deterioration thus helping enhance our clinical outcomes. There was a poster competition, quiz competition and RRT simulation drills at the Nursing stations. The participation of Staff was commendable and it demonstrates and reinforces that at Wockhardt Hospitals we do everything we can to ensure Life Wins Always.

Dr. Clive Fernandes
Group Clinical Director,
Wockhardt Group Hospitals

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Disclaimer: "It is to be noted that the treatments being discussed above are informative in nature and case to case specific. Hence it should not be treated as medical advice. Readers are advised to consult clinicians before making any informed view or decision in this regard."