IMPORTANT TELEPHONE NUMBERS

Emergency / Casualty : 2656 8063 / 2656 8064
Ambulance : 97692 50010
Hospital Board Line : 022-2675 1000 / 2656 8000
Hospital Fax : 022-2640 7655 / 2640 5119
Admission Department : 2656 8080 / 2656 8081 / 2656 8082
TPA Cell : 2656 8089
Appointment-OPD : 2656 8050 / 2656 8051
Billing-Inpatient Department : 2656 1586 / 2656 1585
Billing-OPD Department : 2656 8052 / 2656 8053
Blood Bank Department : 2656 8214 / 2656 8215
Health Check-up Department : 2656 8355 / 2656 8354
Report Dispatch Counter : 2675 1620
MRI Department : 2656 8066
X-Ray, Sonography Department : 2656 8031
CT Scan Department : 2656 8044 / 2656 8045
Physiotherapy Department : 2675 1536 / 2675 1698 / 2675 1699
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Editorial

My journey of being a medical professional is not just a realization of my dream; I regard it as a blessing by which I am able to have an association with the people who are in need and are cured, who return back home with gratifying feeling; feeling of being in safe hands, a feeling of being healthy. Today When I connect with you all through this editorial column I feel much closer to the beyond belief world of literature. Transcribing my feelings, thoughts, and my ideas in words and articulating them for you with the sense of passion is an absolute delight.

For me getting associated with Lilavati Hospital Medical Times (LHMT) is a great opportunity and I am indebted to all the people who passionately have stood up in the past to take the medical times to the next level and I am sure their support and wishes will always be with us.

Indian Health care system is process improving health care system, and we are trying hard as country to meet all expectation to have enough hospitals, doctors, medical staff, medicines or ambulance services for the nation. We of course have the best of medical professionals. The field of Medical Science has come a long way and require a lot of brushing before we catch up with the first world medical system. The possession of good health is the biggest asset and we at Lilavati Hospital make ongoing effort in creating such for everybody. India initiated its health care reform journey a few years back, this journey needs to gain momentum; we need fast reforms and systems in place. What other nations have achieved in three-four decades needs to be achieved by us in much lesser time here.

Dr. Sanjeev Mehta
OVERVIEW: LILAVATI HOSPITAL & RESEARCH CENTRE

LILAVATI KIRTILAL MEHTA MEDICAL TRUST

Lilavati Hospital and Research Centre is run and managed by Public Charitable Trust - Lilavati Kirtilal Mehta Medical Trust which was formed in 1978. The Trust was settled by late Shri Kirtilal Manilal Mehta. The Trust has engaged in innumerable charitable endeavors across India.

The Lilavati Kirtilal Mehta Medical Trust is being managed and administered by:

Interim Board

Chairman
Justice (Retd.) J. N. Patel

and

Trustees
Smt. Charn K. Mehta
Smt. Rekha H. Sheth

LILAVATI HOSPITAL & RESEARCH CENTRE

Lilavati Hospital & Research Centre is a premier multi-specialty tertiary care hospital located in the heart of Mumbai, close to the domestic and the international airport. It encompasses modern health care facilities and state of art technology dedicatedly supported by a committed staff. Lilavati Hospital has focused its operation on providing quality care with human touch; which truly reflects the essence of its motto, “More than Health Care, Human Care”. Being a centre of medical excellence where technology meets international norms and standards, the hospital has got what it takes to be the pioneering quality healthcare institute and hence is one of the most sought after and “Patient Friendly” hospital.

Mission: To provide affordable healthcare of international standard with human care.

Motto: More than Healthcare, Human Care.

HIGHLIGHTS

- 314 bedded hospital including 72 intensive care beds.
- 12 state-of-the-art well equipped operation theatres.
- Full fledged Dental & Dermo cosmetology clinic.
- Modern Cathlabs having specialized SICU & ICCU with highly trained cardiac care medical staff.
- One of the highest nurses to patient ratio in India, which allows patient care in a more prudent manner.
- Lilavati Kirtilal Mehta Medical trust is an approved research organization by Ministry of Science & Technology having all modern facilities necessary for conducting research.
- More than 300 consultants and manpower of nearly 1,800.
- Hospital attends to around 300 In-patients and 1,500 Out-patients daily.

LATEST ADDITIONS

Lilavati Hospital has always striven to provide the best in health care to patients and is always in the front to adopt the latest technology available to its repertoire.

- SOMATOM Definition Flash - CT SCAN
- 3 Tesla MRI with latest Philips Ingenia having digital technology
- Philips Allura Clarity FD10 Low Dose Cathlab

LILAVATI KIRTILAL MEHTA MEDICAL TRUST RESEARCH CENTRE

The Lilavati Kirtilal Mehta Medical Trust Research Centre is a Scientific and Industrial Research Organization approved by Ministry of Science and Technology (Govt. of India). The Research Centre under guidelines of Dept. of Science & Technology works in close collaboration in evaluating and developing technologies for better health care to the sick people. The research centre have undertaken multidisciplinary researches in the fields of Cardiology, Radiology, Cerebrovascular Diseases (Stroke), Ophthalmology, Chest Medicine, Nuclear Medicine, Pathology, Oncology, Orthopedics etc., to cite a few. One of the important aims of the Research Centre is to establish Community based epidemiological researches in Cerebrovascular disease in stroke. As a policy Drug and Device Trials are not undertaken at the Research Centre.
**DEPARTMENT IN FOCUS-DERMO-COSMETOLOGY**

Our Dermo-Cosmetology clinic is one of its kind where dermatology and cosmetology have been amalgamated in a hospital set up.

Signs of ageing are more evident on face due to exposure to sun, wind, pollution and excessive heat or cold. Other factors that can accelerate facial ageing are hormonal changes, depleted collagen production, thinning of skin due to free radical damage, facial bone changes and slackened facial ligaments, improper diet, exercise and smoking.

Face rejuvenation consists of noninvasive to minimally invasive treatments to reduce facial imperfections. The most successful approach is the use of combination of procedures and treatments.

**LASER TONING**

It is carried out with the help of Medlite C6 laser.

It stimulates the collagen production which imparts firmness to the elastic tissue and improves the skin tone. It also decreases the pore size, reduces the pigmentation and resurfaces the scars. It completely rejuvenates your face to get back the youthful glow.

This is a lunch hour procedure without any downtime.

**MICRODERMABRASION**

**SKIN POLISHING**

This helps to exfoliate dead skin and reduce open pores, acne scars and uneven skin tone.

**CHEMICAL PEEL**

Glycolic peel, Nolmelan peel, TCA peed and salicylic acid peel are the different types of peel carried out as per requirements of the patients.

**FILLERS**

Dermal fillers restore volume and fullness to the skin to correct moderate to severe facial wrinkles and folds such as nasolabial folds, lip augmentation and scars.

**DEPARTMENT IN FOCUS-DERMO-COSMETOLOGY**

**TATTOO REMOVAL**

Different colored tattoos can be removed with our multi-wave length laser without the risk of scarring. Medlite laser removes tattoo whilst leaving the surrounding skin unharmed. Only cream anesthesia is required. Pigmented lesions like nevi (mole), age spot, liver spots, freckles, Birth marks (cafe-au-lait spot, nevus of ota, Becker’s nevus, Giant melanocytic nevus) can be easily treated without risk of scarring or causing depigmentation. After few treatments skin returns to almost normal colour. Vascular lesions like Port wine stains (PWS), haemangiomas and telangiectasia can be treated using either Medlite C6 laser or Cool glide excel (cutera) or both together in combination to achieve excellent results.

**BOTOX**

Botox is the most popular wrinkle reduction treatment. It is a simple non-surgical procedure that smoothens the deep persistent facial lines by relaxing the tiny facial muscles that cause expression lines.

**DAAVLIN PHOTOTHERAPY**

The unit consists of both UVA (ultraviolet) and UVB system.

It is useful for treating cases of Psoriasis, Vitiligo, atopic dermatitis, seborrheic dermatitis, urticaria pruritus, pruritus due to cholestatic jaundice and few more conditions. Targeted photo therapy for localized lesion is also available.

Warts, skin tags, Xanthelesma, DPN, corns, seborrhoeic keratoses, small basal cell epitheliomas, actinic keratoses, sebaceous hyperplasia etc can be easily treated using either CARBON DIOXIDE LASER, CONMED HYPERCATOR, RADIO FREQUENCY MACHINE OR CRYOSURGICAL UNIT.

Fractional CO2 laser is available to treat acne scars, post-operative atrophic scars, post chicken pox scars, to tighten the skin.
LASER HAIR REDUCTION (LHR)

LHR is done with cool-glide Excel-Cutera a US-FDA approved, long pulsed ND YAG Laser. Cutera is a safe, efficient laser specifically suited for the Indian skin.

HISTORY OF ANAESTHESIA

Dr. Vaibhavi Baxi, D.A. F.C.P.S DNB

The modern anaesthetic era is just over hundred and sixty years old. Successful anaesthesia for surgery was first demonstrated in 1846. Before that, the few operations that were possible were carried out either with no pain relief or after a dose of opium and / or alcohol.

There were many attempts to relieve pain throughout the centuries. Early examples include loss of consciousness produced by blows to the patient's head or by compression of the carotid arteries (in the neck). In the middle ages, elaborate potions included alcohol and various plant extracts, such as mandrake root. Opium was widely used, particularly in China. Pain relief in an arm or a leg was produced by squeezing the nerves in the upper part of the limb and also by applying cold water, ice, or snow. Hypnotism became popular as a means of pain relief and medical treatment during the late 18th and early 19th centuries.

Listen, an eminent surgeon, was once operating for a bladder stone. The panic-stricken patient finally broke loose from the brawny assistants, ran out of the room, down the hall and locked himself in the lavatory. Listen, hot on his heels and a determined man, broke down the door and carried the screaming patient back to complete the operative procedure.

Before the advent of anaesthesia, surgery was a terrifying last resort in a final attempt to save life. (Fig. no. 1) Few operations were possible. Surface surgery, amputation, fungating cancers and 'cutting for stone' (the removal of bladder stones) were really the only areas in which the surgeon could practice. The inside of the abdomen, chest and skull were essentially 'no go' areas. Speed was the only determinant of a successful surgeon. Most patients were held or strapped down - some would mercifully faint from their agony - many died either on the table or immediately post-surgery. The suffering was intense.

The introduction of anaesthesia changed all this. Surgery could slow down - became more accurate and could move into 'forbidden areas' of abdomen, chest and brain. The evolution of surgical practice has been dependent on anaesthesia and the concomitant introduction of antisepsis through Lister's carbolic spray.

The earliest reference to anaesthesia by inhalation is contained in the works of Herodotus, who states that the Scythians produced intoxication by inhaling the vapour of a certain kind of hemp, which they threw upon the fire or upon stones heated for the purpose. This was probably Cannabis indica (or Indian hemp). In the 15th century the method for producing insensibility to pain was that of inhalation of the volatile principles of drugs, which had been handed down by tradition. We find from the history of the Egyptians, Chinese, Greeks and Hindus that mandragora and Indian hemp were the chief drugs of anaesthetic value.

Joseph Priestley’s demonstration in 1767 that certain gases could be absorbed and compressed in water, led to the introduction of aerated waters; carbonic acid gas being the first given. Priestley also discovered nitrous oxide in 1776 and in 1798 he eased an aching tooth by inhalation of nitrous oxide gas.

Alcohol was used as an anaesthetic in 1842 by Robert Collier, a scientist of New Orleans. He observed the actions of a plantation worker, who while stirring a vat of rum, became unconscious, fell and broke his hip. This Collier reset and the worker declared that he felt no pain during the process.
HISTORY OF ANAESTHESIA

The glory for the discovery of modern anaesthesia is shared by three men. The world is indebted to Horace Wells for nitrous oxide gas; to W. T. G. Morton for ether; and Simpson for chloroform.

On December 11, 1844, Horace Wells was present at an exhibition of the effects of nitrous oxide gas given by a young scientific lecturer named Colton. Impressed by the gas Wells proceeded to test the anaesthetic effect on himself. Being troubled with a raging toothache, he inhaled the gas and had it extracted by another dentist named Riggs. After further successful trials, Wells went to Boston, where assisted by Morton, he gave in the presence of a number of medical practitioners and students an exhibition of the effects of nitrous oxide gas. But the experiment on this occasion, as Wells himself confesses, was not quite a success; the gas bag having been removed too soon. The whole thing was denounced and Wells was hissed out of the room as an imposter.

W. T. G. Morton on September 30, 1846 experimented on himself by inhaling sulphuric ether through a saturated handkerchief. He appealed to the senior surgeon at the Massachusetts General Hospital, and obtained permission to test the anaesthetic on a patient about to undergo a surgical operation. On Friday, October 16, at the appointed time the amphitheatre was full. Morton administered the ether successfully and the operation, which was for a congenital vascular tumour of the neck, of a young man named Gilbert Abbott, was completed in about five minutes without a single groan. (Fig. no.2)

Sir James Young Simpson was the first physician to use chloroform after successful self experimentation just one year after the established use of ether. On November 10, 1847, Dr. Simpson communicated his discovery to the Medico-Chirurgical Society of Edinburgh in a paper, "A New Anaesthetic as a Substitute for Sulphuric Ether." On November 15, 1847, chloroform was used for the first time for a surgical operation in the Edinburgh Royal Infirmary. Three patients were operated on successfully under its influence.

Karl Koller, of Vienna, in 1884, demonstrated the effect of cocaine as a local anaesthetic. The alkaloid now known as "cocaine" was isolated as far back as 1855 by Gadeke. Such an anaesthetic was of great importance and came into general use at once. It was of especial use for ophthalmic operations and in painful conditions of mucous surfaces and minor operations. In New York in 1885, Dr. Corning gave the first spinal anaesthetic and then the first epidural anaesthetic in 1901. Newer, less toxic, local anaesthetic agents were introduced in the early 1900s.

The next important innovation was the control of the airways with the use of tubes placed into the trachea. This permitted control of breathing and techniques introduced in the 1910s were perfected in the late 1920s and early 1930s. Then came the introduction of intravenous induction agents. These were barbiturates which enabled the patient to go off to sleep quickly, smoothly and pleasantly and therefore avoided any unpleasant inhalational agents. Then in the 1940s and early 1950s, there came the introduction of muscle relaxants, firstly with curare (the South American Indian poison) and then over subsequent decades a whole series of other agents. In the 1950s, the investigation of halogenated hydrocarbons as non-flammable, highly potent anesthetic agents resulted in the introduction of halothane and the disappearance of ether and chloroform from most operating rooms.

In the 1960s, with the development of new drugs and the availability of new monitoring techniques and equipment there was a beginning of a new era of anaesthesia. With sophisticated monitoring systems and a greater understanding of body functions anaesthetists began to look more closely at safety and refinement of techniques. Surgery was extended to increasingly complex procedures on patients who might previously have been denied operations on the basis of age or illness.

The end of the 20th century saw major advances in everyday anaesthesia, including the contributions of computer technology, microelectronics, and advances in drugs. Anaesthesia is now tailored to each individual patient, no matter if you are ten weeks premature or a hundred years old. Whether you are sick or well, there has never been a safer time to undergo anaesthesia.
CASE REPORT 1: RENT IN THE VENT: A RARE EVENT

Immediate postpartum, the mother developed strong supra symphysial pain and was unable to move her legs as any movement resulting into severe pain. On the physical examination the patient had a painful and palpable dehiscence of the pubic symphysis. Pelvic horizontal instability was identified but no sign of vertical instability. There were no symptoms of active bleeding or lesions of urinary tract or neurologic deficits. In addition, a pelvic X-ray revealed a pubic symphysial separation of 54 mm with left sacroiliac joint dislocation i.e. open book type of pelvic fracture. This gap is shown in Figure 1(a). The CT scan, shown in Figures 2(a) and 2(b), confirmed open book type of pelvic fracture i.e. pubic symphysis rupture along with dislocation of the left sacroiliac joint.

CASE REPORT

A 26 years old PII who delivered at other hospital 2 days back was referred to our tertiary care hospital with complaints of immediate severe pain in pubic & suprapubic area after delivery and inability to sit, stand and walk because attempts to move legs were associated with extreme pain in pubic, suprapubic area & also in lower back and both hips. Patient is not short statured (height - 173 cm) & not obese (weight - 74 kg). The patient had no previous medical or surgical history. Her antenatal course had been uneventful.

Two days before term, patient was admitted in the outside hospital in prelabour. Pelvic adequacy was confirmed on per vaginal examination. She started having mild uterine contractions after 8 hours of admission and after normal progression of first stage of labour, a shoulder dystocia occurred. By performing mediolateral episiotomy, McRoberts maneuver and suprapubic manual pressure, baby was delivered. The newborn had birth weight 3.11 kg, a length of 48 cm and a cranial circumference of 33.5 cm. Baby had APGAR score of 7/10 and 10/10 at 1 min and 5 mins postpartum consecutively.

Figure 1: X-ray of the pelvis with pubic symphysis separation and left sacroiliac joint dislocation (a). X-ray of the pelvis after surgical fixation of the pubic symphysis and sacroiliac joint (b)

All blood investigations were done and were found normal except “Total 25-hydroxy vitamin D” levels were found low (7.09). USG (abdomen + pelvis) revealed no significant abnormality. X-rays and CT scans were reviewed by senior radiologists and orthopaedician and reported similar findings.
CASE REPORT I: RENT IN THE VENT: A RARE EVENT

Figure 2: CT scan pelvis-3D imaging showing pubic symphysis separation with sacroiliac joint dislocation (a). Axial image showing pubic symphysis separation (b)

Starting therapy with a pelvic binder, bed rest, and analgesia, the patient underwent closed reduction and internal fixation by means of percutaneous anterior internal fixator (titanium pedicle screws and rods) and sacroiliac screw (titanium) under C-arm guidance on the sixth postpartum day. The patient received physical therapy to ambulate and patient could walk with the help of a walker on the third post-operative day. Patient was discharged on the fifth postpartum day. After 2 weeks the patient was able to ambulate without complaints and to take care of her child. A post-operative radiographic control determined the correct position of the implant, which can be seen in Figure 1 (b).

DISCUSSION

Although the initial clinical examination and diagnostic investigation are straightforward, the optimal way of treating a peripartum pubic symphysis rupture is discussed controversially. Several reports have shown that a conservative therapy is a reasonable approach. Even in cases of large symphysial ruptures measuring 5cm, 8cm and 9cm including iliosacral joint rupture a successful conservative therapy has been reported. However, other works have demonstrated the limitations of a conservative treatment. For instance, Zharazer et al. presented four cases of pelvic and sacroiliac joint rupture after vaginal birth; in those women undergoing conservative therapy, posterior pelvic pain remained for more than two years. In addition, Rommets reported three cases of postpartum pubic symphysis rupture with persisting pain after conservative therapy. Those patients did not recover completely until they were operated by an open reduction and internal plate fixation. Niederhauser et al. demonstrated a similar case; after a symptomatic rupture of 60mm occurring in a spontaneous vaginal birth with shoulder dystocia, conservative treatment failed to provide an optimal outcome. A 25mm gap was still present after 3 months and pain also persisted. Finally, surgical treatment by means of an open reduction and internal fixation yielded optimal results. Chang and Wu showed that, in case of contraindication of a plate fixation due to a contaminated pelvic environment, an external fixation can be an equivalent surgical method of pubic symphysis diastasis. Durian et al. further underlined the advantages of an immediate external fixation in a case of a gap of pubic symphysis measuring 62mm. As a consequence, these works suggest the indication of an operative approach if a gap of the pubic symphysis is larger than 40mm.

CONCLUSIONS

Pubic symphysis rupture is an uncommon but often underestimated injury after vaginal delivery that can lead to significant chronic disability. Therefore, in case of peripartum supraspinous pain, it is important to consider a pubic symphysis diastasis that requires interdisciplinary treatment. In cases of a gap greater than 40mm, a surgical intervention may result in better outcome including shorter hospitalization, earlier ambulation, and the opportunity to cope with the new circumstances of her motherhood.

REFERENCES

CASE REPORT II: RARE CASE OF MISPLACED AND RETAINED EPISIOTOMY NEEDLE

She was seen again on follow up after 7 days where the scar line was healthy and patient was free from pain.

CONCLUSION:
A missing broken needle during episiotomy repair is possible particularly in the hands of the house-surgeons and could be retrieved immediately in most of the occasions. But sometimes the problem of retrieving this foreign body becomes a real challenge as was in this case. Therefore one should be very careful during repair, particularly when working in a deeper and higher plane to avoid such complication.

REFERENCES:
CASE REPORT: NEPHROLOGY
FROSTY MAN

Dr. Jhumar Makhija, MD (Med), Dr. Anup Chaudhari, DNB (Med), DNB Nephrology,
Dr. Hemant Mehta, MD (Med), DM (Nephrology), DNB (Nephrology)

A 26-year-old man with chronic kidney disease secondary to chronic tubulointerstitial disease was admitted with generalized weakness, vomiting and itching all over the body for 10 days and with documented non-adherence to medical management. Physical examination revealed a pulse rate of 98/minute, blood pressure of 140/80 mm Hg, bilateral lung crackles, and pitting edema of the lower extremities. The skin over both shins and left side of the face had scattered deposits of white, friable, crystalline material, with a “frosted” appearance. These deposits were confluent in some areas and discrete in other (Figs 1, 2). Pertinent laboratory data were as follows: hemoglobin, 6.7 g/dl; sodium 130 mEq/l; bicarbonate, 10 mEq/l; blood urea nitrogen 182 mg/dl; and serum creatinine 35.74 mg/dl. Hemodialysis was initiated. The crystalline, white material on his shins was uremic frost seen in extreme azotemia, which disappeared after 3 sessions of hemodialysis. Laboratory data after initiation of hemodialysis showed serum sodium 138 mEq/l; bicarbonate 27.6 mEq/l; and serum creatinine 10.57 mg/dl.

Fig. (2). Crystalline white material deposited on the skin.

REFERENCES

CASE REPORT: NUCLEAR MEDICINE
GOLD TOXICITY: A RARE PRESENTATION AS AUTONOMIC NEUROPATHY

Dr. Patil Pallavi, MBBS, Dr. Lele R. D., MBBS, MRCP (Edin), FRCP (London), Hon. D. Litt.
Dr. Ansari Abdul, M.D, IDCCM, FNB

Mr. R.M., a 55 year old non diabetic male presented with complaints of severe giddiness and nausea associated with change in posture. He had a similar episode associated with loss of consciousness 1 year ago. 2 years ago, the patient had pleural effusion attributed to pulmonary Koch’s infection. He underwent a right parietoectomy in August 2014 for a benign cystic lesion. The patient is a jeweller by profession with frequent exposure to gold in his workshop. Clinically the patient is average built, afebrile with a normal pulse rate. The blood pressure was 10/70 mm Hg in supine and 80/50 mm Hg in standing position (postural hypotension).

- CBC showed hemoglobin level of 11.8 gm% with normal WBC and platelet count.
- USG revealed bilateral medical renal disease and moderate prostatomegaly.
- Urine 5 HIAA, Serum & urine VMA levels were normal. The MIBG scan was negative for the presence of a pheochromocytoma.
- MRI of Brain revealed tiny ischemic lesions in the white matter of centrum semiovale.
- Nerve conduction study suggested a sensory motor radicular peripheral neuropathy in the lower limbs.
- Tilt table test was positive for vasodepressive response.
- Holter EKG revealed multiple short runs of sinus tachycardia associated with symptoms of palpitations.

- pANCA, cANCA, Anti ds DNA, Anti Choline receptor antibody, gamma interferon for Tuberculosis, complement C3,C4, ACE, urinary porphobilinogen, rapid plasma reagin were negative.
- Biochemically there was no evidence of thyroid disorder, multiple myeloma or raised IgG, IgA levels.
- Cold agglutinins were detected (titre 32). Prolactin level mildly elevated (20.28 ng/ml).

Toxicity screen of blood revealed raised levels of gold-
01/12/14 - 35.3 µg/L (normal range: 0.006 - 0.018)
02/01/15 - 14.4 µg/dl (normal = 0.1)

After reviewing literature reports of treatment of gold toxicity in patients with Rheumatoid Arthritis (RA) in the 1940s, a decision was made to start treatment with intramuscular injection Dimercaprol (BAL - British Anti- Lewisite) after obtaining written informed consent of the patient.

The following regimen was started on 28/01/15
Day 1 - 100 mg QID
Day 2, 3 & 4 - 100 mg BD
Day 5 & 6 - 100 mg OD

There were no adverse drug reactions after initialising the treatment. Repeat serum gold level estimation after 4 weeks of completion of treatment were found to be in the
GOLD TOXICITY: A RARE PRESENTATION AS AUTONOMIC NEUROPATHY

Our patient had proven autonomic neuropathy on tilt table test with clinically fluctuating blood pressure. Autonomic neuropathy (orthostatic hypotension) has not been described with gold toxicity. It is remarkable that in our patient the orthostatic hypotension disappeared completely after treatment of gold toxicity with BAL.

REFERENCES

CASE REPORT: ORTHOPAEDIC SURGERY HIP REPLACEMENT FOR “FLOATING HIP”

Dr. C. J. Thakkar, M.S.(Ortho), DNB

Floating hip is a term coined when there are fractures on either side of the hip joint. Like in the below illustrated case there was fracture of the acetabulum with dislocation of the hip and multi fragmentary fracture of the upper end of the femur bone

50 years male involved in a road traffic accident had posterior wall fracture with posterior dislocation of hip and comminuted peri trochanteric fracture on the left side

Studying various radiological views it was obvious that only reconstruction of this joint may not give good function and hence it was decided to do primary hip replacement

Approach was posterior as first one had to restore the integrity of posterior wall of the acetabulum. This was done using a reconstruction plate extending from ilium to ischium. A non cemented acetabular cup with ceramic liner was used. In view of comminution of proximal fragment it was decided to use calcar replacement diaphyseal fix femoral prosthesis. Abductor mechanism with pieces of greater trochanter was attached to the femoral stem using stainless steel wires

Challenges faced on the table were reconstruction of comminuted posterior wall and stable fixation of non cemented acetabulum component. Since the dome of acetabulum was intact, primary stability could be achieved with relative ease. This was further supplemented using one screw in the dome.
HIP REPLACEMENT FOR “FLOATING HIP”

The greater challenge in this case was on the femoral side. One had to restore the limb length and correct the femoral version, restore the abductor mechanism and get excellent stability for early mobilization. This was achieved by selection of revision prosthesis, ceramic head of 32mm size was used.

Post operatively, in view of excellent primary stability of both acetabular and femoral components, partial weight bearing with help of walking aid was started immediately. In view of abductor reconstruction, walking aid was continued for 8 weeks.

This excellent result was possible because of team work of highly specialized anaesthetists who gave prolonged hypotensive anaesthesia, team of young DNB fellows who assisted during surgery and took excellent post operative care, well trained theatre staff, motivated physiotherapist who made him up in 24 hours post surgery.

CASE REPORT: PAIN MANAGEMENT MANAGEMENT OF CRPS-TYPE I: COMBINATION OF STELLATE GANGLION BLOCK AND CONTINUOUS BRACHIAL PLEXUS BLOCK (ULTRA SOUND GUIDED)

Dr. D K Baheti, MD, Dr. Prakash Gawankar, M.D., D.A. (Anaesthesia), Dr. Hemangini Barot, M.D (Anaesthesia), Fellowship in Pediatric Anaesthesia
Dr. Sangeeta Deka, M.B.B.S, MD (Anaesthesia)

ABSTRACT

The Complex Regional Pain Syndrome (CRPS) I is a neuropathic pain syndrome, characterized by pain, vasomotor and dystrophic changes, and often motor impairments with reduced mobility. The etiology is unknown so diagnosis can be difficult so main focus remains on pain management and restoration of physical function. The conservative treatment approach is both non-pharmacological, pharmacological methods and interventional pain treatment procedures as diagnostic cum therapeutic therapy is centered on sympathetic and somatic blocks.

We report a case of CRPS type-I, in a 59 yrs female with symptoms of intractable pain following accident and injury to right shoulder which was successfully managed by a stellate ganglion block and continuous inter scalene brachial plexus block resulted in effective pain relief and 90% restoration of function.

INTRODUCTION

CRPS is described as an array of symptoms characterized by a continuous spontaneous and or evoked regional pain that is disproportionate in time or degree to the usual course of any known trauma or other lesion. The pain is regional and nonspecific to nerve injury or dermatome, and usually has distal predominance of abnormal sensory, motor, sudomotor, vasomotor and or trophic findings.

CRPS is further divided in to Type I and II. CRPS Type I is frequently triggered by tissue injury but no underlying nerve injury; CRPS II cases are usually associated with nerve injury.

The syndrome shows variable progression over time. CRPS may occur at any age and affects both men and women, though most agree that it is more common in young women.

The causes of CRPS are unknown. The sympathetic nervous system plays an important role in sustaining the pain. Theories suggest that pain receptors in the affected part of the body become responsive to catecholamines. Animal studies do not indicate that nor can epinephrine activate pain pathways after injury. The incidence of sympathetically mediated pain in CRPS is unknown.

Another theory suggests that CRPS is a result of triggering of the immune response which results in inflammatory symptoms of redness, warmth, and swelling in the affected areas.

Physiological windup and central sensitization are key neurologic processes involved in conduction and maintenance of CRPS. There is evidence at NMDA receptors involved in CNS sensitization. It is also hypothesized that elevated CNS glutamate levels promote physiological windup and central sensitization. The immune process may contribute to peripheral and central sensitization.

We report a successfully managed CRPS type I of right upper extremity with a stellate ganglion block, supplemented with a continuous brachial plexus block (Ultra sound guided) resulted in excellent pain relief and restoration of pain free movements.
MANAGEMENT OF CRPS-TYPE 1: COMBINATION OF STELLATE GANGLION BLOCK AND CONTINUOUS BRACHIAL PLEXUS BLOCK (ULTRA SOUND GUIDED)

CASE REPORT

A 59 yrs old female (LS) visited pain management clinic of this hospital with complaints of pain, swelling burning, even slight touch resulted in severe pain, decreased sweating and painful movements of right upper extremity for duration of 8 months. She had history accident to the right shoulder two years back without any evidence of fracture of bone or nerve injury.

Patient had severe pain, restricted movement of right shoulder and swelling of the right forearm and hand. The pain was described as sharp, shooting with intensity being a 9/10 on Visual Analog Scale (VAS); burning; light touch, even clothes touching the arm was painful (allodynia). The use of multiple drugs including NSAIDs, opioids, steroids and neuropathic medications had little benefit.

The clinical examination revealed circumferential edema over forearm and palm. The skin was shiny with hyperaesthesia to light touch. There was no evidence of hyperhidrosis or excessive hair growth. However patient did mention about decreased sweating in right upper limb. The movements of the upper limb at shoulder, elbow, wrist and finger were minimum and painful. There were no trophic changes of right upper extremity.

The probable diagnosis of CRPS type I done and Rt. stellate ganglion block supplemented with a continuous brachial plexus block (Ultra sound guided) was planned. She was put on medications Gabapentin, Amtryptillalin, Tramadol, Paracetamol and Pantoprazol with Domperidone.

The details of procedure explained and an informed consent obtained. The routine blood investigations such as Bleeding time, clotting time, HIV, HCV and HBsAg was done.

She was given supine position with head slightly extended and turned to left side. The monitoring included pulse oximetry, non invasive blood pressure and continuous ECG monitoring. An IV line was secured on left hand. IV antibiotic was given.

Stellate Ganglion Block (Rt.) - After preparation of area, the transverse process of C6 was identified under fluoroscopy. The right sternocleidomastoid muscle and carotid artery was retracted laterally with firm pressure of operator’s three fingers just above supra sienna notch.

A 22 gauge needle filled with normal saline was directed medially and inferiorly towards the body of C6, to hit transverse process and then inferiorly by 1-2 mm to rest outside the longus colli muscle. Inj. Omnipaque (non ionic contrast) 3cc was injected and spread of dye confirmed fluoroscopically.

Figure 1

Now Inj. Loxicard 2% (preservative free lignocaine) 10cc injected with intermittent repeated negative aspiration. The patient had immediate pain relief VAS 2/3/10 and could move right elbow, wrist and fingers without pain.

Brachial plexus block (RT) - With the patient in the same position, scanning of supraclavicular fossa using ultrasound was done to identify the subclavian artery as it passes over the first rib. The Brachial plexus was identified as a “bunch of grapes” lying supero-lateral to the subclavian artery. Using inplane approach a 50mm 22g compex needle was inserted from lateral to medial direction at a shallow angle under ultrasound so that the entire shaft and the tip of the needle was visualized. (Fig no.2)

The nerve stimulator was connected to the stimulating needle and set to deliver a 0.8 to 1.0 mA current at 1 Hz frequency and 0.1 ms of pulse duration. The needle was slowly advanced until the upper trunk was identified by a muscle twitch of the shoulder muscles. Inj. Loxicard (preservative free lignocaine) 2-3 cc was injected to hydro-dissects and opens up the fascial plane to clearer visualization of the nerve structures. Now Inj. Ropivacaine 0.2% 4-5cc was injected slowly with intermittent negative aspiration for blood, which spread anterior and posterior to the nerve structures and surrounded the nerve like a doughnut shaped hypo echoic area.

An 18g catheter was introduced through the compex cannula and 5 ml of local anesthetic injected through the catheter; the spread of which was visualized under ultrasound to confirm proper catheter placement. The catheter was secured by tunnelling in the skin.

An elastometric balloon pump containing 200ml of 0.2% Ropivacaine was attached to the catheter at the rate 3ml/hr. Patient had immediate relief of about 40-50% with VAS score going down to 4/10 after the block. After 18hrs she complained of numbness of right forearm and wrist. The dose reduced to 1cc/hr. The catheter was removed after 48hrs of continuous infusion and patient was discharged. She had uneventful stay in hospital.

On follow up after four weeks the patient had significant reduction in pain VAS 2/3/10 and range of pain free movements of the right shoulder and arm improved. She could raise her shoulder and arm straight above effortlessly. There was no oedema and allodynia, hyperaesthesia was negligible. The sweating in the right upper extremity increased.
MANAGEMENT OF CRPS-TYPE I: COMBINATION OF STELLATE GANGLION BLOCK AND CONTINUOUS BRACHIAL Plexus block and a single shot of local anaesthetic at the stellate ganglion. Also the continuous brachial plexus block would provide analgesia for both sympathetic and the somatic components of his pain. In this case we noticed numbness due to higher concentration of drug.

Ultrasound visualization of anatomical structures offers safe blocks of superior quality by optimal needle positioning. In addition, the amount of local anaesthetic needed for effective nerve block can be minimized by directly monitoring its distribution. A study conducted by Chan et al. on 188 patients undergoing elective hand surgery demonstrated that ultrasound guidance, with or without concomitant nerve stimulation, significantly improves the success rate of axillary brachial plexus block.

Murrey P. et al. reported continuous brachial plexus block for successful management of reflex sympathetic dystrophy. Toshniwal G et al. compared the efficacy of continuous stellate ganglion (CSG) block with that of continuous infraclavicular brachial plexus (CIBP) block in management of CRPS type I of upper extremity in a group of 33 patients each. They used an infusion of 0.125% Bupivacaine at a rate of 2-5 ml/hr. CIBP group showed statistically significant improvement in neuropathic pain scale score (NPSS) compared with CSG group during the first 12 hours after the procedures (P value <0.05). After 12 hours, the NPSS was comparable between the groups. After 4 weeks, both groups showed clinically significant improvement in edema score and range of movement of all upper extremity joints when compared with the baseline. This study concluded that CIBP block and CSG block may be effective interventional techniques for the management of CRPS type I of upper extremities.

CONCLUSION
CRPS is a complex pain syndrome with many known or unknown etiology and is challenging for treating physician and needs a multi modal approach. If the pain is out of proportion to any injury it has received, it should be assumed that the source is CRPS or sympathetically maintained pain until proven otherwise.

Most physicians believe that early treatment is helpful to limit the disability from CRPS. Patient should be referred to a pain specialist or to a pain center which specializes in the treatment of these conditions. The back bone of treatment for this disease is blocks, physical therapy, drugs and psychological counselling.
REFERENCES


IMAGES OF THE MONTH

Micturating Cystourethrogram showing multiple strictures in anterior urethra with pre-stricteus dilatation of prostatic and membranous urethra and reflux of contrast into ducts of Cowper's gland.

Barium Swallow spot films showing Schatzki ring at lower oesophagus above Gastro-oesophageal junction with hold up of Liquid barium and solids (Bread piece dipped in barium) in that region.
STRAIGHT FROM THE HEART

Great experience! Clean, pleasant atmosphere, patient friendly staff, The Best hospital in Mumbai. I feel like home here!

Dr. D Y Patil

Great Professionalism of the staff, The cleanliness of the hospital and your service made to feel like a home guest rather than just a patient

Mr. Geoffrey Menezes

Everything was excellent. It begins with your slogan "More than health care, Human care". This slogan sums up everything. I am unable to find any flaws; it is so perfect and organized!!

Mr. Harishbhai Kapadi

Lilavati Hospital is very good and clean. Staff at the hospital is well trained and knowledgeable. Appreciate your help

Mr. Ganapathy Subramanian

You are really doing good job. God bless the good souls and returning smiles on our faces

Ms. Monali Ghag

Great team of doctors attended to me during my delivery with utmost care and promptness. Very good service by all the staff, nurses and housekeeping. Very friendly and courteous.

Ms. Diya Jadhav

You people are serving in the best way, thanks to all of your hospital staff for my speedy recovery.

Ms. Ritu Banthia

Excellent Medical expertise, nursing service. Superb dedication of all the doctors and staff. Keep up the excellent standards already set

Ms. Rosy Collaco

EDUCATIONAL ACTIVITIES

LIVE SURGICAL AND INTERVENTIONAL SURGICAL WORKSHOPS CONDUCTED

<table>
<thead>
<tr>
<th>Conducted by</th>
<th>Topic</th>
<th>Organized in</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Rajesh Maniar</td>
<td>Live Knee replacement Surgery</td>
<td>April 2015</td>
</tr>
<tr>
<td>Dr. Samuel Mathew Kalarickal</td>
<td>Live Bifurcation-Coronary Stenting (CSI-NIC, Mid Term Meet)</td>
<td>April 2015</td>
</tr>
</tbody>
</table>

CME

Lilavati Hospital doctors share their intellectual capital and expertise with others through CMEs using means like workshops, seminars, conferences, live telecast of procedures and surgeries, which they are performing. Lilavati Hospital and Research Centre has been accredited by Maharashtra Medical Council for conducting CMEs.

<table>
<thead>
<tr>
<th>Sr. no.</th>
<th>Topic</th>
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<tbody>
<tr>
<td>1</td>
<td>Paediatric Cardiology</td>
<td>Nov, 2014</td>
</tr>
<tr>
<td>2</td>
<td>GI Emergency</td>
<td>Dec, 2014</td>
</tr>
<tr>
<td>3</td>
<td>Nephrology Updates</td>
<td>Jan, 2015</td>
</tr>
<tr>
<td>4</td>
<td>Vascular Disease</td>
<td>Feb, 2015</td>
</tr>
<tr>
<td>5</td>
<td>Minimal Access Surgery</td>
<td>Feb, 2015</td>
</tr>
<tr>
<td>6</td>
<td>Urology Updates</td>
<td>March, 2015</td>
</tr>
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</table>

Pediatric Cardiology

Nephrology Updates

Vascular Disease

Minimal Access Surgery
The conference is under the auspices of, Lilavati Hospital and Research Centre

Organised by:

Pain Management and Research Foundation India & Dept. of Anaesthesiology and Pain, Lilavati Hospital and Research centre
SEWA

The social service wing of the hospital - SEWA - serves the health requirements of the needy people. This department seeks to bridge the gap between the needy patients and the fast evolving medical technology. Various social activities such as Free OPD, services to senior citizen, sending mobile vans to Adivasi areas for organizing free health checkup camps are undertaken as an on-going process. The Rohini Eye bank managed by Lilavati Hospital is a well equipped comprehensive centre for cornea removal, supplying, processing, storing, and corneal transplantation. We have also taken up new initiative of “Swastha Bachpan” which shall comprise of free health check ups for underprivileged children.

<table>
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<tr>
<th>Year</th>
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<tr>
<td>2014-15</td>
<td>14371</td>
<td>21207</td>
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</table>

Swastha Bachpan Initiative
FEATHERS IN CAP...

Efforts and hard work put in by team Lilavati Hospital has resulted in various awards and accolades:

- In 2013, 2014: "THE WEEK" magazine has rated Lilavati Hospital as "Number 1 Multispecialty Hospital in Mumbai".
- Hospital has been rated amongst "Top 10 Hospitals of India" 2013, 2014 by "THE WEEK" magazine.
- Winner in the category "Most Popular Maternity Hospital (All-India)" in the 2nd edition of Child Best Popular Awards, 2014, Child India Magazine.
- Hospital emerged as the Runner-Up in the category India’s Most Popular Maternity Hospital; in the inaugural edition of Child Best Awards 2013 by Child India Magazine.
- Hospital has been recognized as "India’s best Multi Speciality Hospital-Megapolis" by ICICI Lombard and CNBC TV 18 in India Healthcare Awards 2013.
- Hospital has been recognized as "India’s best Multi Speciality Hospital-Metro" by ICICI Lombard and CNBC TV 18 in India Healthcare Awards 2012.
- Hospital is Gold Winner of “Reader’s Digest Trusted Brand Award 2012” in category ‘Speciality Hospital’.
- Hospital is an official ESOM (European Society for Medical Oncology) Asia CME Partner Centre in Colorectal Cancer Program in India.
- Quality Council of India (QCI) has accredited Lilavati Hospital & Research Centre with NABH in December 2011 and Reaccredited in 2014.

Lilavati Hospital Doctors Achievements

- Dr. K. N. Shah has been awarded “Life time achievement award” on 1st February 2013 by C-Ward Medical Association for his contributions to Pediatrics, Pediatric Epilepsy and Pediatric Neurology. He was also felicitated on 28th Feb, 2015 by General Practitioners Association Greater Bombay for his contribution to the Academic programmes for the General Practitioners of Bombay. He is also awarded with “Neucon Lifetime achievement award” 2014 for his accomplishments and contribution to the field of Neurology.
- Dr. Sanjeev Mehta became the chairperson of the Council of Global Governors for Chest (American College of Chest Physicians/ACCP) and also became member of the Board of Regents of The American College of Chest Physicians.
- Dr. P. Jogannath has received distinguished service Gold medal award of Asia Pacific Hepato Pancreato-Biliary at Singapore last month. He is the first Indian to be the immediate past president of the Asia Pacific Hepato Pancreato-Biliary Association.

SERVICES AVAILABLE

MEDICAL
Anesthesiology
Audiology and Speech Therapy
Cardiology
Chest Medicine
Chronic Pain Management
Dental
Dermatologoy
Diabetes & Endocrinology
Gastroenterology
Haematology
Hair Transplant
Internal Medicine
Infectious Diseases
Nephrology
Neurosurgery
Neurology
Head and Migraine Clinic
Psychiatry / Psychology / Neuropsychology
Medical Oncology
Pediatrics
Rheumatology
Physiotherapy
Sleep Medicine

SURGICAL
Bariatric Surgery
Cardiothoracic Surgery
Colorectal Surgery
ENT and Head & Neck Surgery
Gastro Intestinal Surgery
General Surgery
Gynecology, Obstetrics & IVF
Transplant: Corneal & Kidney
Minimal Invasive Surgery (Laparoscopic Surgery)
Neuro Surgery
Spine Surgery
Onco Surgery
Ophthalmology
Orthopedics, Sports Medicine

Critical Care
Intensive Care Unit (ICU)
Intensive Cardiac Unit (ICCU)
Surgical Intensive Care Unit (SICU)
Paediatric Intensive Care Unit (PICU)
Neo-Natal Intensive Care Unit (NICU)
Paralysis & Stroke Unit

Diagnosis
Imaging Services
CT
MRI
X-ray
BMD
OPG
Sonography (USG)
Mammography
Nuclear Medicine
Interventional Radiology

Laboratory Services
Pathology
Microbiology
Histopathology
Blood Bank

24 HRS Services
Ambulance
Emergency
Pharmacy
## DOCTORS ASSOCIATED WITH LILAVATI HOSPITAL

### Andrologist
- Dr. Shah Rezai S.

### Anaesthesiologist
- Dr. Barot Hemangini
- Dr. Bhati Vighvii
- Dr. Bhatwadekar Shraddha
- Dr. Gandhi Nisha
- Dr. Gokhale Sacheta
- Dr. Gavankar Prakash
- Dr. Joshi Kunal
- Dr. Khurwadekar Madhuri
- Dr. Khorkodi Santosh K.
- Dr. Mahajan Amruta
- Dr. Masurekarh Oswal
- Dr. Khati Bhavik

### Audiology & Speech Therapists
- Dr. Bhat Satyajeet
- Dr. Gavankar Pooja
- Dr. Parulekar Bakul
- Dr. Patil Rajesh
- Dr. Thrusha Zobha

### Cardiovascular & Thoracic Surgeons
- Dr. Bhattacharya S.
- Dr. Deshmukh Sandeep T.
- Dr. Jaiswal O. H.
- Dr. Joshi Suresh
- Dr. Kasbekar Pandey
- Dr. Kumar Pawan
- Dr. Mehta Arun P.
- Dr. Nand Kumar
- Dr. Rachhele G. N.
- Dr. Shetty Mohan

### Cardiologists
- Dr. Dalal Prakash H.
- Dr. Deng Vijay
- Dr. Durgapur Ramchand R.
- Dr. Gokhale Nitin S.
- Dr. Herrant Kumar
- Dr. Jala Dushan
- Dr. Kadilkar Supriya N.
- Dr. Lokhande Yash
- Dr. Mehra Vivek
- Dr. Mondal Shanker
- Dr. Menon Ajit B.
- Dr. Mehrotra Himalaksh S.
- Dr. Nadeem Akash
- Dr. Naik Ajit H.
- Dr. Naik Prashant R.
- Dr. Naik Vira R.
- Dr. Naik Punit.
- Dr. Naik Varun R.
- Dr. Naik Pratik J.
- Dr. Naik Sanjay S.
- Dr. Naik Vaibhav S.
- Dr. Naik Parag S.
- Dr. Naik Amey S.
- Dr. Naik Arjun S.
- Dr. Naik Pratik S.
- Dr. Naik Suresh S.
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