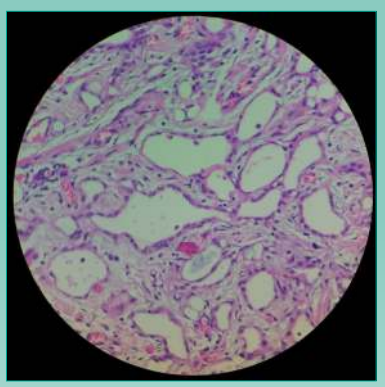
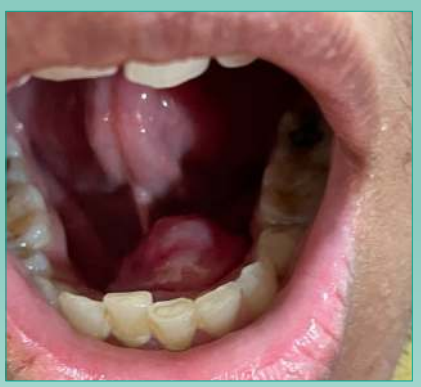
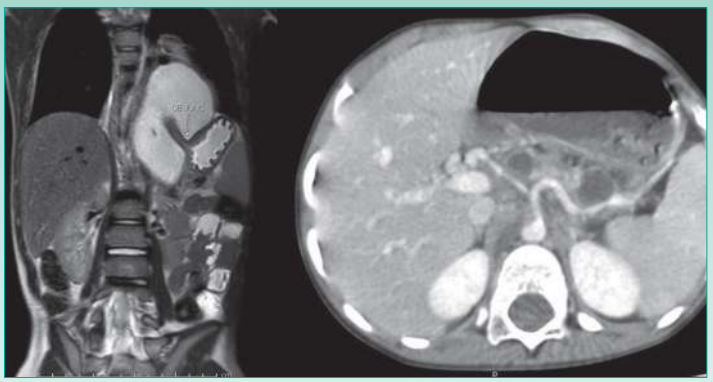
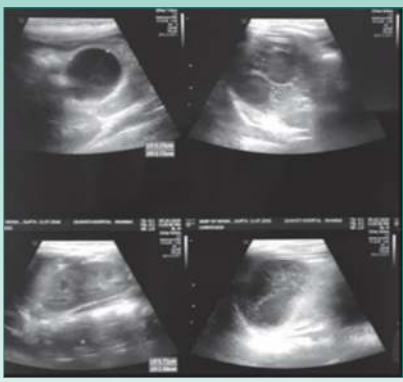
LILAVATI HOSPITAL
MEDICAL TIMES

NOVEMBER 2022









Lilavati Hospital and Research Centre

More than Healthcare, Human Care

NABH Accredited Healthcare Provider

Contents

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From COO's Desk

I am happy and delighted to present one more edition of Lilavati Hospital Medical Times.

This quarter as well Lilavati hospital continued on its tradition of investing in innovations and embracing the modern scientific concepts. Various modern equipment are in the process of induction at the hospital. To name a few are, brand new CT Scan machine, an orthopedic robotics set, new lithotripsy machine, and EBUS (endobronchial ultrasound) bronchoscopy unit.

I would like to congratulate Dr Tushar Reghe for conducting "Live Diabetic Foot Workshop/ Certificate course in Diabetic Foot Management". This workshop was one of its kind and suited his stature as a premier diabetic foot surgeon. Similarly NSSA (Neuro Spinal Surgeons Association) 2022 conference was successfully conducted under the guidance of Dr P S Ramani, the founder president of the NSSA. Dr Suresh Vijan did a workshop wherein cases done in LHRC cathlab were telecasted to audience in hotel Hyatt.

I would like to welcome Ms Anita Sawant (Joint Director- HR & IR), Mr Dattatray Bhargude (Consultant- Security, Facility, Public relations and Liasoning services) and Mr Animesh Singh (Law Officer) to the family of Lilavati hospital.

World Pharmacist day was celebrated to thank the yeomen services rendered by our pharmacist and their team for the first time in Lilavati Hospital.

We have successfully completed our 4th cycle of NABH Re-Accreditation which is an important milestone for the institute I thank all the departments for their cooperation to achieve this.

Apart from routine maintenance work, our ICU and Covid triage are being renovated to maintain the standards of the Lilavati Hospital. Our 5th floor auditorium is also under renovation and very soon we will restart our academic activities. It's heartening to see that the covid cases are at lowest numbers and mortality has been negligible.

We would like to congratulate the Department of Cardiology, Cardiothoracic surgery, Cardiac anesthesia, Ophthalmology and Nephrology for their publications in various renowned scientific journals. Similarly we would like to congratulate our DNB students Dr Raksha Kulkarni and Dr Pallavi Tanpure for Certificate of Commendation from National board of Examinations for their respective research work and dissertations. We would also like to congratulate Dr Rahul Deo Sharma for first prize for his paper presentation at UP-UK PSCON 2022 conference (IAPS).

We are happy to announce that Lilavati Hospital was awarded "India's Best Brand of the year Award- 2022" by Berkshire Media LLC, USA.

We take this opportunity to pay homage and respect to Late Mrs Rekha Sheth who was our beloved permanent trustee and left for heavenly abode on 22nd August 2022.

Wishing all staff a Merry Christmas and a very Happy New Year

Lt. Gen. (Dr.) V. Ravishankar
MS, DNB, MCh, FIACS
Chief Operating Officer and Consultant Cardiothoracic Surgeon

Editorial

I presume everyone had a wonderful Diwali & great New Year festivities.

It is with a very heavy heart I pay homage to Smt. Rekhaben H Sheth, one of our hospital's respectable and loved trustee since its inception, who left for heavenly abode on 22nd August 2022. I pray to God to give her family the strength to bear her loss. She was a lady of great caliber who spent her life in serving the hospital and touched the lives of several patients who were admitted here. She was blessed with a heart inclined towards spirituality and was a very humble & noble soul. She will always be remembered for her compassion and empathy towards the community and the patients.

In the last quarter of Lilavati Hospital, our employees have achieved remarkable academic accolades and performed brilliantly at National and International levels. It is a matter of great pride that Lilavati Hospital has been awarded 'Excellence in Health Care Management at Navbharat Healthcare Awards 2022 by Honorable Governor of Maharashtra. We have also been honoured by Zee Digital with National Achievers Award 2022 for Best Superspecialty hospital in the entire West Zone. Internationally, the Berkshire Media LLC, USA awarded our Institute with the India's Best Brand of the Year Award in year 2022.

Our COO Lt. Gen. Dr. V.Ravishankar was conferred the "AMOG- We for Stree Award" by Hon. Shri Bhagat Singh Koshyari (Governor of Maharashtra). Our Senior Neuro Surgery Consultant Dr. P.S.Ramani received the "Pride of Goa Award 2022" by Herald Global in Panji, Goa. The Covid survey and Global Surgery Collaborations which included Lilavati Hospital as one of its members achieved the distinction of having the most authors (15025) on a single peer reviewed academic paper and this was Guinness World Record.

Our DNB resident Dr. Rahul Deo Sharma from Pediatric Surgery department received the Best Short Paper Award at the National Meeting and the Best Paper Prize. Four of our DNB residents Dr. Raksha Kulkarni (Nuclear Medicine), Dr. Swagna P. (Critical Care), and Dr. Pallavi Tanpure (Nephrology) were awarded Certificate of Commendation for "Outstanding Research Work on Thesis" by the National Board of Examination, New Delhi in 2022.We had 7 international publications and 4 National publications from Department of Cardiology, Opthalmology, GI Surgery and Pediatric Surgery in the year 2022. A total of approximately 6 Lakhs was sanctioned by the hospital for DNB/MUHS students for the year 2022.

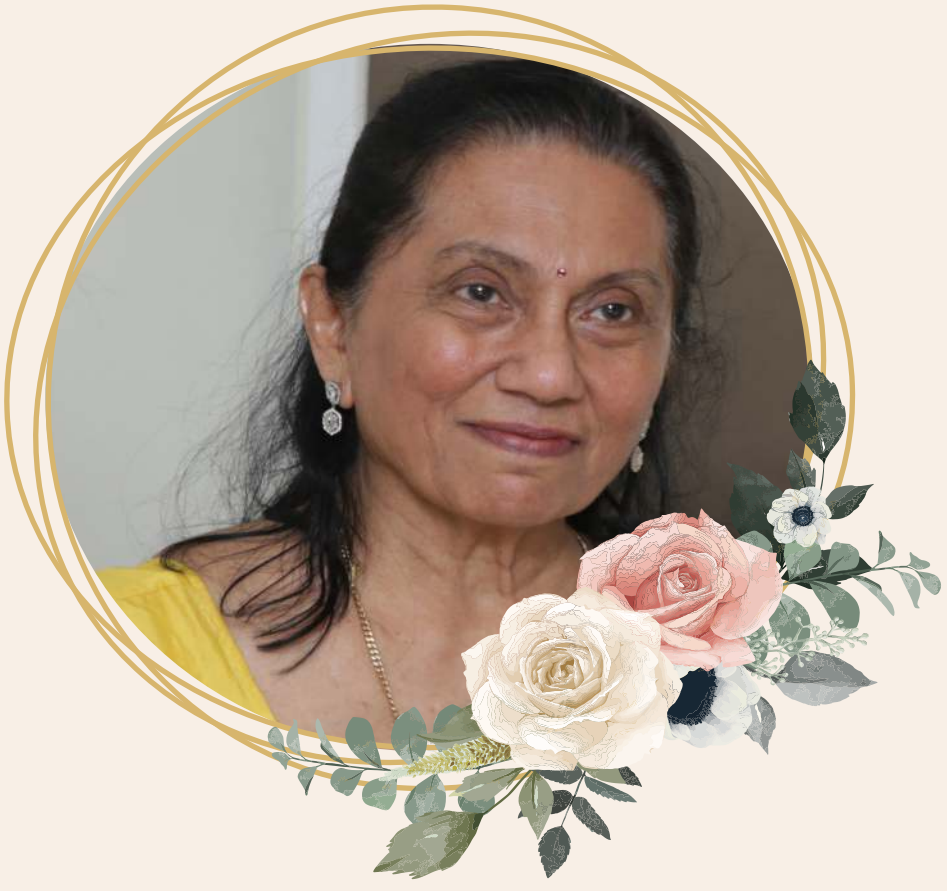
So as we continue in our core competency of Human Care and Academic Excellence, I appeal to all Esteemed Consultants, Residents and also to allied departments like Physiotherapy & Nursing to contribute actively by forwarding their articles in Lilavati Hospital Medical Times. I hope you all enjoy reading this current edition of Lilavati Hospital Medical Times and would appreciate a feedback for improving its outcome.

Wishing all the Doctor's and hospital staff a great and a very Happy New Year in advance!

Respectful regards

Dr. Rajeev Redkar
M.Ch., FRCS (Paed. Surg), MS, DNB, FRCS (Edin), FRCS (Glas), FCPS, IAS
Chairman, Indian Association of Pediatric Surgeons (Maharashtra Chapter)

SAD DEMISE



SMT. REKHA H. SHETH

(01.12.1945 - 22.08.2022)

"Our beloved, you will be sadly missed along life's way
Lovingly remembered everyday
No longer in our life to share
But in our hearts you'll always be there"

Tribute from the Board of Trustees

- Shri Kishor K. Mehta
- Shri Rashmi K. Mehta
- Smt. Sushila V. Mehta
- Smt. Charu K. Mehta
- Shri Nanik Rupani
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Shri S. Lakshminarayanan, IAS (Retd.)

And Team of Lilavati Hospital

Overview: Lilavati Hospital & Research Centre

Late Shri Kirtilal Mehta

Late Smt. Lilavati K. Mehta

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 started 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 Board of Trustees:	
Shri Kishor K. Mehta	Shri Rashmi K. Mehta
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Principal Advisor to the Board of Trustees and Lilavati Hospital & Research Centre **Shri S. Lakshminarayanan, IAS (Rtd.)**	

Lilavati Hospital And Research Centre

Late Shri Vijay Mehta wished to fulfill his parents desire to build a world-class hospital where everyone in need for relief from disease and suffering come in with a certainty to receive the best possible medical care. His passion, attention to details and perseverance resulted in iconic healthcare landmark called **Lilavati Hospital**.

Lilavati Hospital & Research Centre is a premier multispecialty tertiary care hospital located in the heart of Mumbai, close to the domestic and the international airport. It encompasses modern healthcare facilities and state of art technology dedicatedly supported by committed staff.

Lilavati Hospital has focused its operation on providing quality care with a human touch; which truly reflects the essence of its motto, “More than Healthcare, Human Care”. Being a centre of medical excellence where technology meets international norms and standard, the hospital has got what it takes to be a pioneering quality healthcare institute that is also 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

- 12 state-of-the-art well equipped operation theatres.
- Full-fledged Liver Transplant, Heart Transplant, Heart Failure, Hypertension, Bariatric, Foot and Ankle, Dental and Dermo Cosmetology Clinic.
- State of art PET – SPECT CT department.
- Cerebral Embolic Protection System (CEPS), used for Embolic Protection Device to capture and remove thrombus / debris while performing Transcatheter Aortic Valve Replacement (TAVR) procedure.
- The hospital has installed state-of-art Philips Azurion 7F20 in its cath lab. This is the first of its kind high end configuration system installed in India. The new system enables excellent imaging for Coronary, Cerebro & Peripheral Vascular Diseases.
- The department of Invasive Cardiology has been upgraded with the addition of a High Definition Optis Mobile OCT (Optical Coherence Tomography) system. It has the latest configuration which gives better 3 – Dimensional perspective of Coronary Artery before and after stent deployment.
- The hospital has added Intraoperative Nerve Monitoring system which enables surgeons to identify, confirm and monitor motor nerve function of the patients which helps to reduce the risk of nerve damage during various operative surgeries.
- The hospital has upgraded its ENT department by adding a top-of-the line surgical operating microscope to carry out various microsurgeries under high magnification. The microscope electronics allows the surgeon to electronically control object focusing, magnification, illumination, surgical recording, etc.
- All days round the clock OPD Pathology and Radiology investigations without any Emergency charges.
- More than 300 consultants and manpower of nearly 1,800.
- Hospital attends to more than 10000 In-patient, 40000 Out-patient and performs thousands of surgeries every year.
- Hospital is in process of procuring Robotics for Knee Replacement Surgery.
- Auditorium at 5th floor is under renovation and will soon be functional.

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 healthcare to the sick people. The research centre has 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 aim 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.

CASE REPORT I: HISTOPATHOLOGY

I Spy – Mites in your Eye

Dr. Mayank Sharma, Clinical Associate, Department of Histopathology
Dr. Sneha Shah, Oculoplastic Surgeon
Dr. Chandralekha Tampi, Consultant, Department of Histopathology

INTRODUCTION

Among different species of mites, Demodex folliculorum and Demodex brevis are two ubiquitous mites that affect the human eye, living within the meibomian glands and eyelash follicles, and survive by scavenging on keratin and sebaceous secretions. D. folliculorum was detected in 1841 by Henle and first described in 1842 by Simon.[1] Demodex, in small numbers, can be found living symbiotically in asymptomatic adults,[2] however, Demodex superinfestation can cause Meibomian gland dysfunction and blepharitis accompanied by pruritus, dryness and general discomfort in the eye area. It is important to consider Demodicosis during the evaluation of blepharitis [3]

Case

A 55 year old man, complained of redness and itching of both eyelids for over a year, not improving with therapy, from various doctors. On examination, he had thick secretions from the meibomian gland orifices, and cylindrical dense deposits on eyelashes of both eyelids. Epilation of an eyelash was done by the oculoplastic surgeon and was brought to the histopathology department. The eyelash then was dry mounted on a slide with cover slip and was examined under the microscope by the pathologist. Initially the eyelash appeared unremarkable throughout its length, but on pressing the bulb of the hair follicle, two live mites were extruded (Fig A and B) The mites had eight short stubby legs, and a segmented body, and matched the description of Demodex folliculorum. Fully grown Demodex folliculorum mites are approximately 0.3-0.4 mm long but Demodex brevis are little shorter, approximately 0.15-0.2mm, and both species are invisible to the naked eye, being one of the tiniest of the arachnids.

Figure A

Mites of D. folliculorum , extruding from the bulb of the eyelash (A). These mites are transparent, elongated in shape, and divided into head-neck and body-tail parts, with eight short legs. (B)[2]

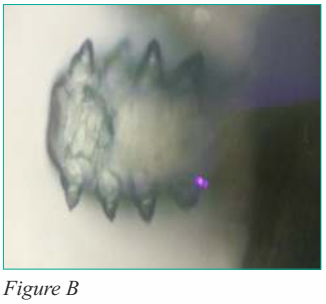

Figure B

A diagnosis of demodicosis was offered and the patient was advised tea tree oil wet wipes for cleaning of eyelashes, eyebrows and face, in the morning and evening.Tea tree oil contains 4-Terpineol, which kills Demodex mites. On review at three months the patient was seen to be relieved of his blepharitis.

Discussion

One cause of Blepharitis , often neglected, is Demodex superinfestation(4). The risk of the occurrence of ocular symptoms due to Demodex infestation, increases with the rise in numbers of the Demodex mites, in the eyelash follicles, as in small numbers they behave more like scavengers, of the follicles and surrounding skin of the face It has also been postulated that the protein inside the Demodex mites and their debris or wastes may elicit host's inflammatory responses via a delayed hypersensitivity or an innate immune(5). Ocular demodicosis has also been implicated in eyelash loss, abnormal eyelash alignment, blepharitis, conjunctivitis and blepharoconjunctivitis.(6-9). Blepharitis caused by Demodex is often under diagnosed, even though its existence has been known for several years. Therefore, it is important to look for Demodex superinfestation, in the appropriate clinical settings, and if the conventional treatment has not proved effective.

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CASE REPORT II:

Pre-implantation Genetic Testing (PGT): The next level in IVF

Dr Nandita Palshetkar,
FRCOG MD FCPS FICOG
President of Indian Society for Assisted Reproduction (ISAR),
Past President Federation of Obstetric & Gynaecological Societies of India (FOGSI),IAGE
Past Chairman of The Maharashtra Chapter of ISAR, FOGSI Representative to FIGO

Case :

30 yrs & 31 yrs old young Couple married for 6 yrs came to OPD with primary Infertility

She had already undergone 2 Cycles of ovulation induction and planned relations. Her Hysterosalpingography was normal means bilateral tubes were patent.

She had already done 2 cycles of IUI. Her AMH levels were fluctuating : 0.8ng/ml … 1.2ng/ml …..1.8 ng/ml. Since simple ART treatment didn't give results , decision was taken for ICSI with embryo pooling with technologies in our BLOOM IVF lab at Lilavati hospital

Embryo pooling is a concept where we pool and bank embryos in cases of low AMH or poor ovarian reserve.2 cycles of egg retrieval were done to create embryos

1st FET (frozen embryo transfer) with sequential transfer : 1 (day 3) +1 (day 5): positive pregnancy : blighted ovum : medical management : D&C done for retained products & Karyotype of RPOC was found to b normal.

2nd FET : sequential transfer : 1+1 : Positive : Blighted ovum : D& C done

After 2 abortions, Decision for PGTA on 2 frozen blastocyst was taken. With proper consents and results showed 1 Euploid embryo. Genetic Fertility analysis of Husband and Wife for RPL done Karyotype Husband & wife was Normal. FET with single euploid blastocyst with Fortified Luteal phase support with PRP , LMWH, GCSF, Intralipids done . Erica Artificial intelligence was also done to see grade of embryo.

Patient got pregnant and was monitored closely thoroughout . All necessary tests were performed in pregnancy .Haematologist reference for RPL & deranged coagulation profile was done and was advised LMWH 40 units through out pregnancy & to continue 6 weeks post delivery . Patient delivered healthy baby 3.2 kgs at 38 weeks.

Preimplantation genetic testing (PGT): is a procedure used to identify genetic abnormalities in embryos created with in vitro fertilization (IVF). PGT is performed before embryos are transferred to the uterus. The biopsy of the embryo is done at the blastocyst stage(day 5).

The goal of PGT is to significantly reduce the chances of transferring an embryo with a specific genetic condition or chromosome abnormality and this increase the success rate

Different types of PGT :

1. Preimplantation genetic testing for aneuploidy (PGT-A)

2. Preimplantation genetic testing for monogenic disorders (PGT-M)

3.Preimplantation genetic testing for structural rearrangements (PGT-SR)

Indications for PGT :

PGT-A : who have had recurrent pregnancy losses (miscarriages), multiple unsuccessful IVF cycles or transfers, a prior pregnancy or child with certain chromosome abnormalities

PGT-M used in cases of

Cystic fibrosis

Sickle cell anaemia

β-thalassaemia

Marfan's disease

Huntington's disease*

BRCA1 & BRCA2**

Duchenne muscular dystrophy

Haemophilia

PGT-SR is an option for patients who have a chromosome translocation or inversion.

Procedure : The embryos are monitored in our laboratory until day 5 or 6 when they are referred to as blastocysts. At that time, a small number of cells are biopsied (removed) from each embryo. The cells are taken from a part of the blastocyst called the trophectoderm, which will eventually form the placenta. These cells are expected to be representative of the rest of the embryo; however, this may not always be the case due to circumstances such as mosaicism. The embryos must be frozen while PGT is performed. An embryo with normal PGT results would be selected, thawed, and transferred to the uterus at a later date.

The results of PGT are highly accurate; however, it is still considered a screening test. This means false positives and false negatives can occur.

It not only helps in improving success rates but also helps in delivering genetically normal babies.

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2. Analysis of IVF live birth outcomes with and without preimplantation genetic testing for aneuploidy (PGT-A): Kathryn D. Sanders, Giuseppe Silvestri, …Darren K. Griffin Show authors Journal of Assisted Reproduction and Genetics 2021
3. Preimplantation genetic testing. ACOG Committee Opinion No. 799. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020

CASE REPORT III:

SCHWANNOMA OF ORAL CAVITY

Dr Preeti Dhingra, Junior Consultant, Department of ENT and Head Neck Surgery
Dr Naresh Palapalle, DNB Resident, Department of General Surgery
Dr Rakesh Katna, Consultant Oncosurgery, Department of Head Neck Surgery
Dr Chandralekha Tampi, Consultant, Department of Histopathology

Abstract: Schwannomas are rare non-cancerous lesions, derived from Schwann cells of the nerve sheath. Intraoral schwannomas are solitary, slow-growing lesions and should be considered in the differential diagnosis of intraoral masses. We are reporting a rare case of schwannoma in a 26-year-old female in the floor of mouth. Complete excision of the tumor with primary closure was done.

Key words: Intraoral Schwannoma, benign neoplasms, floor of mouth.

INTRODUCTION:

Schwannomas are benign lesions that are derived from schwann cells of the peripheral nerves (except the optic and olfactory nerves), or autonomic nerves 1. They are also named as, neurinoma, neurolemoma, neurilemmoma, schwann cell tumor or perineural fibroblastoma. Approximately 25–40% of all schwannomas occur extracranially in the head & neck region, and only about 1% of schwannomas are reported in the oral cavity2,3. Thses are rare slow-growing tumors that should be considered in the differential diagnosis of oral lesions.

Case report:

A 26-year-old female patient came to our department with history of swelling in the floor of mouth midline, which was painless, progressive in nature for 1 years. No h/o discomfort while talking and swallowing. No h/o bleeding from the swelling. She also had history of excision of swelling in the peripheral hospital, but it recurred back. There was no history of trauma, local infection or systemic illness.

On examination, there was single, non tender, smooth, firm to hard well-defined swelling in the floor of the mouth in the midline, measuring approximately about 4 cm × 3 cm in size. Overlying and adjacent mucosa was normal. The swelling was free from the mandible inner surface. Tongue mobility was normal. General physical examinations and other laboratory test were normal. CT scan oral cavity was done which showed focal well defined mildly enhancing lesion in the floor of mouth in the midline at the anterior aspect, measuring about 3.8 cm × 3.2 cm. It was closely abutting the mandible. Based on the history and examination , diagnosis was made of ranula or mandibular cyst.

Figure 1, Intraoral photograph showing solitary, well defined midline lesion floor of mouth.

Patient was planned for excision after taking consent, under general anaesthesia. Incision made over the swelling, separated from the surrounding structures and excised. Mass was circumscribed, well encapsulated, but not infiltrating surrounding tissue.Wound closed in layers. Gross examination of specimen showed a solitary, pinkish, well-encapsulated mass measuring 3.5 cm × 3 cm which was sent for histopathological examination . We could not identify the nerve of origin, as sometimes is difficult to identify the nerve of origin.

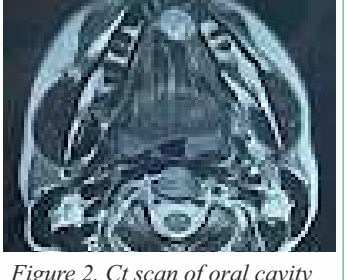

Figure 2, Ct scan of oral cavity showing well defined mildly enhancing lesion in the floor of mouth in the midline at the anterior aspect.

Microscopic examination showed presence of alternating antoni A and B. To confirm the histopathological diagnosis, immunohistochemistry was performed. The neoplastic cells showed strong immunopositivity to S100, diffuse and strong positivity to SOX 10, and immunonegativity to SMA. These findings helps us to confirm the diagnose of 'Schwannoma'.Next day patient was discharged. On follow up wound was healthy with no recurrence after 8 months.

Discussion

Schwannomas were first discussed by Jose Verocay in 1908, when he discovered verocay body, a finding, which is characteristic of schwannoma[4]. Schwannomas are solitary, slow growing tumors, with size ranging from few millimeters to several centimeters. They can arise from any cranial, peripheral, or autonomic nerves that contain Schwann cells, (the sheath cells) that cover mylinated nerve fibers[5,6].

Embryologically, Schwann cells arise from neuroectoderm during the 4th week of development.

Extracranially, about a quarter of all schwannomas occur in the head and neck region and only 1 % are intraoral. Schwannomas of oral cavity are very rare. They are mostly solitary lesions; however, some are seen as multiple lesions as part of neurofibromatosis type I. In head and neck region, schwannoma are commonly seen in the anterior tongue, followed by floor of mouth, palate, gingiva, vestibular mucosa, lips, and mental nerve area[7]. Other common sites are flexor surface of upper and lower extremities and less common are the mediastinum, peritoneum and bone. Schwannoma can occur at any age, but oral cavity schwannomas are mostly seen in the age group of 20 to 40 years and both sexes are equally affected.

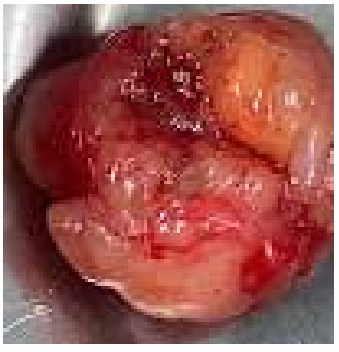

Figure 3: Macroscopic picture of well-encapsulated lobulated mass.

The exact etiology of these lesions is not known but is considered to originate from the Schwann cells proliferation from motor and sensory peripheral nerve sheaths in the perineurium, causing displacement and compression of the adjacent nerve. Mostly it develops from the sensory nerves and rarely from the motor nerves[8].

Oral schwannomas are mostly asymptomatic. Symptoms varies depending on the nerve of origin like cough, dyspnoea, hoarseness, dysphagia, paraesthesia, pain, anaesthesia. In most of the cases the lesion presents as well-circumscribed mass with a smooth margin, as observed in this case. Rarely, it cause compression and displacement of the surrounding normal nerve leading to pain and paraesthesia. Majority of extracranial and intracranial schwannomas are non malignant, however, in 8-10% they are malignant also. Approximately 9-14% of malignant schwannomas occur in head and neck region and cause pain, hoarseness, dysphagia, cranial nerve neuropathies, and even Horner syndrome depending on the site of the lesion[8,9].

There are two types of Schwannomas, central schwannoma which are mainly seen in bone and peripheral schwannoma, seen in the soft tissues. They can present either as encapsulated form, which is more common, where the tumor is surrounded by dense fibrous connective tissue or as pedunculated form.

Schwannomas differential diagnosis includes granular cell tumor, traumatic neuroma, solitary neurofibroma, malignant schwannoma neurofibromatosis, nerve sheath myxoma, adenoma, and ganglion neurofibroma.

The preoperative diagnosis is not easy always being rare tumor and is not usually suspected in the oral cavity. Diagnostic investigations include an ultrasound scan, fine needle aspiration cytology, CT scan and magnetic resonance imaging (MRI). CT scan and MRI are the investigations of choice to see bone involvement and tumor extension10. The characteristic findings of schwannoma on MRI is homogenous enhancing lesion without evidence of infiltration into the adjacent normal. The definitive diagnosis is by histopathology examination and immunohistochemistry. Anti-S100 protein is the most significant antibody used to identify schwannomas. Focal positivity for SOX 10 shows neural crest origin of the cell and imunonegativity to SMA helps to confirm the diagnosis.

The treatment of choice is surgical excision of the tumor with attempt to preserve the nerve to avoid any post surgery neurological deficit. If excised completely, schwannoma has good prognosis with low recurrence rate and the malignant transformation is rare.

Histologically, schwannoma shows various proportions of Antoni A area and Antoni B area. Antoni A area consists of nuclei with surrounded cytoplasm, and palisading nucleic bodies called verocay bodies. Antoni B area are characterised by markedly reduced cellularity with areas of cystic degeneration and edema. Immunohistochemical analysis is important in the diagnosis of these schwannomas which showed high affinity of the Schwann cells to S-100.

Conclusion

Schwannoma of the oral cavity involving floor of mouth is a rare entity, should be differentiated from other oral cavity tumors and should be considered in the differential diagnosis of oral lesions . After complete surgical excision recurrence is very rare with good prognosis.

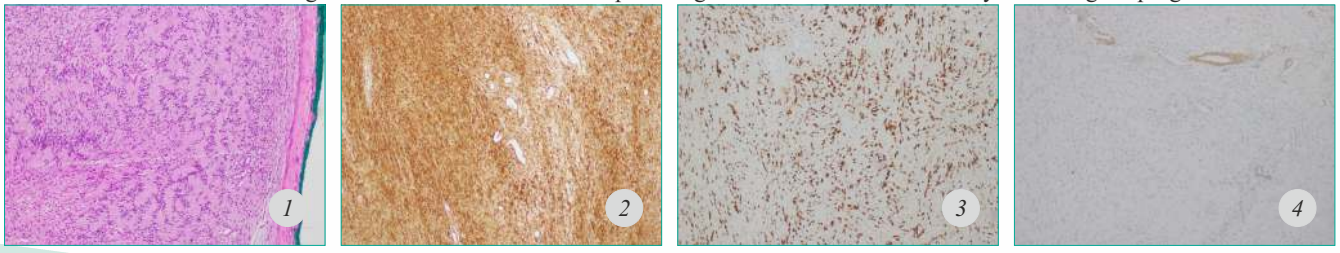

Fig 1 : Encapsulated spindle cell tumour with verrocay bodies • Fig 2 -4 : IHC positivity with S100, and Sox10, and negative for SMA

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CASE REPORT IV:

Mimicker of Malignancy

Dr. Asha Mary George, M.D, Consultant Histopathologist

INTRODUCTION:

Adenomatoid tumors are benign tumors often incidentally detected, but the importance is in its histological recognition as it can be mistaken for malignancy, due to irregular pseudoinfiltration pattern.

Case 1

51 yr old lady, underwent panhysterectomy for fibroid (Leiomyoma). The right fallopian tube showed a fairly circumscribed nodule of 3 mm ,in the tubal fimbriae. Tubular and cystic spaces of varying sizes comprised the lesion, which were lined by cuboidal to flattened cells with round to ovoid nuclei and inconspicuous nucleolus.(Fig. 1) Calretinin positivity by IHC studies, proved the mesothelial origin & confirmed it as an Adenomatoid tumor (AT).(Fig. 2)

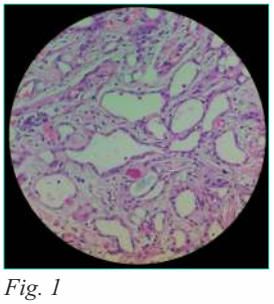

Fig. 1

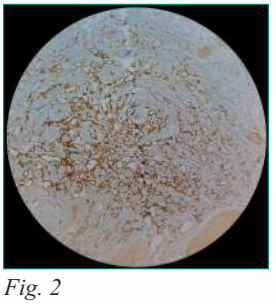

Fig. 2

Case 2

40 yr old lady, underwent pan hysterectomy for extensive endometriosis. Her uterine corpus showed two small intramural leiomyomas in addition to adenomyotic foci. The leiomyoma measuring 1.0 cm in diameter, also showed variably sized cystic and pseudoglandular spaces , lined by cells as described above.(Fig. 3) Immunohistochemistry studies with Calretinin(Fig. 4) confirmed the mesothelial origin of these cells, and a diagnosis of Leiomyoadenomatoid tumor was offered.

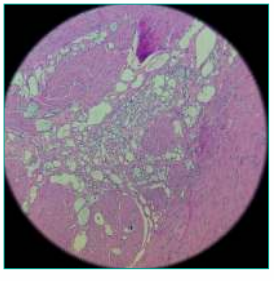

Fig. 3

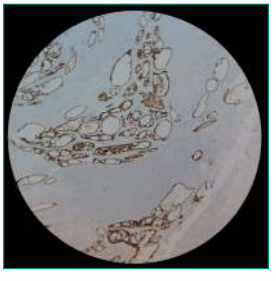

Fig. 4

DISCUSSION

Adenomatoid tumor (AT) is the most frequent type of benign tubal tumor but extremely rare ,and usually an incidental finding in middle aged or elderly women.It is commonly located beneath the serosal surface of the fallopian tube. It originates from mesothelium and at times may be large enough to displace the tubal lumen eccentrically.

In 1992 ,Epstein described a variant of AT, with prominent smooth muscle component & coined the term Leiomyoadenomatoid tumor (LMAT). Due to the prominent smooth muscle component,these tumors may be misdiagnosed as Leiomyoma with malignant tumor infiltrates.Presence of Adenomatoid component intermixed with smooth muscle proliferation, favors the hypothesis that LMAT should be considered as a variant of AT, that originated in the precursor cells with dual differentiation - mesothelial and muscle cells, rather than a collision tumor.

Extrauterine sites of LMAT include Fallopian tube, ovary and epididymis & only 16 cases have been reported so far in the literature revew.

CONCLUSION

Adenomatoid & Leiomyoadenomatoid tumors, though rare & incidentally detected, should be recognised promptly histologically , so as to avoid a misdiagnosis of malignancy.

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CASE REPORT V:

Multidisciplinary Management for Intestinal Obstruction by Gel Ball Ingestion

Dr. Surendra Singh, DNB Resident - Pediatric Surgery, Department of Pediatrics
Dr. Sushma Achugatla, DNB Resident - Pediatric Surgery, Department of Pediatrics
Dr. Rahul Deo Sharma, DNB Resident - Pediatric Surgery, Department of Pediatrics
Dr. Rajeev Redkar, Consultant Pediatric Surgery, Department of Pediatrics

Abstract

Foreign body ingestion is common in young children. Very few cases require surgical exploration for removal. We report a case of superabsorbent gel ball ingestion causing intestinal obstruction, managed by a combination of endoscopic and open surgical removal under intraoperative ultrasound guidance.

Keywords: Endoscopy, enterotomy, intestinal obstruction, ultrasound, water absorbent ball

INTRODUCTION

Foreign body (FB) ingestion is common in the pediatric age group. However, diagnosing these cases is challenging, as history of FB ingestion is usually lacking. Management is based on presenting symptoms as well as on the nature of the FB. Here, we present an unusual case of water absorbent ball (WAB) ingestion, requiring simultaneous endoscopic and surgical exploration with the use of intraoperative ultrasound.

Case Report

A 19-month-old female child presented with multiple episodes of bilious vomiting. She also vomited out part of a hair clip in one episode. History revealed that the child had ingested three gel balls 96 h prior to presentation. Radiological investigations reported the presence of multiple, round structures in both the stomach and duodenum, which was assumed to be either a FB or a duplication cyst and planned for surgical removal at a different hospital. Repeat ultrasound of the abdomen at our center confirmed multiple, rounded, thin-walled, anechoic structures, two in the stomach (2 cm in diameter), one in the proximal jejunum (2.5 cm × 1.6 cm), and another in the distal jejunum (3.6 cm × 2.0 cm) with dilated edematous duodenal and jejunal loops and collapsed ileal and colonic loops [Figure 1]. With a diagnosis of small bowel obstruction, a combined endoscopic and open surgical approach was planned. Initial endoscopy identified two round FBs in the fundus of the stomach, each about 2 cm in size [Figure 2]. Removal was attempted with a basket retriever, but the FBs were friable and broke into several pieces. A Roth Net® standard retriever was then used to bring out all pieces individually. Further endoscopy revealed another FB, 5 cm distal to the duodenojejunal flexure, about 4 cm in size, obstructing the lumen, and was retrieved similarly. An intraoperative ultrasound confirmed a 2–3-cm, round anechoic structure in the distal jejunum. A left periumbilical transverse incision was taken, and enterotomy was performed to recover a partially broken gel ball piece. A repeat ultrasound confirmed clearance of all but few small FB pieces measuring about 7 mm in size within the duodenum. The bowel appeared healthy, and enterotomy was closed in a transverse manner. The patient had an uneventful recovery with escalation to full feeds by the 4th postoperative day.

DISCUSSION

The peak incidence of FB ingestion in the pediatric age group is between 12 months and 3 years. It poses diagnostic and therapeutic challenges and can cause significant morbidity and mortality. Fortunately, most FBs pass through the gastrointestinal tract spontaneously and only 10%–20% need endoscopic intervention, while <1% need surgical exploration.[1] Open exploration is required if there is nonprogression of FB or complications such as intestinal obstruction, perforation, or peritonitis occur.

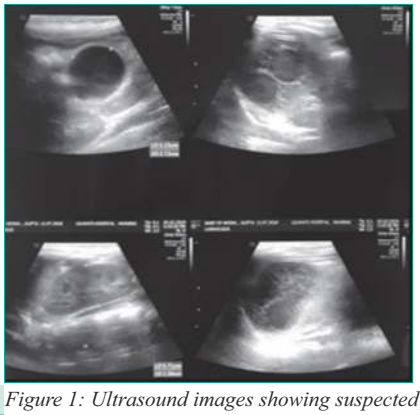

Figure 1: Ultrasound images showing suspected foreign bodies

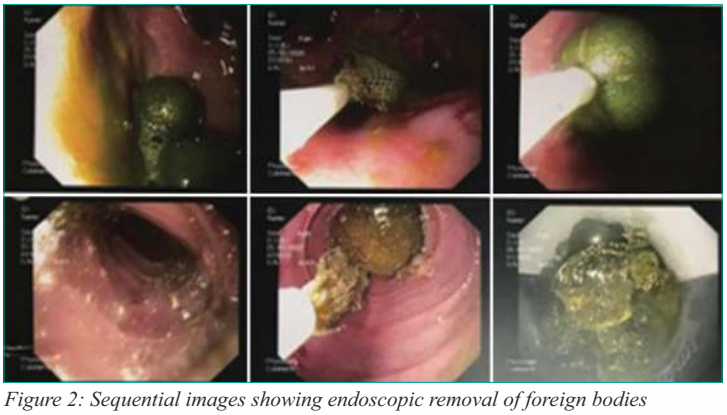

Figure 2: Sequential images showing endoscopic removal of foreign bodies

Commonly ingested FBs are coins, toy parts, button batteries, marbles, and magnets. Occasionally, unusual objects such as safety pins, screws, and water absorbent gel ball have also been recovered. WABs are also known as jelly balls, expandable water toys, fairy/dragon eggs, water/hydro orbs, gel beads, and water monkey. They are made up of super absorbent polymer (SAP) composed of polyacrylate/polyacrylamide copolymer and range between the sizes of 1 and 4 mm.[2] They are capable of absorbing water 500 times their weight, swelling up to 30–60 times of their original volume. The use of WABs was popularized in horticulture for water storage, but they are increasingly being used as decorative items, in crafts, photography, floral decorations, science kits, and as learning aids for autistic children.

WABs are round, are often brightly colored, and may appear candy like to children. Younger children have an instinctive tendency for oral exploration of objects, while older children might accidentally ingest them while playing. Often, the ingestion goes unnoticed as multiple small beads are packaged together. Although WABs are nontoxic, are biodegradable, and are easy to swallow, they begin expanding while transiting through the gastrointestinal tract. Patients can develop symptoms within 24 h of ingestion as these balls enlarge progressively, causing obstruction in either distal jejunum or ileum.[3]

Patients may be asymptomatic or suffer from vomiting, refusal to eat, abdominal pain, constipation, and symptoms of dehydration. Although WABs are radiolucent, X-rays play an important role in evaluation as features of acute intestinal obstruction will become apparent as the presence of air–fluid levels and dilated bowel loops. For definitive identification, ultrasound scans and computed tomography scans are helpful.

The management depends on patient's clinical parameters. Asymptomatic patients can be observed for spontaneous expulsion. However, WABs progressively grow in size, increasing the risk of intestinal obstruction. These patients require hospital admission and early, elective attempt at endoscopic removal of the FB. There are few case reports in literature where WAB removal was done by open surgical exploration or laparoscopy, especially in patients below 2 years of age.

Spontaneous expulsion usually occurs within 24 h, but if symptoms worsen, urgent removal of the FB is warranted. Rarely, complications such as perforation, peritonitis, and even death might occur. Mirza and Sheikh theorized that perforation can occur either by induction of chemical injury to the intestinal wall or progressive increase in WAB size, causing pressure necrosis of the intestinal wall. They have reported two cases, one wherein an 18-month-old child suffered perforation after WAB ingestion and required ileal resection and anastomosis, whereas another 6-month-old child developed burst abdomen due to anastomotic leak, 6 days postenterotomy for WAB removal and succumbed to septicemia.[4]

Mohamed et al. reported two cases of WAB ingestion, requiring surgical removal. One of the patients required re-exploration as two more ingested balls were missed at initial exploration. Thus, it is advisable to assume that the child might have ingested more than one WAB and thorough exploration or intraoperative ultrasound should be made to ensure complete removal.

An in vitro study re-enacting conditions after WAB ingestion, reported that such FBs can grow five times their original diameter at 96 h postingestion.[5] Several countries such as Poland, Italy, Malaysia, Turkey, and the United Kingdom have banned toys incorporating SAP-containing gel balls.

CONCLUSION

We report this case to increase awareness within the community as well as among medical practitioners about the risks that accompany accidental ingestion of SAP products. Such items should be kept out of reach of children below 2 years of age. A timely intervention can significantly decrease the morbidity and mortality. Endoscopy as well as intraoperative ultrasound scan before enterotomy can be successfully utilized for the removal of such FBs.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

Acknowledgement: Dr. Saumil Shah, Consultant Gastroenterologist at Lilavati Hopsital, for his contribution of the therapeutic endoscopy.

Financial support and sponsorship: Nil.

Conflicts of interest: There are no conflicts of interest.

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CASE REPORT VI:

Mediastinal Extension of Pancreatic Pseudocyst: A Rare Pediatric Presentation

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Dr. Sushma Achugatla, DNB Resident - Pediatric Surgery, Department of Pediatrics
Dr. Rahul Deo Sharma, DNB Resident - Pediatric Surgery, Department of Pediatrics
Dr. Rajeev Redkar, Consultant Pediatric Surgery, Department of Pediatrics

Abstract

Pancreatic pseudocysts are cystic cavities which are localized collection of pancreatic secretions, rich in amylase and other enzymes, present in and around pancreas, encased in a false epithelial lining of fibrous or reactive granulation tissue. Extension of a pancreatic pseudocyst into the mediastinum is rare. We are reporting a case of a 5-year-old child with mediastinal pancreatic pseudocyst which was successfully drained by cystojejunostomy.

Keywords: Mediastinal extension, pancreatic pseudocyst, rare

INTRODUCTION

Pancreatic pseudocysts are localized collections of pancreatic secretions without an epithelial lining. Thoracic extension can occur due to pancreatic duct disruption, causing secretions to pass through the diaphragmatic orifices into the mediastinum. There are fewer than 100 cases of mediastinal pancreatic pseudocyst reported in the literature.[1] They can occur at any age, with chronic alcoholism as a common cause in adults, while >60% of reported cases in children occur due to blunt abdominal trauma.[2] Galligan and Williams reported the first case of mediastinal pancreatic pseudocyst in 1966.[3] We are reporting a case of a 5-year-old child with pancreatic pseudocyst, having mediastinal extension, who underwent a cystojejunostomy.

Case Report

A 5-year-old boy had a history of repeat episodes of dull aching upper abdominal pain for 3 years. He underwent extensive radiological investigations and was diagnosed to have pancreatic pseudocyst with mediastinal extension. Endoscopic or open intervention was not attempted, and he was managed conservatively. He continued to have recurrent symptoms. At presentation to us, the child was asymptomatic but had a prominent barrel-shaped chest. Primary investigations revealed raised serum amylase – 359 U/L. Magnetic resonance imaging (MRI) abdomen and chest reported diffuse pancreatic atrophy with large collection below the body of pancreas extending into posterior mediastinum through esophageal hiatus of diaphragm [Figure 1].Left gastric artery was seen traversing through the base, while thoracic component was abutting posterior pericardium, compressing left atrium, and esophagus was coursing through it. Cardiac assessment was normal. Endoscopic drainage was deemed inadvisable due to the proximity of the gastric artery to the base of cyst. An exploratory laparotomy was performed, where cyst was noted at the posterior aspect of stomach. It was aspirated through a small incision, and dye was injected to gauge connection to the mediastinal component. Wide communication between thoracic and abdominal components was established under fluoroscopic guidance [Figure 2]. Cystogastrostomy was not attempted in view of proximity to the left gastric artery, so the patient underwent a cystojejunostomy with Roux-en-Y loop creation [Figure 3]. Amylase level of aspirated fluid was 33370 U/L. The postoperative period was uneventful. Ultrasound done after a week reported a small residual collection adjacent to the body of pancreas. Serum amylase levels dropped to 81 U/L. Follow-up ultrasound after a month reported complete resolution of the mediastinal pseudocyst, and the child is asymptomatic.

DISCUSSION

One of the early sequelae of acute pancreatitis is pseudocyst of pancreas, as per the Revised Atlanta classification.[4] Although 2% of cases of

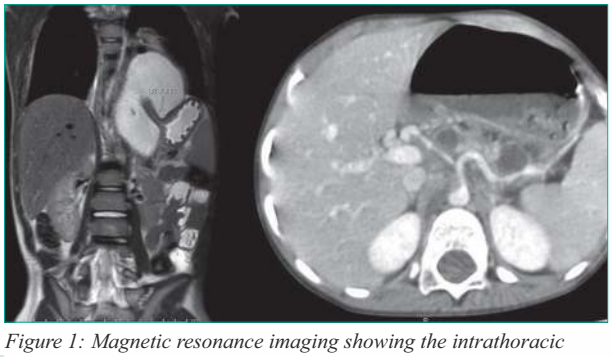


Figure 1: Magnetic resonance imaging showing the intrathoracic extension and gastric artery at the base of pseudocyst

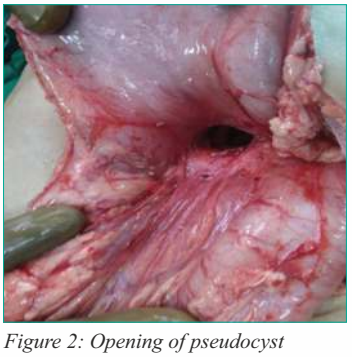


Figure 2: Opening of pseudocyst

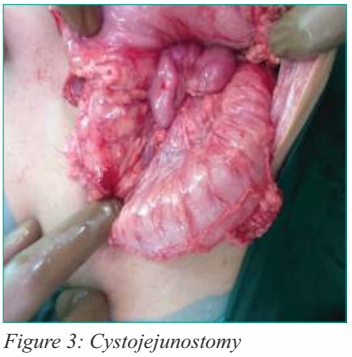
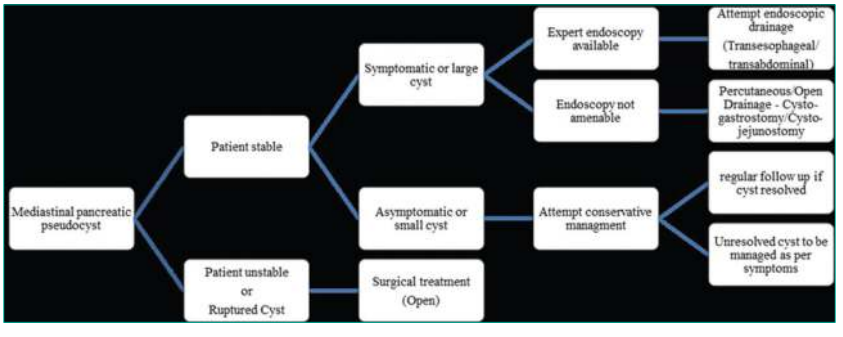


Figure 3: Cystojejunostomy

Table 1: Pediatric mediastinal pancreatic pseudocyst cases reported in literature

Study	Age	Symptoms	Abdominal mass	Route of extension	Suspected cause	Treatment	Associated pancreatitis
Kirchner *et al.*	7 months	Dyspnea	No	Foramen of Morgagni	Idiopathic	Roux-en-Y cystojejunostomy	No
Crombleholme *et al.*	2 years	Vomiting	No	Esophageal hiatus	Anomalous duct	Roux-en-Y cystojejunostomy	No
	7 years	Pain in abdomen	No	Esophageal hiatus	Anomalous duct	Puestow's procedure	Yes
Kotb *et al.*	7 years	Dyspnea	No	Esophageal hiatus	Idiopathic	Cystogastrostomy	No
Sharma *et al.*	8 years	Dyspnea, chest pain	No	Traumatic diaphragmatic hernia	Trauma	Cystogastrostomy	No
Galligan *et al.*	10 years	Nausea, vomiting, anorexia	Yes	Esophageal hiatus	Idiopathic	Cystogastrostomy	No
Bonnard *et al.*	11 years	Not mentioned	Not mentioned	Not mentioned	Anomalous duct	Thoracoscopic drainage	Not mentioned
Nabi *et al.*	11 years	Pain in abdomen	No	Not mentioned	Idiopathic	Endoscopic - Transgastric drainage	Yes
Laird *et al.*	15 years	Nausea, vomiting, anorexia	No	Esophageal hiatus	Trauma	Puestow procedure	No
Lakhtakia S *et al.*	4 patients	Pain in abdomen, vomiting, dysphagia	No	Not mentioned	Not mentioned	EUS-guided transesophageal drainage with double pigtail stent	Not mentioned
Our case	5 years	Pain in abdomen	No	Esophageal hiatus	Idiopathic	Roux-en-Y cystojejunostomy	No

pancreatitis result in pseudocyst formation, intrathoracic extension can only be seen in 0.4% of cases, which makes it quite a rare complication.[5] Pseudocysts are usually located within head and body of pancreas, but extrapancreatic extensions can occur anywhere around liver, spleen, mediastinum, neck, and pelvis.



When the pancreatic duct gets disrupted, the amylase-rich secretions seep along the path of least resistance. A thoracopancreatic fistula will arise if the disruption occurs in the retroperitoneal space and leaks through aortic or esophageal openings into the thoracic cavity. These fistulae can be further subdivided into pancreaticopericardial, pancreaticopleural, pancreaticobronchial, or a mediastinal pseudocyst.[6]

We shall now focus the discussion to one of the varieties, the mediastinal pseudocyst, which was the final diagnosis of our case. To the best of our knowledge, only nine cases and a case series have been reported in the pediatric age group, in addition to ours[7] [Table 1]. These patients usually present with complaints of vague/diffuse upper abdominal pain, dysphagia, dyspnea, or retrosternal discomfort. The symptoms can often be misleading as they are mostly an end result of compression of mediastinal structures. However, as noted in our case, patients might only have occasional symptoms, and even abdominal palpation might not reveal significant findings as the pseudocyst can decompress into thorax through diaphragmatic hiatus.[8]

As the physical examination is mostly inconclusive, investigations play a bigger role in establishing the diagnosis. Blood investigations help to point the etiology toward a pancreatic origin as serum amylase in invariably raised. However, the diagnosis of a mediastinal pseudocyst is typically established by various radiologic investigations such as ultrasound, computed tomography (CT), and magnetic resonance cholangiopancreatography (MRCP). Ultrasound abdomen can easily demonstrate a peripancreatic collection but might be less helpful in delineating a mediastinal pseudocyst, owing to its location. CT of abdomen and chest with contrast enhancement not only outlines the pancreatic anomaly but also detects the mediastinal component. However, MRI of the abdomen provides detailed information about pancreatic ductal morphology, while MRCP is the best modality to detect stricture/dilatation of duct and communication with pseudocyst. Endoscopic ultrasound can be diagnostic and therapeutic modality as it not only detects mediastinal extension of pseudocyst but also can be used for cyst

aspiration.[9] Our patient had a raised serum amylase level, and the definitive diagnosis was made with MRI of abdomen and chest with contrast enhancement.

Individualized treatment plan is made according to the underlying cause, anomaly of the pancreatic duct, and symptoms experienced by the patient [Figure 4]. Conservative management of pediatric mediastinal pancreatic pseudocyst entails the following. Octreotide and bromhexine hydrochloride can be used to decrease pancreatic secretions, while supportive management can be in the form of low-fat diet, antibiotics, analgesics, and intravenous fluid, if required. These methods rarely end in spontaneous regression, as it requires strict compliance and follow-up. It was also unsuccessful in our case, as evidenced by symptom recurrence in patient. Thus, surgical options were explored.

Endoscopic cyst drainage procedures through transesophageal, transgastric, or transpapillary routes have been described in literature.[10] These methods are mainly reported in the adult population as endoscopic cyst drainage in pediatric age group requires expertise and is often deemed unfeasible due to possible difficulty of scope negotiation or stent placement.

The mainstay of surgery in pediatric as well as adult age group is cyst drainage by creating an outlet within the gastrointestinal system, commonly in the stomach or jejunum. Open surgeries include internal or external drainage or pancreatic resection. Procedures commonly done include cystogastrostomy, Roux-en-Y cystojejunostomy, and Puestow's procedure, largely depending on the anatomic location of the cyst. Cystogastrostomy is preferred for retrogastric cyst adherent to stomach, while pseudocysts located at the base of transverse mesocolon are best drained by cystojejunostomy with preferential drainage of secretions into the Roux loop of jejunum. The Roux loop prevents reflux of food and bile into the cyst and also prevents activation of the pancreatic secretions until they reach jejunum.[11] If a wide tract is patent between the abdominal and thoracic components of pancreatic pseudocyst, drainage of the abdominal collection can reduce the pressure in thoracic compartment, leading to resolution of mediastinal pseudocyst. A successful outcome is described as resolution of symptoms and decrease in the size/disappearance of the cyst, documented by radiological investigations, as seen in our case.

CONCLUSION

Mediastinal pancreatic pseudocyst is a rare pathology, but it should be considered a differential diagnosis of any cystic mediastinal mass. Radiological investigations can establish communication between a cystic structure in the mediastinum with peripancreatic collection. Open drainage procedure can be a safer alternative in children as endoscopic procedures require expertise.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

Financial support and sponsorship: Nil.

Conflicts of interest: There are no conflicts of interest.

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5. Wang SJ, Chen JJ, Changchien CS, Chiou SS, Tai DI, Lee CM, et al. Sequential invasions of pancreatic pseudocysts in pancreatic tail, hepatic left lobe, caudate lobe, and spleen. Pancreas 1993;8:133-6.
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7. Kotb M, Oshiba A, Ashour K. Pseudopancreatic Cyst Extending into the Mediastinum in a 7-Year-Old Child. European J Pediatr Surg Rep 2019;7(1):e24-e27.
8. Ajmera AV, Judge TA. Mediastinal extension of pancreatic pseudocyst--a case with review of topic and management guidelines. Am J Ther 2012;19(5):e152-6.
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10. Săftoiu A, Ciurea T, Dumitrescu D, Stoica Z. Endoscopic ultrasound-guided transesophageal drainage of a mediastinal pancreatic pseudocyst. Endoscopy 2006;38:538-9.
11. Weledji EP, Ngowe MN, Mokake DM, Verla V. Post-traumatic pancreatic pseudocyst managed by Roux-en-Y drainage. J Surg Case Rep. 2015;2015(8):rjv094.

List of Publications (International)

S. No.	Author	Title of the Paper / Chapter	Name of Journal
1	Dr. Salil Mehta Dr. Niharika Gill	Retinal Vasculitis in a Patient with Mixed Connective Tissue Disease Following COVID-19 infection: Correlation or Coincidence ?	**Cureus 2022.** Mehta et. al., Cureus 14(6): e26365. DOI 10.7759/cureus.26365
2	Dr. Rao A, Dr. Mehta H, Dr. Reddy KVC, Dr Hajari R Dr. Ravishankar V	First Reported Case of "High-Risk" Protected PCI with Impella in a Very Old Patient with Multiple Comorbidities	Annals of Clinical Case Reports 2022 | Volume 7 | Article 2236
3	Dr. Prakash Sanzgiri Dr. Mohan B. Agarwal Dr. Charan Reddy KV Dr. Priyanka Potdar	Clinical profile of heart failure in beta Thalassaemia major (B-TM): case studies with current consideration and future perspectives	South Africa Heart Journal Vol 19 No. 1 2022

List of Publications (National)

S. No.	Author	Title of the Paper / Chapter	Month of Publication
1	Dr. Rahul Deo Sharma Dr. Rajeev Redkar	GB Duplication with choledochal cyst - An universal case of biliary anatomy	British Association of Pediatrics Surgeons Congress 2022, Birmingham UK 15th July 2022

“Academics & Research Dept. has compiled the publications / honours / special mentions by DNB students and Consultants.”

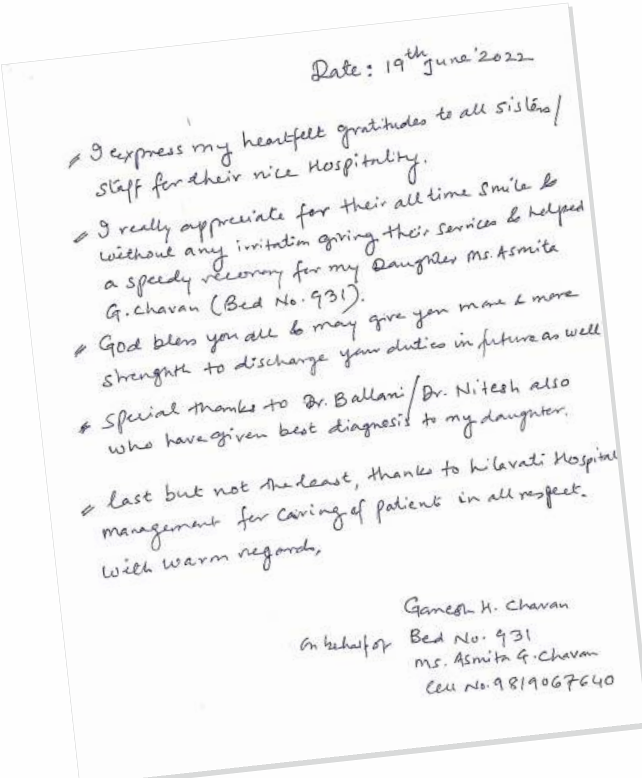
Benevolence

The social service wing of the hospital - SEWA serves to the health requirements of needy people. This department seeks to bridge the gap between the needy patients and the fast evolving medical technology.

Under this service Lilavati Hospital and Research Centre offers

- Assistance to indigent and weaker section patients after due scrutiny.
- Help poor patients who don't fall in the above category for crowd funding and financial help.
- Conduct various free medical camps for socially deprived regions, latest being conducted at Osmanabad on 27th November 2022.

Straight from the Heart - Patient Testimonials

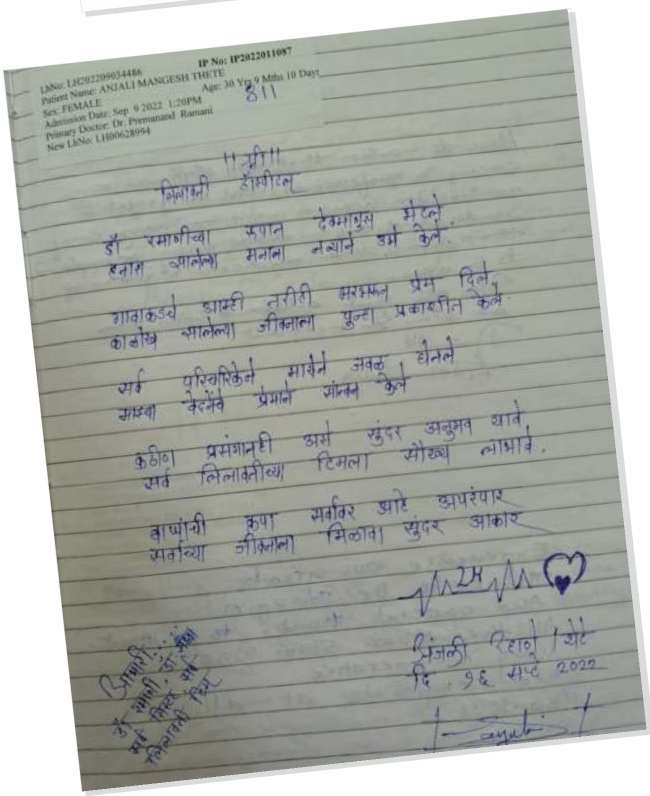


Date: 19th June '2022

- I express my heartfelt gratitudes to all sisters / staff for their nice Hospitality.
- I really appreciate for their all time smile & without any irritation giving their services & helped a speedy recovery for my Daughter Ms. Asmita G. Chavan (Bed No. 931).
- God bless you all & may give you more & more strenghth to discharge your duties in future as well
- Special thanks to Dr. Ballani / Dr. Nitesh also who have given best diagnosis to my daughter.
- Last but not the least, thanks to Lilavati Hospital management for Caring of patient in all respect.

With warm regards,

Ganesh H. Chavan
On behalf of Bed No. 931
Ms. Asmita G. Chavan
Cell No. 9819067640



LhNo: LH202209034486 IP No: IP2022011087
Patient Name: ANJALI MANGESH THETE Age: 30 Yrs 9 Mths 10 Days
Sex: FEMALE
Admission Date: Sep 9 2022 1:20PM
Primary Doctor: Dr. Premanand Ramani
New LhNo: LH00628994

811

॥ श्री ॥
लिलावती हॉस्पीटल

डॉ रमाणींच्या रूपात देवमाणुस भेटले
हताश झालेल्या मनाला नव्याने उभे केले.

गावाकडचे आम्ही तरीही भरभरून प्रेम दिले,
काळोख झालेल्या जीवनाला पुन्हा प्रकाशीत केले.

सर्व परिचारिकेंनी मायेने जवळ घेतले
माझ्या वेदनेचे प्रेमाने सांत्वन केले

कठीण प्रसंगातही असं सुंदर अनुभव यावे,
सर्व लिलावतीच्या टिमला सौख्य लाभावे.

बाप्पांची कृपा सर्वांवर आहे अपरंपार
सर्वांच्या जीवनाला मिळावा सुंदर आकार

अंजली [illegible] / थेटे
दि. १६ सप्टे 2022

आभारी... डॉ. रमाणी, सर्व सिस्टर लिलावती टिम

> The entire health check up section has taken care of me and guided me through out the health check up process. Thank you!
>
> **DWIPEN SAHA**

> Expert and timely medical care given by the experienced doctors and services standards of the nursing staff.
>
> **K. P. NAIR**

> It is most convenient hospital as we just live across the street and one of the best hospitals for us in Mumbai.
>
> **FLORINA FERNANDES**

> The best doctors and nursing staff have interacted with anywhere, very professional and kind staff. Thank you!
>
> **RAJINDER BALARAMAN**

> Excellent and very supportive team helped smoothly to complete my health checkup well in time.
>
> **TARUN KUMAR**

> The entire team of doctors are excellent even issues arised during pre-op were taken care off without putting me in any kind of stress.
>
> **SIDDHIKA KORE**

> Love and affective toward client / immediate, quick response to health issue.
>
> **SHLOK PAWAR**

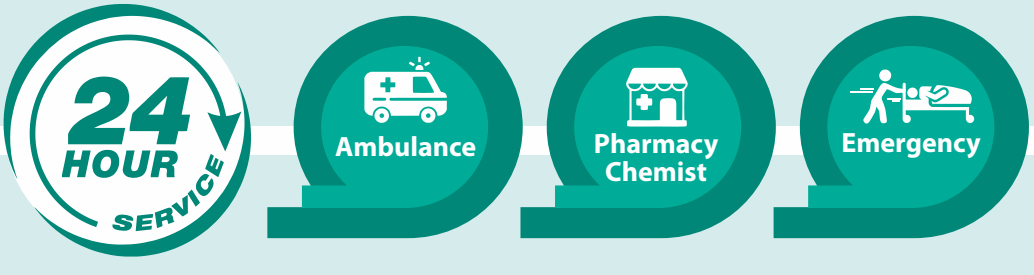
> Doctors and staff members of the hospital are very humble and excellent in providing service.
>
> **FALAK NAAZ**

> Promptness in service no matter who stands in front of the counter the service won't let anyone down.
>
> **VALENTINA LOPES**

> The approach of the doctors and the staff of the hospital was very good. The tests were done speedily. Also cleanliness and hygiene was excellent.
>
> **CRISELLE COLDEIRA**

Services Available

- **Inpatient Services**
- **Outpatient Services**
- **Critical Care**
  - Intensive Care Unit (ICU)
  - Intensive Cardiac Care Unit (ICCU)
  - Surgical Intensive Care Unit (SICU)
  - Pediatric Intensive Care Unit (PICU)
  - Neo-natal Intensive Care Unit (NICU)
  - Paralysis & Stroke Unit
- **Audiology & Speech Therapy**
- **Bariatric Surgery**
- **Cardiology & Cardio-vascular Thoracic Surgery**
- **Chest Medicine & Sleep Study**
- **Chronic Pain Management**
- **Colorectal Surgery**
- **Dental**
- **Dermatology & Hair Transplant**
- **Diabetology & Endocrinology**
- **Diabetology & Diabetic Foot Surgery**
- **ENT, Head & Neck Surgery**
- **Endocrinology & Endocrinal Surgery**
- **Gynecology & Obstetrics**
- **GI & Liver Transplant**
- **General Surgery**
- **IVF**
- **Internal Medicine & Infectious Disease Specialty**
- **Minimal Access Surgery**
- **Nephrology & Dialysis**
- **Neurology & Neuro Surgery**
- **Oncology & Onco-Surgery**
- **Ophthalmology & Corneal Transplant**
- **Orthopedic, Spine Surgery & Joint Replacement**
- **Psychiatry & Psychology**
- **Pediatrics & Pediatric Surgery**
- **Plastic Surgery / Cosmetic Surgery**
- **Physiotherapy**
- **Rheumatology**
- **Reconstructive (Plastic) Surgery**
- **Urology & Kidney Transplant**
- **Vascular & Endovascular Surgery**
- **Imaging Services**
  - X-ray
  - Sonography (USG)
  - CT
  - MRI
  - Nuclear Medicine
  - PET CT
- **Laboratory Services**
  - Pathology
  - Molecular Pathology
  - Microbiology & Serology
  - Histopathology
  - Blood Center & Transfusion Services
- **Free OPD**



Important Telephone Numbers

Toll Free	**18002678612**
New Boardline	**+91 22 6931 8000 / +91 22 6930 1000**
	+91 22 5059 8000 / +91 22 5059 1000
Emergency / Casualty	**8063 / 8064 / +91 86579 07754**
Ambulance	**+91 97692 50010**
TPA Fax	**+91 22 2640 5119**
Appointments for OPD Consultants	**86579 07751 / 52 / 53**

Extensions

Admission Department	**8080 / 8081 / 8082**
AKD Counter	**8650 / 8651**
Billing - Inpatient	**1586**
Billing - OPD	**8052**
Blood Bank	**8215**
Blood Bank Medical Social Worker	**8214**
Cardiology	**8236**
Cath Lab	**8137**
Chemist	**1579 / 1578**
CT Scan Department	**8044**
Dental	**8028**
Dermatology / Hydrotherapy	**8021**
EMG / EEG	**8249**
Endoscopy	**8057**
ENT / Audiometry	**8232**
Health Check-up Department	**+91 86578 96447**
Home Sample Collection (9am - 5pm, Mon to Sat)	**+91 88796 77193 / 196**
IVF	**8226**
Medical Social Worker (SEWA)	**8361**
MRD	**8358 / 8359**
MRI Department	**8066**
Nuclear Medicine / PET & SPECT CT	**8092**
Ophthalmology	**8229**
Physiotherapy	**1536**
Report Dispatch Counter	**1620**
Sample Collection Room	**8028**
TPA Cell	**8089**
Transplant Co-ordinator	**8362**
Urodynamics	**8032**
Visa Section	**Direct No.: 86579 07756 (12-4 pm Mon to Sat)**
	8248 / 8244
X-Ray, Sonography Department	**8030 / 8038**

Few Honorable Mentions

AMOG – We for Stree Puraskar was presented by Hon Shri Bhagat Singh Koshyari (Governor of Maharashtra) to Lt.Gen. (Dr.) V. Ravishankar on 13th October 2022 at Raj Bhavan for his selfless and sincere efforts towards the upliftment of Women's Health

Dr. Rahul Deo Sharma won first place for his paper presentation at the UP-UK PSCON 2022 conference (IAPS) held at Sanjay Gandhi Postgraduate Institute of Medical Sciences, Lucknow.

Indian Medical Association (Mumbai West Branch) felicitated Dr. Murari Nanavati on 11th Sept 2022 on "Teachers Day" occasion for his excellent contribution in field of Gynecology and Obstetrics as a brilliant academician and excellent teacher

Ref.No. NBEMS/THESIS/2022/A-200014 Date:06-05-2022

** सर्वाधिक व्यक्ति के लिए /TO WHOMSOEVER IT MAY CONCERN**

Certificate of Commendation

is hereby awarded to

Dr. TANPURE PALLAVI SHAHAJIRAO

With Registration Number

320-31158-192-225256

For outstanding research work on the Thesis Title

ASSESSMENT OF VOLUME STATUS BY BIOIMPEDANCE SPECTROSCOPY AND OCCURENCE OF INTRADIALYTIC HYPERTENSION

towards partial fulfillment for the award of

Diplomate/Doctorate of National Board in Nephrology

We wish you all the best for your future endeavours.

(Dinesh Chand)

Joint Director (Thesis)

For and on behalf of

Prof. M. Bajpai

MS, MCh, PhD, FRCS, FACS, FAMS, National Board Vice-President & Honorary Executive Director, Fulbright Scholar (USA), Commonwealth Fellow (UK) & Raja Ramanna Fellow (Science & Technology)

National Board of Examinations in Medical Sciences, New Delhi

Our DNB student Dr. Pallavi Tanpure received Certificate of Commendation from National Board of Examinations for her research work and dissertations.

Ref.No. NBEMS/THESIS/2022/A-220260 Date: 25-03-2022

** सर्वाधिक व्यक्ति के लिए /TO WHOMSOEVER IT MAY CONCERN**

Certificate of Commendation

is hereby awarded to

Dr. P SWAPNA

With Registration Number

376-31158-192-226112

For outstanding research work on the Thesis Title

CLINICAL PROFILE, EEG ABNORMALITIES IN PATIENTS WITH SEPSIS ASSOCIATED ENCEPHALOPATHY AND ITS CORRELATION WITH PATIENT OUTCOME:- AN OBSERVATIONAL STUDY

towards partial fulfillment for the award of

Diplomate/Doctorate of National Board in CRITICAL CARE MEDICINE

We wish you all the best for your future endeavours.

(Dinesh Chand)

Joint Director (Thesis)

For and on behalf of

Prof. M. Bajpai

MS, MCh, PhD, FRCS, FACS, FAMS, National Board Vice-President & Honorary Executive Director, Fulbright Scholar (USA), Commonwealth Fellow (UK) & Raja Ramanna Fellow (Science & Technology)

National Board of Examinations in Medical Sciences, New Delhi

Downloaded on 10-Sep-2022 11:05:41AM from IP 43.239.54.186

Our DNB student Dr. P Swapna received Certificate of Commendation from National Board of Examinations for her research work and dissertations.

World Pharmacist day was celebrated to thank the yeomen services rendered by our pharmacist and their team for the first time in Lilavati Hospital

Educational Activities

Live Diabetic Foot Workshop / Certificate Course in Diabetic Foot Management was conducted by Indian Podiatry Association under guidance of our Consultant Dr. Tushar Rege on 20th Aug 2022.

NSSA (Neuro Spinal Surgeons Association) 2022 conference was successfully conducted in Mumbai under guidance of Dr. P. S. Ramani the Founder President of NSSA this event was graced by Hon'ble Governor of Maharashtra Shri Bhagat Singh Koshyari.

Feathers in Cap

Lilavati Hospital ranked amongst Top Hospitals in India in The Week Hansa Research Best Hospital Survey 2022

Lilavati Hospital recognized Nationally as Best Hospital for Obstetrics & Gynaecology, Paediatrics, Neurology & Orthopaedics by Economic Times Healthcare Awards 2022.

Lilavati Hospital honoured with National Achievers Awards 2022 for Best Super specialty Hospital in West India by Zee Digital.

Lilavati Hospital and Research Centre awarded by Berkshire Media LLC, USA with India's Best Brand Of The Year Award 2022.

Doctors Associated with Lilavati Hospital

Andrology
Dr. Shah Rupin S.

Anaesthesiology
Dr. Baxi Vaibhavi
Dr. Budhakar Shashank
Dr. Gandhi Nisha
Dr. Gaiwal Sucheta
Dr. Gawankar Prakash
Dr. Kharwadkar Madhuri
Dr. Khatri Bhimsen
Dr. Kulkarni Satish K.
Dr. Mahajan Anjula
Dr. Mascarenhas Oswald
Dr. Kothari Namrata
Dr. Patil Prajakta
Dr. Shah Falguni
Dr. Waradkar Samidha

Audiology & Speech Therapy
Mr. Bhan Satyan
Ms. Gorawara Pooja
Ms. Parulkar Bakul
Ms. Satam Sneha (Cochlear)

Bariatric Surgery
Dr. Khandelwal Nidhi
Dr. Palep Jaydeep
Dr. Shah Shashank

Blood Bank
Dr. Saraswat Shubhangi

Cardiovascular & Thoracic Surgery
Dr. Bhamre Bipeenchandra
Dr. Bhanushali Amol
Dr. Bhattacharya S.
Dr. Honnekeri Sandeep T.
Dr. Irniraya Krishna Prasad
Dr. Jaiswal O. H.
Dr. Joshi Suresh
Dr. Kumar Pavan
Dr. Mehra Arun P.
Dr. Nand Kumar
Dr. Pandey Kaushal
Dr. Rachmale G. N.
Dr. Ravishankar V.
Dr. Vichare Sanjeev

Cardiology
Dr. Bajaj Harish
Dr. Ballani Prakash
Dr. Bang Vijay
Dr. Dargad Ramesh R.
Dr. Gokhale Nitin S.
Dr. Jhala Darshan
Dr. Kothari Snehal N.
Dr. Lokhandwala Yash
Dr. Mehan Vivek
Dr. Merchant S. A.
Dr. Menon Ajit R.
Dr. Mehta Haresh G.
Dr. Nabar Ashish
Dr. Pillai M. G.
Dr. Pinto Robin
Dr. Punjabi Ashok H.
Dr. Rao Anand
Dr. Rao Ravindra Singh
Dr. Samuel K. Mathew
Dr. Sanzgiri P. S.
Dr. Shah Chetan
Dr. Sheth Siddharth
Dr. Suratkal Vidya
Dr. Vijan Suresh
Dr. Vyas Pradeep R.
Dr. Vora Amit
Dr. Vajifdar Bhavesh

Chest Medicine
Dr. Chhajed Prashant
Dr. Mahashur Abha
Dr. Mehta Sanjeev K.
Dr. Prabhudesai P. P.
Dr. Parkar Jalil D.
Dr. Rang Suresh V.

Colorectal Surgery
Dr. Chulani H. L.

Dentistry / Dental Surgery
Dr. Bhavsar Jaydeep P.
Dr. Deshpande Dilip
Dr. Gala Jigar
Dr. Joshi P. D.
Dr. Khatavkar Arun
Dr. Kamdar Rajesh J.
Dr. Parulkar Darshan
Dr. Samath Shyamcharan
Dr. Sanghvi Sameer

Dermatology
Dr. Goyal Nilesh
Dr. Malvankar Dipali
Dr. Mehta Nimesh
Dr. Oberai Chetan
Dr. Parasramani S. G.
Dr. Pillai Jisha

Diabetic Foot Surgery
Dr. Rege Tushar
Dr. Vaidya Sanjay

Diabetology
Dr. Panikar Vijay

Diabetology & Endocrinology
Dr. Joshi Shashank R.
Dr. Naik Vaishali

Dietician
Dr. Pai Veena

ENT
Dr. Dhingra Preeti
Dr. D'souza Chris E.
Dr. Jayashankar Narayan
Dr. Parasram Kamal S.
Dr. Pusalkar A.
Dr. Shetty Adip (Cochlear Implant)

Endocrine Surgery
Dr. Agrawal Ritesh

Endo Urology
Dr. Utture Anand

Gastro Intestinal Surgery
Dr. Bharucha Manoj
Dr. Khandelwal Nidhi
Dr. Kulkarni D. R.
Dr. Mehta Hitesh
Dr. Palep Jaydeep
Dr. Shaikh Imran
Dr. Shaikh Taher
Dr. Varty Paresh
Dr. Wagle Prasad K.
Dr. Zaveri Jayesh P.

Foot and Ankle
Dr. Kini Abhishek

Gastroenterology
Dr. Barve Jayant S.
Dr. Choksi Mehul
Dr. Kanakia Raju R.
Dr. Parikh Samir S.
Dr. Patel Ruchit
Dr. Phadke Aniruddha Y.

General Surgery
Dr. Mehta Narendra
Dr. Nikam Narendra
Dr. Parikh Ratna
Dr. Trivedi Narendra

Gynaecology
Dr. Agarwal Rekha
Dr. Chhabra Neelam
Dr. Coelho Kiran S.
Dr. Dudhedia Udhavraj
Dr. Goyal Swarna
Dr. Medhekar Mansi
Dr. Nanavati Murari S.
Dr. Pande Shinjini
Dr. Pai Hrishikesh
Dr. Pai Rishma D.
Dr. Palshetkar Nandita
Dr. Salunke Vivek
Dr. Shah Cherry C.

Haematology
Dr. Agarwal M. B.
Dr. Bhave Abhay

Hair Restoration
Dr. Agrawal Sumit

Headache & Migraine
Dr. Ravishankar K.

Healthcheckup Consultant
Dr. Desai Sandeep

Histopathology
Dr. George Asha Mary
Dr. Tampi Chandralekha

Infectious Diseases Consultant
Dr. Nagvekar Vasant C.

Intensivist / Physician
Dr. Gobole Chinmay
Dr. Kavita S.
Dr. Shekade Kiran
Dr. Shrinivasan R.
Dr. Vas Conrad Rui

Interventional Neuroradiology
Dr. Limaye Uday S.

Interventional Radiology
Dr. Rai Jathin Krishna
Dr. Sahu Amit
Dr. Sheth Rahul
Dr. Warawdekar Girish

Joint Replacement Surgery
Dr. Maniar Rajesh N.

Lactation Consultants
Ms. Temkar Swati

Liver Transplant
Dr. Mehta Naimish
Dr. Shaikh Taher

Nephrology
Dr. Mehta Hemant J.
Dr. Shah Arun
Dr. Suratkal L. H.
Dr. Upadhyaya Kirti L.

Neurology
Dr. Chauhan Vinay
Dr. D'souza Cheryl
Dr. Deshpande Rajas
Dr. Sirsat Ashok M.
Dr. Soni Girishkumar
Dr. Vyas Ajay

Neuropsycology
Ms. Panjwani Siddhika

Neuro Surgery
Dr. Ambekar Sudheer
Dr. Andar Uday
Dr. Dange Nitin
Dr. Goel Atul
Dr. Parekh Harshad
Dr. Pawar Sumeet
Dr. Ramani P. S.

Nuclear Medicine
Dr. Krishna B. A.
Dr. Shaikh Nusrat
Dr. Shimpi Mahajan Madhuri

Oncology
Dr. Lokeshwar Nilesh
Dr. Menon Mohanakrishnan
Dr. Parikh Bhavna
Dr. Smruti B. K.

Oncosurgery
Dr. Bushan Kirti
Dr. Chabra Deepak
Dr. Chedda Yogen
Dr. Gupta Amit
Dr. Jagannath P.
Dr. Katna Rakesh
Dr. Mullerpatan Prashant
Dr. Parikh Deepak
Dr. Rao Satish
Dr. Sharma Sanjay
Dr. Shah Rajiv C.
Dr. Shetty Shravan S.

Ophthalmology
Dr. Agrawal Vinay
Dr. D'souza Ryan
Dr. Mehta Salil
Dr. Mehta Himanshu
Dr. Nagvekar Sandeep S.
Dr. Parikh Rajul
Dr. Shah Manish
Dr. Shah Sneha
Dr. Vaidya Ashish R.

Orthopaedic Surgery
Dr. Agrawal Pranav
Dr. Agrawal Vinod
Dr. Amyn Rajani
Dr. Archik Shreedhar
Dr. Bhandari Hemant
Dr. Bhatia Deepak
Dr. D'silva Domnic F.
Dr. Garude Sanjay
Dr. Gurav Suraj
Dr. Joshi Anant
Dr. Kasodekar Vaibhav
Dr. Kodkani Pranjal
Dr. Kohli Amit
Dr. Moonot Pradeep
Dr. Mukherjee Sunirmal
Dr. Nadkarni Dilip
Dr. Nazareth Ritesh
Dr. Padgaonkar Milind
Dr. Panchal Lalit
Dr. Pandey Alok Kumar
Dr. Panjwani Jawahar S.
Dr. Shetty Nagraj
Dr. Vatchha Sharookh P.
Dr. Vengsarkar Nirad
Dr. Warrier Sudhir

Pathology
Dr. Chavan Nitin
Dr. Gohel Tejas
Dr. Mehta Kashvi
Dr. Natarajan Shripriya
Dr. Rangwalla Fatema

Paediatric Surgery
Dr. Bangar Anant
Dr. Karmarkar Santosh J.
Dr. Nathani Rajesh
Dr. Redkar Rajeev G.
Dr. Sandlas Gursev

Paediatrics
Dr. Chittal Ravindra
Dr. Gupta Priyam
Dr. Sharma Shobha
Dr. Ugra Deepak

Paediatric Cardiology
Dr. Bhalgat Parag

Paediatric Critical Care/NICU
Dr. Sheikh Minhaj Ahmed

Paediatric Endocrinology
Dr. Parikh Ruchi

Paediatric Hemato-Oncology
Dr. Kanakia Swati
Dr. Lokeshwar M. R.
Dr. Swami Archana

Paediatric Neurology
Dr. Kulkarni Shilpa
Dr. Shah Krishnakumar N.

Paediatrics Nephrology
Dr. Ali Uma

Paediatric Opthalmology
Dr. Doshi Ashish

Paediatric Orthopedics
Dr. Aroojis Alaric

Paediatric Pulmonology
Dr. Khosla Indu

Pain Medicine
Dr. Baheti Dwarkadas
Dr. Jain Jitendra

Physicians / Internal Medicine
Dr. Ballani A. G.
Dr. Bandukwala S. M.
Dr. Gidwani Vinod N.
Dr. Jadwani J. P.
Dr. Medhekar Tushar P.
Dr. Medhekar Amey T.
Dr. Nair C. C.
Dr. Shikarkhane Pushkar
Dr. Shimpi Shrikant

Plastic & Reconstructive Surgery
Dr. Barve Devayani
Dr. Dixit Varun
Dr. Jain Leena
Dr. Kumta Samir
Dr. Nehete Sushil
Dr. Prakash Siddharth
Dr. Purohit Shrirang
Dr. Wagh Milind

Psychiatry
Dr. Deshmukh D. K.
Dr. Shah Bharat R.
Dr. Vahia Vihang N.

Psychology
Ms. Chulani Varkha

Physician / Rheumatology
Dr. Sangha Milan

Physiotherapy
Ms. Garude Heena

Radiology & Imaging
Dr. Deshmukh Manoj
Dr. Dhedia Khyati
Dr. Doshi Pankaj
Dr. Gupta Kanchan
Dr. Kamath Satish
Dr. Lokhande Kaustubh
Dr. Mehta Mona
Dr. Tyagi Neha

Rehab Medicine
Ms. Shah Labdhi

Rheumatology
Dr. Chitnis Neena
Dr. Gill Niharika
Dr. Sabnis Shailaja

Spine Surgery
Dr. Bhojraj Shekhar
Dr. Chaddha Ram
Dr. Kundnani Vishal
Dr. Mohite Sheetal
Dr. Nagad Premik
Dr. Nene Abhay
Dr. Patel Priyank
Dr. Varma Raghuprasad

Urology
Dr. Bhagat Suresh
Dr. Pahade Sachin
Dr. Pathak Hemant R.
Dr. Raina Shailesh
Dr. Raja Dilip
Dr. Sanghvi Nayan
Dr. Shah Sharad R.
Dr. Vaze Ajit M.

Urological Laparoscopy Surgery
Dr. Ramani Anup

Urodynamics Consultant
Dr. Dastur B. K.

Vascular Surgery
Dr. Patel Pankaj
Dr. Pai Paresh

IMPORTANT INFORMATION

KINDLY NOTE OUR NEW BOARD LINE NUMBERS

022 69318000 / 022 69301000 / 022 50598000 AND 022 50591000

FOR HEALTH CHECK-UP APPOINTMENT

8657896447

OUR NEW DIRECT CONTACT NUMBERS

FOR DOCTOR'S APPOINTMENT

8657907751/52/53

FOR VISA APPOINTMENT

8657907756

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