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ILS TIMES

A NEWSLETTER OF ILS HOSPITALS

ONE VISION | ONE TEAM | ONE ILS

ILS HOSPITALS

TRUSTED FOR 25 Years IN EASTERN INDIA

YOUR **HEALTH,** OUR **HAPPINESS**



What he left behind

takes us forward.



Late Dwarika Prasad Tantia

Karmayogi and Samajsevak

27.05.1954 – 17.08.2025

GPT group | ILS HOSPITALS

GPT INFRAPROJECTS | GPT HEALTHCARE | GPT CASTINGS

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Dr. Om Tantia
Chairman & Managing Director,
GPT Healthcare Limited

Message from Our Chairman

Dear Colleagues, Friends, and Members of the ILS Family, As you turn the pages of this edition of ILS Times, you will discover a vibrant reflection of the many facets that define ILS Hospitals.

The Case Reports showcase our commitment to clinical excellence, complex problem-solving, multidisciplinary teamwork, and innovative approaches to patient care. Our Awards & Accolades celebrate the recognition earned by our hospitals and teams for their continued pursuit of excellence. The Key Activities section captures the initiatives and engagements that strengthen our culture of collaboration, learning, wellness, and community connection. Through Events & Press Releases, we share important milestones, scientific programmes, institutional celebrations, and developments across the ILS network. The New Services featured in this issue reflect our ongoing efforts to expand specialised capabilities and bring advanced healthcare closer to the communities we serve. We are also delighted to welcome our new doctors, whose expertise and dedication will further enrich the ILS family. The Quiz adds an element of learning and engagement, reminding us that knowledge and curiosity are essential to continuous growth in healthcare.

Together, these sections tell a larger story—one of clinical innovation, professional excellence, institutional growth, and meaningful community engagement. They also reflect the collective contribution of our doctors, nurses, technicians, administrators, and every member of the ILS team who works tirelessly behind the scenes.

I hope this edition inspires us to celebrate our achievements, learn from one another, and remain committed to delivering compassionate, ethical, and high-quality care. As we continue our journey forward, let us carry the spirit of excellence that has defined ILS and together build an even stronger future for our patients and our communities.

Dr. Om Tantia



Dr. Poonam Kapoor
Consultant, Histopathology
Laboratory Head
ILS Hospitals, Salt Lake



Dr. Subhrojyoti Bhowmick
Vice President,
Clinical Services & Quality,
GPT Healthcare Limited



Dr. Nivedita Saraogi
General Manager, Medical Services
ILS Hospitals, Dum Dum

Message from the Co-Editors' Desk

It is our privilege to welcome you to this special edition of the ILS Hospitals newsletter—an issue that reflects not just our current achievements, but the remarkable journey that has shaped who we are today.

As we celebrate 26 years of ILS Hospitals, we honour a legacy built on trust, clinical excellence, and an unwavering commitment to patient care. From pioneering laparoscopic surgery in Eastern India to expanding into a multi-specialty healthcare network, our growth has been powered by dedicated teams whose passion continues to elevate our standards year after year.

This milestone year also marks another significant achievement - 800+ successful robotic surgeries at Salt Lake unit. This accomplishment stands as a testament to our ongoing pursuit of innovation, precision-led care, and the integration of advanced medical technologies that enhance patient outcomes.

In this edition, we share the stories, initiatives, and advancements that showcase the spirit of ILS—where compassion meets expertise, and where every milestone inspires us to reach even higher.

Thank you for being an integral part of our journey.

Warm regards

Dr. Poonam Kapoor

Dr. Subhrojyoti Bhowmick

Dr. Nivedita Saraogi



Dr. Vishal Goyal
Group COO
GPT Healthcare Limited
ILS Hospitals

Message from Our Group COO

Building the Future of Healthcare — Together

At ILS Hospitals, Patient centric approach reflects the collective commitment of our clinicians, nurses, technicians, support teams and administrative professionals towards Clinical Outcomes, Compassionate care with a seamless patient experience. Sustainable excellence is built by teams that learn, innovate and improve continuously.

Over the years, I**LS Hospitals has advanced from a neighbourhood hospital network into a provider of tertiary and quaternary care, offering advanced services in Centre of Excellence (COEs)** for Cardiac sciences, Neuro-sciences, Renal-Sciences, Gastro-Sciences, Mother and Child care, besides focussing on evolving areas like Robotic surgery, Oncology and Organ transplantation across Eastern and Central India.

Our **Patient First approach** earned the **ET Edge Best Healthcare Brands Award in 2025 and 2026.** ILS Dumdum and ILS Agartala are **CAHO-affiliated Centres for Quality Promotion (CQP).** Our nursing teams received the **ICC Excellence Award,** while **Outlook ranked ILS among Eastern India's leading hospitals.**

Next phase prioritizes Technology adoption alongside Clinical Governance, and growth in terms of increasing beds and service verticals:

-Clinical dashboards, Clinical decision support systems, Evidence-based care pathways for Outcome benchmarking

-Electronic Medical Records adoption for seamless access of care in and beyond the hospital

-Learning Management System - for focussed skill development with flexibility and greater compliance

-Medication monitoring, Infection prevention and Antimicrobial stewardship for Patient safety towards minimizing the risk

-Academics for PG Doctors and Research in form of Clinical trials to contribute towards Transformative Medical science

-Doctor and Patient applications on mobile platform for easy access to Information

-Upcoming Launch of Jamshedpur - 200 bedded unit in March - April 2027

Together, upholding the highest standards of quality and safety would define this phase of shaping the future of healthcare.

Dr. Vishal Goyal

NEW SERVICES

800+
ROBOTIC SURGERIES PERFORMED

at ILS Hospitals Salt Lake

PET-CT & LINAC

at ILS Hospitals Agartala

MANOMETRY HUTT

at ILS Hospitals Dumdum

PICU

at ILS Hospitals Howrah

CHEMOTHERAPY

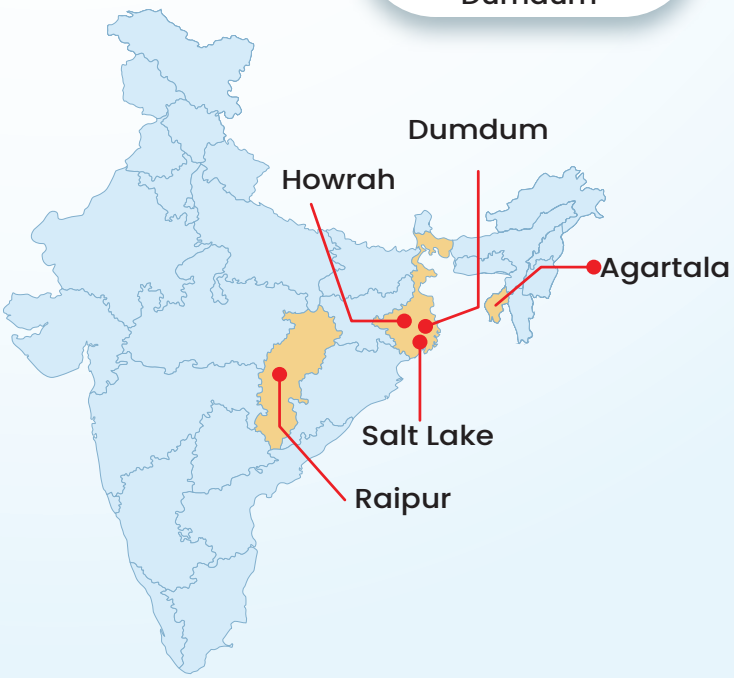
at ILS Hospitals Raipur

ENDOSCOPIC ULTRASOUND

at ILS Hospitals Dumdum

CTVS

at ILS Hospitals Dumdum



A NEW OPPORTUNITY IN ADVANCED MEDICAL EDUCATION

DrNB MEDICAL GASTROENTEROLOGY

PROGRAMME AT

ILS HOSPITALS SALT LAKE

Approved by the
National Board of Examinations in Medical Sciences (NBEMS) New Delhi



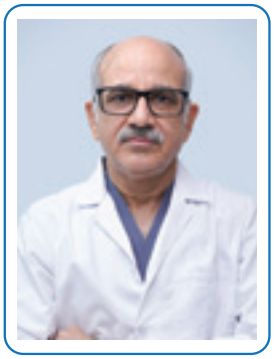
Creating opportunities for future specialists through:

- **Clinical Excellence**
- **Advanced Procedures**
- **Academic Mentorship**
- **Research Exposure**

CASE 1 | Obstructive Uropathy Secondary to Pelvic Endometriosis: A Scary Story



Dr. Aruna Tantia
Consultant, Obstetrics & Gynaecology (Robotic)



Dr. Shashi Khanna
Consultant, Robotic, Laparoscopic & General Surgery



Dr. Gotam Pipara
Consultant, Urology

Introduction: Endometriosis is a chronic, inflammatory, hormonal, immunological, systemic, and diverse disease that can present with three distinct phenotypes — superficial endometriosis. ovarian endometrioma, and deep infiltrating endometriosis. Obstructive uropathy often leads to hydroureteronephrosis and potential renal damage if not decompressed in a timely manner. Among the many common causes such as renal calculi and abdominopelvic tumours, endometriosis is a relatively uncommon cause of obstructive uropathy, often involving the ureters and rarely, the kidneys. The incidence of endometriosis involving the urinary system ranges from 0.3% to 12%.

Endometriosis of the urinary tract and endometrioma should be considered as differential diagnoses, especially in premenopausal women presenting with unilateral or bilateral obstructive uropathy of uncertain cause. Timely diagnosis and intervention, supported by a multidisciplinary approach, help prevent irreversible renal damage.

Case Brief: A 40-year-old married, working female presented to the emergency room with severe left-sided radiating flank pain, a lump abdomen, heavy menstrual bleeding, and inability to pass urine. She had a history of one previous LSCS and suffered from type 2 diabetes mellitus, hypertension, and hypothyroidism.

Physical examination revealed a large 24-week-sized lump abdomen, which was cystic in consistency with tenderness. Imaging studies by using USG

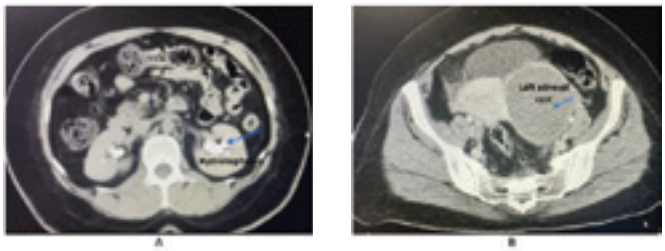


Image 1: CT Urography showing left renal hydronephrosis (A) and left adnexal cyst pressing on the ipsilateral ureter (B).

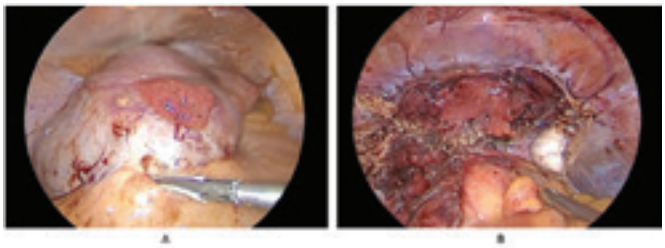


Image 2 : Laparoscopy showing a large cystic left adnexal mass (A) and Vault after removal of the cyst and uterus with preserved right ovary (B).

> "A 40-year-old married, working female presented to the emergency room with severe left-sided radiating flank pain, lump abdomen, heavy menstrual bleeding, and inability to pass urine"

revealed a large cystic left adnexal mass followed by CT urography, which showed hydroureteronephrosis and a large cystic mass measuring 10 cm, compressing the urinary bladder and ureter, along with uterine adenomyosis. (Image 1) The cystic mass was diagnosed as an endometriotic cyst with haemorrhagic content. Considering the urgency of the situation, an emergency cystoscopy and left DJ stenting were performed to relieve the obstruction, which resulted in alleviation of flank pain. As the patient was anaemic, she was transfused with two units of packed red blood cells followed by laparoscopic hysterectomy with left salpingo-oophorectomy, right salpingectomy, and adhesiolysis. Laparoscopically, a left adnexal cyst measuring around 10cm x 12cm, smooth surface was noted. Chocolate coloured material was aspirated from the cyst. The right ovary was found to be normal and was preserved (Image 2).

Postoperative imaging showed complete resolution of left ureteral obstruction and hydronephrosis. Her lower abdominal pain subsided, and to date, she remains in perfect health. Histopathology confirmed endometriotic cyst with adenomyosis.

Discussion: Endometriosis can present with a wide spectrum of symptoms, including chronic pelvic pain, dysmenorrhoea, dyschezia, and in rare cases, obstructive uropathy. Types of endometriosis affecting the genital tract can be classified as superficial or deep, and depending on the location, maybe further categorised as involving the upper or lower urinary tract. Most commonly, the urinary bladder is affected. Endometriosis of the upper urinary tract most commonly involves the ureter, particularly the left side. Ureteral involvement may cause extrinsic or intrinsic compression. Diagnosis of endometriosis involves cystoscopy and biopsy. In cases of superficial disease, transurethral resection (TUR) of the lesion alone may be sufficient. However, in deep endometriosis, partial cystectomy may be required. In cases of ureteral endometriosis with obstruction and acute kidney injury (AKI), the most important initial step is relief of obstruction by insertion of a D–J stent or placement of a percutaneous nephrostomy (PCN) tube.

Deep infiltrating endometriosis of the bladder and ureter may result in compromise of renal function over time. Although hormonal therapy often demonstrates a strong clinical response, once fibrosis develops, medical management is unlikely to relieve obstruction. Therefore, prompt surgical management is essential to avoid irreversible loss of kidney function. In cases of obstructive uropathy, relief of obstruction followed by definitive corrective surgery is indicated. When fertility is not desired, hysterectomy with bilateral salpingo - oophorectomy is considered ideal.

A case similar to ours was reported by Correia et al. (2017), in which a routine examination of a 29-year-old woman revealed altered renal function. This prompted a series of further investigations, which confirmed suspected endometrioma via exploratory laparotomy. Renal function was salvaged by bilateral ureteral D–J stent placement.

Another reported case involved a 65-year-old patient who presented with symptoms similar to our patient. Subsequent CT imaging demonstrated an irregular, infiltrative right adnexal mass measuring 7 × 5.5 × 9.5 cm, with severe chronic right hydroureteronephrosis and marked cortical thinning secondary to obstruction of the right lower ureter by a pelvic mass. The patient underwent exploratory laparotomy with excision of the mass, right radical nephrectomy, right ureteral resection, lower anterior resection, partial excision of the bladder, and colostomy due to severe renal compromise. Histopathology revealed endometrial-type complex hyperplasia with focal atypia arising in a background of endometriosis.

For urinary tract endometriosis, conservative laparoscopic surgery provides long-lasting symptom alleviation and shows a low rate of anatomical relapse. Ureterolysis should be performed in all patients prior to endometriotic nodule resection to recognise and prevent ureteral damage. Modern endometriosis management requires a broad-based, and multidisciplinary approach, centred on the patient's symptoms and priorities.

Conclusion: To conclude, obstructive uropathy due to endometriosis, although rare, is a possibile and challenging condition.

Our case demonstrates successful management of obstructive uropathy and large endometriotic cyst with timely D-J stenting followed by definitive surgery which effectively resolved the obstruction and preserved renal function.

This case underscores the importance of considering urinary tract endometriosis and endometriotic ovarian cysts as differential diagnoses in women presenting with urological symptoms. It also highlights the need for close collaboration between urologists and gynaecologists in such cases, emphasising that rapid intervention and a multidisciplinary management approach are essential for optimal patient outcomes.

CASE 2 | Aberrant Right Hepatic Duct Draining into the Cystic Duct — A Rare Intraoperative Finding



Dr. Om Tantia
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General Surgery

Case Brief: A 71-year-old man presented with a one-year history of intermittent colicky pain in the right upper quadrant of the abdomen, especially following meals. He reported no history of nausea, vomiting, fever, or jaundice. His medical history included diabetes mellitus, hypertension, and dyslipidemia. An ultrasound examination indicated calculous cholecystitis, and preoperative laboratory tests, including liver function tests, were normal. Given these findings, he was diagnosed with symptomatic gallstone disease and was scheduled for a laparoscopic cholecystectomy.

During the surgical procedure, adhering to the Critical View of Safety principles, an aberrant bile duct was discovered originating from the liver bed and draining into the cystic duct. The cystic artery was secured with a Ligaclip LT 300 and subsequently divided. The gallbladder was meticulously dissected from the liver bed, and an endoloop ligature was applied distal to the junction of the aberrant duct and the gallbladder to avoid occlusion of the aberrant duct. The specimen was retrieved in an endobag and sent for histopathological examination; a drain was positioned in the subhepatic space, and the surgical incisions were closed (Images 1, 2, 3, and 4).

The recovery following the surgery was without complications. To exclude the possibility of an accidental bile duct injury, a postoperative MRCP was conducted, which identified an unusual branch of the right hepatic duct extending into the gallbladder fossa, as well as a prominent yet non-dilated extrahepatic biliary tract that exhibited no altered signal intensity. Additionally, pancreas divisum was observed. Follow-up assessments at one week and one month after the surgery indicated normal liver function tests, and screening ultrasonography confirmed a non-dilated biliary system, thereby affirming a smooth recovery.

Discussion: This case underscores the vital significance of comprehensively understanding biliary anatomical variations in the context of surgery.

Utilizing the Critical View of Safety (CVS) approach along with the fundus-first technique facilitated a secure and optimal visualization of the junction between the cystic duct and the aberrant right hepatic duct (ARHD).

According to Hisatsugu's classification, this case is categorized as the rare Type V, where the ARHD connects with the cystic duct. This variation has a reported incidence of 1.02% and poses a significant risk of intraoperative bile duct injury. [6]

Failure to identify and properly manage an ARHD can result in serious complications, including recurrent obstructive cholangitis, intrahepatic lithiasis, liver atrophy, and cholangiocarcinoma [7]. The choice to either preserve or ligate the ARHD is contingent upon its size and functional importance. Longmire and Tompkins [8] advised ligation for ducts measuring less than 1 mm, whereas ducts exceeding 2 mm or those that drain one or more liver segments necessitate reconstruction.

In this instance, the ARHD was recognized during the operation and was successfully preserved owing to its size and importance.

Postoperative MRCP validated the existence of the aberrant duct and indicated that both intrahepatic and extrahepatic biliary ducts were non-dilated. During the follow-up period, the patient exhibited no signs of biliary dilatation on the screening ultrasonography, and liver function tests continued to be within normal ranges at both 1 week and 1 month following the surgery.

Conclusion: We report an unusual instance of an aberrant right hepatic duct (ARHD) discovered during a laparoscopic cholecystectomy performed for symptomatic gallstone disease. The Critical View of Safety (CVS) technique was crucial in precisely recognizing and addressing this anatomical biliary variant. Understanding possible anatomical variations, along with careful surgical methods, is vital for achieving successful results and avoiding iatrogenic bile duct injuries in these situations.

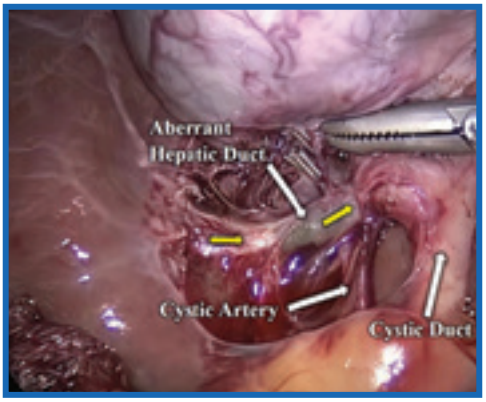


Image 1: Intraoperative image showing an aberrant right hepatic duct draining into the cystic duct

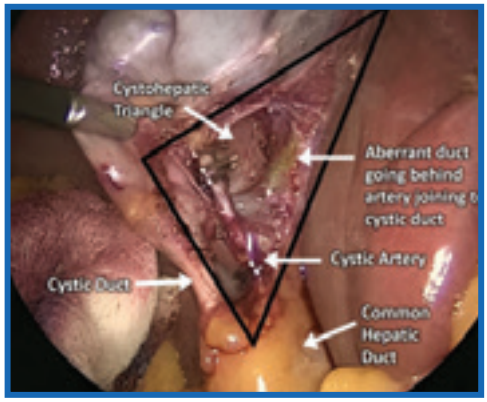


Image 2: Intraoperative image showing the aberrant duct within the hepatocystic triangle



Image 3: Intraoperative image showing preservation of aberrant biliary drainage through the cystic duct following subtotal cholecystectomy

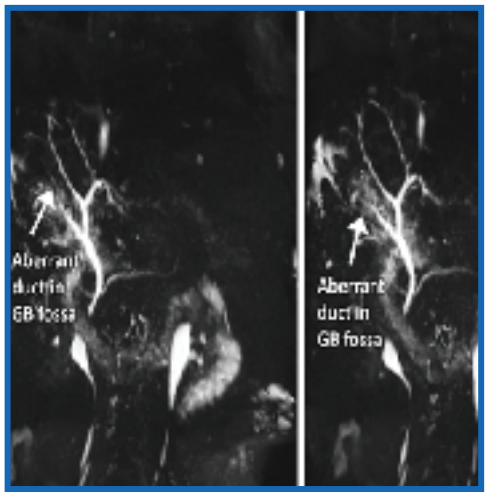


Image 4: Postoperative MRCP image showing an aberrant duct draining in the gallbladder fossa draining into the cystic duct

CASE 3 | Successful Healing of a Chronic Wagner Grade III Diabetic Foot Ulcer Through Advanced Wound Care and Multimodal Management



Dr. Ghanshyam Goyal
Consultant, Diabetology & Endocrinology



Dr. Rekha Srivastava
Clinical Podiatrist & Research Coordinator

Case Brief: A 45-year-old male, with a history of type 2 diabetes mellitus spanning 8 years and bilateral peripheral neuropathy, presented with a chronic non-healing ulcer measuring 3.5 × 3.0 cm^2 on the plantar surface of his left foot, which had persisted for 14 months. He had previously undergone bilateral forefoot amputation due to trauma in 2009. Upon examination, the ulcer was noted to be surrounded by callus. According to the International Working Group on the Diabetic Foot (IWGDF), the standard testing sites for monofilament and Vibration Perception Threshold (VPT) assessments typically include the great toe, first metatarsal, and fifth metatarsal head. However, due to the prior amputation of the forefoot, the monofilament and vibration perception tests were conducted on the plantar surface of the heel area, midfoot, and dorsum of the foot. The results indicated gross impairment in both monofilament and VPT. Pedal pulses, including dorsalis pedis (DP) and posterior tibial (PT), were palpable, and the ankle-brachial pressure index (ABPI) was found to be normal (Left - 1.1 and Right - 1.0).

- Fluorescence imaging of the wound indicated the presence of both Gram-positive and Gram-negative bacterial growth.
- A deep tissue culture sensitivity test revealed the growth of Staphylococcus aureus.
- An X-ray of the foot confirmed the diagnosis of underlying osteomyelitis.
- Glycaemic control was assessed as fair, with an HbA1C level of 7.2%, and laboratory parameters remained within normal ranges.
- Following informed consent, empirical antibiotic therapy was commenced with rifampicin and quinolones.Liver and renal function tests were initially monitored weekly for 2 weeks and subsequently monthly.

Wound debridement and callus shaving were performed, followed by the application of a sterile, silver-based hydro-desloughing advanced dressing. The silver ions provide antibacterial properties that may assist in decreasing the local bacterial load. The Ag+ ion exhibits broad-spectrum antimicrobial activity and is especially effective against Staphylococcus aureus, MRSA, Streptococcus pyogenes, and Pseudomonas aeruginosa. Silver dressings can diminish the bacterial population within the biofilm within 24 to 72 hours. A modified posterior slab with a window was utilized for offloading. Family members received training for regular dressing changes.

At four weeks, the ulcer had decreased in size, with fluorescence imaging showing no microbial growth. Deep-tissue cultures also showed no bacterial presence. The dressing was changed to a hydrocellular-lipido-colloid dressing with a TLC-NOSF matrix to promote healing. Radiographic improvement was noted at twelve weeks, and complete healing was achieved by six months. Rifampicin and quinolones were administered for twelve weeks. Offloading continued for two weeks after healing to prevent recurrence.

- **Discussion:** This case underscores several critical elements in diabetic foot ulcer (DFU) management:
- Diagnosis: X-rays are crucial for evaluating DFUs and may indicate osteomyelitis through bone destruction, periosteal reaction, or intraosseous gas, suggesting infection. Fluorescence imaging and deep tissue cultures are essential for detecting bacterial colonization, guiding antimicrobial therapy, and monitoring progress.
- Antimicrobial therapy: Empirical rifampicin and quinolones proved effective against Gram-positive and Gram-negative bacteria.
- Rifampicin targets Staphylococcus aureus and other Gram-positive bacteria by inhibiting RNA synthesis.
- It is bactericidal and effectively eradicates bacteria while penetrating biofilms.
- Wound care: Innovative dressings assisted in slough removal, moisture balance, and granulation.
- Offloading: A tailored posterior slab with a window enabled healing while allowing dressing changes without pressure on the wound.
- Outcome: Conservative treatment achieved healing within six months, avoiding additional surgery.
- This case highlights the importance of educating patients and caregivers about wound care and ensuring consistent follow-up.
- **Conclusion :** Comprehensive conservative treatment that incorporates targeted antimicrobial therapy, advanced dressing systems, and offloading techniques can lead to complete wound healing.The management of diabetic foot ulcers (DFU) is based on three fundamental principles:
- Adequate debridement and infection control: Callus shaving and wound debridement were performed. Given that the patient has DFU with osteomyelitis, empiric therapy with Rifampicin and Quinolones was initiated after obtaining informed consent.
- Adequate vascularity: Sufficient blood supply is essential for the healing of foot ulcers. In this instance, as the pedal pulses are palpable and the Ankle-Brachial Index (ABI) is normal, vascularity is deemed adequate.
- Offloading: Offloading is essential for the healing of plantar ulcers. It should be tailored to the patient, user-friendly, easy to apply, and cost-effective.
- The choice of dressing material is critical for enhancing wound healing.

At Presentation	
	

Image 1

Ulcer Measurement (3.5 X 3.0cm)	Advanced Dressing Material
	

Image 2

After 4 Weeks	After 8 Weeks	X –Ray After 12 Weeks
		

Image 3

After 18 Weeks	Ulcer in Remission at 27 Weeks
	

Image 4



CASE 4 | Prostatic Artery Embolization in High-Risk Patient with Symptomatic Benign Prostatic Hyperplasia: A Case Series

Dr. Jyotish Roy
Consultant, Radiodiagnosis
& Interventional Radiology

Introduction: Benign prostatic hyperplasia (BPH) is a common cause of lower urinary tract symptoms (LUTS) in elderly men. Although transurethral resection of the prostate (TURP) remains an established treatment, surgery may be unsuitable for patients with significant cardiac or pulmonary comorbidities. Prostatic artery embolization (PAE) offers a minimally invasive alternative that can provide symptomatic relief without the risks associated with conventional surgery and general anesthesia.

Case Brief: An 84-year-old male presented with severe LUTS, including frequent nocturia and weak urinary stream. His International Prostate Symptom Score (IPSS) was 28.

Echocardiography revealed an ejection fraction of 20% following myocardial infarction, making him unsuitable for general anesthesia and conventional surgical treatment. Transrectal ultrasonography showed a prostate volume of 78 g.

Bilateral PAE was performed through the right femoral artery under local anesthesia. A 2.0-Fr microcatheter was used for super-selective catheterization of the prostatic arteries, followed by embolization with 300–500 µm polyvinyl alcohol (PVA) particles.

The procedure was completed uneventfully. At one-month follow-up, the IPSS had decreased from 28 to 10, with improvement in nocturia and urinary flow. Prostate volume also decreased from 78 g to 62 g.

Discussion: This case highlights the feasibility of PAE in elderly patients with symptomatic BPH who are poor candidates for conventional surgery because of significant comorbidities. In this patient, PAE produced substantial symptomatic improvement within one month, accompanied by reduced nocturia, improved urinary flow, and decreased prostate volume.

A major advantage of PAE is that it can be performed under local anesthesia, avoiding the potential risks of general anesthesia. Its minimally invasive nature may also reduce postoperative morbidity.

However, PAE can be technically challenging because of variations in pelvic arterial anatomy and difficulties with selective catheterization. Super-selective microcatheter techniques can facilitate successful embolization of the prostatic arteries.

Conclusion: PAE is a minimally invasive treatment option for selected elderly patients with symptomatic BPH who are at high risk for conventional surgery. Its use under local anesthesia, combined with symptomatic improvement and reduction in prostate volume, makes it a valuable alternative for appropriately selected high-risk patients.



Image 1:
Superselective canulation of left prostatic arteries with microcathter



Image 2:
Superselective canulation of right prostatic arteries with microcathter

A Novel Approach in Urological Care: Successful Prostatic Artery Embolisation in High-Risk BPH Patient

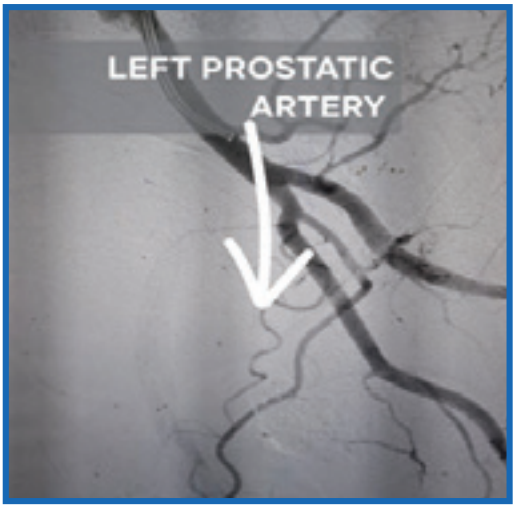


Image 3: Superselective canulation of left prostatic arteries with microcathter

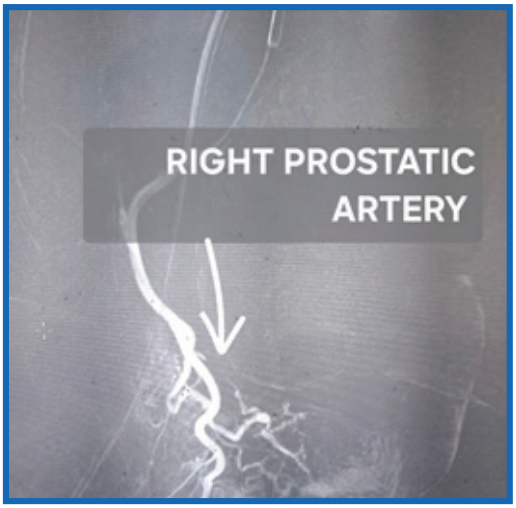


Image 4: Superselective canulation of right prostatic arteries with microcathter

> "A 72-year-old male with known COPD presented with acute urinary retention and a high IPSS of 30."

Case Brief: Due to ppor pulmonary reserve, he was deemed unsuitable for general anesthesia. Ultrasound revealed a prostate volume of 64 grams. PAE was performed via the right femoral approach under local anaesthesia. Despite challenging pelvic anatomy, successful bilateral embolisation was achieved using a coaxial microcatheter system.

The patient tolerated the procedure well. At the 1-month follow-up, he reported substantial symptom relief (IPSS = 12), had normal voiding patterns, and was catheter-free.

Discussion: These cases underscore the feasibility and effectiveness of PAE as a minimally invasive treatment for BPH in patients unfit for surgery. In both cases, PAE provided substantial relief from LUTS within a month, demonstrating its rapid onset of benefit. Prostate volume reduction and improved urinary flow are consistent with existing literature supporting PAE's utility.

PAE's advantages include avoidance of general anaesthesia, reduced hospital stay, and minimal postoperative complications. While anatomical challenges (e.g. tortuous vessels) may complicate catheterisation, modern microcatheter techniques have improved success rates.

Conclusion: Prostatic artery embolisation is a safe and effective option for managing symptomatic BPH in elderly patients with significant comorbidities who are not candidates for traditional surgical interventions. Its minimally invasive nature, low complication profile, and symptomatic efficacy make it an attractive alternative in selected patients.



CASE 5 | Cerebral Hydatid Cyst: A Rare Case of Giant Parieto-Temporo-Occipital Hydatidosis in a Child

Dr. Amit Jain
Consultant, Neuro Surgery

Introduction: Cerebral hydatidosis is a rare parasitic infestation and accounts for 1–2% of all cystic echinococcosis caused by Echinococcus granulosus or less commonly E. alveolaris or E. multilocularis. Most commonly supratentorial in middle cerebral artery vascular territory.

Hydatid cyst disease is acquired via contaminated food with eggs of the tapeworm. Most commonly involved organ is liver followed by lungs and other organs like bones, genitourinary system, bowel and even subcutaneous tissue.

Case Brief: A 7 yr boy, resident of Pacheda, Abhanpur, CG, admitted in ILS Hospital Raipur on 23/06/2026 with complaints of fever with headache & vomiting for last 3 days. No history of seizure or upper and lower limb weakness. On examination patient conscious, irritable, disoriented condition with no neurological deficit. Previously admitted in other private hospital and managed conservatively and MRI Brain done and referred patient to our hospital for further management. MRI Brain shows large left parieto-temporo-occipital cystic lesion around 9 × 7 cm with multiple other cyst also present with edema and midline shift around 13 mm.

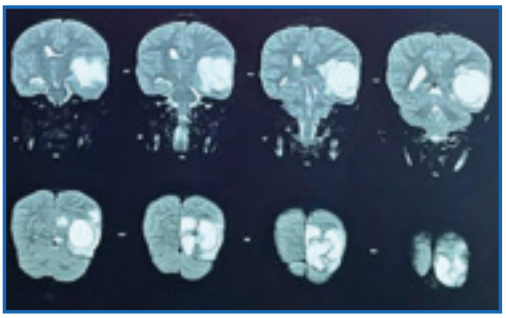


Image 1: Pre-Operative MRI

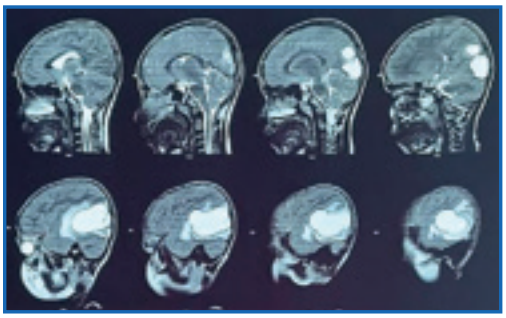


Image 2: Pre-Operative MRI

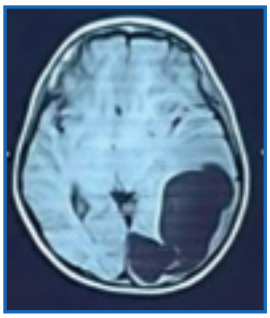


Image 3: Pre-Operative MRI

Discussion: Patient admitted and started antiepileptics, anti-edema agents, paracetamol, antacid and albendazole 200 mg twice a day. After investigations, medical fitness, anesthesia clearance and high-risk consent for surgery and prognosis explained to relatives. Taken for surgery.

After general anesthesia & intubation. Left parieto-temporo-occipital incision planned and patient on right lateral position & head fix in head clamp. Craniotomy & Durotomy done. Cyst visualized and separation of cyst from brain tissue with irrigation of warm saline and hypertonic saline (Dowling's maneuver) and removal of large cyst unruptured with multiple ruptured cyst and irrigation of cavity with hypertonic saline and Lax duroplasty and bone flap reported.

Patient extubated and shift to ICU and post-op CT Brain plain done — complete excision of tumor with post-operative changes seen. Patient conscious oriented with no neurological deficit. Patient shift to ward after 1 day and discharged 7 day after admission in stable condition.

Conclusion: Histopathology shows hydatid cyst. No complications in postoperative period but we have look for recurrence in follow-up period because cyst are ruptured.

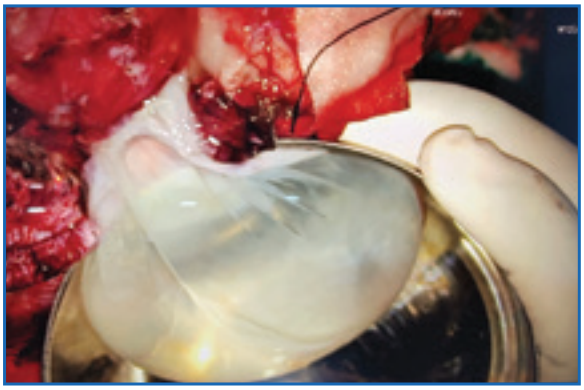


Image 4 Intra-Operative Image

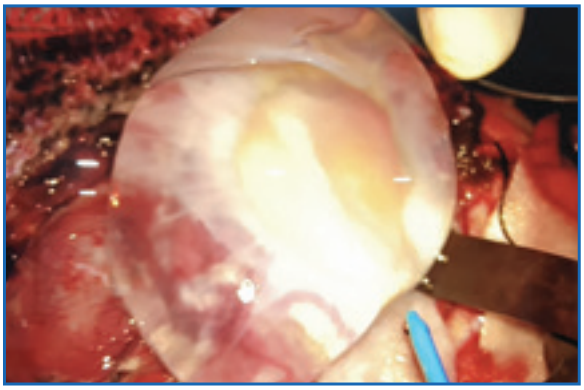


Image 5: Intra-Operative Image

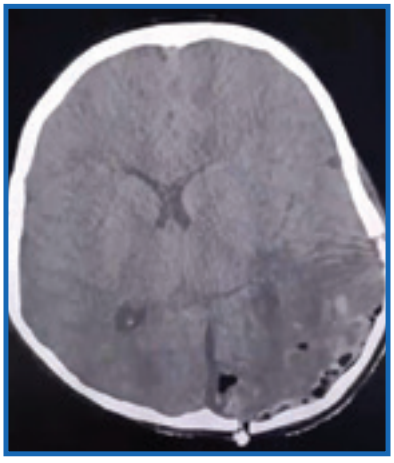


Image 6:
Post-Operative CT Brain

CASE 6 | Occult Rectal Perforation In Polytrauma: A Multidisciplinary Challenge



Dr. K Jayanth Reddy
Consultant, Orthopaedics
& Joint Replacement



Dr. Rahul M Sharma
Consultant, Urology



Dr. Amit Kumar Singh
Consultant, General
& Laparoscopic Surgery

Introduction: Polytrauma patients with pelvic fractures and associated urogenital injuries present significant diagnostic and management challenges. Occult rectal perforation, although rare, can result in faecal contamination, sepsis, and life-threatening complications if not promptly recognised. Vigilant monitoring and a coordinated multidisciplinary approach are essential to optimise outcomes in such complex trauma cases.

On the fifth postoperative day, the patient developed purulent wound discharge. A repeat CT scan demonstrated a rectal perforation at the 11 o'clock position of the lower rectum, extending into the peritoneal cavity and causing intrapelvic faecal contamination. He underwent urgent diagnostic laparoscopy with repair of the rectal perforation on 08/06/2025, followed by vacuum-assisted closure (VAC) therapy and secondary suturing on 11/06/2025. The patient gradually recovered and was discharged in a stable condition after three weeks.

"A 52-year-old male presented to the Emergency Department of ILS Hospitals, Agartala, on 29/05/2025, following a road traffic accident sustained two days earlier, resulting in blunt abdominal trauma and haemoperitoneum."

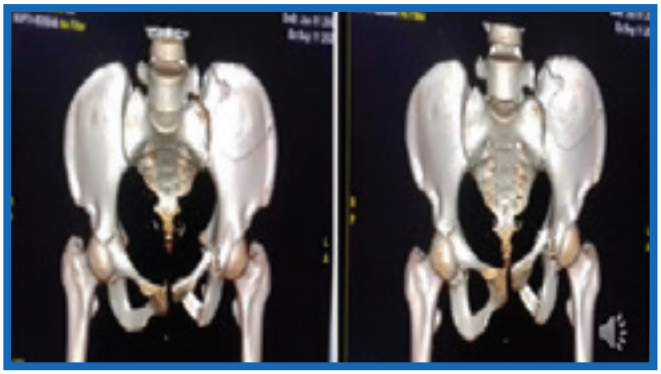


Image 1:
Three-dimensional computed tomography (CT) reconstruction demonstrating multiple pelvic ring fractures involving the bilateral pubic rami, sacrum, and iliac regions

Discussion: Pelvic ring fractures resulting from high-energy trauma may present with diverse patterns and can involve occult visceral injuries, including rare rectal perforations. Missed rectal injuries at initial presentation can lead to faecal contamination, sepsis, and high mortality.

In this case, the occult rectal injury remained silent initially and manifested only when complications developed, highlighting the diagnostic challenges. Careful assessment is therefore essential to identify associated injuries that may require urgent intervention and that could potentially delay definitive pelvic fixation.

Standard approaches for pelvic ring fractures with iliac wing involvement are:

- Modified Stoppa approach with a lateral window.
- Anatomical restoration of the pelvic ring to prevent permanent disability.
- Percutaneous screw fixation for pelvic fractures without iliac wing involvement.

Conclusion: This case highlights the complexity and dynamic progression of polytrauma, emphasising the need for continuous monitoring, as occult injuries such as rectal perforation may present late and mimic postoperative complications. It also underscores the importance of a coordinated, multidisciplinary approach in trauma care to effectively manage complications, prevent sepsis, and reduce the risk of mortality.

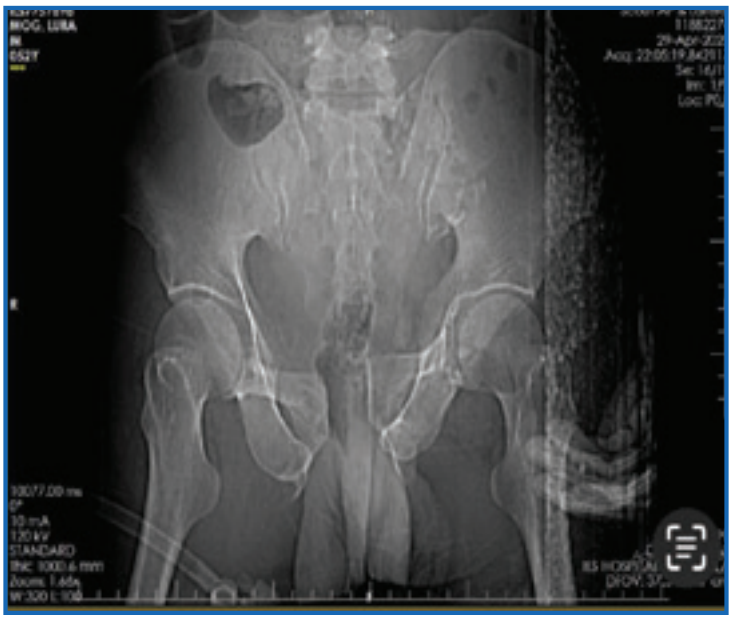


Image 2: Plain radiograph of the pelvis demonstrating multiple pelvic ring fractures, including bilateral pubic rami and sacral injuries, with associated pelvic ring disruption.



CASE 7 | Influenza-Associated Pulmonary Aspergillosis (IAPA) — A Rare and Challenging Respiratory Complication

Dr. Pratik Biswas
Consultant, Chest Medicine & Pulmonology

Introduction: Influenza-associated pulmonary aspergillosis (IAPA) is an increasingly recognized complication of severe influenza infection, with reported mortality rates ranging from 40% to 60%. While invasive pulmonary aspergillosis (IPA) has classically been described in immunocompromised hosts, recent evidence indicates that even immunocompetent individuals with severe influenza are at risk. The pathogenesis is thought to involve influenza-mediated damage to respiratory epithelium, impairment of local and systemic immune responses, and predisposition to opportunistic fungal invasion.

Case Brief: 62yr old male, diabetic with a recent travel history to Dubai, presented with history of cough, rhinorrhoea and high-grade fever, along with exertional dyspnoea. His grandson also had similar symptoms who had recovered recently, suggestive of possible viral infection. The patient underwent swab test which turned positive for Influenza A and was on Oseltamivir already.

However, patient became more sick, with persistent high grade fever and had developed streaky haemoptysis. The patient underwent HRCT thorax which revealed multilobar bilateral cavities. Patient underwent bronchoscopy which revealed profuse purulent expectoration bilaterally and Bronchoaleveolar lavage revealed significantly raised galactomannan and fungal culture revealed growth of aspergillus. The patient recovered gradually with 6 weeks therapy of voriconazole. Repeat CT revealed cavities have disappeared after 6 weeks.

DISCUSSION:

Pathogenesis

- **Local Effects of Influenza:**
  - Viral damage to tracheobronchial mucosa.
  - Disruption of normal ciliary clearance.
  - Mechanisms similar to bacterial superinfections (S. aureus, S. pneumoniae).
  - Allows colonizing fungi to invade.
- **Immune Impairment:**
  - Reduced phagocytosis by alveolar macrophages.
  - Decreased natural killer cell function.
  - Cytokine imbalances impair local immunity.
- **Systemic Effects:**
  - Altered Th1/Th2 immune response.
  - Lymphopenia — a known risk factor for aspergillosis.

Differential Diagnosis of Cavitary Lung Lesions

- **Infectious causes:** Tuberculosis, fungal infections, parasitic infections.
- **Non-infectious causes:** Malignancies, rheumatic lesions.
- **Key point:** Cavitary lesions in the background of influenza are highly suggestive of IPA.



Image 1: Profuse purulent intrabronchial secretions.

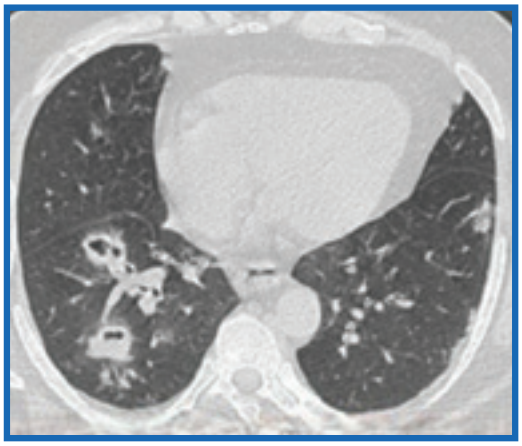


Image 2: Cavities seen before treatment

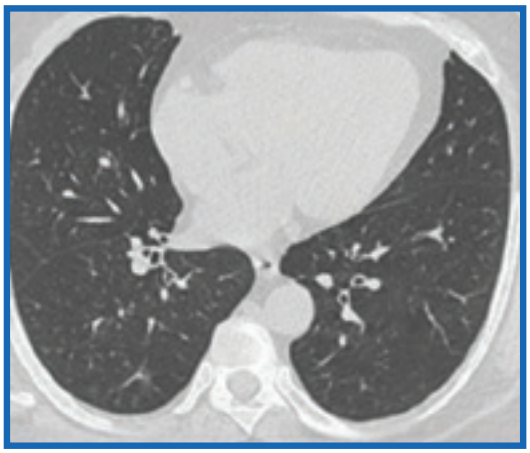


Image 3: Cavities resolved after treatment

Diagnostic Considerations

- **Gold standard:** Histopathological evidence of Aspergillus from a sterile site (rarely performed in ICU).
- **Cultures:**
  - Sputum/tracheal aspirate: low-cost, easy, but sensitivity ≤50% in ICU patients.
- **Non–culture-based assays:**
  - Galactomannan (GM) detection is most validated.
  - BAL GM testing → **sensitivity 88%, specificity 87%**

Prognosis and Mortality

- Severe influenza appears to be a host factor predisposing to IPA.
- IPA in the setting of severe influenza is linked with poorer prognosis.
- Systematic reviews report mortality rates between **40–60%,** higher than mortality from severe influenza with other co-infections or no co-infections.

Superinfections with Streptococcus pneumoniae and Staphylococcus aureus have been a well-known complication of seasonal influenza. However, IPA has emerged as a notable fungal superinfection, particularly in critically ill patients.

CONCLUSION: Influenza-associated IPA typically presents early in the course of influenza infection among patients admitted to the intensive care unit, early diagnosis and rapid antifungal treatment decreases mortality.

CASE 8 | Beyond the Usual Causes: Endoscopic Management of a Rare Case of Upper Gastrointestinal Bleeding



Dr. Mainak Deb
Consultant, Gastroenterology



Dr. Arpan Chowdhury
Consultant, Critical Care



Dr. Ayan Banerjee
Consultant, Critical Care

Introduction: Upper gastrointestinal bleeding (UGIB) is a common medical emergency, most frequently associated with portal hypertension. Among the causes, ectopic varices, particularly duodenal varices, are extremely rare (0.4% by UGIE), and account for up to 5% of portal hypertensive bleeds. Unlike oesophageal varices, duodenal varices are more prone to massive haemorrhage and carry higher mortality rates. Timely diagnosis and intervention are crucial but often challenging due to atypical presentations and diagnostic limitations.

Case Brief: A 58-year-old male presented to ILS Dumdum with sudden-onset massive haematemesis and generalised weakness. He was a regular alcohol consumer and had recently been diagnosed with diabetes mellitus. There was no prior history of liver disease.

On admission, he was hypotensive and tachycardic, with an initial haemoglobin level of 6.5 g/dl. He tested positive for HBsAg. He experienced recurrent haematemesis with progressive hypotension, Necessitating Vasopressor Support and Mechanical Ventilation.

Upper GI Endoscopy revealed large oesophageal varices without stigmata of recent haemorrhage. Numerous clots were present in the stomach. Careful inspection of the duodenum identified a duodenal varix at the D1-D2 junction with a "nipple sign" (unstable platelet plug).

As cyanoacrylate glue was unavailable and the patient's haemodynamics were deteriorating, endoscopic band ligation (EBL) was performed as an alternative. Bleeding was successfully controlled. The patient stabilised over the following days, was weaned off ventilation and vasopressors, and discharged in a stable condition.

At 45-day follow-up, the patient was doing well. Repeat UGIE showed complete resolution of the duodenal varix with no active bleeding. Endoscopic variceal ligation (EVL) of oesophageal varices was performed on the same session.

Discussion: Duodenal varices are rare and typically occur in the context of portal hypertension. Unlike oesophageal varices, they are submucosal and can easily be missed on routine endoscopy. Bleeding from duodenal varices is often more severe, with reported mortality rates of up to 40%.

There is no consensus on the optimal treatment for bleeding duodenal varices. Management options include Endoscopic Glue Injection, EBL, Transjugular Intrahepati Portosystemic Shunt (TIPS), and Surgery. Glue injection is generally preferred but may not always be available. In this case, EBL proved to be a viable, effective, and life-saving alternative. This supports limited existing evidence that EBL can be successfully employed in the management of ectopic variceal bleeding when other modalities are inaccessible.

Conclusion: Duodenal varices, although rare, should be considered in cases of unexplained upper GI bleeding particularly in patients with portal

hypertension. EBL, despite being off-label for duodenal varices, can be a safe and effective alternative when other therapies, such as glue injection, are unavailable or contraindicated.



Image 1: Large Oesophageal Varices



Image 2: Duodenal Varix with 'Nipple sign'

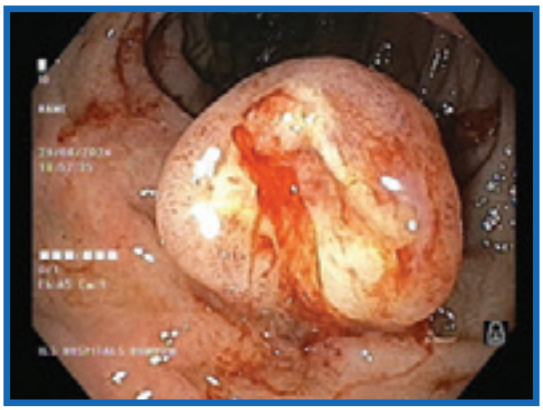


Image 3: Duodenal Varix Tied up EVL

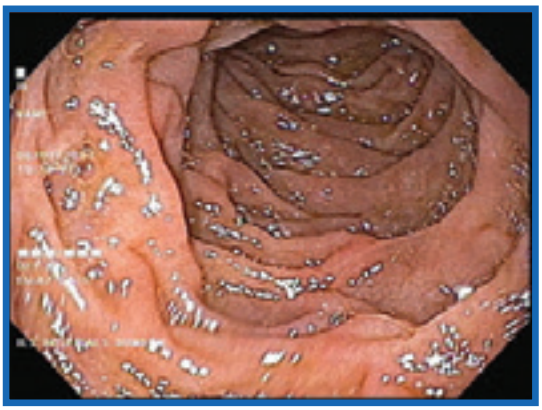


Image 4:
uodenum : No Varix at Follow-up UGIE



CASE 9 | Precision Meets Innovation: The First Robotic Radical Nephrectomy at ILS Hospitals, Salt Lake

Prof. Dr. Sandeep Gupta
Consultant, Urology

Introduction: The implementation of robotic-assisted surgery has revolutionised the management of complex urological malignancies, allowing for improved surgical dexterity and precision. This case report details the first robotic radical nephrectomy performed at ILS Hospitals, Salt Lake, showcasing the hospital's commitment to adopting advanced surgical technologies. By embracing robotic technology, the hospital has set a precedent for providing state-of-the-art care to patients with complex urological conditions.

Case Brief: A 54-year-old female was admitted with complaints related to a renal mass. Imaging studies revealed a 4 cm lesion located in the right renal pelvis, infiltrating the middle calyx. The diagnosis was classified under ICD codes C64-C68, indicative of kidney and ureter malignancies.

The patient underwent comprehensive preoperative evaluations, including laboratory tests and imaging, to confirm the diagnosis and plan the surgical approach. The complexity of the case required precision in addressing the infiltrative nature of the mass, which involved the renal pelvis and calyx. Conventional surgical approaches posed risks of increased blood loss, extended recovery time, and complications. Considering the complexity of the infiltrating mass, robotic-assisted surgery was chosen as the optimal intervention to mitigate these risks.

"A 54-year-old female was admitted with complaints related to a renal mass."



Image 1: Radiology Report showing SOL

The surgery was performed using a robotic-assisted approach. The patient was positioned in the left lateral decubitus position. Robotic ports were inserted, and the surgical field was prepared. The ureter, renal artery, and vein were carefully identified, clamped, and divided. The affected kidney and lesion were excised with precision. The procedure concluded with port site closure and appropriate dressings.

The surgery was completed without complications, with the robotic system enabling exceptional accuracy and tissue preservation. The patient experienced minimal postoperative pain, reduced blood loss, and a significantly shortened recovery time.

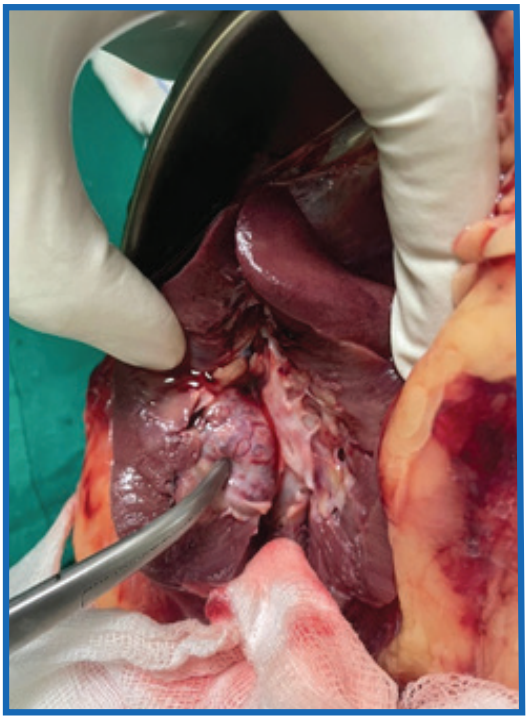


Image 2:-Cut specimen of kidney showing the endophytic mass

Outcome & Follow-up: The patient recovered uneventfully, with minimal pain and early mobilisation. A diabetic diet, wound care and medications for glycaemic and blood pressure control were prescribed. Regular follow-ups were scheduled to monitor recovery and ensure optimal outcomes.

Discussion: Radical nephrectomy remains a cornerstone in managing malignant renal tumours. Traditional open approaches, although effective, are associated with prolonged recovery and increased morbidity. Robotic-assisted radical nephrectomy overcomes many of these limitations, by offering enhanced visualisation, greater precision, and ergonomic advantages. In this case, the robotic platform enabled meticulous dissection around critical vascular structures and facilitated safe resection of an anatomically challenging tumour.

Conclusion: This case underscores the significant advantages of robotic-assisted surgery, particularly in complex procedures like radical nephrectomy. The robotic system's enhanced visualization and precision allowed meticulous dissection and reduced the risk of complications.



The Team



CASE 10 | Tiny Miracle, Advanced Care: Successful Management of an Extremely Low Birth Weight Preterm Neonate with Suspected NEC

Dr. Rajesh Goel
Consultant, Paediatrics

Introduction: ELBW neonates (<1000 g) constitute one of the most vulnerable populations in neonatal intensive care units. With significant risks of complications including respiratory distress syndrome, intraventricular haemorrhage, sepsis, and necrotising enterocolitis, survival and long-term outcomes are highly dependent on gestational age, birth weight, and the availability of advanced neonatal care. We report a case of a 590 g female neonate born at 29 weeks' gestation who survived following aggressive management of RDS and suspected NEC.

Perinatal History: The baby was delivered via emergency lower uterine caesarean section (LUCS) at ILS Hospitals, Salt Lake, on 10.02.2025, indicated for **oligohydramnios and absent end-diastolic flow** in the umbilical artery. The mother had **severe pre-eclampsia** and was on treatment for **hypothyroidism.** Antenatal steroids were not administered due to the emergent nature of delivery.

Birth Profile:

- **Gestation:** 29 weeks
- **Birth Weight:** 590 g
- **APGAR Score:** 6 at 1 min, 8 at 5 mins
- **SGA Status:** Confirmed

NICU Management

Respiratory Support: The neonate was intubated immediately after birth and initiated on synchronized intermittent positive-pressure ventilation (SIPPV). A portable chest radiograph demonstrated bilateral reticular opacities, consistent with respiratory distress syndrome (RDS). Intratracheal surfactant (Neosurf, 3 mL) was administered under aseptic conditions. Following clinical improvement, the neonate was successfully extubated after 26 hours and transitioned to high-flow nasal oxygen (HFNO) support. Follow-up chest radiography demonstrated a reduction in the previously noted pulmonary opacities.

Haematological and Supportive Management: On day 5 of life, the neonate developed significant thrombocytopenia, with a platelet count of 23,000/µL, accompanied by blood-stained gastric aspirates. Platelet and fresh frozen plasma (FFP) transfusions were administered. Further transfusion support was required on days 6 and 9 because of persistent abdominal findings and greenish skin discolouration.

Gastrointestinal Complications: On day 2 of life, the neonate developed abdominal distension accompanied by greenish gastric aspirates. Although meconium passage was achieved following rectal stimulation, the persistence of abdominal distension and abnormal gastric aspirates raised clinical suspicion of necrotising enterocolitis (NEC), consistent with Bell stage I disease. Enteral feeds were withheld, and antimicrobial therapy was escalated accordingly.

Recovery and Nutritional Advancement: The abdominal findings gradually improved, with subsequent resolution of the skin discolouration. Once clinical stability was achieved, enteral feeding with expressed breast milk (EBM) was cautiously reintroduced. The neonate tolerated the feeds well, allowing progressive advancement of enteral feed volumes.

Conclusion: This case highlights the importance of prompt recognition and multidisciplinary management of respiratory and gastrointestinal complications in neonates requiring intensive care. Early respiratory support and timely surfactant administration resulted in pulmonary improvement. Close monitoring facilitated early identification of thrombocytopenia and gastrointestinal manifestations suggestive of early-stage NEC. Appropriate transfusion support, bowel rest, antimicrobial therapy, and cautious nutritional reintroduction contributed to recovery. The case underscores the importance of vigilant monitoring and timely intervention in preventing progression of potentially life-threatening neonatal complications.



Imaging revealed bilateral reticular opacities, suggestive of RDS.

ECONOMIC TIMES EDGE BEST HEALTHCARE BRANDS 2026

ILS Hospitals has been recognized as one of ET Edge Best Healthcare Brands 2026. Dr. Ajeet Madhavrao Gopchade (right) Member of the Parliament, Rajya Sabha & Paediatrician, handed over the award to Dr. Vishal Goyal, Group COO (middle), & Dr. Mridul Tantia, Vice President, (left) GPT Healthcare Limited.



4TH ICC NATIONAL NURSING EXCELLENCE AWARDS 2026









HAPPY STREET 2026

- ILS Hospitals Salt Lake & Dumdum participated as the Health Partner at Times of India Happy Streets, marking a vibrant morning dedicated to movement, fitness, wellness, and community engagement. The initiative brought together people across age groups, encouraging them to embrace an active and healthier lifestyle.

- The event featured a range of sports and fitness activities, creating an energetic environment for participants while promoting the importance of regular physical activity. ILS Hospitals also conducted free health screenings, offering attendees an opportunity to take a proactive approach towards their well-being.



ILS Hospitals Dumdum



ILS Hospitals Dumdum



ILS Hospitals Salt Lake



ILS Hospitals Salt Lake

GLIMPSES OF COMMUNITY ENGAGEMENT



World Cancer Day Walkathon
ILS Hospitals, Agartala



CME at Howrah IMA
ILS Hospitals, Howrah



Doctor's Day Celebration
at ILS Hospitals, Howrah



Free Community Health Camp
done by ILS Hospitals, Dumdum



Doctor's Day Celebration
at ILS Hospitals, Raipur



Nurses Day Celebration
at ILS Hospitals, Salt Lake

In association with
ASI West Bengal State Chapter

MEDSCRIPT 360 – INK TO IMPACT:

Empowering Clinicians Through Scientific Writing

On the occasion of ILS Hospital's Foundation Day, healthcare professionals came together for MedScript 360 – Ink to Impact, a dedicated workshop on Scientific Writing & Medical Research, held on 11th July 2026 at Hotel Golden Tulip, Salt Lake, Kolkata.

The workshop provided an engaging platform for residents, consultants, and faculty members to strengthen their research and academic writing skills. Sessions covered key aspects of research methodology, biostatistics, publication ethics, manuscript writing, critical appraisal, mentorship, and practical approaches to publishing high-quality scientific work.















With insightful discussions, expert guidance, and interactive learning, the workshop reinforced the importance of evidence-based medicine and scientific communication, inspiring clinicians to transform their research into impactful publications that contribute to the advancement of healthcare.

26TH ANNIVERSARY OF ILS HOSPITALS

Celebrating 26 years of care, compassion, and clinical excellence. The Foundation Day of ILS Hospitals was marked with gratitude, togetherness, and vibrant cultural performances, honouring the people, values, and commitment that have shaped our journey of serving communities across Eastern India.

















ONE YEAR OF EXCELLENCE, TOGETHER

Celebrating 1 year of ILS Hospitals Raipur — A journey built on trust, commitment, compassion, and the unwavering dedication of our entire team.

From our first day to this milestone, every achievement has been made possible by our patients, families, doctors, nurses, and support teams who have been an integral part of our journey.

As we look back at the moments that shaped our first year, we look forward to many more years of better care, stronger connections, and continued excellence in healthcare.

Celebrating the journey.

Creating a healthier tomorrow.











PRESS RELEASES



WELCOME TO ILS FAMILY

ILS SALT LAKE

DOCTOR'S NAME	DEPARTMENT	QUALIFICATION
Dr. Mridul Tantia	Gastro Intestinal Surgery	MS, DrNB (Gastro Intestinal Surgery), FMAS (Minimal Access Surgery)
Dr. Mrinalini Chowdhury	Obstetrics & Gynecology	MBBS, DGO (Gold Medalist), DNB (Gynaecology)
Dr. Bisswadeep Kumar Das	Critical Care	MBBS, MD (Anaesthesiology)

ILS AGARTALA

DOCTOR'S NAME	DEPARTMENT	QUALIFICATION
Dr. Diptanu Bhaumik	Anesthesia & Critical Care	MBBS, MD (Anaesthesiology)
Dr. Rajesh Jawale	Gen & Laparoscopic Surgery	MBBS, MS, F.MAS, FALS, FIAGES, EFIAGES, FAGIE
Dr. Pradip Kumar Debbarma	Blood Centre	MBBS
Dr. Kristi Sarkar	Clinical Microbiology	MBBS, MD (Clinical Microbiology)
Dr. Arnab Debnath	Radiology	MBBS, MD (Radio - Diagnosis)
Dr. Kishalay Mahajan	Nephrology	MBBS, DNB (General Medicine), DM (Nephrology)
Dr. Niladri Ranjan Debnath	Critical Care	MBBS, MD, DM

ILS DUMDUM

DOCTOR'S NAME	DEPARTMENT	QUALIFICATION
Dr. Ankit Singh	Radiology	MBBS, MD
Dr. Priyanka Maitra Karak	Cardiac Anaesthesia	MBBS, MD, DM
Dr. Suparna Barik	Anaesthesiology	MBBS, MD (Anaesthesiology)
Dr. Soumi Nag Bhattacharya	Microbiology	MBBS, MD (Microbiology)
Dr. Niharika Tantia	Radiology	MBBS, MD (Radio - Diagnosis)
Dr. Tathagata Mukherjee	Nephrology	MBBS, MD, DM(Nephrology)
Dr. Priya Ranjan Mandal	Neurosurgery	MBBS, MS (Genl. Surg.), M. Ch (Neuro Surgery)
Dr. Bijaya Laxmi Gayari	Radiologist	MBBS, MD (Radio - Diagnosis)
Dr. Sadajit Banerjee	Geriatric Medicine	MBBS, MD (Internal Medicine), MRCP
Dr. Asim Manna	Gen & Laparoscopic Surgery	MBBS, DPH, MS (Surgery)

ILS HOWRAH

DOCTOR'S NAME	DEPARTMENT	QUALIFICATION
Dr. Anand Biyani	Urology	MBBS, MS
Dr. Joyita Bhowmik	Obstetrics & Gynecology	MBBS, MS (Obstetrics & Gynaecology)
Dr. Parijat Das	Critical Care	MBBS, DNB (Family Medicine)
Dr. Tanha Zarin Naaz	ENT	MBBS, MS
Dr. Abhraneel Parames Guha	Gastroenterology	MBBS, DNB
Dr. Dhruv Paul	Orthopedics	MBBS, MS, DNB (Orthopedics)
Dr. Amit Kumar Singh	Gen & Laparoscopic Surgery	MBBS, MS (General Surgery), FMAS, FAIS, FIAGES, FALS

ILS RAIPUR

DOCTOR'S NAME	DEPARTMENT	QUALIFICATION
Dr. Bandari Janardhan	Anesthesiology	MD (Anaesthesiology)
Dr. Kunal Ostwal	Cardiology	DM (Cardiology)
Dr. Shilika Lalwani Budhwani	Endocrinology	MD (Internal Medicine), DrNB (Endocrinology)
Dr. Abhishek Kumar Tripathi	Orthopedics	MBBS, FIJS, FISR
Dr. Ankita Fatnani	Obstetrics & Gynecology	MD (Obstetrics & Gynaecology)
Dr. Pragada Lavan Sagar	Critical Care	MBBS, MD (Anaesthesiology)
Dr. Ashok Kumar Zargar	Medical Administration	MBBS, DIH, DBM

HEAD OFFICE

DOCTOR'S NAME	DEPARTMENT	QUALIFICATION
Dr. Subhrojyoti Bhowmick	Clinical Services & Quality	MBBS (Cal)(Gold Medalist), MD (Pharmacology), Certified in Patient Safety (Johns Hopkins University, USA) EPHM (IIM Calcutta), FRCP (Edin), FRCP (London).

QUIZ TIME!

QUESTION 1

What was the primary cause of **Obstructive Uropathy** in *CASE 1* ?

- **A** Renal Calculi
- **B** Ureteric Endometriosis With A Large Endometriotic Cyst
- **C** Ureteric Tumour
- **D** Bladder Carcinoma

QUESTION 2

The Imaging shows a 20-year-old female patient with a **painless swelling of the hand.** What is the most likely diagnosis?

(Case given by Dr. Himanshu Shekhar Mohanty, Consultant Radiologist, ILS Dumdum)

- **A** Giant Cell Tumor (GCT)
- **B** Enchondroma
- **C** Osteoid Osteoma
- **D** Osteomyelitis



Please send the correct answers to
Ms. Kajari Majumdar, ILS Times Co-ordinator
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