VELNEWS

Voice of Velammal Medical College Hospital & Research Institute

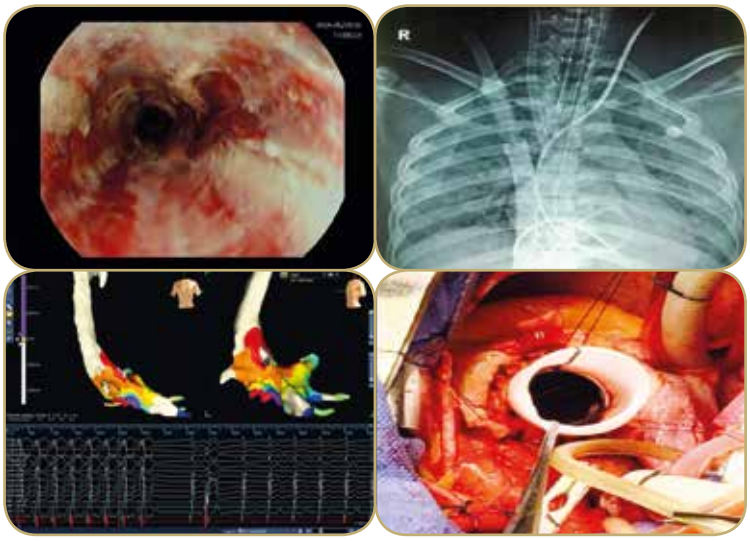
January - March 2016 Volume 4. Issue 1. News 16

Current Events

* "International Women's Day" celebration
* World of Women "WoW"
* "World Kidney Day" celebration
* A sobriety programme of "Nambikkai" Addiction Care Centre
* "World Glaucoma week"

Highlights of Scientific Section

* Candy-cane appearance of the esophagus
* Redo sternotomy: Bentall's procedure with mitral valve replacement
* VV-ECMO for fat embolism – tackling hypoxemia
* Catheter ablation of ventricular tachycardia originating from left aortic sinus cusp



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EDITORIAL

Unite to End TB

World Tuberculosis Day is memorized each year by the International Union Against Tuberculosis and Lung Disease (IUATLD) on 24th March, which is the date when, in 1882, Robert Koch astounded the scientific community by announcing his discovery of the cause of tuberculosis (TB), the TB bacillus.

The theme of this year's World TB Day is "Unite to End TB" – envisage a paradigm shift in the fight against TB.

Tuberculosis is one of the leading infectious killer disease in the world. Almost 9.6 million cases and 1.5 million deaths in 2014 were attributed to tuberculosis.

India shares the highest TB burden accounting for nearly quarter of the world's tuberculosis cases. India reports almost 2.3 million new cases and 3,00,000 deaths every year. Since commencement, India's Revised National TB Control Programme (RNCTP) has made significant impact on tuberculosis control through free, quality-assured TB diagnosis and supervised treatment to patients seeking care in the Government sector. So far, more than 44 million tuberculosis suspects have been screened, more than 13 million patients have been put on treatment and more than 2.3 million lives have been saved. However, despite availability of effective drugs, vaccine and successful implementation of RNTCP, the control of tuberculosis has remained elusive because of the newer challenges like emergence of multidrug-resistant TB (MDR-TB), and tuberculosis HIV co-infections. Delayed diagnosis and ineffective treatment are important contributors of maintaining the chain of transmission in the community.

There is a need to focus more in the areas of early diagnosis and treatment, community involvement and operational research. The involvement of private sector, NGOs and medical colleges are vital areas for effective disease control.

We have made the transition from the Millennium Development Goals to the new era of the Sustainable Development Goals ensuring a paradigm shifts in all sectors, including health. The year 2015 is a demarcation in the history of battle against tuberculosis where Stop TB Strategy is transformed into the End TB Strategy.

The Global Plan to End TB 2016–2020

• The Global Plan introduces three people centered targets called the 90-(90)-90 targets: Reach 90% of all people who need TB treatment, including 90% of people in key populations, and achieve at least 90% treatment success.

• A paradigm shift in the fight against TB identifies several fundamental changes including optimized funding, leadership and gender based approach.

Indian scenario

Being a home to one in four people living with TB, the progress made in India will directly affect the global achievement.

1. Increasing domestic funding for TB.
2. Reforming and modernizing TB care in the public sector.
3. Taking advantage of modern technology for improving public-sector-funded programmes.
4. Improving the quality of care in the private sector.
5. Scaling up special models of care for the poor residing in large cities.
6. Increasing access to care for remote and tribal populations.
7. Reaching PLHA, indigenous/tribal peoples and other vulnerable groups.
8. Strengthening existing community systems to improve access and implement screening campaigns.
9. Scaling up rapid molecular tests and DST towards universal access
10. Improving the use of X-ray as a screening tool
11. Establishing electronic web-based, mobilebased,and call-centre-based models for notification, and incorporating information technology in key programme functions.
12. Eliminating catastrophic costs for people by using cash transfers, insurance and social protection.
13. Addressing risk factors, such as HIV, malnutrition, smoking and diabetes.

Dr. Samir Bele
Professor and head, Department of Community Medicine

VICE CHAIRMAN'S MESSAGE

Dr. S. Asokan
Vice Chairman

Greetings,

The 'VELNEWS' is improving and the contents are more of Scientific. I thank Prof. Samir Bele and the editorial committee for the same.

Let me make use of this opportunity to welcome, Prof. R.M. Rajamuthiah as the Dean and Prof. S. Somasundaram as the Medical Superintendent. Both of them have been richly contributing to the Velammal Medical College, in their earlier capacities and the management has rightly rewarded them with additional responsibilities. I wish them both a bright and fruitful career at Velammal.

The article on "Catheter ablation of ventricular tachycardia originating from left aortic sinus cusp" by Dr. Shunmuga Sundaram our cardiologist is highly informative. I congratulate him for his wonderful work as the only cardiologist with electrophysiology of heart as additional qualification in this region. The cardiology team under the dynamic leadership of its director Dr. A Mathavan has been consistently doing excellent work in all spheres like intervention and stenting (PTCA), device closures, pacemaking etc.

Dr. A. C. Arun along with Dr. A. G. Alwar Ramanujam and their team has reported a case of 'Esophageal injury due to ingestion of hot boiling tea'. The departments of Medical and Surgical Gastroenterology are doing wonderful work. Their case report will make us educated on the deleterious effect of drinking hot liquid on the oesophagus.

Our cardiac surgical team under the leadership of Dr. Mohanakrishnan T. L. has been doing wonderful work. They perform risky procedures on patients who have been given up by most other centers. A case of redo sternotomy: Bentall's procedure with mitral valve replacement is one such case. I am very sure that this team will perform a heart transplant in a year's time.

Our Dermatology department under the dynamic leadership of Prof. A. S. Krishnaram has started practicing Cosmetology offering all services at a very economical cost. Their paper "Chromoblastomycosis involving the face" is very interesting and educative.

Dr. P. Selvakumar, our Director of Medical Services, a leading cardiac and critical care anesthetist has reported a case where 'ECMO' (Extracorporeal membrane oxygenator) was used. We can proudly say that we are the only hospital in this region having this life saving equipment.

He has reported about delay of 48 hours in instituting this therapy and attributes this to "decreasing awareness of the patients". It is not the 'awareness' but the "lack of knowledge" by the public. It is time; we educate our patients, win their confidence and involve them in decision making. I am sure in times to come we will be more adept on these things.

Dr. N. Subramanian, our enthusiastic Rheumatologist has presented a paper in 10th International Congress on Autoimmunity held at Leipzig, Germany from April 6 – 10, 2016.

Ms. Jane Selvan Sathiavadivu of III year MBBS has presented another paper in the same congress.

I also congratulate Dr. Gopi Nallaiyan, Consultant Paediatric Cardiac Surgeon for his oral and poster presentation at the 24th annual meeting of Asian Society for Cardiovascular and Thoracic Surgery held between April 6-10, 2016 at Taipai, Taiwan. Dr. Suganthy, Associate Prof. in Biochemistry has also made us proud by winning the first prize for her e-poster in fellowship in Medical Education at SRMC-MCI nodal centre for faculty development held at Sri Ramachandra University between March 13-15th 2016.

I also congratulate Dr. Muthumathi Dharuman, our Chief Librarian who received the "Best Librarian Award" from Library Professionals Association, Delhi, India.

I congratulate all of them and request to continue the good work.

I request other friends of Velammal family to do research work and keep publishing.

Thanking you,

Yours sincerely,

Dr. S. Asokan

Vice Chairman

CATHETER ABLATION OF VENTRICULAR TACHYCARDIA ORIGINATING FROM LEFT AORTIC SINUS CUSP

ABSTRACT

The most common site of origin of idiopathic ventricular tachycardia (VT) is from the right ventricular outflow tract. Idiopathic VT can also arise rarely from the left ventricular outflow tract. In this report, we describe a rare case of 55 years old lady with symptomatic, repetitive, sustained monomorphic VT, refractory to anti-arrhythmic drugs who underwent radiofrequency ablation. The arrhythmia origin and ablation target was located in the left coronary cusp 7 mm below the left main coronary artery.

Keywords: Ventricular tachycardia, left coronary cusp, arrhythmia, radiofrequency ablation

INTRODUCTION

Ventricular extrasystolic activity, Ventricular tachycardia (VT) and symptomatic ventricular premature contractions (VPCs) in patients with normal heart commonly originates from right ventricular outflow tract and is often provoked by emotional and physical stress.1 The ECG pattern of the arrhythmia is typical in most patients, showing a left bundle branch block (LBBB) QRS morphology with right axis deviation.2,3 However some patients can have VTs coming from the left ventricular outflow region. The ECG in these cases will show right bundle branch block morphology (RBBB) with right axis deviation.4 Radiofrequency ablation can be performed with a high success rate and provides a curative approach resulting in alleviation of symptoms for these patients.

CASE REPORT

A 55 year old lady was referred to our institute for the management of complex ventricular arrhythmia. She had recurrent episodes of short lasting palpitation and documented ventricular tachycardia, which was a DC - cardioverted. She was a non-diabetic and non-hypertensive lady. Her echocardiography showed normal left ventricular function. Coronary angiography done elsewhere showed normal epicardial coronary arteries. Multiple anti-arrhythmic medications including beta blocker and amiodarone, failed to control the arrhythmia. Prior to the procedure the patient underwent a complete physical examination and echocardiography which revealed normal findings.

Figure 1: ECG of ventricular tachycardia – RBBB morphology with right axis deviation

The patient's ECG during ventricular tachycardia showed wide QRS (>120 ms) with right bundle branch block morphology (R/S in V1 > 1) and right axis deviation at the rate of ~ 150 bpm and retrograde P waves (Figure 1). A baseline ECG showed normal sinus rhythm with no evidence of pre-excitation syndrome. After informed consent was obtained, the patient underwent an electrophysiological study. Catheters were introduced under fluoroscopy to the right ventricular apex, His bundle region and coronary sinus via the right femoral vein. Left ventricular cavity was entered retrogradely via the right femoral artery.

The study involved the creation of three dimensional (3D) geometry of the left ventricle. The tachycardia could be easily induced by pacing right ventricular catheter at 180 beats per minute. The induced tachycardia ECG, matched with the clinical tachycardia. Mapping of the left ventricle was done using a 3D system (EnSite Velocity) during ventricular tachycardia with invasive arterial blood pressure monitoring (Figure 2A). Mapping of the left ventricular regions, including the septum, mitral annulus and aortomitral continuity regions were done to look for a good early signals (compared to the surface QRS). Since the signals were not early it was decided to map the aortic cusps. Mapping of the left aortic cusp showed sharp early signals (34 ms earlier as compared to the surface QRS) (Figure 2B).

After activation mapping, the left coronary artery was cannulated with 6F left Judkin's catheter, as a marker and for protection in case of ablation catheter dislodgment. The distance between the ablation catheter and the ostium of the left coronary artery was 7 mm (Figure 3). Radiofrequency energy (RF) was delivered at the distal electrode of irrigated tip catheter, starting at 20 watts (titrated to a maximum 40 watts) with a preselected temperature of 55˚C. A single RF delivery at the site with earliest activation terminated the tachycardia within 7 seconds (Figure 4). However, to consolidate the lesion, ablation was continued for 180 seconds. Ablation success was defined by the inability to induce the tachycardia despite aggressive induction protocol at the end of the procedure and no arrhythmias during 48 hours on Holter monitoring. No procedure related complications occurred and no damage to the left main coronary artery or the aortic valve was revealed. During a follow up period of one month, the patient was free of arrhythmias, without antiarrhythmic drugs.

CONCLUSION

In conclusion, symptomatic ventricular tachycardia originating from right or left ventricular outflow tract can be safely ablated and cured by radiofrequency ablation system. The 3D system helps in precise localization, effective delivery of energy and potential safety (avoid injuring coronary arteries in this case) for the patient.

P. Shunmuga Sundaram

Consultant Interventional Cardiologist and Electrophysiologist, VMCH&RI, Madurai

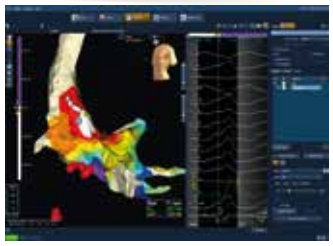

Figure 2A: 3D activation mapping showing earliest activity (white color) at left aortic sinus

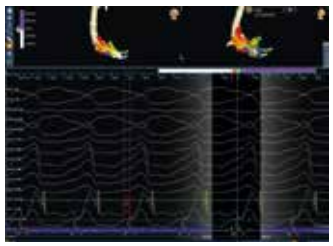

Figure 2B: Electrograms at the left coronary cusp – sharp signals 34 ms earlier than surface QRS

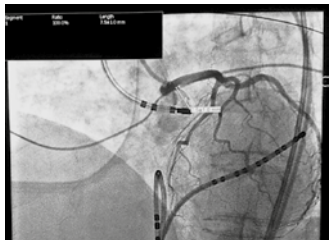

Figure 3: Left coronary angiography using Judkin's catheter, ablation catheter is just 7 mm from the Left coronary ostium

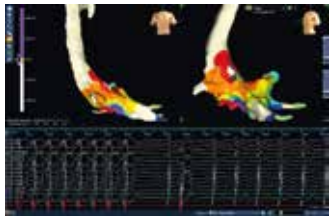

Fig 4: Termination of tachycardia during ablation

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CANDY-CANE APPEARANCE OF THE ESOPHAGUS

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ABSTRACT

The Candy-cane appearance of the Esophagus has been described in the literature for acute thermal injury. We report a rare case of esophageal injury due to ingestion of hot boiling tea in a local competition. A 21 year old male presented to us with history of haematemesis of one day duration. The endoscopic evaluation revealed diffuse necrosis and ulcerations of the esophageal mucosa with a typical "Candy cane" appearance. The patient responded well to the conservative management with parenteral nutrition, proton pump inhibitors and sucralfate.

Keywords: Candy-cane appearance, Esophagus, Tea

INTRODUCTION

Acute mucosal injury to the esophagus occurs due to various etiologies. The common ones are drug induced ulcers, Mallory Weiss tear, Corrosive injury, Boerhaave syndrome, severe Gastro-esophageal reflux disease.1 Thermal injury to Esophagus occurs commonly in patients for whom radiofrequency ablation (RFA) of Left Atrium is done for Atrial Fibrillation. We report a very rare case of acute esophageal injury due to ingestion of hot boiling tea producing a typical Candy-cane appearance.

CASE REPORT

A 21 year old male presented to us with a history of haematemesis of one day duration. There was no similar history in the past. He denied taking alcohol. There was no history of jaundice, altered sensorium or abdominal distention. He denied taking any drugs in the recent past. Clinical examination showed pallor with no other significant findings. Laboratory investigations showed a Hemoglobin level of 10.7 gm%.

We took up the patient for endoscopic evaluation. Oropharynx showed ulcerations with granulation tissue. On entering the Esophagus, there was diffuse necrosis and ulcerations of the esophageal mucosa with a typical "Candy cane" appearance (Figure 1, 2). Stomach and duodenum were essentially normal. The candy cane appearance has been described in the literature for acute thermal injury to the esophagus. So after the endoscopic evaluation, we probed the patient further for any ingestion of corrosive solutions or hot beverages. Then he admitted taking boiling tea as a part of a local competition one day prior to the episode of haematemesis. He has poured the boiling tea directly into the throat without sipping it, and so there were injuries in pharynx and esophagus, sparing the oral cavity. So the diagnosis of acute thermal injury to the esophagus due to hot tea was made.

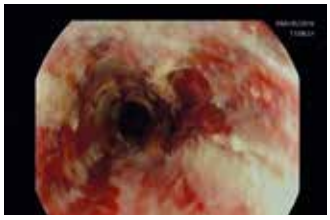

Figure 1

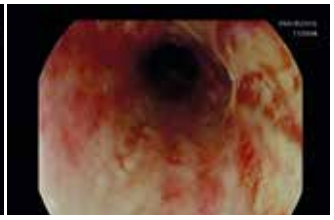

Figure 2

Chest x-ray did not show any evidence of esophageal perforation. He was managed conservatively with parenteral nutrition, proton pump inhibitors and sucralfate for one week. The subsequent endoscopic evaluation showed significant healing of the esophageal mucosa and he was allowed to take liquid diet and discharged. Endoscopy after 1 month showed completely healed esophageal mucosa. He was educated about the injurious effects of taking boiling tea.

DISCUSSION

Acute esophageal thermal injury caused by food has been reported to occur mostly after drinking hot liquids or swal¬lowing solid foods, both of which are reversible. Its occurrence is more common in the East than in the West because of differences in food culture.[1] In most of the occasions, the patients were not aware of the fact that hot beverages can cause injury to the gastrointestinal tract.

The most common presentations of the patients are odynophagia, chest pain, haematemesis and melena. The endoscopic evaluation shows alternating white and red linear mucosal bands (resembling a "candy cane"), esophageal ulcers or pseudomembranes. [2] The candy-cane appearance is a typical endoscopic feature of esophageal thermal injury caused by hot liquids, which was present in our patient. The apparent reason for the candy-cane appearance of the esophagus was due to the flow of hot liquid over the esophageal mucosa.[3]

Most patients respond well to conservative management with proton pump inhibitors and sucralfate. There is complete healing of esophageal mucosa in most of the patients within one month.[4] Esophageal perforation may occur rarely in these patients. Long term complications are uncommon. Only one case of esophageal stricture requiring Esophagectomy and Ileo-colon transposition has been reported in the literature.[5]

Very few cases of esophageal injury due to hot beverages have been reported in the world literature. Choi et al[3] reported the candy-cane appearance of the esophagus after the patient drank hot tea and found a mucosa with a mixed whitish pseudomembrane and flare. Dutta et al[6] and Cohen et al[7] also reported cases in which there was a candy-cane appearance and a mixed whitish pseudomembrane after drinking boiling hot beverages. Our patient had the esophageal injury following a local competition of pouring hot boiling tea directly into the throat, which has not been reported in the literature so far.

CONCLUSION

We report a rare case of esophageal injury due to ingestion of hot boiling tea in a local competition. He developed the typical Candy-cane appearance of the esophageal mucosa, reported in acute thermal injury to the esophagus. He responded well to the conservative management with parenteral nutrition, proton pump inhibitors and sucralfate. It is of paramount importance to create awareness among the people regarding the harmful effect of drinking very hot beverages.

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A CASE OF REDO STERNOTOMY: BENTALL'S PROCEDURE WITH MITRAL VALVE REPLACEMENT

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ABSTRACT

Ascending aortic aneurysm is the second commonest aneurysm with connective tissue pathology is implicated in many. We are reporting a case of post ASD closure patient going in for progressive multiple defects in 40 years needing intervention for aortic aneurysm, aortic regurgitation and mitral regurgitation. A 51 years old male presented with the complaints of tiredness, frequent giddiness and breathlessness on exertion. He had undergone open heart surgery for atrial septal defect closure, at the age of 12 years. Investigations revealed that he has aneurysmal dilatation of ascending aorta with severe aortic regurgitation and moderate to severe mitral regurgitation. Redo sternotomy, Bentall's procedure combined with mitral value replacement was performed. The postoperative stay was uneventful and the patient was discharged on 8thpost-operative day

Keywords: Redo sternotomy, Bentall's procedure, mitral valve replacement.

INTRODUCTION

Ascending aortic aneurysm is the second commonest aneurysm of aorta occurring in 10 out of one lakh population. Of the thoracic aortic aneurysms 60% occur in ascending aorta. Though the cause cannot be pinpointed in a particular patient, connective tissue pathology is implicated in many. Atrial septal defect (ASD) is a common congenital acyanotic cardiac defect and is said to be associated with mitral valve regurgitation in 17% of cases. Closure of ASD at an early age prevents the alteration in the geometry of the heart and hence can arrest the progress of regurgitation in both tricuspid and mitral valves. Need for intervention of mitral regurgitation with ASD repair is 7 %. According to a study by Park et al1 only 18 patients out of 286 cases who had MR at time of ASD closure showed increase in MR. But independently mitral regurgitation can progress if the pathology involved is a connective tissue disorder despite closure of ASD at an early age. We are reporting a case of post ASD closure patient going in for progressive multiple defects in 40 years needing intervention for aortic aneurysm, aortic regurgitation and mitral regurgitation.

CASE REPORT

Clinical details: A 51 years old gentleman came to the Cardiac Surgery department with complaints of tiredness, frequent giddiness and breathlessness on exertion. Breathlessness was of Class II – III status. He had undergone open heart surgery - atrial septal defect closure, at the age of 12 years at Chennai. That time itself, he was found to have a mild leak in mitral valve called mitral regurgitation. Since it was not significant, only ASD closure was done then. Presently investigations revealed that he has aneurysmal dilatation of ascending aorta with severe aortic regurgitation and moderate to severe mitral regurgitation.

Investigations: A complete blood haemogram revealed normal values so too his renal and liver biochemical parameters were normal. ECG revealed left ventricular hypertrophy. ECHO revealed moderate to severe aortic regurgitation and mitral regurgitation with left ventricular hypertrophy. Aortic annular dilatation and dilated ascending aorta was also seen. CT angiogram revealed dilated ascending aorta around 5 cm and coronaries were normal.

Figure 1: CT Angiogram showing the dilatation of ascending aorta

Figure 2: Showing the artificial graft which has replaced aorta with artificial aortic valve inside

Figure3 : The coronary artery is isolated for re-implantation on artificial aorta

Figure 4: Showing the aorta replaced with graft

Treatment: If untreated, he can go to further enlargements of aorta with an impending risk of rupture of the aorta, leading to sudden death. An association of aortic regurgitation and mitral regurgitation can cause the heart to dilate further leading to cardiac failure leading to severe impairment of functional ability. A dilatation beyond 7.5 cm in LV diastolic dimension and over 5.5 cm systolic dimensions can cause poor prognosis. Hence his condition needs early attention.

He needed replacement of the dilated damaged ascending aorta with an artificial graft, replacement of the aortic valve, re-implantation of coronary artery into the newly created artificial aorta (combination of these three procedures are known after the person who first performed it – Hugh Bentall) and replacement of damaged mitral value. Bentall's procedure combined with mitral value replacement is a rare combination. The complexity of the procedure is enhanced by the fact that he had previously undergone an open heart surgery. So it becomes a redo procedure. The surgery went on uneventfully and he was discharged on 8thpost-operative day.

If untreated, he can go to further enlargements of aorta with an impending risk of rupture of the aorta, leading to sudden death. An association of aortic regurgitation and mitral regurgitation can cause the heart to dilate further leading to cardiac failure leading to severe impairment of functional ability.

He underwent redo Sternotomy, the heart was freed of all adhesions and he was put on cardiopulmonary bypass and was cooled and heart was arrested with blood cardioplegia. The mitral valve was replaced first with a mechanical prosthesis (On X mechanical mitral valve), this was done through LA, Subsequently the ascending aorta and the aortic valve was excised and they were replaced with Dacron graft and On X aortic mechanical valve. Coronary artery was explanted from the aorta with a button of aorta and this was anastomosed to two holes punched out in the root of artificial graft. Once the procedure was over he was weaned off the heart lung machine and was shifted to ICU. He was extubated on the first postoperative day and further stay was uneventful. He was discharged on 8thpost-operative day.

DISCUSSION

Though the cause cannot be ascertained, likely connective tissue etiology should be considered in view of the combination of ascending aortic aneurysm with regurgitation of both aortic and mitral valves.

Mean growth of all thoracic aneurysms seen by Davies et al2 is 0.1 cm/year. Variations occur between various types and pathology. Chance of rupture also varies and is found to be annually 2% in aneurysms less than 5 cm and 3% for those between 5 -5.9 and 7% for those above 6 cm. This patient needs his aneurysm to be addressed. The fact that he has a combination of double valve regurgitation further accelerated the timing of surgery.

Hugh Henry Bentall's was the first to perform the ascending aortic replacement surgery. This involves the replacement of both aorta and the aortic valve. As coronaries arise from aortic root, these have to be reimplanted on the new graft. The combination of replacement of the ascending aorta with a Dacron graft, which will be anastomosed to the annulus along with a prosthetic aortic valve and re-implantation of coronary arteries to the graft is named after Bentall's. This patient needed mitral valve replacement too, along with Bentall's procedure.

CONCLUSION

We reported this case because of the rarity of the combination of Post ASD closure, patients needing replacement of mitral valve with Bentall's procedure.

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Case report submitted by:

Dr. H.A. Rieyaz,

Assistant professor, Anatomy, VMCH&RI.

CHROMOBLASTOMYCOSIS INVOLVING THE FACE: A CASE REPORT

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ABSTRACT

Keywords: Chromoblastomycosis, face

Chromoblastomycosis is a rare deep mycotic infection reported worldwide mainly in tropical and subtropical countries. We report an interesting case of chromoblastomycosis involving less common site. A 62 year old male was presented with a lesion on the face of 4 years duration. Dermatological examination revealed a well defined irregular plaque of 5x8 cms in size, with raised margin and thick minimally friable scales involving the lower and sides of the nose and whole area above the upper lip. Biopsy was done from two different sites on two different occasions. Second biopsy revealed muriform cells measuring 10 millimicron with brown round thick walled bodies and longitudinal and transverse septa in the deep dermis clinching a diagnosis of chromoblasatomycosis. A culture under sabourauds dextrose agar medium showed growth of dark brown colonies after 6 weeks confirming a diagnosis of chromoblasomycosis. Patient was treated with ATT for 9 months without much improvement. He was started on Itraconazole 400 mg daily after confirming the diagnosis of Chromoblastomycosis. Since the patient did not show desired improvement intermittent treatment with cryotherapy was started and is currently under regular follow up.

INTRODUCTION

Chromoblastomycosis is a rare deep mycotic infection reported worldwide mainly in tropical and subtropical countries. It is caused by a black pigmented dematiaceous fungus belonging to 5 different species. It involves skin predominantly rarely involving sub cutis and other systems. Extracutaneous site is involved in 24% of the cases.1 We report an interesting case of chromoblastomycosis involving less common site.

Fig 1: clinical picture showing well defined verrucous plaque with scaling and atrophy involving lower half of the nose and skin above upper lip

CASE REPORT

A 62 year old male tailor was examined on October 2014 in our department for a lesion on the face of 4 years duration. Started as a papule near the upper lip and gradually increased in size to attain the present size in 4 years time. Lesion was asymptomatic throughout the course. There were no systemic complaints. He was non diabetic and there was no history of tuberculosis. Systemic examination was normal.

Dermatological examination revealed a well defined irregular plaque of 5x8 cms in size, with raised margin and thick minimally friable scales involving the lower and sides of the nose and whole area above the upper lip (Figure 1). Lesion was non tender and showed minimal scarring in the centre. There was no deformity. There was no regional lymphadenopathy.

Clinical differential diagnosis included lupus vulgaris, cutaneous leishmaniasis, Chromoblastomycosis, Sarcoidosis, lethal midline granuloma, basal cell carcinoma, Keratoacanthoma centrifugum marginatum and Bowen's disease.

Investigations were done in accordance with the possible differential diagnosis. Basic investigations were normal. Blood for HIV and STS were normal. Mantoux was 15 mm positive. Scrapping from the margin under 10% KOH was negative for fungus.

Biopsy was done from two different sites on two different occasions, one before and one after 9 months of ATT. Histopathology revealed pseudoepitheliomatous hyperplasia, micro abscess, epitheloid cells and giant cells. Second biopsy under extensive examination and deeper sections revealed muriform cells measuring 10 millimicron with brown round thick walled bodies and longitudinal and transverse septa in the deep dermis clinching a diagnosis of chromoblasatomycosis (Figure 2).

Further confirmation was done by culture under sabourauds dextrose agar (SDA) medium which showed growth of dark brown colonies after 6 weeks confirming a diagnosis of chromoblasomycosis (Figure 3). Wet preparation from culture media under lacto phenol blue revealed hyaline and phaeoid hyphae with conidia arranged in short chains (Figure 4). Phaeoid conidia in short chains and sheid cells with hilar scar were also seen (Figure 5). Species identification confirmed growth of cladophialophora carrionii.

Patient was treated with ATT for 9 months without much improvement. He was started on Itraconazole 400mg daily after confirming the diagnosis of Chromoblastomycosis. Since the patient did not show desired improvement intermittent treatment with cryotherapy was started and is currently under regular follow up.

DISCUSSION

Chromoblastomycosis is a deep mycotic infection caused by Fonsecaea pedrosoi (involves 90% of the cases), Cladophialophora carrionii, Phialophora verrucosa, occasionally by Rhinocladiella aquaspersa. They exist as saprophytes in soil. Mode of infection is by inoculation where in the transform in to parasitic muriform bodies which cannot be destroyed by host defense cells. Farming community is usually affected. Sub-Himalayan, eastern and western coastal areas in India have incurred most of the disease (1). The disease is basically intracutaneous with rare extracutaneous spread. Usually manifests as nodule, tumoral masses or large verrucous plaque involving lower extremities. Patients with involvement of uncommon sites like face, vulva, and penile shaft and with extracutaneous spread have been reported sporadically from different parts of India (2).

The case under study is interesting in many aspects. Apart from rarity the morphology of the lesion was well defined scaly plaque with raised margin and minimal scaring mimicking many dermatosis especially lupus vulgaris, leishmaniasis, basal cell carcinoma to mention a few. The disease normally affects lower extremities and commonly seen in farmers. Our patient was a tailor by occupation with lesion occurring on the face. Identifying the source of infection was thus difficult. There was no history of trauma as well.

Lupus vulgaris was considered as the first diagnosis and was started on ATT considering a positive mantoux test and histopathology showing a granuloma.Since the patient did not respond to full course of 9 months therapy a second biopsy was done which showed granuloma with the sclerotic/ copper penny bodies a diagnosis of chromoblastomycois. Culture and wet mount with lacto phenol blue confirmed the diagnosis showing a growth of cladophialophora carrionii and hyaline and phaeoid septate hyphae arranged in short chains and phaeoid conidia in short chains and sheid cells with hilar scar.

Spontaneous resistant is rare and response to drug is limited. Drugs found to be useful are itraconazole, terbinafine, 5-flucytosine, SSKI and amphotericin B. Surgical excision, cryotherapy, co2 laser therapy are tried in resistant cases. Our patient is on itraconazole 400 mg per day with two sitting of cryotherapy showing minimal response.

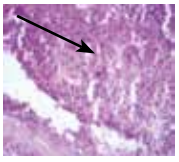

Fig 2: arrow showing sclerotic bodies H&E 40x10

Fig 3: positive growth in SDA

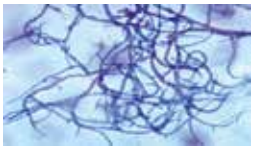

Fig 4 ; wet preparation under lacto phenol blue showing hyaline and phaeoid septate hyphae

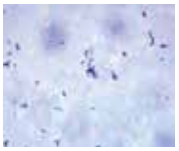

Fig 5 Phaeoid conidia in short chains and sheid cells

This case is reported for its rarity, patient being a tailor rather than farmer by occupation, unusual site, distinct morphology mimicking many other dermatosis, slow response to treatment and first case to be reported from Madurai.

ACKNOWLEDGEMENT

We thank the department of Pathology and microbiology for aiding the diagnosis of chromoblastomycois by histology and culture.

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VV-ECMO FOR FAT EMBOLISM – TACKLING HYPOXEMIA

Selvakumar P[1], Balaji E[2], Noel Agnel Pradeep D[3]

[1]Director of Medical Services, [2] Cardiac Anaesthesiologist, [3]Consultant, Critical Care Unit, Velammal speciality hospital Madurai.

ABSTRACT

Pulmonary fat embolism is an infrequent but a serious complication of major trauma or any surgical procedures for long bone fractures and manifest as mild shortness of breath to severe respiratory failure. Extra-corporeal membrane oxygenation (ECMO) has increased the survival rate up to 65% in most of the acute respiratory distress syndrome (ARDS) patients but pulmonary fat embolism patients are still a challenge to ECMO. Herein, we describe a case of 19 year old male with fracture neck of femur, diagnosed as a pulmonary fat embolism after orthopedic reconstruction surgery. . As the patient was a young with no previous co morbities, and an expected short ECMO run, it was decided to offer the extra corporeal membrane support. The detailed procedure, prognosis and outcome are discussed in the present case report.

Keywords: Fat embolism, fractures, acute respiratory distress syndrome, extra-corporeal membrane oxygenation.

INTRODUCTION

Pulmonary fat embolism is an infrequent but a serious complication of major trauma. The spectrum of presentation varies from mild shortness of breath to severe respiratory failure, which can happen within 24 hours of trauma or after any surgical procedures for long bone fractures.1 Although mechanical ventilation is the first choice of treatment but still a group of patients are unable to achieve a targeted oxygenation. The latest modality of treatment for these kind of patients is Extra-corporeal membrane oxygenation (ECMO).This rapidly expanding medical intervention (ECMO) has increased the survival rate up to 65% in most of the acute respiratory distress syndrome (ARDS) patients, but pulmonary fat embolism patients are still a challenge to ECMO.2 In cases of pulmonary fat embolism the fat load can be transferred to the oxygenator and retard its function. However, on the grounds of good prognosis for recovery and the potential for short term support, ECMO could still be attempted as a last resort and a life saving intervention in these patients. Even though with all the hurdles and financial constraint, our director of anesthesia & intensive care has geared up to form a skilled ECMO team. With all the support from our chairman of the institution, we are proud to say that we are the only hospital in southern Tamil Nadu to form a full-fledged ECMO - ICU.

CASE REPORT

A 19 year old male alleged history of road traffic accident (self-fall from a two wheeler) was taken to a private hospital, diagnosed with fracture neck of femur (left leg), no other major organ injury with a Glasgow Coma Scale (GCS) of 15/15. The patient was taken for orthopedic reconstruction surgery after 24 hours of injury. The procedure went uneventful under regional anesthesia. The post procedure patient went in for a respiratory distress, for which patient was referred to our hospital. Immediately patient was attended by our emergency physicians. On examination patient was irritable tachypneic with a heart rate of 170/min, temperature103 F, spo2 of 48% in room air, which improved to 88% with 15 l o2 /min. Blood gas analysis revealed a po2 of 55mmhg with 15 l 02 / min. Few petechial rashes were seen over the axilla and chest region. Primary resuscitation was done in an emergency room. The patient was intubated and shifted to ICU. A provisional diagnosis of pulmonary fat embolism was made, which was supported by the Gurd's clinical criteria and chest x-ray which revealed B/L ground glass opacities.

After receiving the patient in ICU, he was completely sedated and paralyzed and started on low tidal volume lung protective ventilation strategies. The patient was started on high dose antibiotics and negative fluid balance maintained as a part of the ventilatory protective strategy bundle. Patient landed up with early ARDS, which was confirmed by taking serial X-rays and declining trend of po2 in blood gases. The po2 has declined to 35 mmhg over a period of 48 hours, in spite of all ARDS oriented ventilator strategies. Immediately the ECMO team was activated. The previously published fat embolism cases were reviewed and negative experiences with fat degrading the oxygenator function were noted. As this was a young patient with no previous co morbities, and an expected short ECMO run, the team decided to offer the extra corporeal membrane support.

There was a delay in institution of ECMO by 48 hours in spite of deteriorating patient condition, the delay was due to decreased awareness among the patient's relatives and due to the financial constraints. Proper counselling regarding the advantages and disadvantages of ECMO was given to the family by the team.

The patient was immediately shifted to OT for insertion of ECMO catheters. The right femoral vein was cannulated with a 21G biomedicus femoral cannula for venous drainage and the return cannula of 17 G was inserted over the left femoral vein and placed at a higher level confirmed by x-rays to rule out recirculation. The patient was then connected to the maquet ECMO. The patient was shifted to the ICU and continued on broad spectrum antibiotics and proper anticoagulation, with close monitoring system. Blood gases, blood glucose, ACT; serum electrolytes were checked and maintained at an optimum level. X-rays were taken to confirm the position of the ECMO catheters. Intensivist and perfusionist were available for the patient round the clock.

ECMO was started at a flow of 2800 ml (2.5 l/min), with a sweep of 3.0. The blender was started with a Fio2 of 100%. Our aim of the treatment was to give rest to the lung and reduce the Fio2 in both the ventilator and the extra corporeal system. We had a close monitoring of the colour of the blood in both the catheters; there was a significant colour difference. The po2 was measured from both drainage catheters and the return catheters which showed as 40 mmhg and 350 mmhg respectively. Immediately after connecting to the ECMO, saturations picked up to 90% and po2 improved to 80 mmhg. After a period of 2 hours, we tried to increase the flow, because the target flow rate was around 4-5 l/minute. Initially, while increasing the flow to 3 l/minute, we could see the chattering in the ECMO catheters. This chattering was due to inadequate blood flow from the drainage catheters, so we planned to increase the flow by placing an additional catheter over the right jugular vein. Immediately after placing the additional drainage catheters, the flow was increased to 4 l/minutes, the oxygen saturation was improved to 92% and the po2 improved to 70 mmhg. The patient was sedated and paralyzed and continued on the control mode ventilation. Broad spectrum antibiotics were continued. The patient was under the close monitoring system. Patient improved significantly on day 3 and day 4. On the latter half of day 4 the po2 started falling and the bilirubin levels started raising. There was a significant drop in the hemoglobin levels. We started on an adequate amount of blood transfusions. As expected the oxygenator started getting contaminated by the fat globules. This had resulted in the mechanical destruction of cells. The patient started becoming ECMO dependent and had an increased extraction of oxygen from blood. Immediately the oxygenator was changed, but over the following days the patient's clinical condition worsened. On day 7, patient went for a cardiac arrest, immediately code blue activated and resuscitation started. Finally, patient couldn't be revived back. Though we didn't have a positive result, we had learned a quite few things from this challenging case of fat embolism.

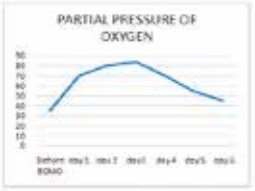

Figure 1: Graphical representation of partial pressure of oxygen

Figure 2: X-ray after insertion of two femoral ECMO

Figure 3: X-ray after insertion of the additional jugular catheter

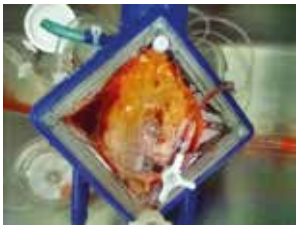

Figure 4: Oxygenator contaminated with fat globules

CONCLUSION

The theme of this case report of VV ECMO for fat embolism is

I. There was a delay in instituting the ECMO for the patient, due to decreased awareness about the advancement among the public and the primary physicians. Early institution would have dramatically changed the result.

Tackling Hypoxemia

II. The contamination of the oxygenator by the fat globules was an expected one, we were well prepared for it, but still there was no proper method for identification except the visual finding. This oxygenator failure had led to the mechanical destruction of blood cells, leading to irreversible damage.

III. VV-ECMO for fat embolism needs higher blood drainage with a flow of at least 4-5 l /min. The oxygen saturation will be improved and will be around 85 - 90%. Hence always use an additional drainage catheter.

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VASOPLEGIA SYNDROME ON CPB AND ITS MANAGEMENT

P. Selvakumar
Director of Medical Services,
Director of Anaesthesia & Intensive care,
VMC Speciality Hospitals, Madurai.

Invited Faculty for 19th National Cardio Thoracic and Vascular Anesthesiologist Conference held at Chennai.

INTRODUCTION

Vasoplegic syndrome is a well-described form of vasodilatory shock that potentially can occur during or after separation from cardiopulmonary bypass (CPB). It is a state of low systemic arterial pressure despite high CO (CI>2.5 l/min/m2) and adequate fluid resuscitation characterized by markedly low SVR (SVRI<1,600 dyn-sec/cm5/m2).

PATHOPHYSIOLOGY

• It is attributed to the combination of endothelial injury, AVP system dysfunction and release of vasodilatory inflammatory mediators, including TNFα, IFN and IL- 1 which promote vasodilation through an increase in Cyclic GMP. cGMP causes vasodilation and decrease myocyte contractility with myocardial and vascular smooth muscle relaxation. On pump provokes a vigorous inflammatory response.

• Endotoxemia secondary to repeated episodes of hypotension due to displacement and mobilization of the heart.

63rd National Anesthesia Conference held in Jaipur during December 2015 as an inaugural Speaker about "Anesthesiologist as Peri Operative Physician".

12th National Conferences of Indian College of Anesthesiologist at Chennai. Topic: "Post Heart Transplant patient for TURP"

MANAGEMENT

• R/O other types of shock : Tamponade, hypovolemia, cardio genic
• R/O treat other causes of vasodilation
• Minimize vasodilators (milrinone, dobutamine)
• Treat sepsis if suspected
• Vasopressors
• Noradrenaline often used first line
• Vasopressin
• Methylene blue (2mg/kg)

Chair person for Neuro Emergency & Critical Care CME Program

VMC Speciality Hospital CTICU & ICU Pooja.

ROLE OF EXOGENEOUS VASOPRESSIN

1. Vascular vasopressin receptors are left unoccupied due to its relatively low plasma concentration whilst NE and AT II concentrations are high in vasodilatory shock leading to receptor desensitization.

2. Exaggerated response in patients with ANS dysfunction.

3. Potentiates the vasoconstrictor effect of NE.

4. Directly inactivates K-ATP channels in vascular smooth muscle.

5. Blunts the increase in cGMP induced by NO.

ROLE OF METHYLENE BLUE

When severe hypotension persists despite NE > 14 mcg/min and AVP up to 6 units/hr (maximum dose), a state of vasoplegia is considered to exist and it is at this stage that infusion of MB is usually considered. Proposed mechanism of action is smooth muscle vasodilatation due to blockade of NOS dosage of 2mg/kg.

COSMETOLOGY FOR ALL

Department of Dermatology & Cosmetology VMCH &RI offers a wide range of treatments for various skin, hair, nail, STD and leprosy disorders since 2012. Our department comprises of senior faculties with 30 years of experience in clinical Dermatology &teaching besides young, dynamic dermatologists with a flair for cosmetology. Our department treats an average of 60 to 80 cases per day; with this background we are proud in introducing our very own state of the art "cosmetology unit". Cosmetology is the science of beautifying the skin and its appendages which play an important role in socio economic communication. The majority of the cosmetic procedures are costly and are available in limited centers only. Beneficiaries have been rich and affluent people mainly. Here is the revolution in cosmetology in Madurai city. Like never before in Tamil Nadu, VMCH&RI introduces cosmetology treatment at an unbelievable and affordable price with latest technology and advanced equipments.

Highlights of Cosmetology Wing

1. Free counseling and consultation.
2. All procedural costs range from Rs. 500 to 1000 only.
3. Poor people will be given concession even on above mentioned rates.
4. Advance technology and latest equipment for aesthetic and cosmetology treatments.
5. Procedures are done for hair loss and baldness, excessive /unwanted hair, acne and scars, pigmentation, tattoo removal, dull and dark skin, etc.
6. There is no waiting period.

a) Q switched ND YAG LASER –Korea/USA	Skin pigmentation, Tattoo removal
b) Fractional CO2 LASER- KOREA/USA	Acne scars ,benign tumor removal
c) Hair and skin analyzer- KOREA	Skin and Hair analysis
d) Diode LASER-KOREA	Hair removal
e) Derma roller	Acne scars, PRP
f) PRP- Platelet rich plasma Therapy	Baldness, hair loss, non healing ulcers, scars
g) Micro derma abrasion-MDA	Skin lightening
h) Chemical peels- glycolic acid, salicylic acid, TCA, various combination peels pumpkin peels, orange peels etc.	Acne, scars, melasma, skin rejuvenation.
i) PHOTO THERAPY- NBUVB , UVA	psoriasis, vitiligo
j) VITILIGO SURGERIES-PUNCH GRAFT, SSG,	Vitiligo

Beauty for all is within reach!! Come and avail the opportunity with nominal costs!!

COMBINATION THERAPY FOR ACNE & SCARS WITH CHEMICAL PEELS & FRACTIONAL CO2 LASERS

A 25 year old female presented with complaints of recurrent pimples, pustules along with extensive scars and uneven skin tone over the face for past 1 year. On examination patient had Grade III acne with various atrophic scars and post acne pigmentation. She was initially managed medically for acne and showed partial response in acne outbreak. The patient was anxious for better cosmetic appeal in view of her upcoming wedding.

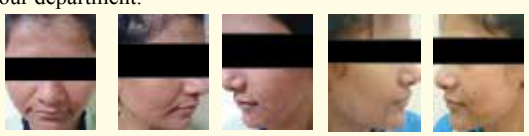
We offered her a range of Cosmetological treatments at an affordable cost with assured results as we were short of time.

Once active lesions subsided, we subjected the patient to 3 sessions of Chemical Peeling with Salicylic acid at intervals of 2 weeks and she showed very good improvement in skin tone, reduction in acne and pigmentation.

The patient was then subjected to one session of fractional CO2 laser, following which she showed dramatic improvement in scars and skin tone & texture within 10 days of treatment.

She was satisfied with the results and is now on maintenance therapy.

The highlight of this presentation is to create awareness about the latest Cosmetological Procedures available in our department.



Before treatment | After 3 Sessions of Chemical Peeling | After 1 session of fractional CO2 laser

DEAN

Dr. R.M. Raja Muthiah

- Efficient administrator as a medical superintendent at our hospital for nearly half a year.
- The new stint as Dean since 01-03-2016.
- A perfect gentleman, assertive and polite at the same time.
- Student-friendly and deeply interested in student welfare.
- Approachable by staff and workers and keeps them comfortable at work.

MEDICAL SUPERINTENDENT

Dr. S.Somasundaram

- Has been a Professor and Head of Surgery at our institute since 2012.
- Also executing the role of the medical superintendent since March 2016.
- Widely known for his excellent administrative skills that keep a hospital as large as ours run smoothly.
- An academic scholar maintaining effective coordination and communication with faculties and staff.

E-POSTER HAS BEEN AWARDED FIRST PRIZE IN FELLOWSHIP IN MEDICAL EDUCATION AT SRMC-MCI NODAL CENTRE FOR FACULTY DEVELOPMENT, SRI RAMACHANDRA UNIVERSITY. (MARCH 13-15TH 2016).

Enhancing interpretation skills of laboratory investigations among undergraduate medical students
MCI Advance Course – SRU THIRD FIME

Dr. K. Suganthy, Dr. P. K.Mohanty, Dr. V. Rajagopal, Dr. N.Vijayabanu, Dr. B. Sumanthkumar
VELAMMAL MEDICAL COLLEGE HOSPITAL & RESEARCH INSTITUTE,MADURAI

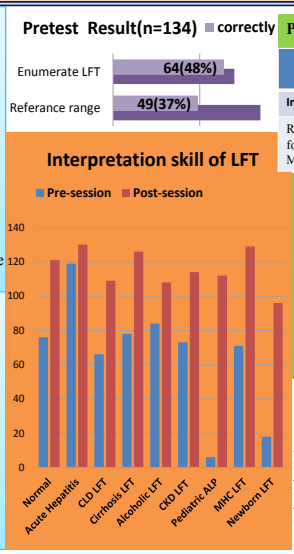
INTRODUCTION

- Re-structuring of practical Biochemistry curriculum has already on the way to make more of clinical relevance.[1]
- CDC report May 2009 aforementioned that "Medical education on laboratory testing is inadequate despite the integral role of laboratory testing in the health care providers.[2]
- Medical student education is being reviewed at many levels for training in the laboratory testing and their interpretation clinically among the pre-paraclinical year undergraduate students.

METHODOLOGY

A cross section study of passed first MBBS students, on interpretation skills of LFT. Institutional ethical committee clearance obtained and student informed consent undertaken from 134 students .

(a) A pre-test questionnaire on LFT .
(b) Routine Lecture, chart based discussion, interactive sessions on LFT conducted.
(c) Student interpretation skills assessed by OP/IP LFT laboratory reports (27students/faculty)
(d) Post session student perception feedback.



Post-session student perception

	SA	A	N	DA	SDA
Interpret skill	26	70	30	6	2
Recommend for 1st/clinical MBBS	51	47	24	6	6

CONCLUSION

- Multiple modalities of T-L assessment methods improve the interpretation skills.
- Stimulated further learning & self assessment
- Understand the Clinical relevance of LFT
- Recommends for practical pre/para clinical and lab side teaching in MBBS students.

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Dr. MUTHUMATHI DHARUMAN,
Chief Librarian, VMCH & RI,
received the "Best Librarian Award" from Library Professionals Association, Delhi, India.
The award function was held on 10th March 2016 at P.K. Das Institute of Medical Science, Palakkad, Kerala.

Dr. Jeyashree K was invited by the International Union Against Tuberculosis and Lung Diseases to facilitate The Union's Operational Research (OR) Course Module 2 at Colombo, Sri Lanka: March 7-12, 2016.

As an outcome of the course, she is now mentor and co-investigator of two OR projects at China and Srilanka.

Dr. Deneshkumar. V, Assistant Professor in Statistics, Department of Community Medicine, Velammal Medical College Hospital and Research Institute Madurai, has attended state level workshop on Statistical Methods and Applications as resource person and delivered a talk on "Time Series Analysis" held at G. Venkataswamy Naidu College Kovilpatti on February 9th. Nearly 300 students attended the workshop from various institutions from Tamil Nadu.

Welcome To Velammal Family

- Dr. S. Nataraja Rathinam, Professor in Paediatrics
- Dr. M. D. Ameen, Associate Professor in Radiology
- Dr. Kishan R Siddapur, Associate Professor in Forensic Medicine & Toxicology
- Dr. Geetha Kishan Siddapur, Associate Professor in ENT
- P. Suresh, Assistant Professor in Biochemistry
- Dr. Karthikeyan G, Assistant Professor in General Surgery
- Dr. K. Jeyashree, Assistant Professor in Community Medicine
- Dr. Vadivelu, Assistant Professor in Cardiology
- Dr. F. Biravinth Solomon, Master of Surgery
- Dr. R. Rakesh Kumar, Senior Resident, General Surgery
- Dr.Jim Divakar, Senior Resident in ENT
- V. Ganesh, Tutor in Biochemistry
- A. Kavitha, Tutor in Biochemistry

bashes....

APRIL

1 April - Dr. R. Kowsalya, General medicine
3 April - Dr. S. R. HariSudhan, Orthopedics
4 April - Dr. S. N. Krishnamoorthi, Anaesthesia
6 April - Dr. G. Vithiya, Microbiology
12 April - Dr. K. Bharath, Anesthesiology
14 April - Dr. B. N. Vallish, Pharmacology
Dr. S. T. BabuJeyakar, JR
16 April - Dr. P. Thangapprakasam, General Surgery
Dr. V. Vaitheki, JR
17 April - Dr. Suma B. Pillai, Pathology
20 April - Dr. R. M. Rajamuthiah, Dean
Dr. D. Anitha, Gynecology
Dr. B. Rita, Community Medicine
23 April - Dr. S. Maheswaran, ENT
25 April - Dr. E. Ratheesh, JR
26 April - Dr. M. Mariappan, Radiology
28 April - Dr. K. Thiyagu, JR
29 April - Dr. E. Inbalatha, JR
30 April - Dr. D. Alwin Gunaraj, General Surgery
Dr. AR. Karthik, Anesthesia

MAY

2 May - Dr. B. Vanarani, Veterinary officer
4 May - Dr. Praveena Daya, SPM
Dr. Kranti Gouripur, ENT
7 May - Dr. K. Selvalakshmi, JR
8 May - Dr.N.G.Remughi, JR
9 May - Dr. D. Chandrasekaran, General Medicine
Dr. R. SenthilMurugan, General medicine
Dr. K. Rekha, Physiology
10 May - K. J. Jeevitha, Gynecology
11 May - Dr. Jhansi Charles, Microbiology
Dr. M. Balamurugan, Orthopedics
Dr. Shanmuga Sundaram, General medicine
16 May - Dr. P. M. Padmanabhan, JR
17 May - Dr.T.Balamurugan, Orthopedics
18 May - Dr. S. Adhithya Muthu, JR
Dr. M. Rathi Nivedhana, JR
19 May - Dr.N.Prethivee, JR
20 May - Dr. S. Tamilarasi, Pharmacology
Dr. M. Parasuraman, JR
24 May - Dr. Biprojit Debbarman, Forensic medicine
25 May - Dr. D. Noel Agnel Pradeep, Critical care unit
27 May - Dr. S. P. Damayanthi, RMO
Dr. K. Yegumuthu, Pathology
30 May - Dr. R. Yoganandha, Dentistry
Dr. Mohamed Ramadhan, JR
31 May - Dr. Tharik Ajees, Tutor

JUNE

1 June - Dr. Dixit, Physiology
2 June - Dr. R. Ramalakshmi, Tutor
4 June - Dr. R. V. Jeya Balaji, Pediatrics
Dr. V. Manikandasamy, Pediatrics
5 June - Dr. K. Anandhi, General Medicine
6 June - Dr. Usha Ravikumar, Pathology
Dr. A. S. KaniethaPriya, Physiology
7 June - Dr. T. Rajendran, Microbiology
Dr. Parineeta Suman, Anatomy
Dr. R. Ramanarayanan, Anesthesia
8 June - Dr. Muthuramalingam, Ophthalmology
9 June - Dr. P.K. Mohanthy, Vice Principal
Dr. T. VenkatRamanaiah, Forensic medicine
Dr. S. Anu, Physiology
10 June - Dr. E. P. Rajarajan, General Surgery
11 June - Dr. B. Megala, JR
13 June - Dr. S. Venkatesh, General Surgery
15 June - Dr. N. Ashokkumar, Neurosurgery
Dr. P. Sethuammal, Blood bank
Dr. P. PrakashKarath, Anesthesia
Dr. V. Jothi Lakshmi, Gynecology
Dr. A. Sangeetha, General Medicine
17 June - Dr. G. Kavitha, Gynecology
19 June - Dr. B. Sumanth Kumar, Biochemistry
20 June - Dr. I. Veeramani, Pediatrics
Dr. R. Ashok, General medicine
Dr. M. Niranjana, JR
22 June - Dr. N. Nagarajan, JR
23 June - Dr. K. Maheswari, Pediatrics
25 June - Dr. N .Backiyalakshmi, JR
26 June - Dr. B. Kiruthikaa, Anesthesia
Dr. D. Vimala Parasakthi, General Medicine
27 June - Dr. Muthu Kumar, Orthopedics
29 June - Dr. K. S .Nandeeswaran, JR
Dr. M. Mariappan, JR
30 June - Dr. Siva Krishna, Anesthesia

An Otorhinolaryngological Love Poem

My ossicles shiver at the sound of your name
My cochlea swirls at the sound of your voice
I get symptomatic labyrynthitis when I see your beauty
And my world becomes vertiginous when you enter it

When my optic nerve see your beauty, my facial nerve gets excited
Temporal and zygomatic open my eyes wide
The buccal and mandibular pull a smile
And I start to salivate

There's nothing more pleasant
Than the fragrance of your presence on my olfactory fossa
Than the tympanic reverberations of your voice
Than the tactile impulses of your lips on my cheeks

The laryngologists have never heard a kinder voice than yours
The otologists have never met a better listening ear than yours
And the facial plastic surgeons have got nothing to add
To your perfectly symmetrical facial beauty

Your vocal cords calm me, comfort me, and strengthen me
Your tympanum have forgiven me much for my bitter tongue
There are no sinuses too deep, earwax too thick, or neck nodes too big
To keep me from loving you and thanking God for you

Anonymous

Submitted by,
Dr. Kranti Gouripur,
Department of ENT.

Visit to Bethany Children's Home

India is a country with largest orphan population (20 million). Various Governmental and Non – Governmental organizations are trying to protect and save these children by introducing various Programs and Acts.

Our Visit: We, the students of the Community Medicine department, visited Bethany Children's Home located in kalavasal, Madurai on 19/03/2016, Saturday. It is a home for 28 semi-orphans boys. We did medical checkup and educated them with various personal hygiene habits. We provided them medicines, hand washing soaps and first aid kits for the clinical facilities for the children.It was a nice visit and much important information on the life of children's living in a children's home was studied and reported.

P. Gownisha
II Year MBBS Student, VMCH & RI.

"HOSPITAL INFECTION CONTROL COMMITTEE" MEETING

INTRODUCTION

Hospitals cater to diagnostic, therapeutic and prophylactic needs of patients with various types of infections. While receiving care at the hospital, patients with infections also act as a possible source of infection to other patients and health care providers. A team of doctors and supporting health staff monitors issues related to infections in hospitals and ensure adequate infection control measures, the team is called Hospital Infection Control Committee (HICC).

FUNCTIONS OF HICC

The role of the Infection Control Committee is multi-faceted. It is involved in planning, monitoring, evaluating, updating, and educating. It formulates general infection control policy and provides input into specific infection control issues. Simply stated, its function is to prevent and control nosocomial infections. That is accomplished in a variety of ways, some of which include: surveillance of nosocomial infections, product evaluation, investigation of infection outbreaks and infection clusters, development of infection control procedures for all departments, staff and patient education, biomedical waste management, etc.

HICC OF VMCH&RI

A hospital infection control committee of the Velammal Medical College Hospital functions under the chairmanship of Dean while Medical Superintendent, heads of departments of Microbiology, Community Medicine, all clinical specialities, Nursing Superintendent, Personnel in-charge of Operation Theaters, Central Sterile Supply Department, housekeeping, etc. are members. The committee meets on the first Tuesday of every alternate month to discuss about important issues related to infection control in the hospital.

The 24th HICC meeting was conducted on 1st March 2016. Dr. Jhansi Charles, professor and head of Microbiology presented the data of laboratory assessment of infections, common micro-organisms causing them and their antibiotic susceptibility patterns in the hospital pertaining to the previous two months. Details of environmental surveillance of critical areas in the hospital (Operation Theatres, ICUs, Dialysis unit, etc.) were also discussed and were found to be appropriate. Dr. Samir Bele, professor and head of Community Medicine discussed measures (desalination, reverse osmosis, filtration, chlorination, etc.) being taken to ensure good quality of water supplied in the Velammal Medical College campus including the hospital. Water samples were tested in Velammal Hospital and also at Government authorised testing centres and have been certified to be fit for use.

MINUTES OF THE RNTCP 4TH QUARTER 2015 PERFORMANCE REVIEW MEETING

The meeting was held on 9/03/15 at hospital board room in VMCH & RI.

1. The meeting was presided by Dr. Raja Muthiah, Dean, Dr. Samy, DD (TB) Madurai, Dr. Somasundaram, MS along with the head of all the departments attended the meeting.

2. Dr. Prem Ananth, AP department of Respiratory Medicine presented the performance of the TB Cell in VMCH&RI for the last quarter of 2015 (October to December).

3. The total number of patients, number of smear positive cases, smear negative cases & EPTB cases that are detected, started on ATT, transferred out in VMCH TB cell were presented in the meeting.

4. Following Suggestions were made out by the committee to improve the performance:

(i) To increase the number of referrals for AFB smears examination (both sputum & extra pulmonary specimen) to TB cell directly.

(ii) To register all the TB cases in VMCH TB cell and then transfer out to the DOTS centre, nearest to patient residence, rather than directly referring to any Government hospitals for initiation of ATT.

(iii) Regular observation and follow-up of TB cell activities by the respective STS and STLS as per norms.

(iv)To improve the feedback of referral & transfer out activities.

(v)To increase the number of ICTC/VCTC samples for referrals from all departments.

Report submitted by,
Dr. Prem Ananth,
Nodal officer, TB cell, VMCH&RI

TUMOUR CLINIC

Tumour clinic was conducted once in the last week of every month in our hospital board room between 2 pm to 3 pm. The meeting was coordinated by Prof. Somasundaram, HOD of General Surgery/ MS. The idea behind this meeting was to create a multidisciplinary approach towards evidence based management of tumour cases. Every month one to two tumour cases were discussed by a panel of experts from the department of Surgery, Medicine, Radiodiagnosis, Pathology, Medical Oncology and Surgical Oncology. February was the month for breast oncology where a "Triple negative breast cancer" case was discussed. The speakers were Dr. Muralikannan (General Surgery), Dr. Poongodi (Pathology), and Dr. Ravikumar (Medical Oncology). Many faculties and JRs from concerned departments had attended the meeting. The speakers have given a brilliant lecture starting from the basics to the up-to-date knowledge about triple negative breast cancers. The areas that were deeply appreciated are histological and molecular classification of breast cancers, its clinical presentation, BRCA mutations and recent chemotherapeutic trials.

Report submitted by,
Dr.R.Sudhakar,
Department of Pathology.

VISIT TO YMCA SCHOOL FOR THE MENTALLY RETARDED CHILDREN

YMCA school for the mentally retarded children is located at Elise Nagar, Madurai; We visited this school on March 15 2016. Most of the children were affected with microcephaly, Down's syndrome, cerebral palsy, etc. We, the batch of 28 students were taken to the school by the department of Community Medicine as a part of the field visit program. Brief introduction was given about the school.

We attended the morning session along with them. These children were require repeated narrating and the teachers do it so patiently. The classes of children are divided based upon their grades. Vocational activities like candle making and paper cup making is also being taught to older children. Two volunteers from Germany were staying and helping all these children as a part of their internship. To conclude, this school is providing a second life to children who are mentally retarded.

Jai Chandra Bose,
II Year MBBS Student,
VMCH & RI.

A SOBRIETY PROGRAMME OF "NAMBIKKAI" ADDICTION CARE CENTRE

On 24-02-2016 the department of Psychiatry, Velammal Medical College Hospital and Research Institute, conducted a programme to recognise and encourage patients who had undergone de-addiction treatment at "Nambikkai". A total of 32 patients who were successfully fighting the habit and remained abstinent off alcohol and other drugs till date were invited to attend the programme with their families.

The programme was conducted at the very premises of the "Nambikkai" ward, where the patients underwent treatment. The programme was graced by our respected Vice Chairman, Dean, Medical Superintendent, Director of Medical Services and the Resident Medical Officer. The chief guest and speaker, Dr. Sugadev, Associate Professor, Department of Psychiatry, Government Rajaji Hospital, Madurai distributed prizes to the patients.

It was a heartwarming and a rewarding experience to see tears of joy, hear emotional testimonies of patients and their families. The programme was followed by lunch provided by the department of psychiatry for all invited patients and their families.

Gathering of recovered persons with family members

HOD, Psychiatry welcomed the gathering

Vice chairman sir addressing the gathering

VC sir honouring the chief guest

Recovered persons with family members honoured by the chief guest

Recovered persons expressed their feeling and sharing's

Doctor Rena gives a vote of thanks

"NAMBIKKAI" THE LAST HOPE

Addiction of alcohol and other drugs is a problem for us all, not only for the misuser, but also for the caregiver, family, workplace, neighbourhood and for the society at large. It can affect young and old, rich and poor, male and female equally. It cuts across time and space, and does not discriminate by geographical location, race or religion, whether it is brewed or distilled products like alcohol and natural products, such as opium or cannabis, semi-synthetic products such as heroin or synthetic products as pentazocine, the consequences can be similarly tragic everywhere.

Wasted lives, Ruined families, Impoverished societies.

Most societies have their implicit permissions for use of certain categories of drugs in low quantities, under certain circumstances.The problem of substance abuse and dependence, however goes much beyond these socially sanctioned, tacit innocuous limits.Indeed the problem goes straight to the heart of human civilization, its prosperity maintenance and finally to its very existence.

Since the last few decades alcohol and drug abuse have raised concerns not only about the large scale implications for health, but also about social and economic well being in general. The growing menace of alcohol and drug abuse have been continuously challenged the existing resources to combat the problem. For such a multifaceted complex problem, it is but natural that the responses mounted against it, must also be multidimensional in nature. As per our chairman's mission "Quality health services at an affordable cost", we are committed to continuously improving our quality, maintaining high standards of patient care with excellence, competence and compassion. We also have an innate and social responsibility to combat this menace of drug addiction.

Within a short span of time the steady increase of patients inflicted by substance abuse indicate that it's only a tip of the Iceberg, and the real issue is much deeper.

Substance use disorders are among the most common psychiatric disorders and the associated morbidity and mortality are substantial.

Keeping all the above factors in mind, with the guidance of our beloved chairman the Addiction care centre NAMBIKKAI was started by the Department of Psychiatry.

The centre was formally inaugurated on May 24th, 2014, by Mr. Radhakrishnan IAS., Principal Secretary Department of Health and Family Welfare, Government of Tamil Nadu and fully operational from June 20th 2014.

It's a 20 bedded, state of the art centre with attached restroom facility, individual counselling room, group activity room, yoga room and recreational room.

So far, we have admitted and treated 300 patients, mostly alcoholics and around 1000 patients are treated as an outpatient basis.

Periodically we are conducting "Relapse prevention" programmes with family members to encourage them with rewards to maintain sobriety. Patients who have lost follow-ups are contacted via telephone by the staff to re-establish contact and prevent prolonged relapse.

Above all some of our patients treated by us, has given job opportunities in this institution, who are doing exemplary work in their respective areas.

The comprehensive services include Detoxification, De addiction, Occupational therapy and Rehabilitation.

The ward has 24 hour nursing and medical care, a systematic program with regular individual and family interventions, yoga and recreational activities. The patients are seen daily by a team of qualified psychiatrists. Physicians, Surgeons, Gastroenterologists and Neurologists are available on call. There is round the clock duty physician and surgeon call over facility in case of emergencies. There is 24 hour security and monitoring available for safeguarding of patients and staff. All these are offered at an affordable cost.

Department of Psychiatry,
VMCH&RI, Madurai.

WORLD GLAUCOMA WEEK

CME - Preserving Eyes, Preserving Vision
An event for "World Glaucoma Week"

The world glaucoma week is celebrated by the ophthalmologist and glaucoma specialist globally between 6th to 12th March every year. The main aim of this initiative is to create awareness of this disease, which is aptly named as the silent thief of sight. Glaucoma is known among the medical fraternity and to some percentage of the general public as the eye condition which results due to increased intraocular pressure (IOP).

However, glaucoma is a multi factorial, progressive optic neuropathy leading to damage of the optic nerve with loss of visual function. The only known modifiable risk factor is increased intraocular pressure. But glaucoma can occur in the presence of normal IOP as well (Normal Tension Glaucoma). The disease is asymptomatic till late stages and affect the side vision (Peripheral Visual Field) rather than the central vision. It is the silent thief of sight and manifests later, after considerable damage had happened.

In commemoration with the celebration of glaucoma week, Department of Ophthalmology, Velammal Medical College and Research Institute joined hands with the Madurai Ophthalmologist Association, conducted a CME- Preserving Eyes, Preserving Vision to create awareness on early detection of eye diseases and prevention of blindness for the non-ophthalmologist as well as medicos on 11/03/2016. Honorable president of Madurai Ophthalmologists Association, Dr.T. S. Chandrasekaran was the chief guest .Our beloved vice chairman, Dr. Asokan inaugurated the CME. Respectable Dean, Dr. Raja Muthiah and Medical Superintendent, Dr. Somasundaram graced the occasion with their presence.

Two guest speakers, namely Dr.A. Vijayalakshmi from Aravind Eye Hospital, Madurai and Dr. M. Dheepa from Nethra Eye & Retina Specialty Hospital spoke on the occasion. Their respective topics were: Beating Invisible Glaucoma & Retinal Disease-Silent Killer of Sight.

Both the speakers enlightened the audience about the eye morbidity caused due to glaucoma & retinal diseases. Dr. Krishnadas, Secretary, gave vote of thanks.

As part of celebration, lots of patients were screened for glaucoma in the department of Ophthalmology. If those patients can spread word of awareness among acquaintance & family members about the condition, the purpose of the CME is served.





"CHILDREN'S DAY" CELEBRATION

The Department of Pediatrics had the privilege of celebrating Children's day 2015 under the able guidance and encouragement of our beloved Chairman Shri. M. V. Muthuramalingam, Vice Chairman, Dr. S. Asokan and Dean Dr. A. Srinivasan. We had a grand celebration in our hospital auditorium in which Prof. Dr. G. Mathevan, Head of the department of Pediatrics welcomed the gathering. Mr. Ganesh Natarajan, Vice-Chairman of Velammal schools and engineering colleges delivered the Chief Guest address. The event was also graced by the presence of Mrs. Gajavalli Srinivasan who lighted the lamp. She, along with Mrs. Jayanthi Asokan actively participated as judges in the competitions for the children of Velammal staff conducted on 7-11-15 within the hospital premises.

It was a day of joyful celebration with mind-blowing performances by the little heroes of various competitions like singing, dancing, storytelling and fancy dress. Puppet show was organized by the trainee nurses. Prizes were distributed for the winners from Velammal schools- Anuppanadi, Viraganoor, Ladanenthal and Thirupuvanam and also for VMCH family by the chief guests of the event. The entire event was attended by around 350 students from Velammal Vidhyalaya, Anuppanadi.

Department of Pediatrics.

Vice chairman sir addressing the gathering

WORLD OF WOMEN "WOW"

An event for "International Women's Day" Celebration.

VMC Speciality hospital & The Hindu organised a day-long celebration "WORLD OF WOMEN" at hotel Pandiyan Madurai on 12/3/16.

The day started with a car rally cum treasure hunt "Heals on Wheels". Flagged off by our honourable Chairman Thiru. M.V.Muthuramalingam at VMCH campus.

Cheers to our staff Ms. R. Saranya (In charge pest control) Ms. Gayathiri (Incharge Billing) who won the first Prize.

Free Medical camp & blood donation camp were held at the same venue.

Among the energetic crowd 3 Ladies donated their blood.

Dr. Sethu ammal (HOD-blood bank) explained the importance of blood donation.

Dr. S. Raja Rajeshwari (HOD, OB/GYN) Gave on enthusiastic speech & Gave an Interview to Sagar TV regarding women's health.

Chairman, Thiru. M.V.Muthuramalingam and vice chairman Dr. Ashokan established their esteem presence in the event.

INTERNATIONAL WOMEN'S DAY CELEBRATION - 8TH MARCH, 2016

The staff of Velammal Medical College Hospital & Research Institute celebrated the International Women's Day on 8th March, under the guidance of Honorable Chairman and Honorable Vice Chairman. More than 500 Staff members participated in the event enthusiastically. Mrs. Jayanthi Asokan was the special guest invited for the event.

As per Indian tradition, the event started by lighting the lamp which was followed by a prayer dance of "Bharatanatyam" performed by our Staff. This was followed by elegant dance performances, classical dance by Ms. Sangeetha, solo dance by Ms. Gayathri, Group dance by Mrs. Priya & Team.

A soulful poem was sung by Ms. Venkateswari. Ms. Manimala, one of the housekeeping staff also delivered a spirited speech on "Power of Empowerment".

The interactive audience enjoyed participating in fun competitions and games like Rangoli, Running Race, Musical Chair, Speech Competition and Gandhi Memory Game.

All the female workers of our institute who participated in the various events were presented with a gift by our Honorable chairman and chief guest Mrs. Jayanthi Asokan.

The event highlighted the human touch and social concern which is a special characteristic of our institute. The invited guest, Mrs. Jayanthi Asokan, was presented with a memento. She enlightened the audience about the power of women in the family and society and gave tips on maintaining harmony in the family.

As we celebrated this momentous occasion, each of us carried good memories. The program was organized and coordinated by the HR department.

Report submitted by,

Ms. Srimathi Soundararajan,

Assistant Manager HR,

Velammal Medical College Hospital & Research Institute,

Madurai.

"WORLD KIDNEY DAY"

"World Kidney Day" is a health awareness movement celebrated every year all across the world, emphasizing on prevention of kidney diseases and related health problems. This year it was commemorated on March 10th and VMCH&RI celebrated this event on 18th & 19th of March. A circular was issued a month ago, before the event to all the staffs and doctors to participate in the poster competition. We got a very good response and many participants contributed to the poster completion. Accordingly, we have selected 1st, 2nd, 3rd prizes for the best posters. The entire event was celebrated for two days in which we have displayed the various posters and model specimen prepared from food items providing information regarding what kind of food should be taken and avoided for chronic kidney disease, acute kidney disease and the kidney stones.

We displayed all the health education material in front of medicine OPD and the response from the patients was good, the majority of them found the information very useful. Handouts for both kidney stones patients and chronic kidney disease were distributed to the patients. In these two days, around 1000 patients, staffs, students and doctors visited this event.

From the Nutrition And Dieticties department, I would like to thank our Hon. Chairman Sir, Vice Chairman Sir, Dean Sir, MS Sir and DMS Sir for giving this opportunity to GET connected with this event. It's my pleasure to thank once again to all who work behind the success of this event.

Report submitted by,

Befeena Christopher,

Dietician, VMCH&RI.

World of Women "WoW"

Women's Day Celebration

"Medicare" National Healthcare Exhibition 2016,Organized by Government of Sri Lanka on 4-6th March

"World Kidney Day"