A Newsletter of ILS Hospitals

ILS TIMES

Facts & Experience about Ankylosing Spondylitis

Unraveling the Mysteries of Childhood Polyuria and Polydipsia

Management of Urogenital Fistula

Surgical Gastroenterology A Journey to Recovery

VOLUME 4 | ISSUE 1 | JANUARY 2024

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SALT LAKE
DUMDUM
HOWRAH
AGARTALA

ILS HOSPITALS

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Foreward by Managing Director

Dr. Om Tantia

Dear Readers,

I take this opportunity to wish all the readers a very **Happy and Prosperous New Year 2024 !**

I am sure by now you must have read the earlier volume of ILS Times that highlighted GPT Healthcare's expansion and upgradation of facilities. You will be happy to know that in the last two months, ILS has further improved its services and facilities to provide international level healthcare not only to patients in Eastern India but also to Raipur and Chhattisgarh.

Our commitment is to have a team of dedicated doctors, nurses and paramedical staff of high standard who with the help of the latest diagnostic and other equipment, will offer physical, mental and human healthcare and treatment at an affordable cost.

Our Centre has always been a pioneer in providing superior quality care to our patients.

Continuing our pursuit for excellence, it gives me immense pleasure to share with you that our Institute has completed 250+ Robotic Surgeries and thereby taking the surgical excellence to the next level.

We are committed to our philosophy of providing world class facilities so that patients can enjoy the treatment.

This issue of ILS Times gives you an insight into the latest innovations and techniques that have been implemented for holistic treatment of patients.

Best regards,

Dr. Om Tantia

Managing Director, ILS Hospitals

EDITOR'S NOTE
Welcome to the 4th Edition of ILS Times !

Dr. Poonam Kapoor
HOD – Department of Pathology
ILS Hospitals

As we greet the new year with anticipation and optimism, I wish each of you and loved ones good health and cheerful tidings. This month's ILS Times has some interesting cases and stories from all our group hospitals in Kolkata, Howrah and Agartala.

An incredible story covered in this issue is the case of a 34 year old young female patient presented with features of septic shock after a laparoscopic cholecystectomy done at a local hospital at Howrah. Miraculously, with conservative management followed by redo of exploratory Laparotomy at **ILS Hospitals Howrah**, she is finally back on her feet with clinically & emotionally stable condition.

Another unique story from **ILS Hospitals Dumdum** is the case of a 12 year old boy diagnosed with Nephronophthisis – a rare autosomal recessive kidney disease in children. Our case report highlights the significance of early recognition of often-neglected symptoms like polyuria and polydipsia in childhood, as they may be indicative of underlying genetic disorders such as Nephronophthisis.

You will also find an inspiring story of an aged female from **ILS Hospitals Agartala** who was admitted in the ICU with complains of sudden onset of descending paralysis. The present case describes the successful management of an atypical Guillain-Barre Syndrome (GBS) using a multidimensional approach. More stories featured in the newsletter include the case of a middle-aged man who was suffering from Ankylosing Spondylitis and could barely carry on his daily activities or walk. Total Hip Replacement for both the hips were successfully done at **ILS Hospitals Saltlake** and this young man could stand without support the very next day of surgery. It was miraculous to see him walk with stride and a confident smile just couple of weeks after the surgery.

ILS hospitals further grew its presence enabling us to serve many more patients than ever before, launch several new clinical programmes, enhance service delivery and augment medical technology across locations. We have reached each of these milestones without ever wavering from our core values. As a group, it has always been a constant endeavour to push the frontier of care and offer healthcare services of global standards to our patrons.

I, on behalf of the editorial team, wish to thank all the contributors of this newsletter. We hope to receive the same support in future as well. If you have any stories which you think is ideal for the newsletter do share it with us through email at info@ilshospitals.com

Stay Healthy, Stay Happy!

ILS TIMES // A Newsletter of ILS Hospitals | Volume 4, Issue 1, 2024

Ischio Rectal Abscess Evolving Into Peritonitis – Atypical Presentation And Its Management

Dr. Om Tantia Dr. Tamonas Chaudhuri Dr. Shashi Khanna

CASE REPORT

A 34 year old male presented with complaints of pain abdomen and fever for 5 days duration. On examination, patient appeared toxic, dehydrated, abdomen revealed tenderness and guarding in lower abdomen raising the suspicion of peritonitis due to burst appendix.

Radiological investigations revealed – intraperitoneal and minimal retro peritoneal collections.

Patient taken for emergency dianostic laparoscopy, pus drained, lavage done, drain placed.

Post operative period patient had persistent high grade fever and also complained of perianal pain and flank pain on 2nd post operative day. Examination revealed echymosis of right flank with subcutaneous edema and crepitations. Digital rectal examination revealed indurated bilateral ischio rectal fossa. Patient managed with incision drainage and debridement of anterior, right lateral abdomonal wall and bilateral ischio rectal fossa. Patient improved, fever spikes settled. Further managed with regular dressing and vacuum assisted closure. Patient discharged on post operative 14th day in stable condition with healthy healing wound after secondary suturing of abdominal wound without any sign and symptoms of sepsis.

Ischio rectal abscess presenting with abdominal symptoms is very rare. Initial diagnosis is very difficult in such special scenario and needs high degree of suspicion. This unusual presentation of ischio rectal abscess is rare and challenging to manage.

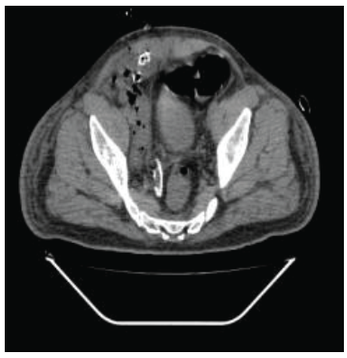


Fig 1: CT image showing intraperitoneal and retro peritoneal collections.

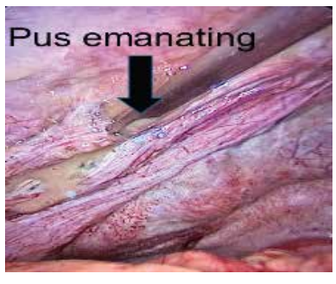


Fig 2: Diagnostic laparoscopy revealed normal appendix with pus emanating from anterior abdominal wall.

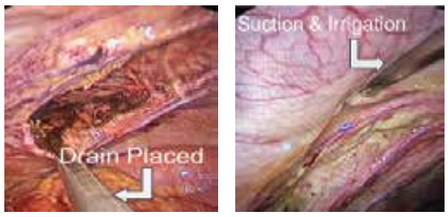


Fig 3: Suction irrigation of abscess cavity and placement of drain in anterior abdominal wall.

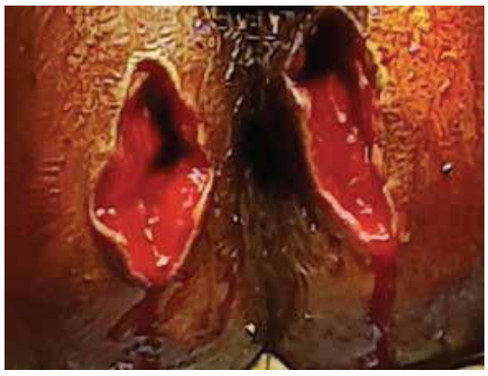


Fig 4: Incision and drainage of bilateral ischio rectal abscess.

Fig 5: Vaccum assisted closure of abdominal wound.

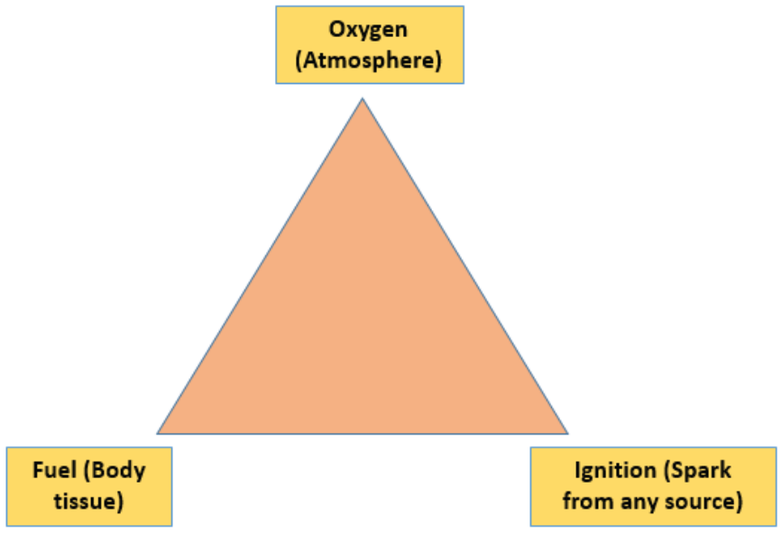
Fig 6: Healing wound

Pre Hospital Management of Burn

In case of burn emergency, care in initial few hours determines the outcome.

FIRE ELEMENTS

Dr. Abhishek Mandal
MBBS, MS (General Surgery),
FNB Trainee (MAS)
ILS Hospitals Salt Lake

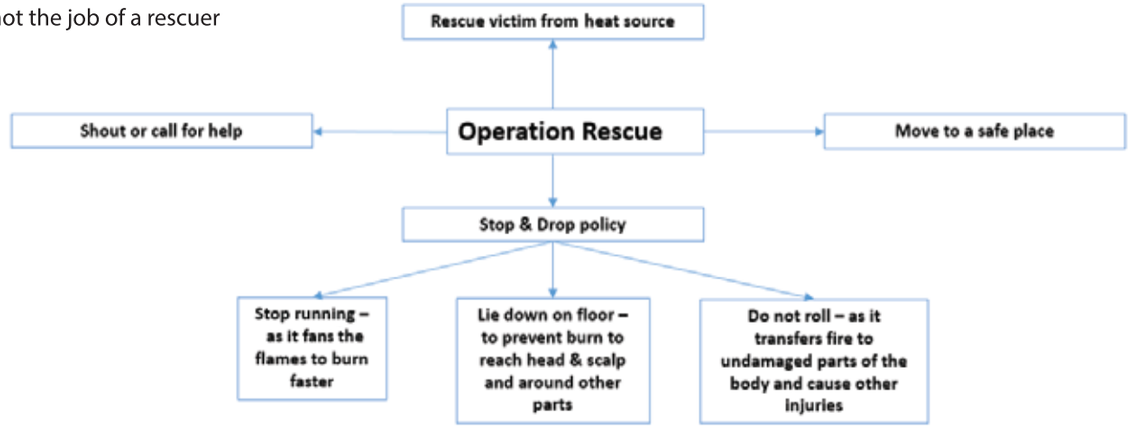


Elimination of any of these three will prevent / extinguish fire

On-site management constitutes major part of First Aid. It begins at scene of fire and concludes when hospital care is obtained. The two key elements of on-site management are:

(i) Do not become a "VICTIM" &

(ii) "FIRE FIGHTING" is not the job of a rescuer



If a Lot of Smoke is There with Fire, Then:

- Rescuer ties a rope around waist for own safety
- Crawl on floor
- Breathe through wet handkerchief

Cooling of the Burns:

Continuous cooling required for first 10 minutes, as it

- Dissipates heat
- Reduces pain
- Delays onset of edema / swelling
- Minimizes extent of burn edema
- Decrease Histamine release from skin

Caution to Maintain for Major Burns in Infants, Young Children, Adults:

Prolonged cooling leads to Hypothermia, shivering & cardiac complications -Do not use Ice / ice cold water

After Fire Extinguishes:

- Remove burnt clothes
- Remove all ornaments / rings around fingers and toes
- Be a rescuer and do not become a burn specialist
- Do not break blisters
- Do not apply anything over burn wound like creams, lotions, toothpaste, butter etc.
- Prevent contamination by wrapping burned areas by clean cloth / sheet / plastic bag
- Recognize other injuries
- Shift the victim to hospital as early as possible

Unraveling the Mysteries of Childhood Polyuria and Polydipsia: A Case of Senior Loken Syndrome

Dr. Pratim Sengupta
MBBS, MD (Medicine), DM (Nephrology)
Consultant Nephrologist
ILS Hospitals Dumdum

CASE REPORT

A 12 year old boy had been experiencing loss of appetite, nausea, and lethargy for the past 2-3 weeks and was admitted at ILS Hospitals Dumdum for further management. He was also experiencing pain in his lower limbs with gait instability. He was an active child and had achieved all developmental milestones, but he used to fall frequently while playing outdoor games and often complained of pain in his legs. Upon examination, he appeared afebrile, with signs of pallor. The neurological evaluation showed nystagmus of both eyes, verbal and motor response was normal and there was a gait instability. Examination of the fundi showed narrowing of the retinal arterioles and waxy pallor of optic discs. There were no previous instances of oliguria, hematuria, edema, headaches, or hearing issues in the past. There was no history of urinary incontinence or recurrent urinary infections. Additionally, there was no history of chest pain, palpitations, syncope, or seizures. He had an elder sister who had no history of renal disease. The only notable history we found was the frequent urge to drink water. He used to drink 10-14 glasses of water a day from childhood and had an increased frequency of micturition, sometimes even every hour and also at night. Surprisingly, we discovered that his serum creatinine was 8.19 mg dl-1, with urea at 90.75 mg dl-1 and hemoglobin at 6.1 gm l-1. Potassium registered at 5.1 mmol L-1 and sodium at 142 mmol L-1. Follow-up ultrasonography of the abdomen revealed bilateral hypo dysplastic kidneys with a loss of corticomedullary differentiation, other organs were normal. His symptoms of anorexia aggravated hence we had to put him on hemodialysis through the right femoral catheter. A renal biopsy could not be done as the kidneys were shrunken and fibrosis. He further developed high blood pressure which was managed by calcium channel blockers. After taking 4 sessions, he was shifted to peritoneal dialysis (PD). A few days down the line, he further developed peritonitis and was treated with intravenous antibiotics. A doctor's review board was called and the case was discussed. A diagnosis of Nephronophthisis type 4, Senior Loken syndrome was made. The boy was advised for a living donor renal transplantation as that was the best modality of treatment for him considering his age. One of his distant aunt, with matching blood group, agreed to donate her kidney to him. During the post-transplant recovery phase, the patient's progress was uneventful. Follow-up ultrasound showed good pole-to-pole flow with a normal resistive index in the transplant kidney artery and Hilar artery. The boy gradually improved and was passing more than 3 liters of urine per day.

DISCUSSION & CONCLUSION:

Nephronophthisis (NPH) is an autosomal recessive kidney disease that is one of the common causes of End Stage Renal Disease in children, accounting for approximately 15% of ESRD cases in children worldwide. NPH is known to be caused by mutation of more than 20 genes. They produce proteins that are expressed in the centrosomes or primary cilia of renal epithelial cells. Our case report highlights the significance of early recognition of often neglected symptoms like polyuria and polydipsia in childhood, as they may be indicative of underlying genetic disorders such as Nephronophthisis (NPH). NPHP4 mutations (Senior-Loken Syndrome) can result in juvenile-onset NPH with retino-renal involvement. Genetic testing is essential for early diagnosis, as renal ultrasound may not detect the disease in its early stages. While there is no definitive cure for NPH, supportive care is crucial to delay CKD progression and manage complications. Kidney transplantation remains the most effective treatment for NPH patients who progress to end-stage renal disease as the disease does not recur after transplantation.

Prompt identification, genetic testing, and proper intervention are crucial for delivering the best possible care to individuals diagnosed with Nephronophthisis.

Enhancing awareness among paediatricians, primary care physicians, and parents regarding the importance of these symptoms can result in early diagnosis and improved outcomes.

Facts & Experience about Ankylosing Spondylitis

Dr. Siddharth Gupta
MBBS, MS (Orthopaedics)
Consultant Orthopaedic &
Joint Replacement
ILS Hospitals

CASE REPORT

A 42 year old man presented with complaint of gradually progressive low back pain since 10 years, associated with stiffness and deformity of the spine and hip. Patient could barely carry on his daily activities or walk with assistance for a few steps. He was a young man, with an ardent wish to carry on with his life with physical independence.
When he came to my clinic, his

spine and both hips were fused with no movement at all. Total Hip Replacement for both the hips were planned so that the mobility of hips increases, thus allowing him to walk freely. The planned surgery was successful and this young gentleman could stand without support the very next day of surgery. It was miraculous to see him walk with stride and a confident smile just couple of weeks after the surgery.
"After ten years of being home-bound during Pujas, his wish to go pandal-hopping with his friends finally came true."

ABOUT ANKYLOSING SPONDYLITIS:

Ankylosing spondylitis is a form of arthritis that primarily affects the spine, although other joints including hips and knees become involved. It causes inflammation of the spinal joints (vertebrae) that can lead to severe, chronic pain and discomfort. In more advanced cases this inflammation can lead to ankylosis — new bone formation in the spine — causing sections of the spine to fuse in a fixed, immobile position. It can also cause inflammation, pain, and stiffness in other areas of the body such as the shoulders, hips, ribs, heels, and small joints of the hands and feet. Sometimes the eyes can become involved (known as iritis or uveitis), and — rarely — the lungs and heart can be affected.

"Ankylosing Spondylitis can be debilitating and, in some cases, lead to disability" It is important to note that the course of ankylosing spondylitis (AS) varies greatly from person to person. Although symptoms usually start to appear in late adolescence or early adulthood (ages 17 to 45), symptoms can occur in children or much later in life.
Though the exact cause of Ankylosing Spondylitis is unknown, we do know that genetics play a key role in the disease.

WHO IS AT RISK?

The risk factors that predispose a person to AS include:

- Testing positive for the HLA-B27 marker
- A family history of AS
- Frequent gastrointestinal infections
- Unlike other forms of arthritis and rheumatic diseases, general onset of Ankylosing Spondylitis commonly occurs in younger people, between the ages of 17 and 45. However, it can also affect children and those who are much older.

"Ankylosing Spondylitis can be debilitating and, in some cases, lead to disability"

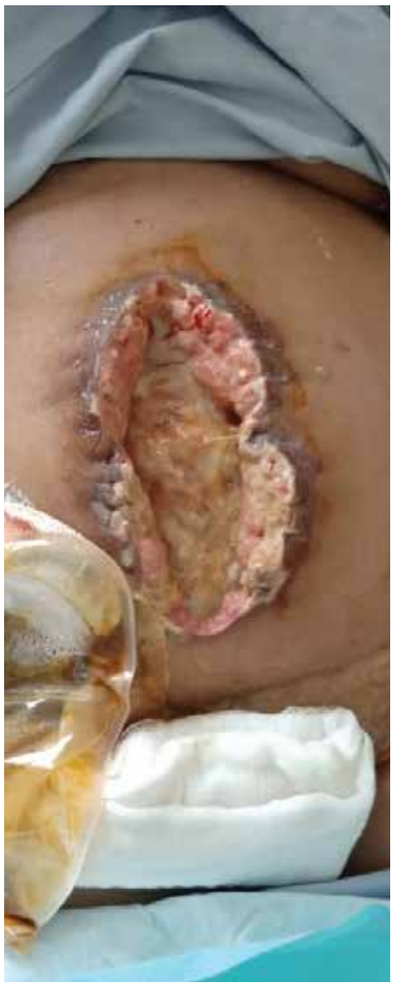
Surgical Gastroenterology – A Journey To Recovery

Dr. Santanu Sarkar
MBBS, MS (Surgery),
FIAGES, FMAS
Consultant General &
Laparoscopic Surgery
ILS Hospitals Howrah

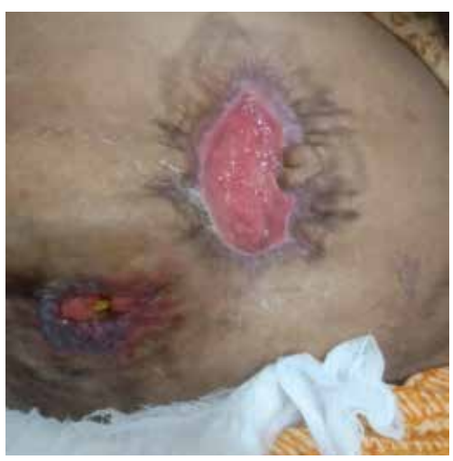
Authors: Dr.Santanu Sarkar, Consultant Surgeon, Dr.(Col.)Shubhojeet Chatterjee, Consultant Anaesthesiologist, Dr. Ruchi Roumya Das, Consultant Critical care

CASE REPORT:

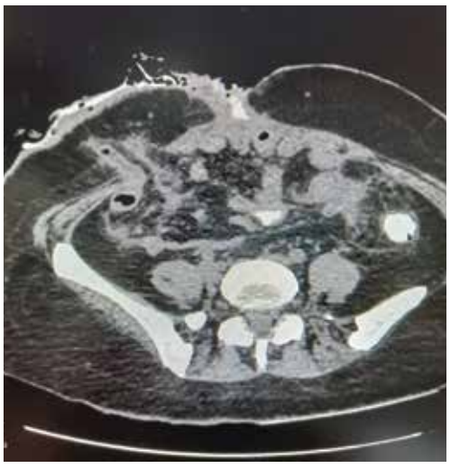
We received ahaemodynamically unstable 34 year old young female patient with features of septic shock on 3rd week of April'23 at ILS Hospitals Howrah. Past h/o laparoscopic cholecystectomy for calculus cholecystitis & resection of ovarian endometriotic cyst on 1st week of April'23 and on 4th post-operative day patient developed marked abdomin al distension and features of peritonitis, which was recognised by operating surgeon and Exploratory Laparotomy was performed ; where leakage of faecal matter from inadvertent injury site on sigmoid colon was seen and then suture closure of sigmoid colon perforation and proximal loop diversion ileostomy was done ; but due to clinical deterioration after laparotomy patient was referred to higher centre. At ILS Hospitals Howrah, we immediately started resuscitation followed by conservative management with IV fluids ; IV Antibiotics, Amino acid infusions, maintenance of electrolyte balance, blood transfusions and high protein nutrition etc. but unfortunately she developed 'Abdominal Wound Dehis-cence'(Burst Abdomen) during the course of treatment and for that we used VAC (Vacuum Assisted Closure) as it was the better alternative to surgical intervention so as to avoid abdominal compartment syndrome. After 3 weeks of hospitalisation she was released. Total 6 times VAC was applied every 7-10 days intervals and she was regularly followed up in OPD. Burst abdomen wound size significantly reduced after several VAC applications but even after 3 months of her release from hospital still there was pus



Burst Abdomen



Wound condition after VAC application



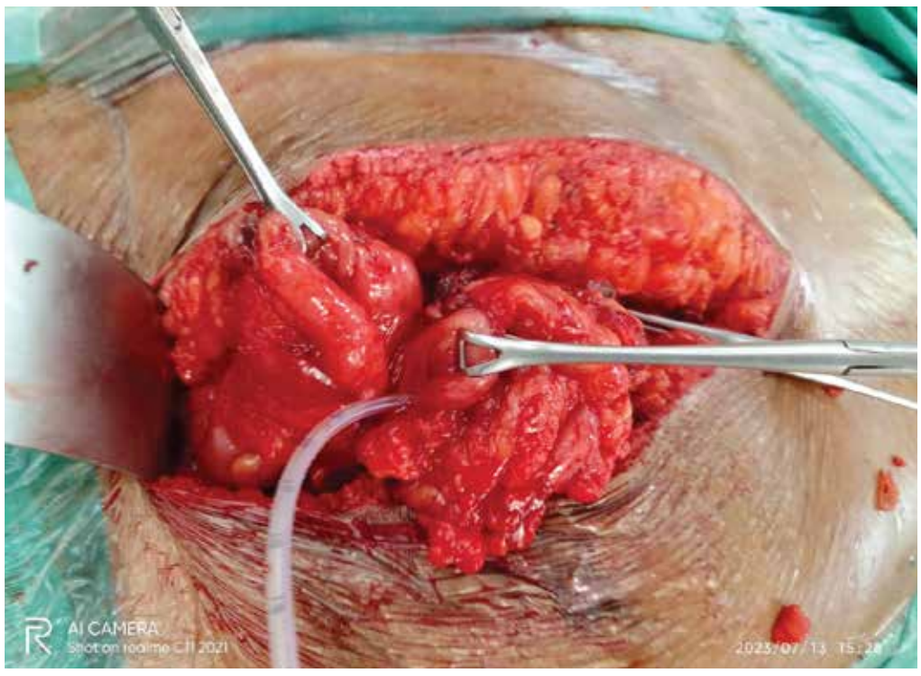
Enterocuutaneous Fistula

discharge from burst abdomen wound and drain site (Growth of E. Coli). Eventually we did CECT whole abdomen with oral and per rectal contrast where an enterocutaneous fistula involving sigmoid colon was found. We did redo Exploratory Laparotomy 3 months after 1st Exploratory Laparotomy and resection & anastomosis done at sigmoid colon fistula site (non-healing fistula). One and half months later we performed closure of loop ileostomy and she was discharged in clinically; haemodynamically and emotionally stable condition on 2nd week September' 23.

DISCUSSION & CONCLUSION:

Complications were defined as any deviation from the normal postoperative course. This definition also takes into account asymptomatic complications such as arrhythmia and atelectasis. A sequela is an 'After-Effect' of surgery that is inherent to the. If the original purpose of surgery has not been achieved, this is not a complication but a 'Failure to Cure'. Sequela and failure to cure should not be included in the classification of complications. Our case was grade III B surgical complication. Bowel injury is a serious complication of laparoscopic surgery. Its incidence depends on the treated pathology and the type of procedure (diagnostic, minor operative, or complex operative procedure). Lack of surgeon's experience and presence of previous abdominal surgery and adhesions increase the risk of bowel injury. The incidence of bowel injury is 0.13% for laparoscopic surgical procedures. The most common site of bowel injury is the small intestine, followed by the large intestine and stomach. If recognized early and on table by an experienced laparoscopic surgeon, majority of bowel injuries can be repaired by laparoscopy or by mini-laparotomy. Delay in diagnosing a bowel injury can lead to acute peritonitis and even death. In that particular case during 1st Exploratory Laparotomy; sigmoid colostomy was better option instead of ileostomy. In a case of burst abdomen in hemodynamically unstable patient we did not consider for redo surgery and prefer VAC application along with other conservative measures. The expected time period for spontaneous closure varies with the anatomic location of the enterocutaneous fistula. Fistulas from the oesophagus and duodenum are expected to heal in two to four weeks. Colonic fistulas may heal in 30 to 40 days. Small bowel fistulas may take at least 40 to 60 days. We did 2nd exploratory laparotomy for non-healing sigmoid colon fistula after 3 months of 1st exploratory laparotomy. Depressive symptoms occur in almost half of stoma surgery patients and we faced the same in this 34 yrs young lady who has undergone 4 major surgeries in last 5 months; Emotional support (from doctors ; nurses; dieticians ; physiotherapist & psychologists) also played a major role to her road to recovery.

Due to clinical deterioration after laparotomy patient was referred to higher centre at ILS Hospitals; Howrah.



Nearly transected sigmoid colon

Atypical Guillain Barre Syndrome

Dr. Tarun Arun Sahu
MBBS, DM (Critical Care)
ILS Hospitals Agartala

CASE REPORT

A 70 year old Bengali Hindu female from Agartala, Tripura, India got admitted in the ICU with complains of sudden onset of descending paralysis on 28th July 2023. She had complains of numbness, weakness and tingling sensation which started from both the hands and radiated downwards to both of the legs with complete quadriplegia happening over a span of 2 days. She also had difficulty in swallowing accompanied by dyspnoea. Patient was first given a trial of NIV on ICU admission but as her condition deteriorated, she was intubated and put on the ventilator. A detailed neurological work up done. Physical examination showed absent motor reflexes in all the four limbs. Cerebrospinal Fluid (CSF) study showed mild elevation of protein levels with normal cell counts. CT Scan, MRI brain and spine suggested no significant findings. Nerve Conduction Velocity (NCV) test revealed findings like motor nerve conduction slowing in all the four limbs, prolonged distal motor latency and absent F-wave. Vit B12 and potassium levels were done which were found to be normal. Detailed history suggested that the patient had an episode of mild diarrhoea after eating food from a local restaurant 2 weeks before the incident date. Based on all these findings a diagnosis of atypical GBS was made. She was given intravenous immunoglobulin IVIG on the day 1 of ICU admission but was stopped mid transfusion because of anaphylactic response. After which 5 sessions of plasmapheresis were administered over a course of 10 days. On day 4 of ICU stay patient was tracheotomised in anticipation of requirement of prolonged mechanical ventilation. Supportive ICU care included regular suctioning, dvt prophylaxis, enteral nutrition, prevention of bed sores, chest and limb physiotherapy. Within ten days after initiation of plasmapheresis sessions, she had a discernible improvement in her lower limb power and also was able to generate adequate tidal volume following which she was weaned off the ventilator and put on oxygen through T piece. 1 month after ICU admission patient complained of severe abdominal pain and was medically managed with pro-kinetics, neostigmine, gastric decompression and parenteral nutrition following which her condition resolved over a period of 3-4 days. 10 days later patient had an episode of cardiac arrest. The tracheostomy tube was found to be blocked and promptly changed and ROSC was achieved in a minute. Bedside fibre optic bronchoscope was done and mucous plugs were sucked out of the airway. Following all these measures her saturation improved and she was gradually weaned off the ventilator. 80 days after her admission she gradually started to regain her swallowing capacity and could swallow liquids without much difficulty. Following which a speaking valve was attached to the tracheostomy tube which allowed her to phonate. After 100 days in the hospital which included 90 days of ICU stay, the patient was finally discharged out of ICU to her home after being provided with a detailed and tailored rehabilitation program. Currently she is able to mobilize using a wheelchair on her own.

DISCUSSION & CONCLUSION:

Guillain-Barre Syndrome (GBS) is a rare autoimmune disorder characterized by rapid-onset muscle weakness caused by the immune system damaging the peripheral nervous system.

While classical GBS manifests as an ascending paralysis noted by weakness in the legs that spreads to the upper limbs and face, atypical forms exist challenging clinicians with diverse presentations. Through diligent clinical oversight and a patient-centered approach, this case exemplifies the potential for positive outcomes in the management of atypical GBS, even in complex clinical scenarios.

Management of Urogenital Fistula (Uretero Vaginal) Post Gynaecological Procedures

Dr. Gotam Pipara
MBBS, MS, MCh (Urology),
FRCS - Edinburgh
Consultant Urologist & Andrologist,
ILS Hospitals

CASE REPORT

A 45 year old lady underwent TLH for a related cause. She did absolutely well after operation, catheter removed on POD 1 and discharged on next day. Her first follow up after one week was also fine. However on POD 14 she complained of voiding normally along with leak per vaginum of a fluid that made her undergarments smell of urine. On examination it looked like urine and hence a CT urogram was ordered after renal function tests were normal. She was found to have a left uretero vaginal fistula with a collection in the pelvis. After discussion of all options ureteoscopy was done which showed a small rent likely due to thermal injury on the medial aspect of the ureteric wall in the pelvic ureter. With a lot of erythema - a RGP was done that confirmed pelvic extravasation. A soft silicon 5ft stent was placed across the injury with the double J in the renal PCS and bladder. She was catheterised. Stent was removed at 3 months followed by a repeat RGP that showed only minimal narrowing at the site. A gentle balloon dilatation was done. The patient is keeping good and on follow up after almost a year. In today's Laparoscopic era, most patients look for key hole / minimally invasive surgeries. One of the common complications seen after total laparoscopic hysterectomy is uretero vaginal fistula. Most common sites of injury are - dorsal to infundibulopelvic ligament near or at pelvic brim, cardinal ligament where ureter crosses under the uterine artery, lateral pelvic sidewall above the uterosacral ligament and intramural portion of the ureter.

3D reconstructive image showing the ureteric injury site with proximal hun.

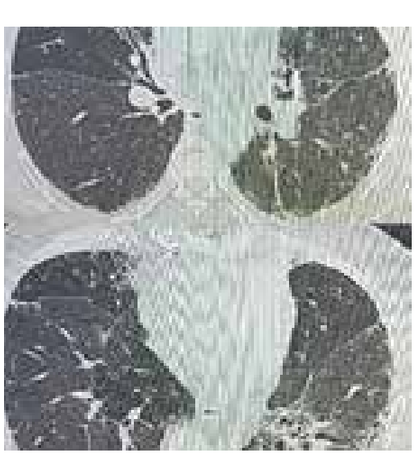
Most common presentation is with constant urine leak for 1-4 weeks post-surgery with normal voiding

"Most common presentation is with constant urine leak for 1 to 4 weeks post-surgery with normal voiding". Once a diagnosis is made, we must also exclude VVF. Prompt drainage of the upper tracts to preserve renal function as some amount of obstruction would be present. Definitive management should not be delayed. An on table RGP and URS would delineate the fistula well. Attempt to pass a stent 5/6 ft. Keep the stent in situ for 6 to 12 weeks. Also continuous bladder drainage is advisable for some time. Bladder relaxants should be added. If however a stent placement is not possible the patient needs ureteroneocystostomy. Sometimes a psoas hitch / Boeri flap may also be needed. Post stent removal the patient should be followed up by a repeat imaging to confirm resolution of fistula.

Hypersensitivity Pneumonitis: How Howrah's well fed pigeons are killing the residents

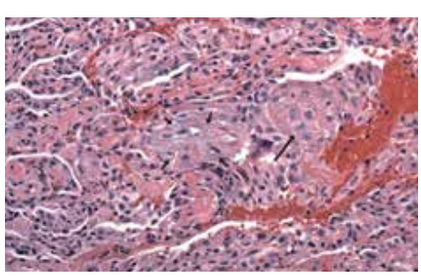
Dr. Pratik Biswas
MBBS, MD (Pulmonology Medicine)
Consultant Pulmonology & Chest Medicine
ILS Hospitals Howrah

Hypersensitivity Pneumonitis (HP) or extrinsic allergic alveolitis or Bird's Fancier's Lung (due to birds, pigeons in particular) is not an orphan's disease anymore. It causes an immunologically mediated lung disease due to repetitive exposure of air-borne avian antigen. It is under diagnosed cause of ILD & needs high clinical suspicion. The number of cases and deaths are on rise in Howrah which needs attention. **Case 1:** 56 year old female came with chronic cough and breathlessness who



desaturated to 50% on minimal exertion was on home oxygenation for last 2 years. History revealed she had significant pigeon exposure for 30 years at her home. CT-UIP pattern, CTD markers were negative and serum avian precipitin test was positive. She was put on immunosuppressant and anti-fibrotic, however she succumbed to her illness.

Case 2: 35 year old male suffering from dry cough and dyspnoea only on exertion. On 6MWT it was found that he desaturated from 97% to 90% after 6 minutes of walking. CT-reticulation, traction bronchiectasis and honeycombing. On probing, it was found he fed pigeons every day for last 10 years. He is on immunosuppressant and



is under follow up. Acute HP mostly present as flu like illness after exposure to offending agent (x-ray being normal). Subacute or chronic HP presents gradual onset progressive dyspnoea, chronic cough, digital clubbing and classical "Velcro" crepitation i.e., end inspiratory crepitation (classically seen in ILD)

- There is great variability of illness among exposed individuals and apparent resistance to most who are exposed. It occurs due to the nature, duration and intensity of exposure and host response. (inborn/acquired)
- A complex mixture of high- and low-molecular-weight proteins from pigeon serum, faeces, and feathers damages the lung (dominated by T cell–mediated effector activities)

On probing, it was found he fed pigeons every day for last 10 years.

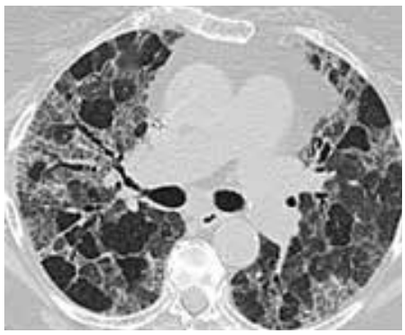
- Non-fibrotic HP- predominantly seen in non-smokers (possible anti-inflammatory effects of nicotine). However long term smoking associated with increase in fibrosis in patients of HP.

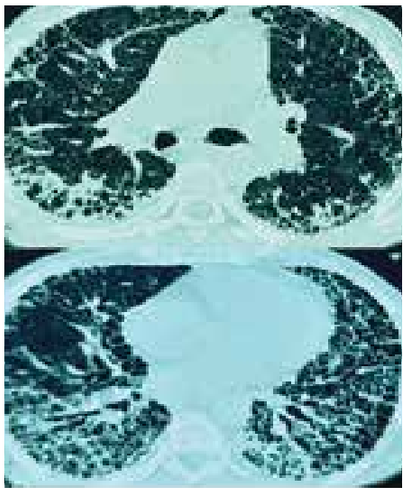
Treatment

- Identifying pigeon as the offending agent and avoiding exposure forms the most important intervention.
- In severely symptomatic individuals-Systemic glucocorticoids or when treatment is required for long duration then, steroid sparing agents such as mycophenolate mofetil or azathioprine is indicated.
- Anti-Fibrotic - Such as Nintedanib in progressive Chronic HP helps in slowing functional decline (i.e. FVC)
- Lung transplantation- For end stage lung disease (HP may recur in transplanted lung if there is no exposure avoidance)

In advanced cases with fibrosis, physiological abnormalities are only partly reversible after exposure avoidance. Sometimes, even after complete avoidance of pigeons, there is disease progression, suggesting possibility of self-perpetuation.

"Identifying pigeon as the offending agent and avoiding exposure forms the most important intervention".





KEY ACTIVITIES

At the EIILM Branding & Marketing Leadership Awards held at Taj Bengal Kolkata on 4th Oct, ILS Hospitals won the award for Excellence in Marketing Innovation & Brand Strategy from Healthcare & Hospital Sector

ILS Walkathon 2023 organized on World Diabetes Day by ILS Hospitals Howrah

12th Foundation Day celebration @ ILS Hospitals Agartala

Children's Day celebration @ ILS Hospitals Dumdum

Sarodiya celebration @ ILS Hospitals Dumdum

Diwali celebration @ ILS Hospitals Corporate Office

UPCOMING EVENT

ILS TIMES // A Newsletter of ILS Hospitals | Volume 4, Issue 1, 2024

DISEASE A HIDDEN ICEBERG: EXPERT

Advice on how to help patients with Alzheimer's

DEBRAJ MITRA

Calcutta: Establishing a routine and simplified communication can be a timely intervention in dealing with people suffering from Alzheimer's disease, doctors said on Thursday.

September 21 is observed as World Alzheimer's Day. Several hospitals, clinics and mental health institutes conducted awareness campaigns on the disease on Wednesday and Thursday.

Alzheimer's disease is a neurodegenerative disorder that usually starts slowly and worsens progressively. The most common and early symptom is difficulty in remembering recent events. With time, the symptoms can include disorientation, mood swings and self-neglect.

Many people tend to confuse Alzheimer's with dementia. But doctors pointed out that while dementia is a general term for a decline in the most common cause of dementia.

"Alzheimer's disease is like a hidden iceberg affecting 7.4 per cent of the elderly population of India over the age of 60 years," said Nodee Chowdhury, consultant neurologist, ILS Hospitals Howrah.

"The early symptoms can be forgetfulness — like misplacing things, lack of attention and decreased social interaction. Mood issues like anxiety and depression also accompany this disease. When advanced, Alzheimer's disease can produce problems with speech in the form of forgetting words or replacing words with similar but wrong words," he said.

Aparupa Ojha, clinical psychologist at Monoshij, an institute for mental health support, listed the following "interventions" that would help caregivers.

■ Establish a routine: Create a daily schedule to eliminate confusion.

time, speak slowly, and use clear, basic language. Use motions while maintaining eye contact.

■ Use visual aids: Visual cues like photos or written notes can improve recall and communication.

■ Safety precautions: Make sure their surroundings are secure by eliminating trip risks and, if necessary, adding locks or alarms.

■ Use a whiteboard with crucial information as a memory help, or mark drawers and cupboards.

■ Engage in familiar activities: Encourage the person to take part in hobbies such as gardening or drawing.

On Wednesday, Dignity Foundation, an NGO, announced the launch of dementia day care centre in Dhakuria.

The centre should be operational after the Puja, said Gopal Srinavasan, trustee of the foundation.

"The centre will provide comprehensive care to patients. It will be open from 10am to 4pm."

DISEASE A HIDDEN ICEBERG: EXPERT

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Hypertension cure & prevention

डायाबेटिस-सचेतनतায় হাওড়া শহরে পদযাত্রা

এই সময়, হাওড়া: ১৪ নভেম্বর বিশিষ্ট বিজ্ঞানী ফ্রেডরাক ব্যানটিংয়ের জন্মদিনটিকে আইডিএফ (বিশ্ব ডায়াবেটিস ফেডারেশন) ও বিশ্ব স্বাস্থ্য সংস্থা ডায়াবেটিস ডে হিসেবে ঘোষণা করে। উল্লেখ্য, ফ্রেডরাক ব্যানটিং ও আর এক বিজ্ঞানী চার্লস বেস্ট ইনসুলিন আবিষ্কার করেছিলেন। যা ডায়াবেটিস প্রতিরোধে প্রধান ভূমিকা পালন করে। তাই ডায়াবেটিস সম্পর্কে মানুষের মধ্যে সচেতনতা

হাওড়া

বেলুন উড়িয়ে কর্মসূচির সূচনা

सन्मार्ग

महानगर

वर्ल्ड डायबटिज डे पर आईएलएस हावड़ा की ओर से वॉकथॉन

WALKATHON 2023

The Telegraph

DISEASE A HIDDEN ICEBERG: EXPERT

Advice on how to help patients with Alzheimer's

DEBRAJ MITRA

এই সময়

ডায়াবেটিস-সচেতনতায় হাওড়া শহরে পদযাত্রা

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HEALTH TALK

Keep anaemia at bay

विश्व मधुमेह दिवस पर वाकथॉन का आयोजन

राष्ट्रीय रंग

सच्ची बदलते भारत की

आईएलएस हॉस्पिटल, हावड़ा की एक और चिकित्सकीय उपलब्धि

खतरनाक तरीके से सीमित पुटनों का मरीज बिना सहारे खुद खड़े होने एवं चलने में हुआ समर्थ

डॉ. सिद्धार्थ गुप्ता एचओडी एंड एचओडी (ऑर्थोपेडिक्स) आईएलएस असरफाल, हावड़ा

प्रतिदिन

Thoracic Aortic Aneurysm

अनियन्त्रित रक्तचाप मारात्मक हते पारे

The Telegraph

Gynaecologist Ariana Tarnia of ILS Hospitals and a CL Block resident offers post-pregnancy tips

Words of wisdom for new moms

प्रतिदिन

खेई हारानো বয়সকাল

प्रभात खबर

रोबोटिक सर्जरी से स्त्री रोग संबंधी जटिल बीमारियों का आसान इलाज

प्रतिदिन

গ্রোথ ফ্যাক্টর

THE TIMES OF INDIA

Temp flip-flop triggers high fever, cough, resp illnesses

Sr Citizens, Kids Are More At Risk

NEW VIRUSES?

HEALTH TALK

Keep anaemia at bay

आईएलएस हसपिटालस-एर उद्योगे जरूरि ও আপৎকালীন চিকিৎসার ক্ষেত্রে কী করণীয় তা নিয়ে প্রকাশিত হল বই 'এমার্জেন্সিস ইন মেডিক্যাল প্র্যাকটিস'। উপস্থিত ছিলেন ড. সুকুমার মুখোপাধ্যায়, ড. ওম তাঁতিয়া, ড. ঘনশ্যাম গোয়েল। রবিবার।