

ILS TIMES

SALT LAKE • DUMDUM • HOWRAH • AGARTALA

“ People grow but institutions grow bigger .

This one line defines the true essence of ILS which started its services as Institute of Laparoscopic Surgery in the year 2000 July 10th with a humble 8 bedded set up under the leadership of Dr.Om Tantia with support of Dr Aruna Tantia and Dr. Ghanshyam Goyal .

Ever since, there was no looking back as the institution grew first to 3 floors and then quickly needed the whole building "Jeewansatya" to expand its operations followed by the group's other ventures in Agartala, DumDum and Howrah .

The services followed the addition of several stars who



Dr. Poonam Kapoor

MBBS, MD(PTH) BHU
Consultant Histopathologist,
ILS Hospitals
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make the spirit of ILS in the form of leaders in Surgery, Gastroenterology, Critical Care, GynaeObs, Orthopaedics, Urology and other services including Renal Transplant and Neuro Surgery.

The lab services are being challenged with various difficult cases daily and is processing almost 40 Histopathology samples per day with ample support of very good Radiology and the best diagnostic services in-house for the doctors and patients.

The parallel growth of academics has been the biggest achievement of ILS group of Hospitals and Fnb in Laparoscopic Surgery/Bariatric Surgery along with a very active research based Department of Diabetes which has been churning out research and trials on a regular basis and are shining examples of a very evolved academic forum in our institution.

This newsletter embodies the

academic character of our institution and now, with contributions from our very able faculty would enrich us with their experiences and it would keep us updated about the new and happening issues in their branches of expertise.

I hope you enjoy going through this issue. I would welcome suggestions and more articles for our future newsletters. Also welcome are suggestions and ideas for making this beginning better and improving the newsletter and its content.

As they say famously... glory is all yours and errors are mine, needing all your help to iron out the errors in future .

Your Truly ,

Dr. Poonam Kapoor



Destiny's Child – Life's Second Innings

The only thing predictable about life is "Its Unpredictability"



Dr. Devraj Roy

(General Surgeon)
ILS Hospitals, Dumdum

How true it is - life can be so unpredictable, one minute, everything is so good and then suddenly the next minute, in a snap of a finger, everything turns topsy turvy and you never know what's coming next. Human destiny is bound to remain a gamble, because at some unpredictable time and in some unforeseeable manner nature will strike back. Our life is helmed by the entity called "Fate".

All these words, appeared to me like spiritual fundas in the yesteryears, until some real-life experiences during my practice as a surgeon in the past few years forced me to believe in 'Fate & Destiny'. These three real-life incidences of patients presenting in ILS Hospitals Dumdum, in the past 4 years will make you believe too, about life's unpredictability on one hand and the beauty of medical science on the other - snatching life from the jaws of death.

Kaboom

8:30 am, 2nd October, 2018, a perfect morning on a national holiday, with people thronging the bazaar, in the neighborhood. The sound of screeching tyres, honking of horns and babbling of the masses was suddenly pierced by a deafening sound of "BOOOOM" halting everyone in their places. Was it a bomb or a gas cylinder bursting? I was about to visit the bazaar myself, when, within few minutes of the mayhem, I got a call from the emergency. I rushed to the emergency to find the entire area filled with injured patients and our medical staff. The floor was in a pool of blood. Among the injured was a 31-year-old female, drenched in blood and her lower abdomen was ripped open with almost the whole small intestine outside. There was a spurting blood vessel, like a small fountain, from within the abdomen. I just grabbed an artery forceps and clamped the bleeding vessel immediately and

covered the exposed gut. She had also sustained 2nd to 3rd degree burn over face, arms, abdomen and lower limbs. A quick verbal consent from the patient's relatives was taken and she was shifted to the operation theatre within minutes. Luckily our anesthetist, Dr Bipasa Dasgupta, was in the OT at that moment and we immediately took up the patient for Exploratory Laparotomy along with Dr. Binay Agarwal and Dr. Debduitta Banerjee.

The picture inside the abdomen was a surgeon's nightmare, a complete jigsaw puzzle. The peritoneal cavity was filled with almost 2-3 liters of blood mixed with mud and faecal matter not to mention food particles and shrapnels as well. The small intestine was completely in tatters with multiple perforations. At many places it was torn off through and

through with free pieces floating in the peritoneal cavity. Few rents were present in the large intestine too. Now the job of fixing these jigsaw puzzles started after ascertaining the anatomy. Massive resection of the small intestine was done (about 20cm) with end-to-end anastomosis and proximal loop ileostomy.

The next big challenge was the post op period and as expected it was stormy. But the care of our ITU team and the consultants of all the concerned departments could finally bring her out of this dicey situation. She was out of ventilator on the 3rd post-op day, received 4-5 units of blood and 8-10 units of FFP and was discharged on the 13th post-op day. Her loop ileostomy was closed after 3 months and at present she is leading a completely normal life.

"SHE WAS DESTINED TO LIVE"

Neurointervention -

A new department at ILS



Dr. Apratim Chatterjee,
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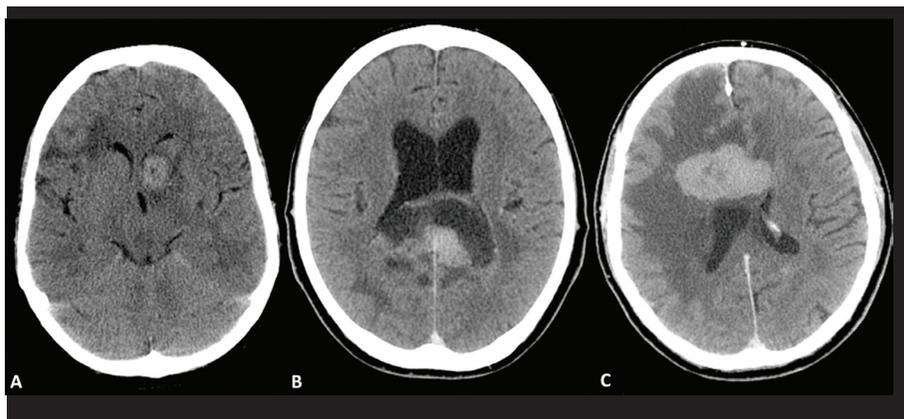
Neurovascular intervention is the field of neurology in which vascular procedures in brain and spinal cord are done by means of endovascular approach.

We at ILS hospitals have started Neurointerventional works where we are doing regular DSA, Carotid Stenting, Aneurysm Coiling for SAH. The beauty of the procedures lies in the magical outcome and early discharge if procedures go as per plan. We hope to develop this discipline with time and cater to neurovascular emergencies in this area.



Case Report : A Rare Case of Reversible

Cerebral Vasoconstriction Syndrome in a young female with Post-partum Cardiomyopathy



Patient after 7 days postpartum came to us with status Epilepticus.

Initially managed in Emergency department, CT showed parasagittal hypodensities and posterior watershed hypodensities. Urgent MRI with MRV was done to rule out CVT. Possibilities kept were:

1) PRES - initial vision loss followed by altered sensorium and seizure.

2) RCVS: No h/o thunderclap headache was odd.

Patient improved in GCS the next day, but had right sided complete hemiplegia.

A repeat CT was done, no fresh areas of involvement were found. However an infarct and diffusion restriction was unlikely in PRES.

Vasculitis profile, which came negative later, was sent keeping in mind the initial MRA revealed left sided beading appearance. However since she had this ongoing paresis, we decided to repeat the MRA again with contrast MRI in case we were missing an ADEM. Repeat MRA revealed bilateral gross increase of spasm in the cerebral vessels. With guarded prognosis, we started IVF almost @ 100 ml/hr and

Nimodipine for diagnosis of RCVS.

A differential of PACNS was kept, but in 1 day span such increase in PACNS was unlikely. Hence steroids were withheld. Added to this was the challenge of postpartum cardiomyopathy with an EF of 30% and use of diuretics was challenging keeping a balance between fluid overload and intra-vascular fluid depletion as we needed to give IVF in a higher dose to reverse the cerebral vasospasm.



Dr. Apratim Chatterjee,
Interventional Neurologist,
ILS Hospitals, Dumdum



Dr. Abhinjan Maji
(Panel Consultant, General Medicine)
ILS Hospitals, Dumdum



Patient recovered very well and was extubated. The EF also improved to 64% now and is planned for discharge after few turbulent in-admission courses. A mother was thus returned to her child with a smile and we are so so happy.

Geriatric Care – Need of Time

The branch of medicine concerned with the diagnosis, treatment and prevention of disease in older people and the problems specific to aging.



Dr. Yogesh Chandra
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Medical Superintendent
ILS Hospitals, Agartala

Why Geriatric Care is required

- The burden of morbidity in old age is enormous.
- Non-communicable diseases (life style related and degenerative) are extremely common in older people irrespective of socio-economic status.
- Disabilities are very frequent which affect the functionality in old age compromising the ability to pursue the activities of daily living.



Preventive measures for elderly

A. Screening

- Screening of elderly patients can be done in the outpatient department, with basic questions, on routine basis for early detection of functional limitations, social problems, cognitive disorders and geriatric syndromes.
- Any abnormality detected on screening requires further assessment with other scales and tests, e.g. depression scales, mental status examinations, etc.

B. Screening test for specific disease

- Screening tests have been advised by various committees for screening of elderly population to identify those, at risk of developing specific diseases.

C. Vaccination

- Elderly population is at a higher risk of acquiring pneumococcal infection, influenza and shingles. Centre for the Disease Control and Prevention has recommended following vaccines for elderly population:-
 1. Influenza
 2. Tetanus, diphtheria, pertussis
 3. Zoster
 4. Pneumococcus – pneumococcal 13 valent conjugate vaccine (PCV 13) and pneumococcal 23 valent polysaccharide vaccine (PPSV 23) are recommended.

How to Prepare for a Blood Test

“Right Patient Preparation And A Correct Diagnosis Is Three Fourths The Remedy”

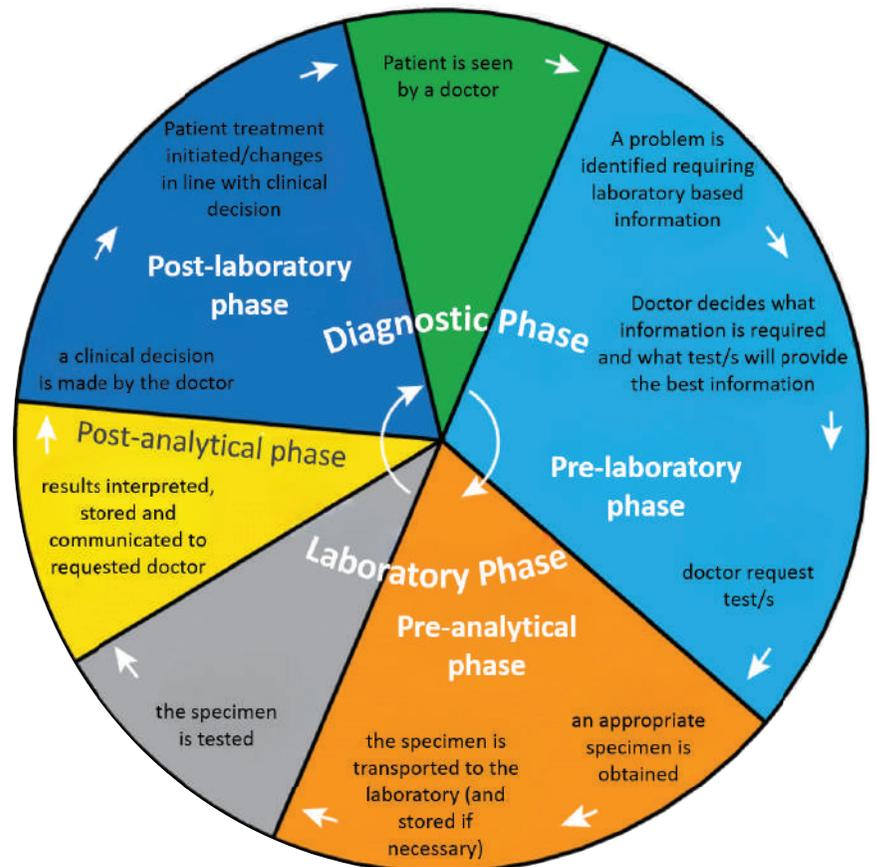


Dr. Anumita Pushilal

(MBBS, MD, PGDHHM)

Consultant Biochemist and Quality Head,
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In this era of evidence-based medicine, a good quality, error free report having accuracy and precision is very essential. Hence, we must know - how to prepare for a blood test - as right preparation will give us the most appropriate result - which helps clinicians to diagnose correctly and thereafter treat a patient.



Pre-examination or the Preanalytical phase

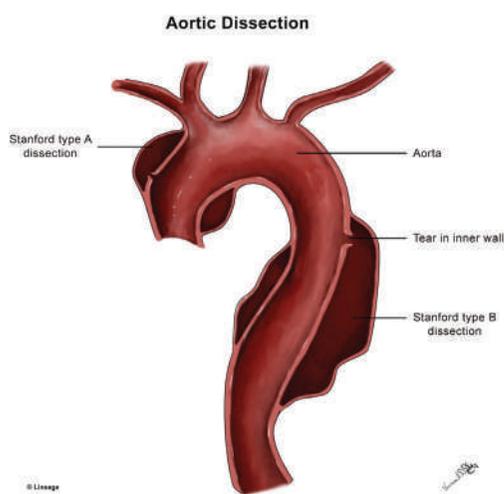
Examination or the Analytical phase

Post- examination or the Postanalytical phase

Few points to remember before going for a blood test:

- Do not take alcohol, cigarettes or tobacco before any test. There are certain parameters whose concentration vary with these factors.
- Overnight 8 - 10 hours fasting for estimating fasting blood glucose and 10 - 12 hours fasting for lipid profile test. For PP blood sugar, 2 hours to be calculated from the starting of a meal.
- Avoid red meat, beetroot for at least 2 days before going for stool occult blood test.
- Always give urine samples before starting any antibiotics if UTI is suspected. For routine urine and culture - first morning mid-stream urine sample is necessary.
- For semen analysis, sample to be given after 3 days of abstinence.
- Hormone assay to be done at a fixed time (either morning or evening). Certain common drugs like Domperidon increases the Prolactin level and OCPS increase the Thyroid Hormone level.
- Inform history of any drug intake to the phlebotomist.
- Avoid any kind of stress, as it increases the production of cortisol and other hormones.

Case report



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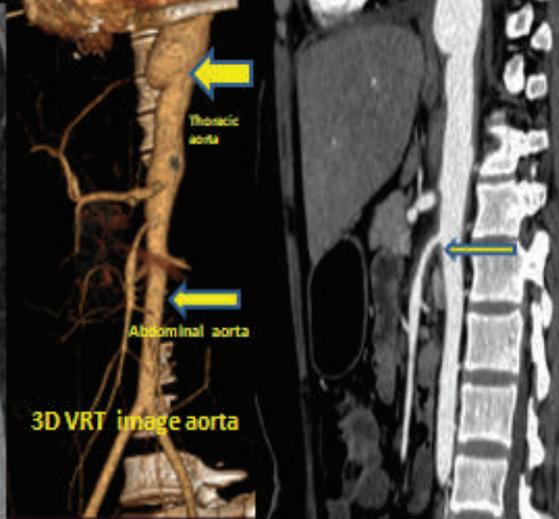
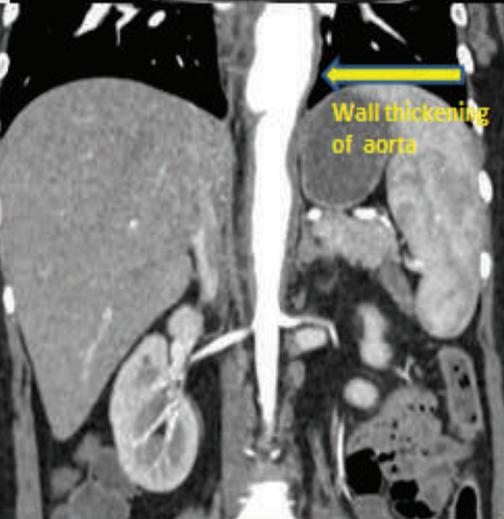
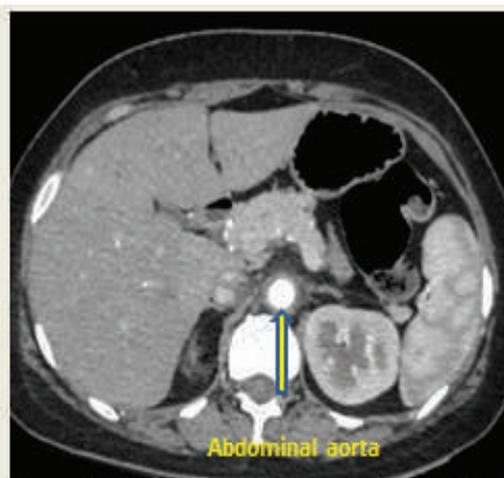
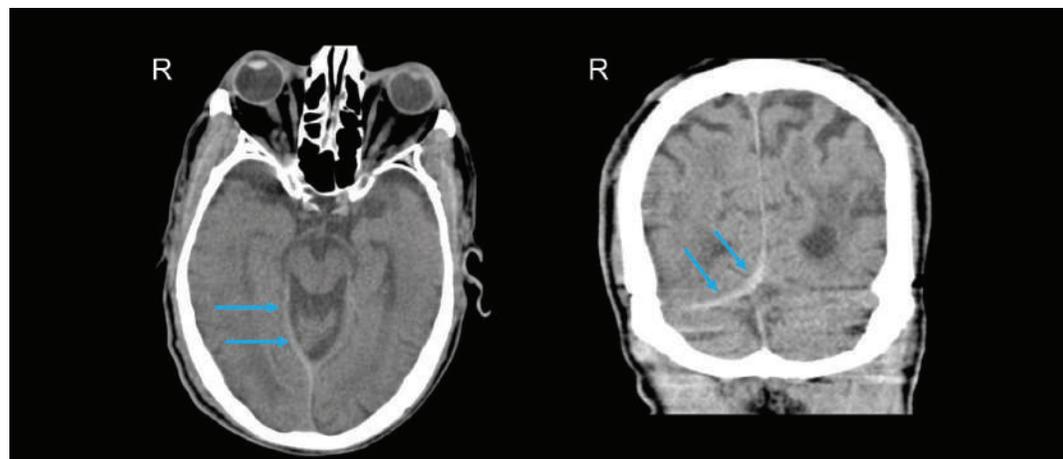
Clinical History & Imaging Findings:

23 year old female patient admitted to ER department of ILS Howrah with recurrent history of abdominal pain. She had history of exposure to pulmonary Kochs.

On clinical examination she was having right iliac fossa tenderness.

Urgent USG abdomen was advised which did not reveal any abdominal mass / or inflamed appendix in the lower abdomen. Ruptured ectopic and ovarian torsion was also ruled out.

To investigate further, contrast enhanced CT abdomen was done which revealed long segment concentric wall thickening of abdominal aorta with luminal narrowing (almost >50% luminal narrowing compared to thoracic aorta). Superior mesenteric artery was also showing similar wall thickening and surrounding inflammatory changes.



Conclusion:

In a young patient with concentric wall thickening, involving abdominal aorta and superior mesenteric artery associated with inflammatory changes may be suggestive of Aortoarteritis (Differential diagnosis : Takayasu and Giant cell arteritis)

Takayasu Arteritis (Pulse less disease)

- Predilection for young women (>80% of cases)
- More common in females of Asian origin, Takayasu arteritis is thought to be secondary to an autoimmune process
- It is associated with mycobacterial infection (tuberculosis), with occurrence after streptococcal infections, and with rheumatoid arthritis
- Treatment is generally with high-dose glucocorticoids

Giant cell Arteritis (GCA)

- Aortic involvement occurs in 15% of GCA patients
- GCA is rarely diagnosed in patients less than 50 years of age

A review article on Endotracheal Intubation in ICU & ER



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Difficult intubations are common in the Intensive Care Unit (ICU), emergency department (ED) and pre hospital settings, with the incidence ranging between 8% and 13%.[1-5] The All India Difficult Airway Association (AIDAA), therefore, developed guidelines to provide a stepwise approach to Tracheal Intubation (TI) in the ICU with the goal of improving safety and outcomes in ICU patients.

AIDAA 2016 Guidelines for Tracheal Intubation in the Intensive Care Unit

STEP 1 : Preoxygenation and induction of anaesthesia

- Two persons (one experienced)
- Optimize preoxygenation with one of the following:
 - Noninvasive ventilation with 100% O₂, pressure support of 5-15 cm. H₂O with PEEP of 5 cm H₂O for 3 minutes (nasal cannula with O₂ flow at 15 L/min)
 - HFNC O₂ therapy
- Induction - Etomidate or Ketamine with Succinylcholine (if not contraindicated) or Rocuronium
- Use cricoid pressure
- IPPV with hag-valve mask with reservoir bag (use external PEEP valve set to 5-10 cm H₂O if available) / IPPV with PEEP using the ventilator



STEP 2 : Laryngoscopy and tracheal intubation

- Continue nasal oxygen using O₂ flow at 15 L/min OR HFNC O₂
- Direct / Video Laryngoscopy
- Maximum two attempts (repeat attempts only if SpO₂ ≥ 95%)
- Mask ventilation between attempts
- Optimise position, use external laryngeal manipulation, release cricoid pressure, use bougie / stylet if required
- Consider changing device / technique / operator between attempts
- Maintain depth of anaesthesia

Succeed

Confirm tracheal intubation using capnography

Failed Intubation

Call for help



Secretory Carcinoma Of The Breast, Commonly Exhibits The Features Of Low Grade, Triple Negative Breast Carcinoma- A Case Report With Updated Review Of Literature



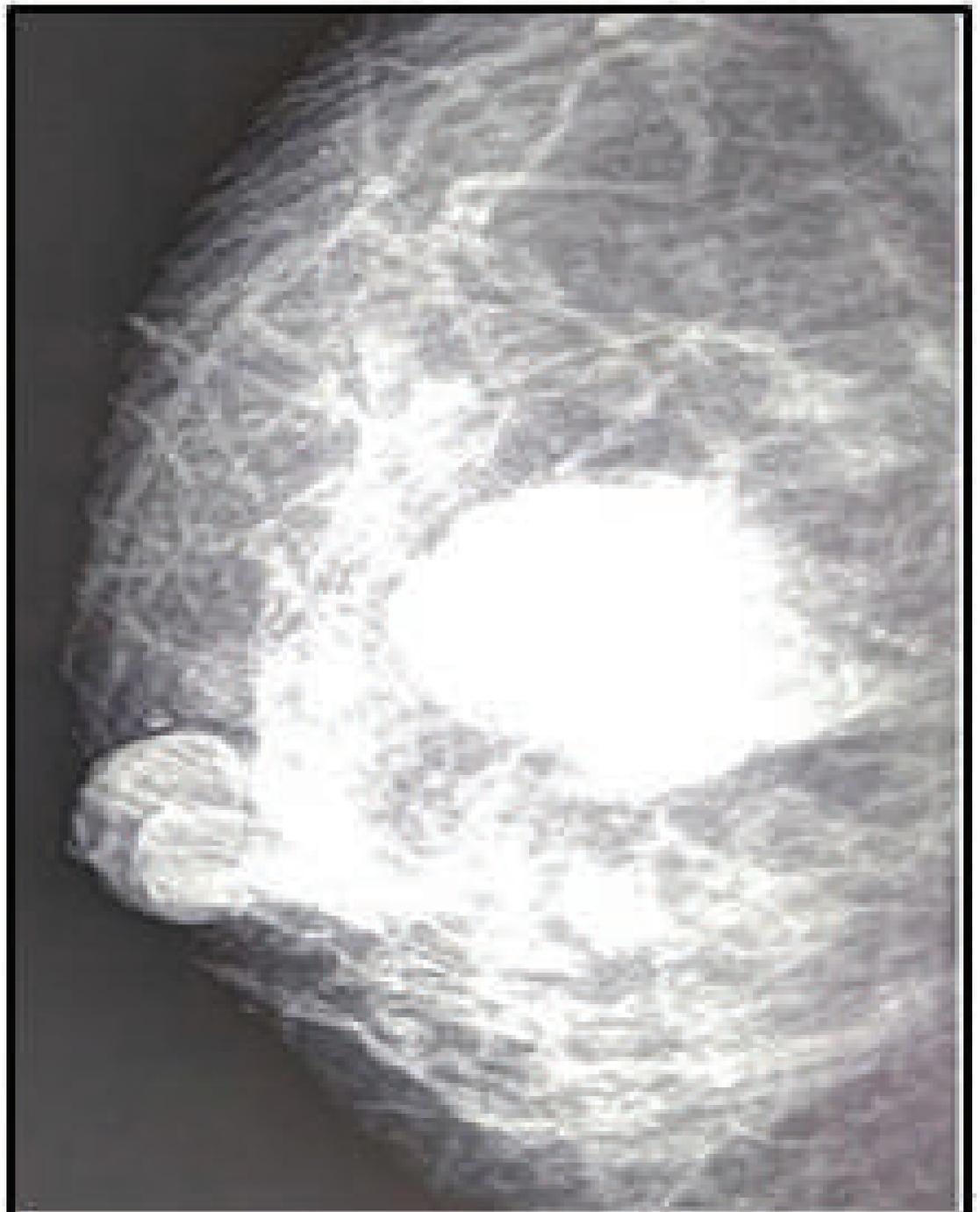
Dr. Nirmalya Banerjee

DNB, MD (Pathology),

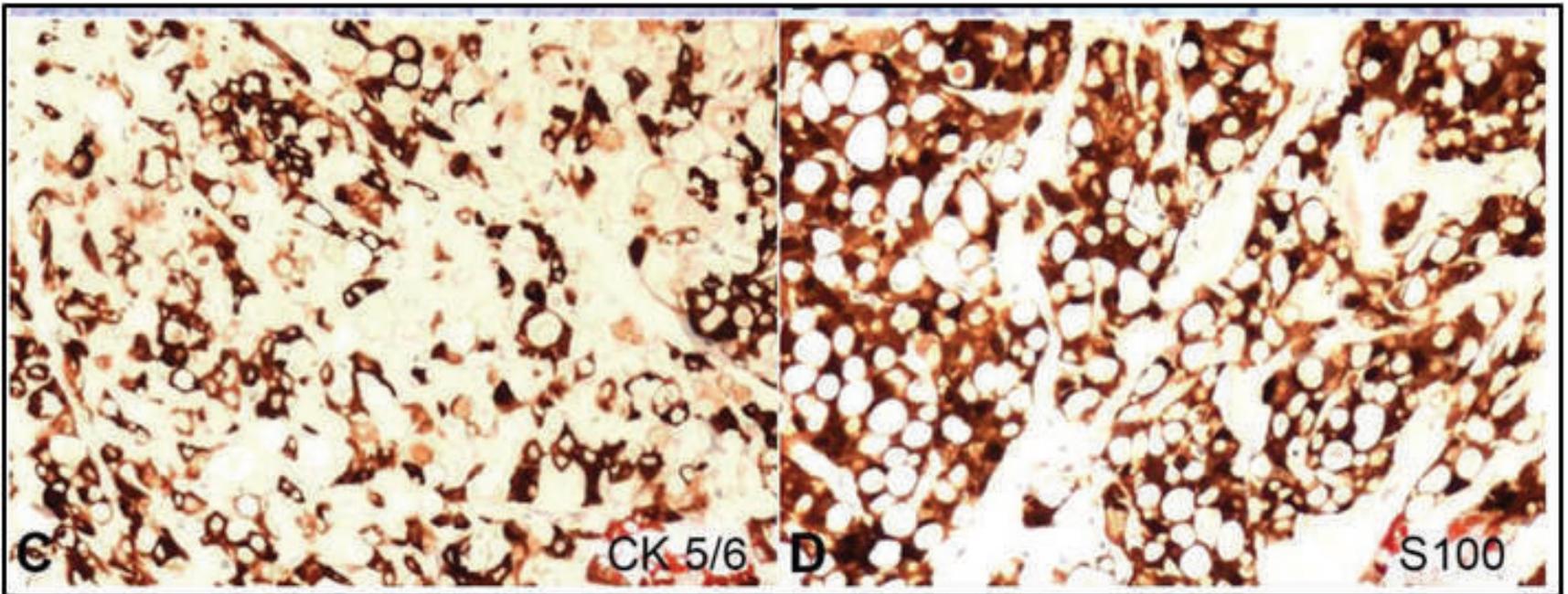
DM (Histopathology), PGIMER (Chandigarh)

Secretory carcinoma of the breast (SBC) is a rare breast neoplasm. Most of the patients present at an early stage with a relatively indolent clinical course. Lymph node and distant metastasis are also very infrequent. The histomorphological features of the secretory breast carcinoma are quite characteristic. Predominantly three histological patterns, solid, microcystic, and tubular, have been noted with copious amounts of intra and extracellular secretory material. Most commonly, no positivity for estrogen receptor (ER), progesterone receptor (PR) and ERBB2(HER2/neu) is observed in SBCs. As SBC can occasionally be hormone receptor-positive, they should not be categorized in the triple-negative breast carcinoma (TNBC) group in general. A very characteristic genetic translocation t(12;15) has been noted in this rare tumor, resulting in a fusion between ETV6 and NTRK3 proteins. We present a case of a 60-year-old lady who presented with right breast lump of 1-month duration and was managed by lumpectomy and sentinel lymph node dissection. Axillary dissection was not performed because the sentinel lymph node biopsy was negative.

Postoperative radiotherapy was given to the right breast with a boost to the tumor bed. No adjuvant chemotherapy was given, no recurrence has been noted even after a year of the completion of treatment.

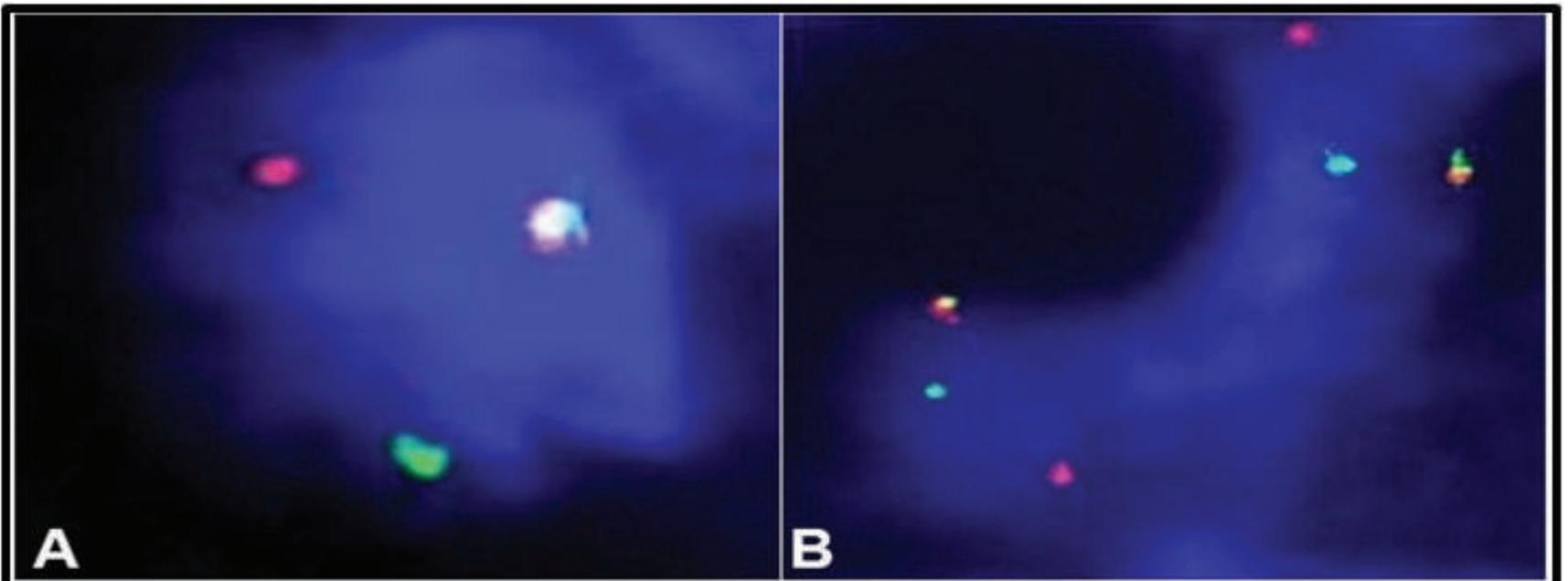


Mammography and photomicrographs of the aspiration smears. Well defined, sub-areolar, radio-opaque lesion within the breast



C - Diffuse membranous and cytoplasmic positivity for cytokeratin 5/6 (400X);

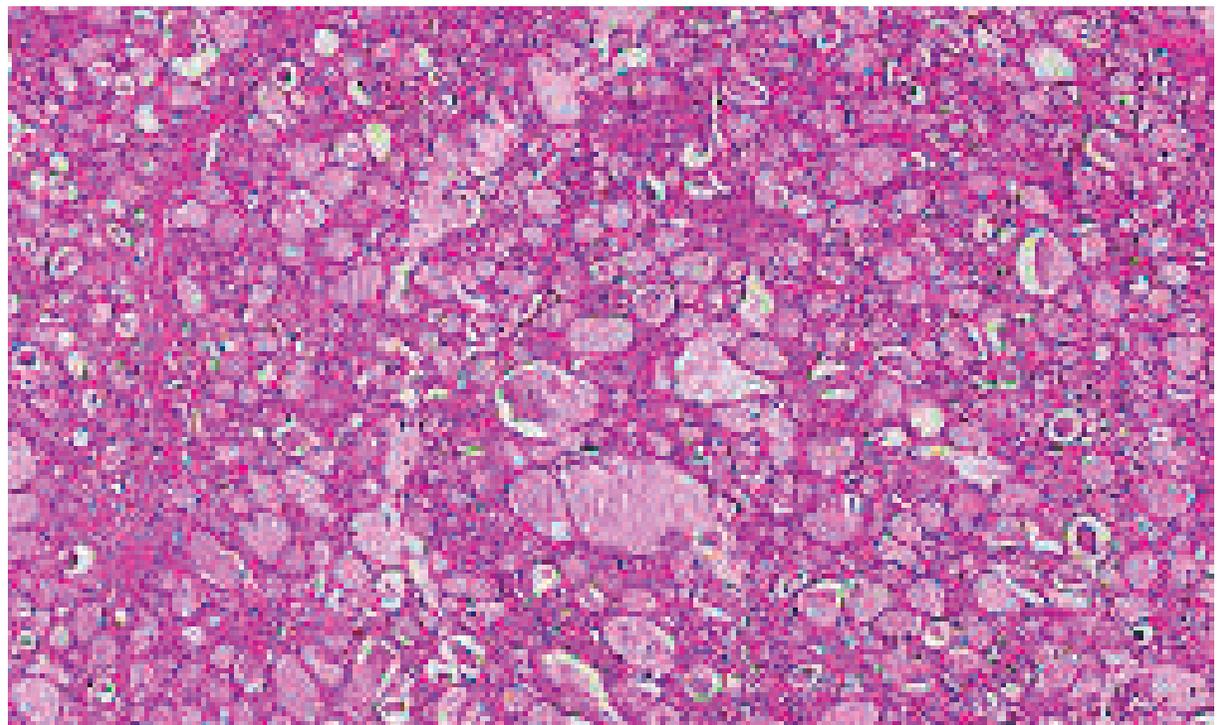
D - Diffuse membranous and cytoplasmic positivity for S100-P (400X).



A - FISH analysis by dual-color break apart ETV6 probe. One fusion signal (red/green/yellow; arrowed) and one split (rearrangement) signal in the nucleus (400X);

B - FISH analysis by dual-color break apart NTRK3 probe. Two fusion signal (red/green/yellow; arrowed) and two splits (rearrangement) signal in the nucleus (100X).

Secretory breast carcinoma is an uncommon, triple-negative breast tumor with a favorable clinical course. Radiologically, this tumor closely mimics fibroadenoma and other benign breast lesions. The morphology and genetic translocation of this tumor are also quite characteristic. There are no consensus guideline recommendations for the treatment of SBCs. Due to the indolent and slow-growing nature of this tumor, most recurrences are seen between 10-20 years after the initial presentation. Therefore, all the patients irrespective of their age demand long term follow-up.



New Gems In Our Family Of ILS Hospitals



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Celebrating 22 Years' Foundation Day of ILS Hospitals

ILS Hospitals is the pioneer institute of Laparoscopic Surgery in Eastern India, completed 22 successful years of service of mankind. On 10th July 2022 ILS Hospitals celebrated with all its glory and pomp as the foundation day of ILS Hospitals and birthday of our beloved doctor Sir, Dr. Om Tantia (Medical Director & Head) with the group of three units, Salt Lake, Dumdum and Howrah consistently in the gracious presence of our Chairman D. P. Tantia, Dr. G. S. Goyal, Mr. Atul Tantia, Mr. Anurag Tantia, Mrs. Kriti Tantia and all other members of Team ILS. The program started with Saraswati Vandana and the evening became delightful with the cultural programs like, dances, songs and drama in which 100 members (doctors and staffs) of our Team ILS participated and showed their amazing talent. This evening became more flourished with the cake cutting ceremony and song of Dr. Sir and ended with Bhangra dance.

We are proud to celebrate this 22nd Foundation Day of ILS Hospitals through a gathering of 400 people.



