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SALT LAKE | DUMDUM | HOWRAH | AGARTALA

Managing Case of Hemolytic Uremic Syndrome

Skull Base Osteomyelitis – a Diagnostic Enigma

Endoscope Assisted Removal of Intracerebral Hemorrhage

Miraculous Rectification by Plastic & Reconstructive Surgery

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Message from Managing Director

Dr. Om Tantia
Managing Director
ILS Hospitals - GPT Healthcare

Dear Readers,

It gives me immense pleasure to announce before you the successful listing of **GPT Healthcare** at BSE & NSE!

Healthcare has become one of the largest sectors of the Indian economy, in terms of both revenue and employment. It has been growing at a CAGR of 22% since 2016. Several factors are driving the growth of the Indian healthcare sector including an aging population, a growing middle class, the rising proportion of lifestyle diseases, an increased emphasis on public-private partnerships as well as accelerated adoption of digital technologies.

The healthcare sector has received heightened interest from investors (venture capital and private equity) over the last few years. A slew of investments by global health players have strengthened the perception of India as an attractive healthcare investment destination. Growth in multi-specialty and single-specialty hospitals in the country has taken place mainly on the back of private equity (PE) funding.

In this edition of **ILS Times,** we delve into the profound impact of healthcare investment, exploring how advancements in technology, coupled with medical expertise and superior infrastructure, are significantly benefiting humanity. These case studies provide compelling evidence that medical miracles can and do occur, turning the concept of a second chance at life into a tangible reality.

The highlight of this issue is a multidisciplinary topic that spans from Diabetic Foot to Plastic & Reconstructive Surgery, covering a range of other issues in between.

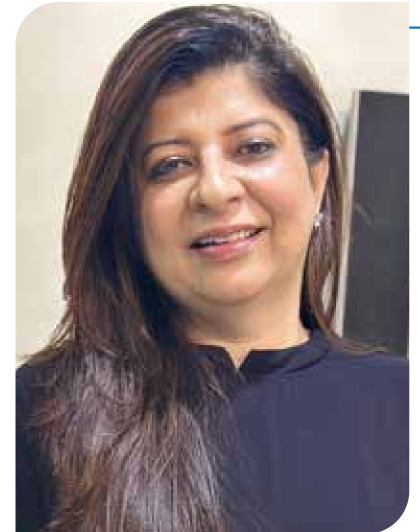
Wish you all embark on a journey of a brighter future this Bengali New Year –

Subho Nobo Borsho!

Warm Regards

Dr. Om Tantia

Editor's Note



Dr. Poonam Kapoor
HOD – Department of Pathology
ILS Hospitals

WELCOME BACK TO THE LATEST QUARTERLY EDITION OF OUR ILS TIMES!

The recent **IPO launch of ILS Hospitals** stands as a beacon of hope and progress in an era of unprecedented challenges to national and global private healthcare systems.

ILS Hospitals' decision to go public signifies not only confidence in its own capabilities but also reflects a broader trend of increasing investor interest and support in the healthcare sector. This IPO launch is not just about a single institution; it symbolizes a larger movement towards public participation and equity in bolstering healthcare infrastructure, improving access to quality care, fostering innovation in medical technology and services.

In this edition, we are excited to share eight remarkable case studies showcasing successful treatments done at various units of **ILS Group of Hospitals.** These stories demonstrate that illness knows no age boundaries, featuring patients ranging from just a few months old to seniors. These cases highlight the transformative impact of our doctors' expertise, offering renewed hope and second chances at life.

We are also thrilled to display the diverse talents of our doctors beyond their medical expertise. Join us as we explore the fascinating world of wildlife photography in the eighth continent, revealing extraordinary creatures whose existence was previously unknown to many.

The last quarter was a hive of activity across our various **ILS Hospitals'** locations, with a range of significant events and developments. Here, we offer a glimpse into these updates, providing a general overview of the exciting happenings that have unfolded.

I, on behalf of the editorial team, wish to thank all the contributors of this newsletter. We hope to keep receiving same support in future as well from our management , clinicians and staff .

If you have any stories which you think is ideal for the newsletter do share it with us through email at **info@ilshospitals.com.**

Welcome to ILS Family

ILS HOWRAH

DOCTOR'S NAME	DEPARTMENT	QUALIFICATION
Dr. Arka Bhattacharya	Radiology	MBBS, MD
Dr. Manish Kumar	General & Laparoscopic Surgery	MBBS, MS, FMAS
Dr. Aparajita Mitra	Emergency	MBBS, MEM

ILS AGARTALA

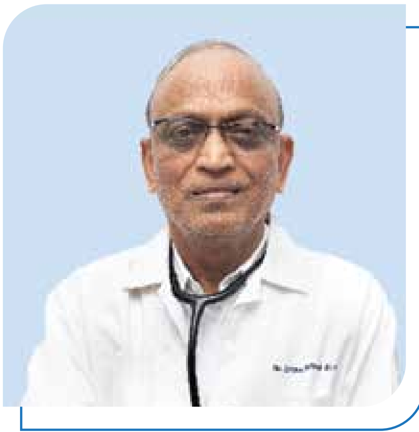
DOCTOR'S NAME	DEPARTMENT	QUALIFICATION
Dr. Seetharam Thejavth	Urology	MBBS, MS, MCh (Urology)

ILS SALT LAKE

DOCTOR'S NAME	DEPARTMENT	QUALIFICATION
Dr. Naman Agrawal	ENT	MBBS, M.S (Oto Rhino Laryngology)
Dr. Mainak Deb	Gastroenterology	MBBS, MD, DNB (Gastro), DA
Dr. Harsh Vardhan Binaykia	Orthopaedics	MBBS, MS (Ortho)
Dr. Debjani Das	Paediatric Surgery	MBBS, MS (Genl Surgery)
Dr. Chaitali Roy	Obstetrics & Gynaecology	MBBS, MS (Obs & Gynae)
Dr. Pravin Jain	Anaesthesiology	MBBS, MD, DA
Dr. Shaswat Agrawal	Orthopaedics	MBBS, MS (Ortho)

ILS DUMDUM

DOCTOR'S NAME	DEPARTMENT	QUALIFICATION
Dr. Mousumi Kundu	Cardiology	MBBS, MD, DM
Dr. Jyotish Roy	Radiology	MBBS, MD (Radio Diagnosis)
Dr. Himansu Shekhar Mohanty	Radiology	MBBS, DNB (Radio Diagnosis)
Dr. Sumona Ghosh Banerjee	Gynaecology & Obstetrics	MBBS, MS
Dr. Soma Das Pal	Clinical Cardiology	MBBS, PG Dipl. (Clinical Cardiology)
Dr. Susanta Kumar Das	Urology	MBBS, MS
Dr. Ayan Banerjee	Critical Care	MBBS, DNB (Anaesthesia), IDCCM
Dr. Shainy Priyanka Tirkey	Anaesthesiology	MBBS, MD (Anaesthesia)
Dr. Sudipta Saha	Anaesthesiology	MBBS, MD (Anaesthesia)
Dr. Aniruddha Chattopadhyay	Neuro Surgery	MBBS, MS, MCh (Neuro Surgery)



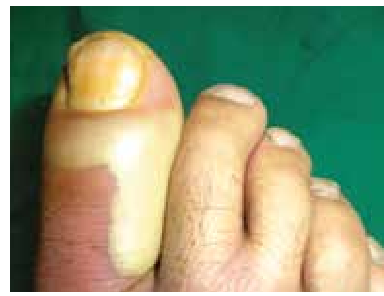
Dr. Ghanshyam Goyal
MBBS, MD
Consultant – Diabetology & Endocrinology
ILS Hospitals, Salt Lake

Diabetic Foot Infection

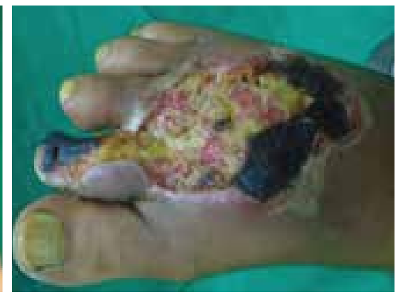
The prevalence of diabetes continues to increase globally and this situation leads to a rising incidence of foot complications, including infections. 15% - 20% of diabetics having DFU have Diabetic Foot Infection (DFI). About one million amputations are performed every year in which 85% of amputations are due to DFI and DFU. Diabetic Foot Infection can be classified as mild, moderate and severe.

IDSA CLASSIFICATION (INFECTIOUS DISEASES SOCIETY OF AMERICA)

Grade	Description
Grade 1	No sign of Infection
Grade 2	Mild infection of skin and subcutaneous tissue only At least two findings: • Local swelling, induration • Cellulitis <2cm around ulcer • Tenderness or pain • Local warmth • Purulent discharge
Grade 3	Moderate to severe infection • Cellulitis >2 cm plus one of Grade 2 signs • Or deep structure involvement such as abscess, fascitis, septic arthritis, osteomyelitis • No systemic toxicity
Grade 4	Systemic inflammatory response syndrome (SIRS) Any infection with: • Temp >38 or <36 • HR 90 beats/min • Resp rate > 20/min • PaCO2 <32 mmHg • WBC >12000 or<4000 • 10% bands



MILD DFI



MODERATE DFI

SEVERE DFI

Gram-positive bacteria Staphylococcus aures and streptococci are the most common pathogens in untreated mild to moderate infection. Severe, chronic or previously treated infections are often polymicrobial. However the diagnosis of DFI is based on the clinical signs and symptoms. Deep tissue culture should be taken to identify pathogen.

INVESTIGATION TO DIAGNOSE DFI:

- **Microbiological sampling**
- **Hematologic and biochemical markers**
- **Radiological diagnosis of osteomyelitis**

Radiological, clinical assessments with laboratory tests, should help in differentiation of infectious from noninfectious bone lesions.

MANAGEMENT OF DFI:

Diabetic foot infection (DFI) management requires multidisciplinary team approach. There are 3 basic tenets of DFU (Diabetic Foot Ulcer) management – Adequate Vascularity, Adequate Debridement and Off-loading. Systemic antibiotic treatment gives positive outcomes.

Principle of Antibiotic therapy (DFI)

- Select empiric antibiotic regimen depending on severity of infection
- Consider therapy against MRSA in pts. with H/o of MRSA infection
- Definitive therapy after C/S reports & patients response to empiric treatment
- Oral antibiotics in mild and in some moderate infections
- Parenteral therapy for all severe & some moderate infection

Protocol which is followed at ILS Hospitals, Salt Lake
Empiric Antibiotics for mild DFI

Drug	Dose	Frequency
Amoxicillin/Clavulanate	**875 / 125 mg orally**	**B I D**
+ Levofloxacin/Ciprofloxacin	**500 mg**	**OD/BD**

EMPIRIC ANTIBIOTICS FOR MODERATE DFI

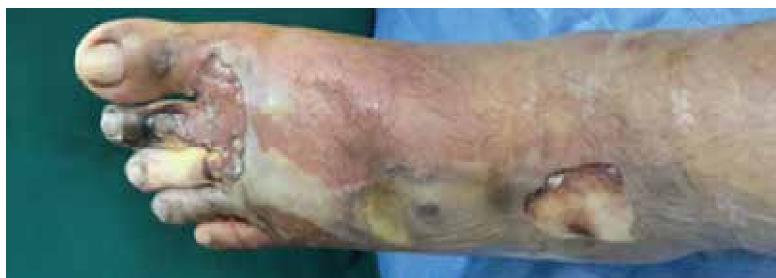
Clindamycin +Levofloxacin /Ciprofloxacin	600 mg IV 500 mg IV	TDS OD/BD
Or Ertapenem (Once it is not Pseudomonas)	1 g IV	OD
Piperacillin /Tazobactam + (MRSA) Linezolid	4 gm+ 0.5 gm IV 600 mg IV	TDS BID

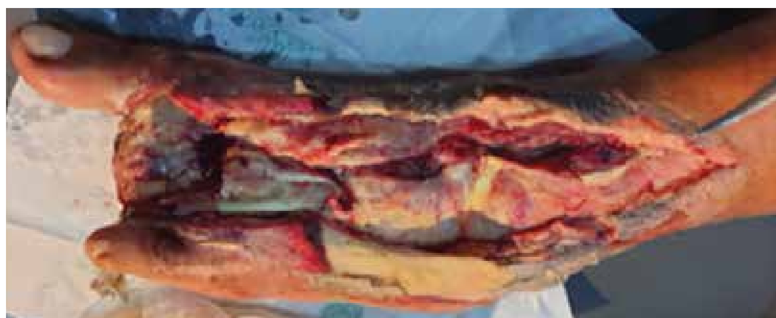
EMPIRIC ANTIBIOTICS FOR SEVERE DFI

Meropenem + Tecoplanin	1 gm IV + 400 mg IV	TDS OD

According to Culture sensitivity reports antibiotic therapy can be escalated or de-escalated.
Doses of antibiotics can be adjusted according to e GFR.
Topical agents have no role in DFU management. There are some advanced dressings and modalities available to treat DFI and DFU like Hydrogels, Hydrocolloids, Alginates, Foam, Silver Impregnated Dressing, Growth Factors, Silicon Impregnated Atraumatic Dressing, Vacuum Aided Dressings, HBO, Topical Oxygen Therapy.

A CASE OF SEVERE DFI WITH POSITIVE OUTCOME





TAKE HOME MESSAGE

Diabetic foot infections have long term implications in diabetics in the form of morbidity and mortality.

- DFI may often present without any symptoms
- Antibiotics **should not be started** in non-infected ulcers
- Empiric antibiotics should be started in all DFI after taking deep tissue cultures
- Multidisciplinary Team approach is crucial in the management of DFI for successful outcome

Dr. Anupam Majumdar
MBBS, MD (MED), DNB (NEPHRO)
Consultant Nephrologist
ILS Hospitals, Agartala

Managing Case of Hemolytic Uremic Syndrome

CASE REPORT

A 32-year-old female presented at ILS Hospitals Agartala's emergency department with chest pain and weakness. Initial tests revealed ST elevation on ECG and oliguria, along with metabolic acidosis on ABG. Her blood pressure was 95/60. Admitted to the nephrology department, further investigations showed creatinine levels of 6.2, Hb of 6, normal urine report, LDH > 4000 iu/dl, and platelet count < 50,000. Suspecting mismatched blood transfusion or atypical Hemolytic Uremic Syndrome (HUS), two units of PRBC given, and hemodialysis started due to clinical urgency. Additionally, the patient had received two units of PRBC transfusions prior to arriving at ILS Hospitals. USG indicated normal kidney size, and a peripheral smear suggested hemolysis. While plasma exchange was planned, financial constraints led to initiating immunosuppression with Methyl Prednisolone 500 mg once daily for 5 days. After 3 sessions of hemodialysis and 3 doses of Methyl Prednisolone, her urine output gradually increased, and there was no drop in hemoglobin or platelet count. Although a renal biopsy was planned but not performed due to financial reasons, the patient's clinical condition continued to improve. After 7 days of treatment, with urine output exceeding 1 litre per day and HB at 9.8, creatinine at 2.8, and platelet count at 1.2 lacs, the patient requested discharge and was allowed, with follow-up advised after 3 months. At the 15th day follow-up, her creatinine was 1.2, HB was 10.2, platelet count was 1.5 lacs, and per day urine output was 1.5 litres, indicating a stable condition.

"Initial tests revealed ST elevation on ECG and oliguria, along with metabolic acidosis on ABG. Her blood pressure was 95/60."

DISCUSSION AND CONCLUSION

Hemolytic uremic syndrome (HUS) is a clinical syndrome characterized with the triad of microangiopathy hemolytic anemia, thrombocytopenia and acute renal damage. aHUS or Atypical Hemolytic Uremic Syndrome is a very rare genetic disease that causes tiny blood clots to form in the blood vessels, blocking blood flow to important organs. aHUS can cause kidney failure, heart disease and other serious health problems. While there is no known cure for aHUS but it can be treated.

In atypical case and renal failure, Dialysis or Plasmapharesis and Immunosuppressive therapy can be given with supportive therapy. Clinical and laboratory findings are Hemoglobin <10 g/dL, frequently <8 g/dL, Negative Coombs test, Increased reticulocyte count, Increased serum lactic dehydrogenase (LDH) level, Decreased serum haptoglobulin level, Fragmented erythrocytes on peripheral blood smear (helmet cells, schystocytes).

Dr. Soumyarup Das
MBBS DLO MS (WBUHS)
Consultant ENT, Head & Neck, Cochlear Implant and Skull Base Surgeon
ILS Hospitals, Dumdum

Skull Base Osteomyelitis – a Diagnostic Enigma

CASE REPORT

A 77 year old male diabetic patient presented at ILS Dumdum ENT & Head Neck OPD and got admitted with sudden onset alteration of voice with difficulty in swallowing and speech. He was being treated at OPD for last 7 days for left acute otitis externa along with left hemifacial disproportionate pain. Preliminary investigations showed left CSOM with acute exacerbation and positive blood IgG varicella with HRCT temporal bone and CT PNS showed as left otomastoiditis with paranasal sinusitis with normal CT brain. Patient was immediately asked for Fiberoptic Nasopharyngolaryngootoendoscopy which showed isolated left vocal fold with left palatal and tongue palsy without any deep meatal granulations. Nasopharyngeal biopsy was taken and HPE found to be inflammatory without any granuloma or malignant cells. Deep middle ear swab send for C/S showed growth of pseudomonas aeruginosa sensitive to beta lactam and ciprofloxacin and negative for fungus and mycobacteria. Finally patient was asked to do whole body PET scan and autoimmune disease markers and it showed metabolically active soft tissue at the left side of nasopharynx with erosion of adjacent skull base and left mastoid with negative autoimmune markers. Patient was referred to physician for diabetes control and Infectious disease specialist for opinion and neurologist accordingly in course of time. Monitoring done with CBC and CRP at regular interval along with endoscopy. Beta lactam antibiotic was given for approximately 3 weeks and ciprofloxacin for 5 months along with multiple repeat whole body PET scan which showed gradual improvement. Patient was earlier treated in a tertiary care hospital of India for his recent sudden onset blindness. After this treatment he also regained his vision from blindness to finger counting. Finally Ryles tube was removed and he was chewing with drinking and swallowing normally without any choking or discomfort.

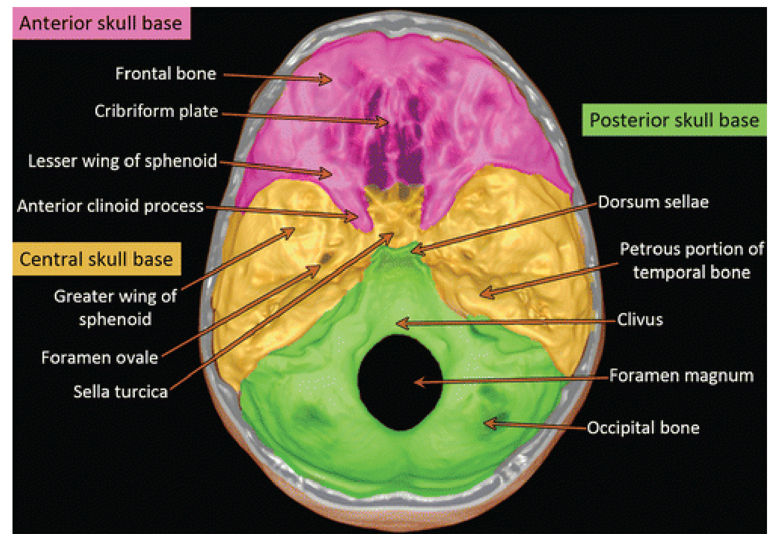
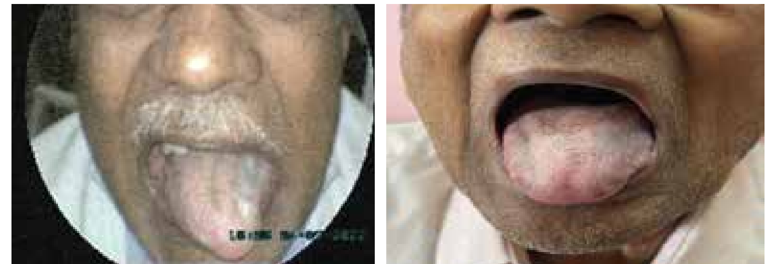


FIGURE – ENDO SKULL BASE VIEW



DISCUSSION

Skull base osteomyelitis (SBO) is an infection of the temporal, sphenoid, or occipital bones that is typically caused by a complication of improperly treated otogenic or sinonasal infection in elderly patients with diabetes or immunocompromised patients. SBO is an uncommon but life-threatening condition. The typical patient is an elderly man with diabetes mellitus and an otogenic infection. The most frequent bacterial infections are caused by P aeruginosa and S aureus. Causative pathogens in fungal infections depend on the study, but many authors agree that the most frequent fungal pathogen is Aspergillus species. The diagnosis should be based on the combination of clinical findings, medical history, imaging, and microbiologic and histologic findings.

Various imaging techniques support the diagnosis. CT shows bone erosion with a soft-tissue mass, while MRI is useful for evaluating the anatomic location and extent and shows an enhancing mass with an infiltrating pattern, bone marrow involvement, and adjacent soft-tissue edema. Nuclear imaging can allow confirmation of bone involvement and is useful for follow-up. Regardless of which imaging modality is used, a biopsy is always required.

Lastly, the diagnosis of SBO is frequently delayed because of its nonspecific symptoms, long clinical course, and radiologic findings that usually mimic those of malignancy. Therefore, the diagnosis of SBO requires a global perspective of the patients who are at risk, recognition of the more typical radiologic features, and inclusion of this rare entity in the differential diagnosis for skull base lesions

"The diagnosis of SBO is frequently delayed because of its nonspecific symptoms, long clinical course, and radiologic findings that usually mimic those of malignancy."

Dr. Jayanta Mukherjee
MD, DM (Gastroenterology)
Consultant Gastroenterologist
ILS Hospitals, Salt Lake

Miracle through ERCP

CASE REPORT

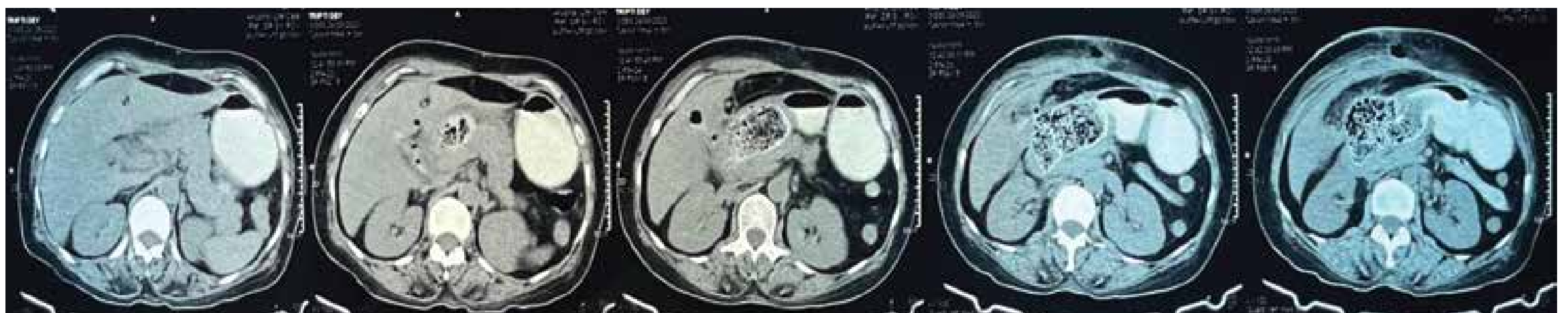
A middle-aged lady presented for ERCP with a history of open CCx (1-1/2 months prior). She had developed pain in upper abdomen with bilious vomiting after discharge. The discharge certificate did not mention any additional intervention apart from the open cholecystectomy. Primary evaluation done elsewhere suggested dilated CBD with sludge on USG with minimally deranged LFT. Subsequent CECT abdomen suggested possibility of anterior gastric wall dehiscence with extravasation of oral contrast into GB fossa, pneumobilia and few intra-abdominal lymph nodes. She was tolerating oral feed with few episodes of vomiting. She was referred for ERCP because of the USG findings. In view of the CECT report, a primary endoscopy was done and a gauze like material was removed from the stomach with difficulty and was identified as an OT mop after extraction. No obvious perforation was identified on subsequent endoscopy. The ERCP was successfully completed and endoscopic sphincterotomy, biliary sludge extraction and stenting was done. The patient subsequently improved without any further events.

RETROSPECTIVE ANALYSIS

A possible stomach or duodenal injury during CCx and subsequent bleeding was compressed by the mop, which was inadvertently left behind. The mop migrated into the stomach and caused the gastric outlet like symptoms. The USG findings of the CBD sludge was a "red herring" which led to the ERCP and subsequent chain of events leading to removal of the mop and improvement in the patient's symptoms.

> **"Primary evaluation done elsewhere suggested dilated CBD with sludge on USG with minimally deranged LFT"**

> **"In view of the CECT report, a primary endoscopy was done and a gauze like material was removed from the stomach with difficulty and was identified as an OT mop after extraction."**

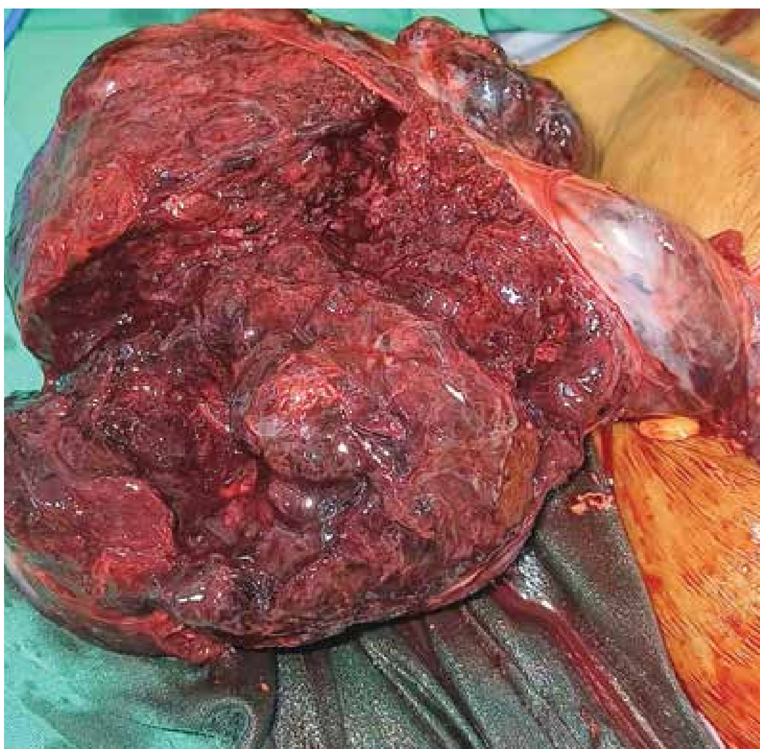


Dr. Anshu Agarwal
MBBS, DNB (Obstetrics & Gynaecology)
Consultant Gynaecologist
ILS Hospitals, Howrah

Success Story of High Risk Laparotomy

CASE REPORT

One 49 yrs female got admitted at ILS Hospitals Howrah in critical condition on 3.1.24 midnight with complain of severe pain in abdomen along with nausea and vomiting. She had severe anaemia. Urine output was low. Immediate resuscitation with blood transfusion done. Ultrasound showed a large pelvic mass. Even after transfusion of two units of blood, her haemoglobin fell down to 5.7 g/dl. Repeat USG showed size of mass increased and there was huge amount of fluid in the peritoneum. Judging the critical condition,



"On laparotomy, huge amount of blood was found in abdomen with a large pelvic mass about 20 cm size was bleeding profusely."

family was counselled for need of urgent laparotomy even though it was a high risk procedure. On laparotomy, huge amount of blood was found in abdomen with a large pelvic mass about 20 cm size was bleeding profusely. The tumour was removed completely with uterus and other side tube and ovary. Three units blood and 8 FFP were given post operatively. From this point her recovery was uneventful and she was discharged on post OP day 5 in a stable condition. Histopathology showed spindle cell tumour with areas of hyalinisation and areas of epithelial neoplasm having papillary configuration. No definite evidence of malignancy found.

DISCUSSION & CONCLUSION

Patients undergoing high-risk laparotomy require careful preoperative evaluation and preparation to minimize the risk of complications. The surgical team must be experienced in managing complex cases and be prepared to handle any unexpected challenges that may arise during the procedure. Postoperative care is also crucial for patients undergoing high-risk laparotomy. Close monitoring is required to detect and manage any complications that may occur, such as infection, bleeding, or organ dysfunction.

Despite the higher risk involved, it can be a life-saving procedure for patients with serious abdominal conditions. It is important for patients and their families to discuss the risks and benefits of the procedure with their healthcare team to make an informed decision about their treatment options.

"Postoperative care is also crucial for patients undergoing high-risk laparotomy. Close monitoring is required to detect and manage any complications that may occur."

Dr. Abhishek Mandal

Dr. Shashi Khanna

Dr. Tamonas Chaudhuri

Dr. Om Tantia

Appendicular Perforation at Cecal Base, a Rare Operative Challenge in Acute Appendicitis

"Laparoscopy revealed acutely inflammed appendix with perforation at base involving cecum with surrounding cecal and ileal pregangrenous changes. Pus pockets in right illiac fossa with pulled up cecum."

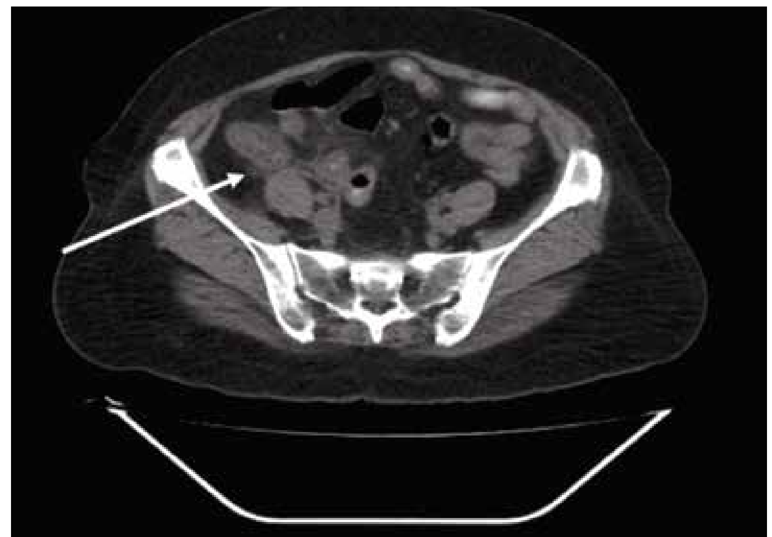
BACKGROUND

Acute appendicitis is the most common cause for emergency intervention in acute abdomen. Diagnosis is made upon clinical history, examination and supportive investigation. 1 Sometimes large bowel perforation is associated with severe acute appendicitis, but definitive surgical management of this condition is not well established in literature.

CASE REPORT

A 58 year old hypertensive and diabetic lady presented with history of sudden onset peri-umbilical pain of two days shifting to right iliac fossa associated with nausea, vomiting and increased urinary frequency. There was no significant past surgical history. No history of recent travel and family history of colitis or inflammatory bowel disease. On physical examination, she was afebrile and her vitals were stable. Her abdomen revealed tenderness in the right iliac fossa with some voluntary guarding. Rebound tenderness and rovsing sign were elicited on examination. Full blood count shows leucocytosis (16500/mm3) and rest all routine blood investigations and urinalysis were within normal range. Plain film of Abdomen and Chest X-Ray were normal. CECT abdomen revealed acute appendicitis with surrounding inflammatory changes.

Diagnosis of acute appendicitis was made and the patient was posted for laparoscopic appendicectomy under general anaesthesia. Laparoscopy revealed acutely inflammed appendix with perforation at base involving cecum with surrounding cecal and ileal pregangrenous changes. Pus pockets in right illiac fossa with pulled up cecum.



CT scan showing acute appendicitis

Decision to perform a right hemicolectomy was made, right colon mobilised and an extracorporeal stapled ileo-transverse anastomosis was done. Peritoneal lavage and closure over abdominal drain done. Post operative period was uneventful and drain removed on 5th post-operative day and discharged under satisfactory condition. The histopathology of the appendix showed features of gangrenous appendicitis with diffuse mucosal ulceration with dense transmural necrotizing inflammation of the colonic wall.

DISCUSSION

Appendicular perforations commonly occur at the tip of the appendix. 2 Perforation at base involving caecum is an uncommon finding. 3 Options available in such scenario include primary repair with omental patch or a right hemicolectomy. 4, 5 In the presence of an uncomplicated perforation, absence of severe infection, and well controlled localized disease a less invasive surgical approach would be the management of choice. Right hemicolectomy carries a higher morbidity and mortality but it is generally recommended only in selected cases. The presence of severe appendicitis or caecum appears necrotic in some cases warrants right hemicolectomy to be performed.5

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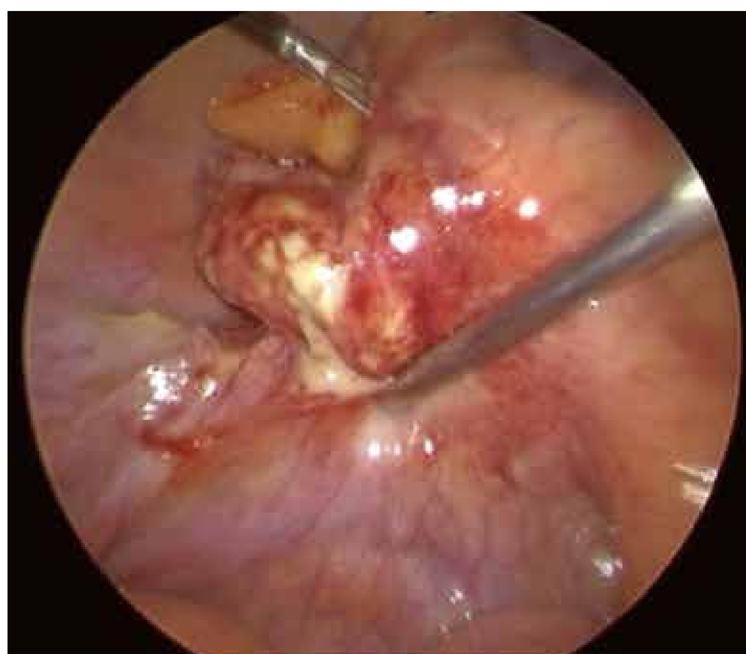
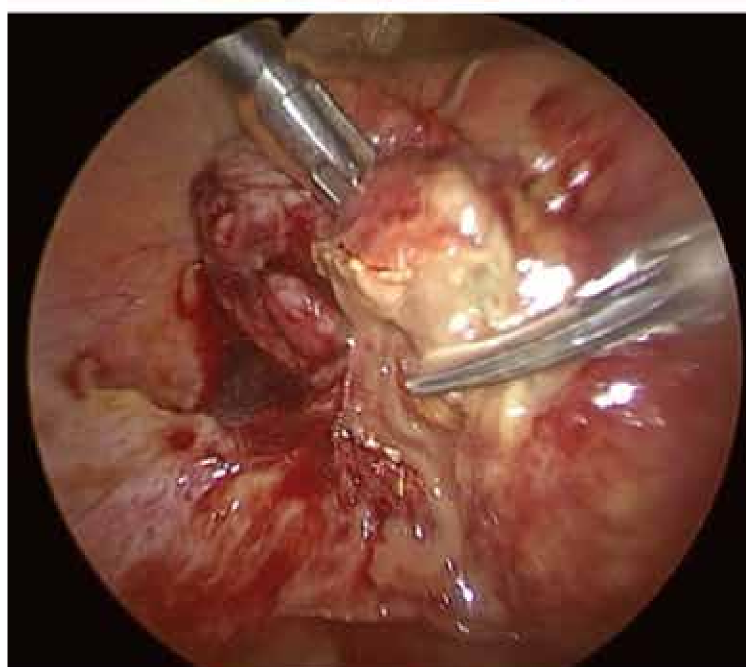
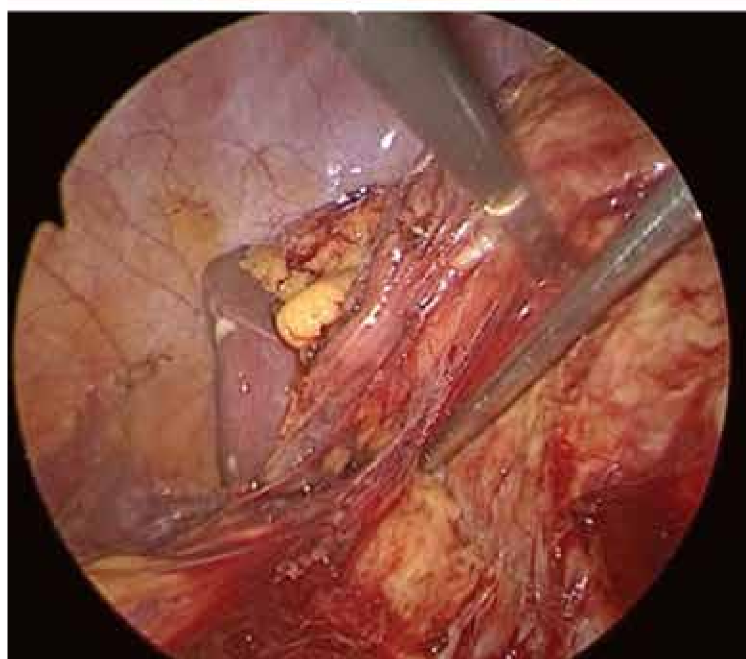
“Perforation at base involving caecum is an uncommon finding.3 Options available in such scenario include primary repair with omental patch or a right hemicolectomy.”







Intraoperative images showing perforated appendix at base with pus and mobilisation of caecum

Dr. Nirankar Dev
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Sr. Consultant Neurosurgeon
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Endoscope Assisted Removal of Intracerebral Hemorrhage

CASE REPORT

A 40-year-old male CRPF jawan presented with sudden onset of slurred speech, hemiparesis followed by altered sensorium. Initially he was taken to GB hospital before bringing to ILS Hospitals Agartala. He underwent left Decompressive Craniectomy with endoscope-assisted removal of Intracerebral Hemorrhage. Post op CT brain was satisfactory and patient weaned off from ventilation and extubated on POD 1. Post op patient improved neurologically and became E4V4M6 on POD 3. He remained neurologically stable and was discharged on POD 11th.

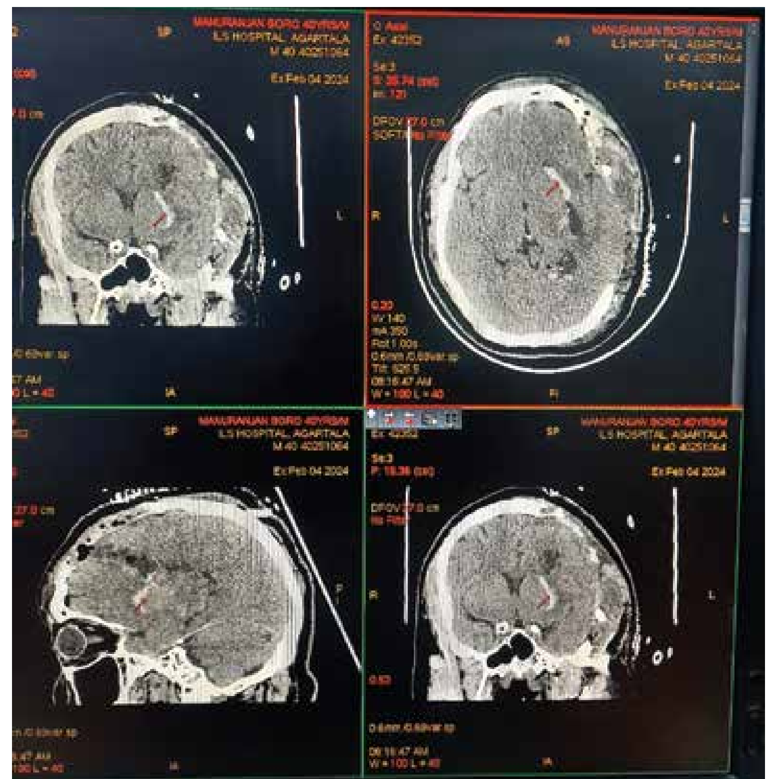
DISCUSSION AND CONCLUSION

Intracerebral hemorrhage causes an acute and spontaneous bleeding within the brain parenchyma and is considered third most frequent cause of stroke, following cerebral embolism and thrombotic disease. It is common (12-15 cases per 100000 people per year) and accounts 10%-15% of all stroke cases. Intracerebral hemorrhage has a 30-day mortality rate of ~ 50%. Hypertension is most common cause of ICH (70-80%) but it could also be secondary due to other disease e.g. vascular malformation, Bleeding disorders/anticoagulant, Amyloid angiopathy, Tumour, Trauma and Drug abuse. Putamen & Internal Capsule, Thalamus, Lobar Location, Pons, Caudate Nucleus and Cerebellum are involved commonly in descending order of frequency. Due to involvement of such important structure patient suffers risk to life and in survivors, morbidity of loss of function of body parts is devastating.

Till now studies (STICH I STICH II,) which have been done mainly in western countries, does not show superiority of surgical management over best medical management due to equal functional outcome. But they also say that surgery is better in mortality prevention (STICH II and MISTIE III trial).

> **"ENRICH (Early Minimally Invasive Removal of Intracerebral Haemorrhage) trial was established to provide Level 1 evidence in the acute management of ICH."**

Pre-op Image



ENRICH (Early Minimally Invasive Removal of Intracerebral Hemorrhage) trial was established to provide Level 1 evidence in the acute management of ICH. In this study, in Surgical Cohort a case of deep seated ICH (basal ganglia) was investigated by MRI Brain to know fibre tract orientation around ICH and endoscope was inserted with navigation to circumvent fibre tract and ICH was evacuated as much as possible within 8 hours of ICH occurrence. The primary results of the ENRICH trial presented at ESOC 2023, demonstrated a Bayesian posterior probability of superiority of 0.9813, indicating the superiority of minimally invasive trans-sulcal parafascicular surgery over standard guideline-based medical management for improving outcomes of patients with ICH. In our case minimal invasive, endoscope assisted ICH evacuation was done which causes less tissue damage to brain and better functional outcome in pt.

Dr. Arnab Mondal
MBBS, MS, MCh
Consultant Plastic and Reconstructive Surgeon
ILS Hospitals, Howrah

Miraculous Rectification by Plastic & Reconstructive Surgery

CASE STUDY 1:

One young adult came to ILS Howrah emergency at midnight with RTA (he was in front side of an Auto which faced an accident and his face was rubbed against road for a distance). He came with severe laceration on one side of face with definite tissue loss with active bleeding. On imaging was found to have also a parasymphyseal mandible fracture. Initially he was treated conservatively for 2 days with broad spectrum antibiotics and dressing (as the initial wound was very contaminated) followed by plating for mandible fracture and skin graft was applied over face in same sitting. The wound healed excellently. He followed up for 4 months after the incidence and found to have quite a satisfactory result.

Fig. 1

Fig. 2

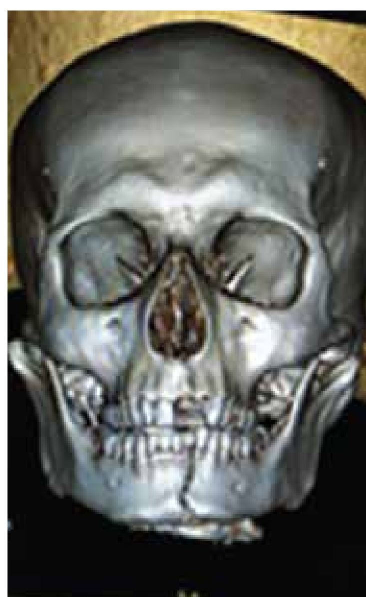


Fig. 3

Fig. 4

Fig. 5

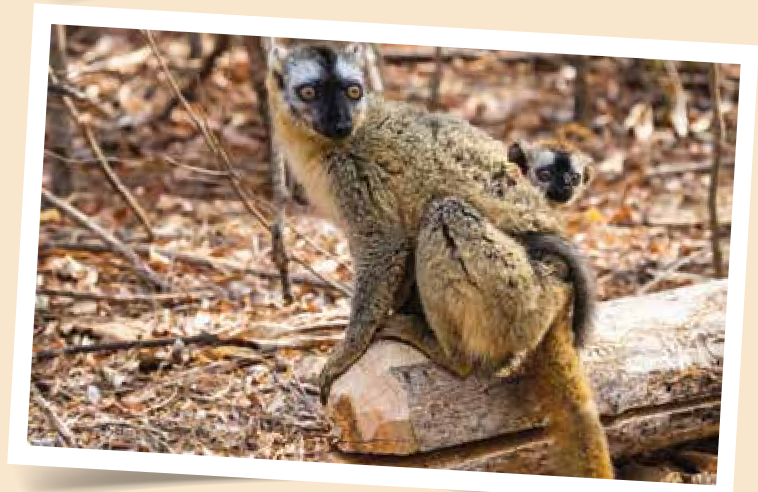
CASE STUDY 2:

A one year old boy came with simple complete syndactyly (fused fingers since birth). After admission we performed release of syndactyly successfully with resultant raw area covered with flap and full thickness skin graft. Post operative result was excellent.

Dr. Devraj Roy
MBBS, MS (Surgery)
Consultant - General & Laparoscopic Surgery
ILS Hospitals, Dumdum

MADAGASCAR – THE 8th CONTINENT

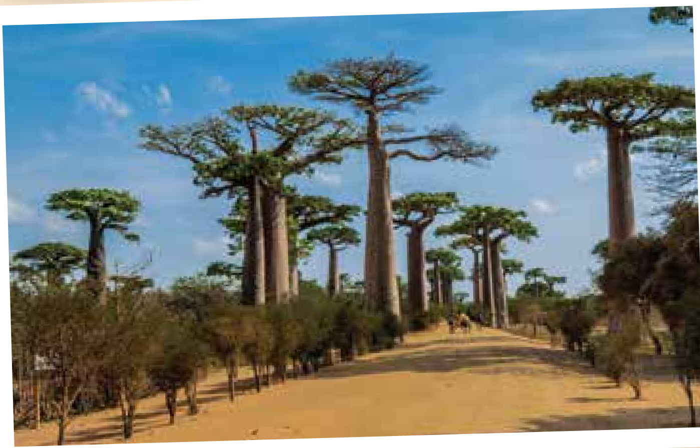
Embarking on a photographic trip to Madagascar was always in my bucket list since I took up wildlife photography seriously. I have visited a number of places all over the world in search of capturing wildlife in my frame but MADAGASCAR was a WORLD APART. It was an unparalleled journey into a realm of biodiversity unmatched anywhere else on Earth. I set foot on this island brimming with endemic species, in the dense rainforests of Andasibe-Mantadia National Park, where the haunting calls of the indri lemurs echoed through the misty canopy. Patiently waiting amidst the towering trees, I was rewarded with glimpses of these majestic creatures leaping effortlessly from branch to branch, their expressive faces a window into this unique and fragile ecosystem. Besides the INDRI we could capture almost 8 other species of Lemurs in various national parks, leaping, playing, howling and foraging amidst the dense foliage captivating us with their expressive faces and acrobatic movements.



Whatever we photographed henceforth was endemic be it lizards, geckos, chameleons, frogs and even birds. Not to mention many were endangered.

Our enchanting trip never could have been complete without the exploration of the otherworldly Avenue of the Baobabs, in MORONDAVA. The baobab trees, known locally as renala or reniala (from Malagasy reny ala "mother of the forest") are a legacy. Capturing the iconic trees silhouetted against the sunset, was a dream come true for me.

Other than wildlife, the rich cultural tapestry of Madagascar provided a colorful backdrop to my visual exploration. From the bustling markets of



Antananarivo to the tranquil fishing villages along the coast, every frame told a story of resilience and tradition. The warmth and hospitality of the Malagasy people added a human element to my photographic narrative, creating a deeper connection to the land and its inhabitants.

Madagascar, with its unique blend of nature and culture, offered a treasure trove of visual inspiration that continues to resonate in my photographic work to this day. The island's unique ecosystems and rare wildlife species have left me with some awe-inspiring captures and a bagful of memories which I would definitely like to share.

ILS THROUGH LENS

SPREAD THE
HEALING TOUCH

KEY ACTIVITIES

ILS Salt Lake Elevates Gastroenterology Department with New Procedure Rooms & Latest Equipment Under One Roof in January 2024

Insurance & TPA Associates Meet at Kolkata in February 2024

Republic Day Celebration at ILS Hospitals

Inauguration of GPT Sports Complex at Bidasar (Rajasthan) in January 2024

GPT Group Annual Picnic Organised in Feb 24

Basic Neonatal Resuscitation Training Programme for Doctors & Nurses Conducted by Quality Team in March 2024

IPO Listing of GPT Healthcare in February 2024

Annual Inter Unit Cricket Tournament of GPT Group Organised in January 2024

Women's Day Felicitation of ILSS Nursing Head

PRESS RELEASE

হাড়ের মজবুতির নেপথ্যে

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ফাইল ছবি প্রতীকী, সৌজন্য- পিক্সাবেয়

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কলকাতা: বয়স বাড়লে শরীরে একে একে নানা রোগ বাসা বাঁধে। একই সঙ্গে দুর্বল হতে থাকে হাড়ও। বয়স বাড়লে অনেকেই হাড়ের নানা রোগে ভুগতে থাকেন। এর মধ্যে রয়েছে অস্টিওপোরোসিস, অস্টিওআর্থ্রাইটিসের মতো সমস্যা। এই ধরনের সমস্যা দিন দিন আরও দুর্বল করে দেয় শরীর। তবে হাড়ের স্বাস্থ্য খুব সহজেই ভাল রাখা সম্ভব। তার জন্য জরুরি স্বাস্থ্যকর ডায়েট। হাড় ভাল রাখতে ডায়েটে কিছু নির্দিষ্ট খাবার রাখা জরুরি। এই ধরনের খাবার হাড়ের জরুরি পুষ্টি উপাদানগুলির জোগান দেয়। এই উপাদানগুলি হাড়কে ভিতর থেকে মজবুত করে। এই বিষয়েই এবিপি লাইভকে বিশদে জানালেন **আইএলএস হাসপাতালের ডায়েটিশিয়ান সোনম গুপ্তা।**

সকাল, দুপুর না রাত? কখন দাঁত মাজলে সবচেয়ে উপকার

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সকাল, দুপুর না রাত? কখন দাঁত মাজলে সবচেয়ে উপকার? (ছবি সৌজন্য: পিক্সাবে)

কলকাতা: কেউ সকালে ঘুম থেকে উঠেই দাঁত মাজেন। কেউ আবার সারাদিনে দাঁত মাজেন না। রাতে ঘুমোতে যাওয়ার আগে দাঁত ব্রাশ করেন। আবার কেউ স্নানের আগে দুপুরবেলা দাঁত মেজে স্নান করেন। কিন্তু দাঁত মাজার সঠিক সময় কোনটা ? কখন মাজলে দাঁত সবচেয়ে ভাল থাকে ? এমনকি মুখের স্বাস্থ্যও বেশ ভাল থাকে ? এই বিষয়েই এবিপি লাইভের সঙ্গে বিশদে কথা বললেন **আইএলএস হাসপাতালের ডেন্টাল সার্জেন অক্ষয় লাধানিয়া।**

ভিটামিন E মাখলে কতটা লাভ? কী বলছেন ডার্মাটোলজিস্ট

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ভিটামিন E ক্যাপসুল ত্বকে মাখলে কেমন উপকার? (প্রতীকী ছবি সৌজন্য: পিক্সাবে)

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কলকাতা: শীতকাল হোক বা গরমকাল, একের সময় ত্বকের একেকরকম সমস্যা। আর সেই সমস্যা সামাল দিতে অনেকেই নানা টোটকায় ভরসা রাখেন। কেউ নিয়মিত কিছু উপকরণ দিয়ে ত্বকের পরিচর্যা করেন। এর মধ্যেই একটি বিশেষ উপকরণ হল ভিটামিন E ক্যাপসুল। ভিটামিন E শরীরের একাধিক উপকারে লাগে। কিন্তু ত্বকের যত্নে কি এটি আদৌ জরুরি? ভিটামিন E ক্যাপসুল ত্বকে মাখলে কেমন উপকার? কতটা লাভ? (vitamin E benefits for skin) এই বিষয়ে এবিপি লাইভকে বিশদে জানালেন **আইএলএস হাসপাতালের সিনিয়র ডার্মাটোলজিস্ট ও মেডিক্যাল কসমেটোলজিস্ট চিকিৎসক আশারাণী ভোল।**

কিছু বোঝার আগেই কেন ফ্যাটি লিভার হয়?

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কিছু বোঝার আগেই কেন ফ্যাটি লিভার? (Pixabay)

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কলকাতা: শরীরে ফ্যাট জমছে। তরতরিয়ে ওজন বাড়ছে। আর কিছু বুঝে ওঠার আগেই নানা রোগ বাসা বাঁধছে দেহে। ... এমনই একটি রোগ হল ফ্যাটি লিভার। লিভারে খাবার হজম করার জন্য গুরুত্বপূর্ণ উৎসেচক তৈরি হয়। সেই লিভারেই ফ্যাট জমতে থাকে। বর্তমানে চিকিৎসকেরা দুরকম ফ্যাটি লিভারের (fatty liver) কথা বলে থাকেন। এর মধ্যে একটি হল অ্যালকোহলিক ফ্যাটি লিভার (alcoholic fatty liver)। অন্যটি নন‌অ্যালকোহলিক ফ্যাটি লিভার (nonalcoholic fatty liver)। মদ্যপান না করলেও অনেকে ফ্যাটি লিভারের সমস্যায় ভোগেন। আর সেই সমস্যাকে ... নন‌অ্যালকোহলিক ফ্যাটি লিভার। এই ধরনের লিভারের সমস্যায় কী কী উপসর্গ দেখা দেয়? এই ব্যাপারে ... এবিপি লাইভকে জানালেন **আইএলএস হাসপাতালের বিশেষজ্ঞ চিকিৎসক ...**

শীত পড়তেই পিরিয়ডের ৫ সমস্যা

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শীত পড়লেই পিরিয়ডের ৫ সমস্যা (প্রতীকী ছবি সৌজন্য: পিক্সাবে)

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কলকাতা : শীতকাল এলেই সর্দি, কাশির মতো নানা সমস্যা লেগে থাকে। তবে মহিলাদের ক্ষেত্রে এই সময়টা আরও কষ্টের। কারণটা হল ঋতুস্রাব (period)। শীতকালে বেশ কয়েকটি শারীরিক পরিবর্তন হয়। তার ফলে এই মরসুমে ঋতুস্রাবজনিত সমস্যা বেড়ে যায়। সেই সমস্যাগুলি কী কী? এই বিষয়ে এবিপি লাইভের সঙ্গে বিশদে আলোচনা করলেন **আইএলএস হাসপাতালের বিশিষ্ট স্ত্রীরোগ বিশেষজ্ঞ চিকিৎসক অংশু আগরওয়াল।**

...p dip, pollution spike fill ...spital beds with lung...

...Spurt In ...mber In ...Week'

MERCURY FLUCTUATION UNLEASHES VIRUS...

...to cause ... public health crisis: Docs

This time, the common presentation is either respiratory symptoms, like sore throat, runny nose, body ache, fever and gastrointestinal symptoms, like loose motion. Though mild, it has a high infectivity rate

News Nat...

ILS Hospitals' Renovated Fac... Quality of Gastroenterology

रविवार — डॉक्टरी सलाह

प्रभात खबर | 04

दांतों की समस्याओं को दूर रखने के लिए नियमित लें चिकित्सकीय सलाह

अकेशनाल विञ्ज ड्रिङ्कार, आपनारও কিন্তু শিয়রে...

কালেজের পানের ক্ষতি

কলকাতা: হাড়ের জোর কমে গেলে অনেকেই বলে ফেলেন "বয়স হয়েছে"। আসলে কি সবার ততটা ব... হয়, অতটা বয়সে হাড়ের এমন সমস্যা শুরু হয় ? বরং বাস্তব বলছে, সময়ের আগে ক্ষয় শুরু হয় হাড়ে... আমাদের বেশ কিছু অভ্যাস এর জন্য দায়ী। আবার কিছু ক্ষেত্রে হাড়ের এই ক্ষয়ে যাওয়া নাকি আমা... হাতে থাকে না। কিন্তু কেন সময়ের আগে হাড় ক্ষয়ে যেতে থাকে ? কাদেরই বা এই বিপদ বেশি ? ... করলে অকালে হাড়ের ক্ষয় থেকে রেহাই পাওয়া সম্ভব ? এই বিষয়ে এবিপি লাইভের সঙ্গে বিশদে আলোচনা করলেন **ফর্টিস হাসপাতালের রাষ্ট্রপতি পুরস্কার প্রাপ্ত অর্থোপেডিক সার্জেন অনি... বসু ও আইএলএস হাসপাতালের অস্থিবিশেষজ্ঞ চিকিৎসক সিদ্ধার্থ গুপ্ত।**

Ear Cleaning Tips: চাবি, কাঠি দিয়ে কান সাফ করেন ? পর্দার বিপদ, বিকল্প কী

Ear Cleaning Myths and Facts: চাবি, কাঠি দিয়ে কান সাফ করেন অনেকেই। কিন্তু আদৌ কি কান সাফ করার কোনও প্রয়োজন রয়েছে

By : ABP Ananda

কলকাতা: কান সাফ করতে অনেকেই চাবি, কাঠি ব্যবহার করেন। কিন্তু এতে কি কান স... হতে পারে? এবিপি লাইভের সঙ্গে এই বিষয়ে বিশদে আলোচনা করলেন আইএলএস হ... ইএনটি বিশেষজ্ঞ চিকিৎসক সৌম্যরূপ দাস (Senior ENT and head neck cochlear ... skull base consultant surgeon)।

গ্যাস্ট্রো-এন্টেরোলজি বিভাগ নতুন করে সাজিয়ে পরিষেবা চালু আই এল এস হাসপাতালে। উদ্বোধনী অনুষ্ঠানে সিনিয়র ভাইস প্রেসিডেন্ট দেবাশিস ধর, ম্যানেজিং ডিরেক্টর ডাঃ ওম তাঁতিয়া, ডাঃ জয়ন্ত মুখার্জি, ডাঃ অরুণা তাঁতিয়া, ডাঃ ঘনশ্যাম গোয়েল প্রমুখ

Online News 9

"ILS Hospitals Elevates Gastroenterology Care With Revamped Facility And Expanded Services"

""ILS Hospitals has always led the way in providing excellent medical care. The improved Gastroenterology section demonstrates our dedication to keeping up with medical developments and customising our services to our community's changing demands", said Dr Om Tantia, HOD – General & Laparoscopic Surgery, ILS Hospitals Saltlake, Managing Director & Founder, ILS Hospitals."

Biz Rapidx Fast News

"ILS Hospitals Elevates Gastroenterology Care With Revamped Facility And Expanded Services"

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EasternChronicle

Hosp elevates gastroenterology care

CHRONICLE NEWS SERVICE

KOLKATA: ILS Hospitals, a renowned name in the healthcare industry announced the relaunch of its gastroenterology segment that demonstrates its determination to provide complete healthcare solutions.

The redesigned gastroenterology department offers a wider range of gastro treatments and state-of-the-art medical care for individuals with digestive health issues.

The hospital has increased its patient capacity for gastrointestinal treatments which is a major step forward. The renovated facility can now handle up to 50 patients per day for outpatient consultations and operations, meeting the increasing need for gastrointestinal health specialists.

"The hospital has always led the way in providing excellent medical care. The improved Gastroenterology section demonstrates our dedication to keeping up with medical developments and customising our services to our community's changing demands", said Dr Om Tantia, Managing Director and Founder.

A greater number of consultation rooms in the relaunched section contribute to a more seamless and effective patient experience. Additionally, more operation rooms have been added, giving the medical staff the latest equipments to provide cutting-edge gastroenterological treatments.

Patients can now benefit from a more comprehensive range of services, supported by Ils Hospitals' dedicated team of experienced gastroenterologists and cutting-edge medical infrastructure.

Business Micro – Stories That Matter

"ILS Hospitals Elevates Gastroenterology Care With Revamped Facility And Expanded Services"

লিপি

আইএলএস হাসপাতালে গ্যাস্ট্রোএন্টেরোলজি কেয়ারের উন্নতি

আজকাল

পরিষেবা বৃদ্ধি

গ্যাস্ট্রোএন্টেরোলজি বিভাগকে নতুন করে সাজিয়ে পরিষেবা বাড়াল আইএলএস হাসপাতালের সল্টলেক শাখা। অন্ত্রের সমস্যায় আধুনিক মানের চিকিৎসা দিতে নতুন করে সংস্কার করা হল বলে জানিয়েছেন সংস্থার সিনিয়র ভাইস প্রেসিডেন্ট দেবাশিস ধর। ওপিডিতে রোগীদের পরামর্শের সঙ্গে দৈনিক ৫০ জন রোগীর অস্ত্রোপচার করা সম্ভব হবে।

प्रभात खबर

अस्पताल ने गैस्ट्रोएंटरोलॉजी यूनिट की री-लॉचिंग

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(Near City Centre 1)
ILS CARE 4020 6500

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1, Mall Road
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ILS CARE 4031 5001/02

HOWRAH
98, Dr. Abani Dutta Road
Opp. Golabari P.S.
ILS CARE 4088 0000

AGARTALA
Capital Complex Extention
P.O. New Secretariat
ILS CARE 089740 50300

Coming soon at Raipur

Corporate Office
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We invite your valuable comments and suggestions at **info@ilshospitals.com**.

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