MEDICOVER
HOSPITALS
KAKINADA

SUCCESS STORIES

INDEX

MEDICOVER HOSPITALS

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Electrical Burns Case

Abstract

A 55year old male was harvesting coconuts on the occasion of festival. When he lifted a bamboo stick, he was electrocuted and his left hand and his body burnt up to 50%. He didn't notice that bamboo stick and electrical pole were in contact. The incident resulted in shock and burn injury extending to both the upper limbs, front and back of the trunk and parts of the back. The patient was seeking admission in all the corporate and established hospitals in Kakinada but no hospital could admit him due to lack of 24 hrs qualified medical personnel. No hospital in the region was equipped with the required experts and the system to treat second degree electrical burns.

Though Medicover at Kakinada was established recently, we decided to take up this challenging case. We were required to meet the high standards needed to treat 50% Types 2 burns case, which carries high mortality even under fully equipped Burns ward.

The Injury:

Shown in Pictures below are the lesion sites

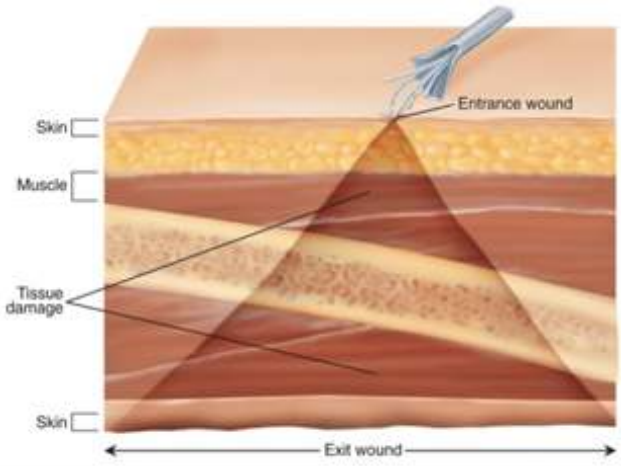
The patient is a known case of hypertensive for the past 10 years on regular medication. On arrival at ER, he was immediately resuscitated with IV fluids and stabilized after the initial assessment. A Plastic surgeon was requested to see this patient and he diagnosed 2-degree Deep burns and 50% involvement. He was conscious, coherent with stable vitals. GCS-15/15.

Within 45 minutes, patient was shifted to OR and the major debridement and dressing was done. Post operatively he was kept in ICU separately from the other patients with adequate medical care with separate nurse. Proper isolation methods ensured that he would not contract Infections. Counselling sessions were conducted daily and feedback was taken from the patient's attendant. After one week of stay, surgeon identified that gangrene developed on little finger of his left hand and amputation was done. Major dressings were done regularly. He stayed in hospital for more than 15 days with proper nursing care. Two gratings were performed on him; first graft at Medicover Kakinada and second graft at Vizag after few weeks.

Patient recovered from such high degree of deep burns only with the collaborative work of plastic surgeon, critical care team and nursing staff. This case gave us ample opportunity to streamline CSSD and critical care services. The patient received multiple debridement and dressings in both ICU and room. The patient recovered well and discharged home after 20 days stay at hospital.

Discussion:

Electrical burns are different from other types of burns in that they typically affect less surface area. However, Complications and risks are much higher due to internal organ injury. Damaged tissue can cause complications like gaseous gangrene, ischaemic necrosis and loss of blood flow to limbs. The damaged body parts may need to be amputated. Repeated removal of the damaged tissue with dressings and debridement are common in the management. Limbs and fingers amputation rates reach as high as 75%. Burns treatment for severe wounds may require skin grafting, debridement, excision of dead tissue, and repair of damaged organs.



BURN ASSESSMENT

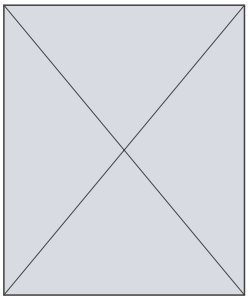
Assessment of burn depth

	Burn type			
	Superficial	Superficial dermal	Deep dermal	Full thickness
Bleeding on pin prick	Brisk	Brisk	Delayed	None
Sensation	Painful	Painful	Dull	None
Appearance	Red, glistening	Dry, whiter	Cherry red	Dry, white, leathery
Blanching to pressure	Yes, brisk return	Yes, slow return	No	No

Fig 1 : The figure depicts the course of electrical burn

Ultra-modular Operation Theatres

Contributor



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Surgical Case- Burst Abdomen

A 56-year-old female patient presented to ER with spontaneous abdominal burst and high-grade fever. History says she had severe abdominal discomfort for one month and treated at a private hospital in Vijayawada. She was diagnosed with urinary tract Infection and uremic encephalopathy. She stayed for 12 days and was managed conservatively.

After reaching home, she had an episode of vomiting. Later, she noticed evisceration of bowel loops through previous surgical scar. She was rushed to nearby well-known hospitals at Vijayawada and Eluru. Was denied treatment due to associated multiple co-morbid conditions and **Covid Positivity.**

She had a history of congenital heart disease and underwent open heart surgery for valve repair in 2010. Since then, she was on Acitrom tablet. She also had a history of two caesarean sections and operated for incisional hernia one year back.

On arrival:

She was dehydrated and dis-oriented,
Bp 100/60 mmHg, PR-130/minute, SPo2- 94% with room air, Resp. rate-30/mt. Temp-100*C

On examination, it was observed that she had eviscerated bowel loops in her lap with severe oedema, congestion and discolouration. Further evaluation was done and high-risk outcomes were explained to the patient. She was shifted to emergency operation theatre for surgery.

Intra-OP findings:

Showed oedematous bowels outside the abdomen with a loop formation. The following picture shows gangrenous intestine with colour change. Hence, it was resected and double barrel Ileostomy was performed as a first stage surgery.

Remaining intestines were placed inside the abdomen and a polystyrene cover was used as a layer to prevent protrusion of intestines.

She was shifted to ward and treated for covid. After her recovery from Covid, second stage operation was performed and colostomy was created. She was shown to a cardiologist for cardiac related issues. Now, she was stable.

After close observation for 2 months, final stage surgery was performed to close the colostomy and abdomen. Presently she is doing fine at her home.

DISCUSSION

All abdominal surgeries carry 33% risk of a post-operative incisional hernia. An incisional hernia occurs at or in close proximity to a surgical incision through which intestine protrudes. It results from weakening of the abdominal muscle due to surgical incision. The precipitating factors are individuals who participate in excessive or premature physical activity after surgery, gain excessive weight, continuous activity that results in raised abdominal pressure. Usually occurs within 3-6 months post-surgery but can happen at any time. Treatment modalities include herniorrhaphy and laparoscopic repair. In serious cases, like that of present patient, resection of gangrenous part, colostomy or end to end anastomosis are performed based on the complexity of the illness.

World Class Intensive Care Units

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Central airway Obstruction

Abstract

Central airway obstruction (CAO) refers to the obstruction of air flow in the trachea and mainstem bronchi. It is a potentially a life-threatening condition that can be due to a number of malignant and non-malignant processes.

The incidence of this disorder appears to be rising because of the epidemic of lung cancer. An estimated 20–30% of patients with lung cancer will develop complications associated with airway obstruction.

Management of these patients is difficult, but therapeutic and diagnostic tools are now available that are beneficial to most patients and almost all airway obstruction can be relieved expeditiously.

Obvious challenge is availability and accessibility to centres with these facilities. Though flexible bronchoscopy interventional services are fast expanding in our country, facilities with rigid bronchoscopy and therapeutic interventional procedures are lagging due to lack of expertise and technically sound interventional team.

Here we present a case of such central airway obstruction due to tracheal tumour, managed successfully at our centre- Medicover hospital, Kakinada.

A 38-year male came to our ER with symptoms of difficulty in breathing, cough, haemoptysis, difficulty in swallowing and feeling of chocking for 1 week.

He has history of squamous cell carcinoma oesophagus for which he underwent surgery and radiation 2yrs ago.

He was not a smoker or alcoholic.

on examination, he has been in respiratory distress with inspiratory stridor.

His general condition is poor and his psychological condition is very low.

Vitals at presentation:

BP- 100/60 mm of Hg, TEMP- 99'F, PR- 120/MIN

Respiratory Rate- 28/MIN, SPO2- 94% with room air.

Immediate CT scan chest done showed upper mediastinal growth around the oesophagus extending anteriorly causing near-complete occlusion of tracheal lumen (>80). ABG showed- Respiratory alkalosis.

He was admitted in ICU and started on NIV support, IV fluids and other supportive care. In view of advanced nature of the disease and bad prognostic signs, family had been counselled and clearly explained about the patient condition and expected outcome.

An immediate multi-disciplinary team discussion had been called for, including Surgical oncologist, Cardiothoracic surgeon, Radiation Oncologist, Medical Oncologist, Anaesthetist, Intensivist and Pulmonologist. After explaining the risk versus benefit of the planned procedure patient and his family decided to take aggressive approach and opted not to leave any stone unturned. The team decided to go ahead with Pulmonologist suggested Rigid Bronchoscopy guided debulking and stenting. At the same time, the benefits of possible improvements in breathing and extension of life for few more months were explained.

PROCEDURE:

After providing general Anaesthesia, patient's head positioned in" sniffing" position and intubated directly with rigid bronchoscope (Navitech, tracheoscope 14 mm O.D) under visualisation.

Trachea showed extrinsic luminal compression and tumor invasion into lumen causing near total occlusion of tracheal at mid-level. After injecting 1% Adrenaline peri-lesionally, mechanical debulking done by coring with rigid scope and tumor extracted in piece meal. Hemostasis secured by tamponade effect of tracheoscope. Electrocauterization of tumor base done. Near-normal patency of tracheal lumen achieved.

In view of extrinsic compression by the tumor, self-expandable metallic stent (otomed, fully covered, 16x 80 mm) deployed using flexible bronchoscope guidance through rigid scope.

Oxygenation was maintained with Intermittent positive pressure ventilation through a tube connected to one of the bronchoscope ports on one end and to Anaesthetic ventilator on the other end. Patient's condition remained stable throughout the procedure and his EtCO2 normalised immediately after stenting.

Figure 1 Stent after the insertion at Trachea and below

He gained consciousness and was extubated on table and could be maintained on oxygen support with nasal prongs.

Check-bronchoscopy was done the following day and showed well-positioned and expanded metallic stent in situ. Stridor and respiratory distress completely relieved and patient went home walking on his own.

In view of extensive tumor burden causing lymphedema and brachial plexus compression, he was advised palliative radiotherapy. He has been under follow up for 2 months with improved quality of life post-debulking and stenting.

Discussion:

The most common cause of MCAO is direct extension and invasion from an adjacent tumor, often bronchogenic carcinoma. Three basic types of MCAO have been widely described:

(I) Intrinsic or endoluminal obstruction: Airway lumen compromised purely by an endo-bronchial/tracheal obstructive tumor.

(II) Extrinsic or extraluminal obstruction: Airway compressed by an extra-bronchial/tracheal malignant process.

(III) Mixed obstruction: A combination of intraluminal and extraluminal airway obstruction.

MCAO not only carries a very poor prognosis if left untreated, but also results in significant daily life disturbances. Patients are often quite symptomatic with severely impaired quality of life. The symptomatology of MCAO is diverse and

nonspecific, with shortness of breath and cough being the most commonly reported symptoms. Other frequently reported symptoms include haemoptysis, hoarseness, chest discomfort, orthopnea, and dysphagia.

The management of MCAO is challenging and requires a multidisciplinary team approach with the involvement of a pulmonologist, medical and radiation oncologist, Anesthesiologist, ENT specialist, thoracic surgeon, and interventional pulmonologist. Surgery is often not indicated due to the advanced disease state or the patient's comorbidities.

Chemotherapy has inconsistent and delayed beneficial effects and radiotherapy often yields suboptimal results, with delayed atelectasis resolution obtained in only half of the cases.

Significant malignant airway obstruction presenting with severe respiratory distress requires immediate action to promptly and effectively re-establish and secure the airway as well as to relieve the obstruction.

Unfortunately, the majority of lung cancer patients present in advanced stages, either stage III or stage IV, therefore management is focused primarily on symptom palliation and quality of life improvement.

In patients with inoperable tumours of the central airway, restoration of airway patency provides palliation and may prolong life, especially in cases presenting with impending respiratory failure.

No established guideline exists for the management of MCAO. Several techniques are available for relieving the airway obstruction; the choice of which to use depends on the obstruction type, the patient's clinical condition, equipment availability and treating physician's expertise.

Consequently, the 2013 American College of Chest Physicians (ACCP) evidence-based clinical practice guidelines recommend that in patients with inoperable lung cancer and symptomatic airway obstruction, therapeutic bronchoscopy with mechanical or thermal ablation, brachytherapy, or stent placement, should be offered with the aim of improving dyspnoea, cough, haemoptysis, and quality of life.

Bronchoscopic therapy, performed via flexible or rigid bronchoscopy, results in an improvement in symptoms, quality of life, and survival. Both techniques may be complementary.

Rigid bronchoscopy offers excellent airway control. It is a safe and highly effective way of securing the airway while providing the capability to ventilate and oxygenate during diagnostic and therapeutic airway procedures.

Rigid bronchoscopy is considered by experts the modality of choice in patients with impending respiratory failure. It requires general anaesthesia and an operating theatre. Contraindications include those related to anaesthesia as well as complex anatomy of the neck and mandible (i.e., unstable cervical spine, oral or maxillofacial trauma)

Rigid bronchoscopy requires specialized training and as such it is underutilized.

Airway stents are prostheses of various materials used to support and maintain patency of the airway. Two types of stents (silicone and metallic/hybrid) are frequently used in the management of MCAO. Airway stents are best suited for extrinsic malignant compression. They are sometimes used to maintain airway patency after intrinsic or mixed endobronchial tumor ablation, or in cases of persistent airway narrowing. Stents deliver immediate and durable palliation, with symptomatic relief achieved in up to 84% of patients.

Tracheobronchial stents improve quality of life and survival in patients with advanced malignant obstruction. When used for prolonged periods of time, stents may develop significant complications. Reported complications include migration, infection, granulation tissue formation, halitosis, stent fracture, metal fatigue, perforation of vessels and airway wall, mucosal tears, and obstruction of lobar orifices.

Two retrospective studies showed improved palliation and improved survival after airway stenting in advanced lung cancer. Additionally, a recent prospective study showed that therapeutic bronchoscopy for MCAO significantly improved spirometry values (i.e., FVC, FEV1),

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Two retrospective studies showed improved palliation and improved survival after airway stenting in advanced lung cancer. Additionally, a recent prospective study showed that therapeutic bronchoscopy for MCAO significantly improved spirometry values (i.e., FVC, FEV1),

quality of life scores and overall survival. A recent report from the ACCP multi-centre registry study of therapeutic bronchoscopy for MCAO showed a very high technical success rate of more than 90%. The highest success rates were associated with stent placement and endobronchial obstruction.

A 48% clinical improvement in dyspnoea was reported, with 42% improvement in health-related quality of life scores. A more meaningful improvement was seen in those patients who had greater dyspnoea at baseline.

An overall complication rate of 3.9% (range, 0.9–11.7%) was seen after therapeutic bronchoscopy for MCAO. The risk factors identified for complications included emergent/urgent procedures, an ASA score >3, redo-therapeutic bronchoscopy and moderate sedation. A 14.8% 30-day mortality was described.

CONCLUSION:

In summary, Midline Central Airway Obstruction (MCAO) is an important disease entity which significantly impacts a patient's quality of life and can determine candidacy for systemic or surgical therapies. There are many minimally invasive broncho scopic interventions which can be used to relieve MCAO, resulting in rapid relief of symptoms, even in acutely ill patients.

Current modalities include a variety of thermal techniques, cryotherapy, mechanical debulking, airway dilation, and airway stent placement. Delayed therapies such as brachytherapy and photodynamic therapy are very useful in select cases.

Thorough working knowledge of the risks and benefits of each modality is critical when individualizing a patient's treatment plan. A team of experts including interventional pulmonologists and thoracic surgeons should be involved in these cases to reduce the risk with collaboration.

Contributor

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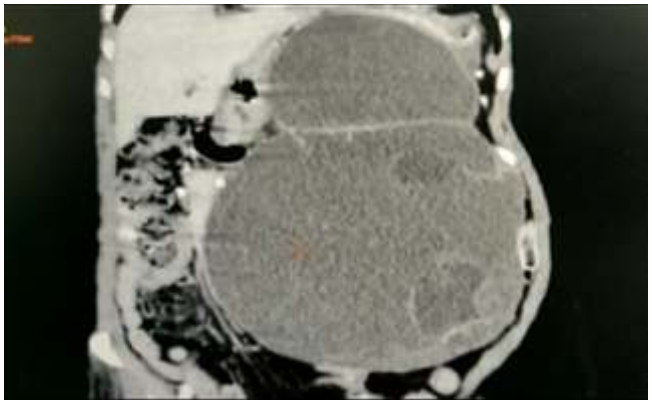
Retroperitoneal Mass

A 55-year-old female came to Medicover Kakinada with gross abdominal distension and breathlessness due to mechanical effect of the distended abdomen. On enquiring further, she was diagnosed to have large abdominal mass of inconclusive origin 4 years ago and she had history of recurrent Supraventricular Tachycardia episodes and was on treatment with medicines.

In view of old age and frailness, very large abdominal complex cystic mass of inconclusive origin, cardiac arrythmia - surgical treatment was deferred by most hospitals. Patient and her attendants lost hope of cure and went for alternative medicine but tumor size increased further in size, caused mechanical pressure effects and nutritionally deprived her.

She was admitted and optimised nutritionally. Once patient got better symptomatically, she was reviewed again with all her old reports and imaging data. At the request of patient's attendants, we proceeded with re-evaluation of mass for chance of operability. She was nutritionally compromised with severe malnutrition due to mechanical effects of tumor and tumor cachexia.

CECT abdomen with proper protocol performed, suggestive of large cystic mass of about 33x25 cm size which was extending from left dome of diaphragm to pelvis compressing all near-by structures and identified to be arising from distal body of pancreas probably mucinous cystadenoma of pancreas.



It was further confirmed by CA 19.9 - > 1000.

After thorough evaluation – patient's attendants were counselled about the possibility of resection. Explained very high risk of the procedure and the possible complications that can arise from such major surgeries. Patient attendants gave consent to proceed with surgery.

Patient was optimised -

- Nutritionally - started her on high protein diet with supplementary TPN for 1 week

- Cardiology team - optimised SVT medication and DVT prophylaxis

- Spirometry started to enhance lung capacity with moderate exercise as much as possible

After one week she was posted for surgery after getting all the clearances and arranging adequate blood products.

Exploration done - it was a large complex cystic mass replacing body of pancreas with compression of all surrounding organs with infiltration into splenic flexure mesocolon.

Radical Distal Pancreatico splenectomy done along with large mass and splenic flexure of colon resected and colo-colic anastomosis done. (In view of possibility of malignancy)

Figure 2- Resected Pancreatic mass

Patient tolerated procedure well with no significant haemodynamic changes and needed only one packed RBC transfusion intraoperatively.

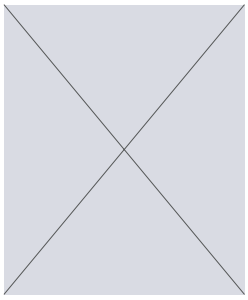
Patient shifted to ICU with minimal ionotropic supports and maintained for one day. She recovered well and was on mask ventilation with 2litres of oxygen for two days post-op. She was shifted to room on post-op day-3, started on oral diet. She was started on deep vein thrombosis prophylaxis and permissive spirometry post operatively.

On post-op day 5, she developed SVT with HR> 170 with hypotension- shifted to ICU and started on minimal supports and amiodarone infusion (under complete supervision of cardiology team)- recovered in few hours and her cardiac medicines were optimised.

Patient discharged on post-op day 8 in fully ambulating, orally tolerating condition.

This was one of the major procedures performed at Medicover, Kakinada. No reference of removal of such large pancreatic mass (33x25 cm) was found till date in medical literature.

Contributor



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Acitrom Induced Pseudo-obstruction: A Case Report

Abstract:

Bleeding is the most serious complication of oral anticoagulation in the prevention and treatment of thromoboembolic complications. Even after NOACs (Novel oral anticoagulants) discovery, Acitrom or Acenocoumarol is the most common oral anticoagulant used in practice. Here we present a case report of Acitrom causing bleeding into intestinal submucosa causing acute pseudo-obstruction.

Case Report:

A 70-yr old female presented with complaints of abdominal bloating, nausea, early satiety, haematuria, increased belching, severe generalized weakness since 3 days, constipation, b/l pedal oedema, abdominal pain and recurrent vomiting since 2 days.

She is a known case of Diabetic, Hypertensive, CRHD, status post PBMV and Atrial Fibrillation and was on Acitrom since 5 yrs. At the time of admission, she is Conscious and Coherent. BP: 170/70 mm Hg PR: 96/min, irregularly irregular rhythm, RR: 22/min RBS: 339 mg/dl. TEMP: 98.6°f, SpO2 : 98% at room air. CVS: S1, S2+ Mid diastolic murmur+. RS: BAE+, Clear airways. P/A: Diffuse vague tenderness+. CNS: NAD.

Lab evaluation shows – Hemogram is s/o microcytic hypochromic anaemia, relative neutrophilia. HbA1c is 8%. Renal function tests and Electrolytes were with in normal limits. CUE shows sugar 2+, protein 1+, plenty of RBC 's. INR is >100 [N -0.8 - 1.2].

CECT Abdomen done and is s/o Ill-defined non- enhancing hypodensity measuring 8.1 x 2.6 x 3.9 Cm (coronal x sagittal) was seen in endometrial cavity extending into the anterior and posterior wall myometrium, predominantly in the distal body and cervical region without extension into parametrium and vaginal suggestive of Carcinoma. 2D Echo study was s/o moderate mitral stenosis, EF – 52%, Atrial fibrillation. Cardiologist, Surgeon, Gastroenterologist and Gynaecologist consulted. Upper GI Endoscopy was done and suggested ulceration at GE junction, sub mucosal haemorrhages with oedematous mucosa at D1, Cap and D2 region with duodenal obstruction - Acitrom induced (Fig.1). She was kept on Nil by mouth.

Acitrom was withheld in view of high PT/INR. Vitamin K 10mg IV once in a day for 3 days was given. She was treated with empirical Antibiotics, Insulin, Cordarone, Metoprolol, Paracetamol, Proton pump inhibitors, IV fluids and Supportive measures.

She responded well to the above treatment and passed stools 2 days later. INR improved to 3.5 on day 3. Haematuria subsided. She was discharged in stable condition with advice to attend the surgical oncologist. Here, our patient was presented with clinical features suggestive of but radiological features not consistent with intestinal obstruction – making it atypical presentation.

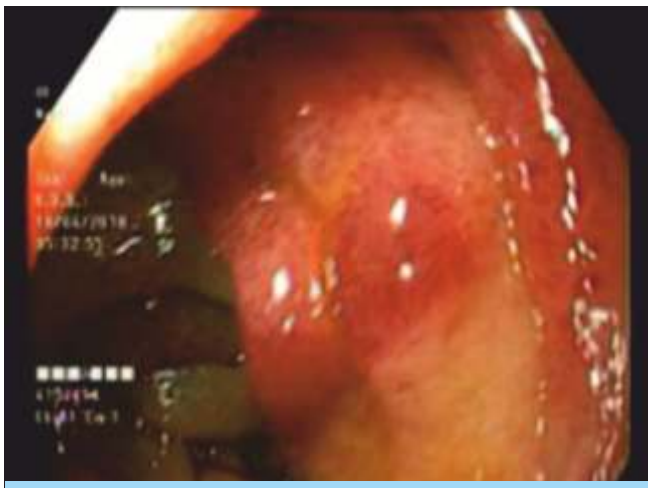

Fig.1 UGIE study shows submucosal haemorrhage with oedematous mucosa.

Acitrom Induced Pseudo-obstruction: A Case Report

Discussion:

Pseudo-obstruction can be Primary or idiopathic and Secondary1. It present in acute or chronic form. Clinical features are abdominal pain, distension, nausea, vomiting, constipation, or diarrhoea and obstipation. It often affects colon more than small intestine and duodenum. It arises from disordered gut motility and is more common in dysmotility states, such as diabetes, amyloidosis, and scleroderma.

Acute colonic pseudo-obstruction, also known as Ogilvie syndrome, most commonly affects the large intestine from the cecum to the splenic flexure. The exact pathophysiology is unknown, but it has been linked to dysregulation of the autonomic nervous system.

It is more common in men and patients over the ages of 60. It is commonly found in hospitalized patients after surgery or after a severe illness. Medications, metabolic imbalances, non-operative trauma, surgery, and cardiac disease have all been associated with intestinal pseudo-obstruction.

Chronic intestinal pseudo-obstruction is a more rare form of pseudo- obstruction. Autoimmune disorders like scleroderma, lupus etc, Porphyria, Disorders that affect nerves like Diabetes,

Parkinson's disease, Medications like Opiates, TCAs, Atropine etc, Paraneoplastic syndromes, Radiation treatment and some viral infections like EBV are known to cause Chronic intestinal pseudo-obstruction.

Pseudo-obstruction is diagnosed based on symptoms, clinical findings, and tests to rule out the presence of a mechanical obstruction. Drug-related pseudo-obstruction remains underreported, but is of importance in modern society where drugs are endemically abused. Thorough evaluation is needed to rule out mechanical obstruction and initial management includes bowel rest, nasogastric decompression, intravenous fluid resuscitation, and treatment of the underlying cause.

Acenocoumarol and the coumarin anticoagulants are structurally similar to vitamin K and competitively inhibit the enzyme vitamin K-epoxide reductase. Hence, they are called vitamin K antagonists.

Oral anticoagulation has become safer in recent years, especially if monitored regularly. Tolerability of Acenocoumarol was similar in younger and elderly population (aged >70 years), with Acenocoumarol being well-tolerated in both the populations. Caution is required especially in elderly patients to prevent bleeding complications and anticoagulation intensity should be closely monitored to reduce periods of overdosing.3 The INR should be reduced to a safe level (<5) if excessive increase in prothrombin time and/or INR occur without bleeding or prospective surgery. If serious bleeding is present, the INR should be reduced to 1 as soon as possible. If elective surgery or urgent surgery is required, the INR can be reduced to 1 to 1.5 at the time of surgery. INR can be reduced temporarily by withdrawing anticoagulant therapy and, if necessary, administering oral or parenteral vitamin K. When immediate restoration of clotting factors is necessary for serious overdose or life-threatening bleeding, transfusion of fresh frozen plasma or prothrombin (factor IX) complex concentrate along with vitamin K may be necessary.

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State of Art Technology Mri, Ct. pet-ct And All Oter Diagnostic Services

CT

MRI

PET-CT

Contributor

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Organophosphorus Poisoning

A 45-year-old female brought to emergency room hospital with history of OP poisoning. Apparently, she consumed chlorpyrifos poison on 02/05/2022 at her Residence. She was taken to nearby private hospital and got admitted.

Her sensorium started deteriorating on 5thMay. She was intubated and started on mechanical ventilation. She was brought to Medicover hospital Kakinada for further management. On examination, patient is in altered sensorium, agitated, irritable, moderately dehydrated, GCS – 11/15, E4M4V3, BP 140/100 mm Hg. Pulse rate-90 per minute. Respiratory rate-20 per minute, RBS 144mg /dl, temperature 98.6-degree F, SPO2 100% with room air. CVS - sinus tachycardia, Respiratory system and abdomen were normal. Pupil bilaterally 0.5mm dilated and sluggishly reacting to light. However, she was not able to move her both upper and lower limbs.

She was admitted in ICU after thorough evaluation. Serum electrolytes showed Hypernatremia and Hypokalaemia. D-dimer was 2,819ng FEU/ml. Serum Cholinesterase levels was low with 1,537U/L. All other reports were normal limits. During hospitalization she had an episode of generalized seizures, for which she was treated with Leviphil and phenytoin.

She developed both upper and lower limb neuropathy. Nerve condition studies (NCS) was done and diagnosed motor and sensory axonal neuropathy of both upper limbs and lower limbs. Venous doppler of both lower limbs showed thrombosis of right superficial, femoral popliteal and proximal posterior tibial vein for which Inj. heparin was started.

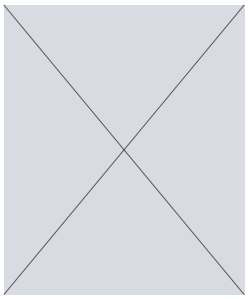
In view of prolonged ventilation, tracheostomy was done on 14th may. She was treated with atropine, PAN, empirical antibiotics, broncho dilator nebulization, IRON injections, PPIs, IV fluids, and supportive measures. Physiotherapy was done regularly. Antibiotics were changed according to Culture/Sensitivity patterns. Three units of PRBC transfused to treat anaemia. Ventilator gradually weaned off and kept on oxygen with mask ventilation. She responded well to the above treatment and symptoms improved, serum cholinesterase and potassium levels improved.

She returned to hospital for follow-up after a month for tracheostomy closure. She completely recovered and was able to walk without any support.

DISCUSSION

Organophosphorus compounds are widely used in agriculture, domestic pest control and chemical warfare. Pesticide self-poisoning accounts for one sixth to one eighth of world's suicide. OP pesticides inhibit cholinesterase enzyme leading to lost stimulation of

Contributors



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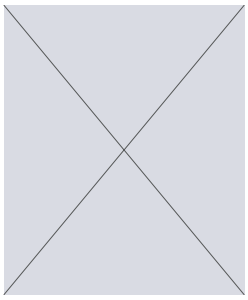

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Prevalence of second primary in oral cavity- squamous cell carcinoma of maxillary sinus.

A 65-year-old female patient presented with painless swelling in left zygomatic region for one month. However, according to her history, this patient was once already treated for a similar swelling in the same region six years ago.

H/o present illness: - She observed a swelling one month back and it was rapidly progressing in size and associated with intra-oral ulcers.

She was a known diabetic and smoker, and chewer for 15 years.

Past History: - Similar complaints were observed six years back for which she underwent Hemi mandibulectomy and reconstruction along with adjuvant Radio Therapy at Vizag for a primary developed at gingivo-buccal sulcus.

Clinical Examination:- Firm, fixed, swelling left zygomatic region measuring 9x7x4 cm with left submandibular and cervical lymphadenitis.
Intra-oral Examination: Ulcero-proliferative growth measuring 4 to 6 cm in dimension.
-Ulcer was covered with necrotic slough, purulent discharge. Bleeding was observed at the lesion.
-Intra-oral extension was evident the inferior medical wall of left maxillary sims.
-CT- Scan showed a lesion extending into left maxillary sinus and hard palate with the destruction of posterolateral wall medical wall and four as left maxillary antum, inferiorly extending into oral cavity.
-Patient was subjected for FNAC which was positive for malignancy and planned for composite resection and reconstruction.


Patient was subjected for **composite resection and reconstruction** done. The specimen was sent for Histo-pathological examination and it was confirmed as "Squamous cell carcinoma" of maxillary sinus.

-Patient recovered well and discharged home. Normally she would have needed RT. Since margins and nodes where negative Patient was kept on surveillance.

Figure 3&4- post-Op pictures

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Complete Hanging

A 29-year-old female allegedly attempted complete Hanging on 03.05.2022 @7pm at her home. She was found unconscious and not responded to any stimuli. Her husband started CPR for some time and shifted her to nearby hospital. There they continued CPR and intubated her. She was started on Inotropes and mechanical ventilation. She was referred to Medicover Kakinada for further management. On examination, patient was unconscious, not responding. No Pallor, icterus or cyanosis.

Cervical collar was applied to her neck and Endotracheal tube found In-situ. Hanging marks were observed on front side of her neck. Respiratory rate-30/minute, SPo2-90% on Bain's circuit, HR- 140/Mt, BP- 90/60 mmHg, GRBS- 290mg/dl. GCS- E1VetM2. Pupils bilaterally reacting to light, both eyes are open to pain full stimuli moments observed left upper limb, bilateral plantar extension reflexes were present de cerebrate. Diagnosis was decided as Spinal shock with Pulmonary oedema, and Cerebral Hypoxia. CT scan and other blood investigations were done. On Auscultation, bilateral crepitations present on both lungs. The diagnosis was Complete Hanging, Neurogenic Shock, Neurogenic pulmonary oedema, And hypoxic ischaemic injury and subsequently she developed lower respiratory tract Infection. She was connected to the ventilator with Volume control mode. Patient was treated with Levipil, Methyl prednisolone, Piptaz, Pantop, Dalacin, Mucomix nebulization, Glycopyrrolate, Midazolam, Amikacin, Metrogyl, Lasix, clexane and Noradrenaline infusion. CT-Brain suggested mild cerebral oedema and after two days patient started opening her eyes spontaneously and slowly started localizing. Vitals started improving and noradrenaline was reduced. CT-C spine reports suggested no fractures. However upper limb motor weakness continued and was more compared to lower limbs. Weaning off the mechanical ventilation was tried and could not continue on T-piece trial. In order to avoid Hypoxemia, ventilation was continued and Tracheostomy was done in view of prolonged ventilation. After one week of admission patient became conscious and obeying all commands, minimally moving all four limbs with good physiotherapy. On 8th day mechanical ventilation was stopped and kept on oxygen mask. After two days patient oxygen requirements were reduced and shifted to room.

A week later, Patient was discharged. In Follow-Up visits, she started walking and after 3 months she completely walked on her own without any support. The interesting point was her recovery and her ability to walk in very short time. It' startling to our critical care and treating physician because of her severe motor weakness that was there when she was presented to the hospital ER Dept. However, her grit and the fine work of the ICU and Physiotherapy team made her recovery faster.

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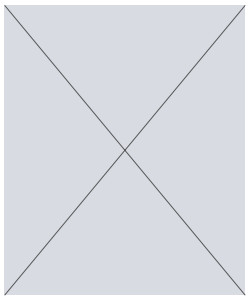

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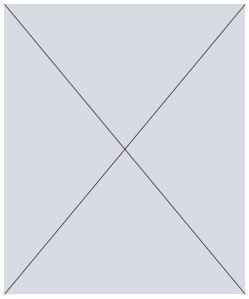

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Pelvic Acetabular fracture

Abstract:

The pelvic acetabulum injuries are rare injuries. Most displaced acetabular and pelvic fractures are appropriate for open reduction and internal fixation to restore anatomical reduction of the hip joint

Case report:

A 33-year-old male patient came to the hospital ER with history of runover by a lorry. He complained of pain, swelling, deformity at pelvic area, and not able to stand. After resuscitating and stabilizing the patient, x-rays and CT scan of the pelvis was done. He was found to have fracture of the pelvis and acetabulum. The observed findings in CT and X-ray were involvement of the roof of the acetabulum, the anterior column of the acetabulum and subluxation of the right hip and displaced fracture of the left superior and inferior pubic rami and Sacro-iliac joint injury left side and moralle devalle lesion of the back.

After stabilisation of the patient and secondary survey, the surgery was done after 1 week.

The pubic rami and the anterior column fracture of the acetabulum was approached through anterior ilioinguinal approach in supine position. The pubic rami fracture was stabilised using 8 holed plate and 7 screws. The anterior column of the acetabulum was stabilised with 10 holed plate and 7 screws.

The posterior wall fracture of the acetabulum was approached through the posterior kocher langenbach approach in prone position. The femoral head was found subluxed. The femoral head was reduced and posterior wall, and roof of the acetabulum was fixed with spring plate and buttress plate.

showing x-ray of pelvis involving fracture of the right acetabulum with anterior column, posterior wall, roof of the acetabulum fracture with dislocation of the femoral head and superior and inferior pubic rami of the left pelvis

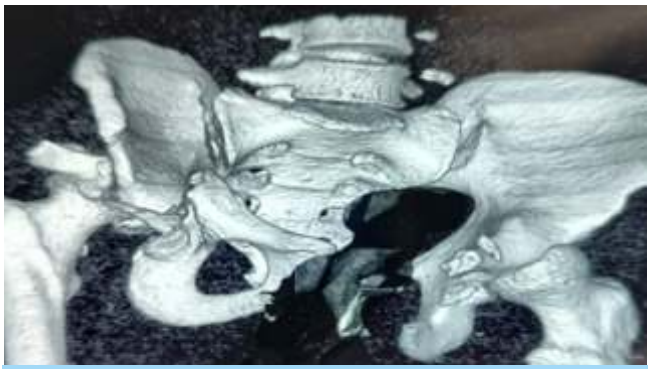


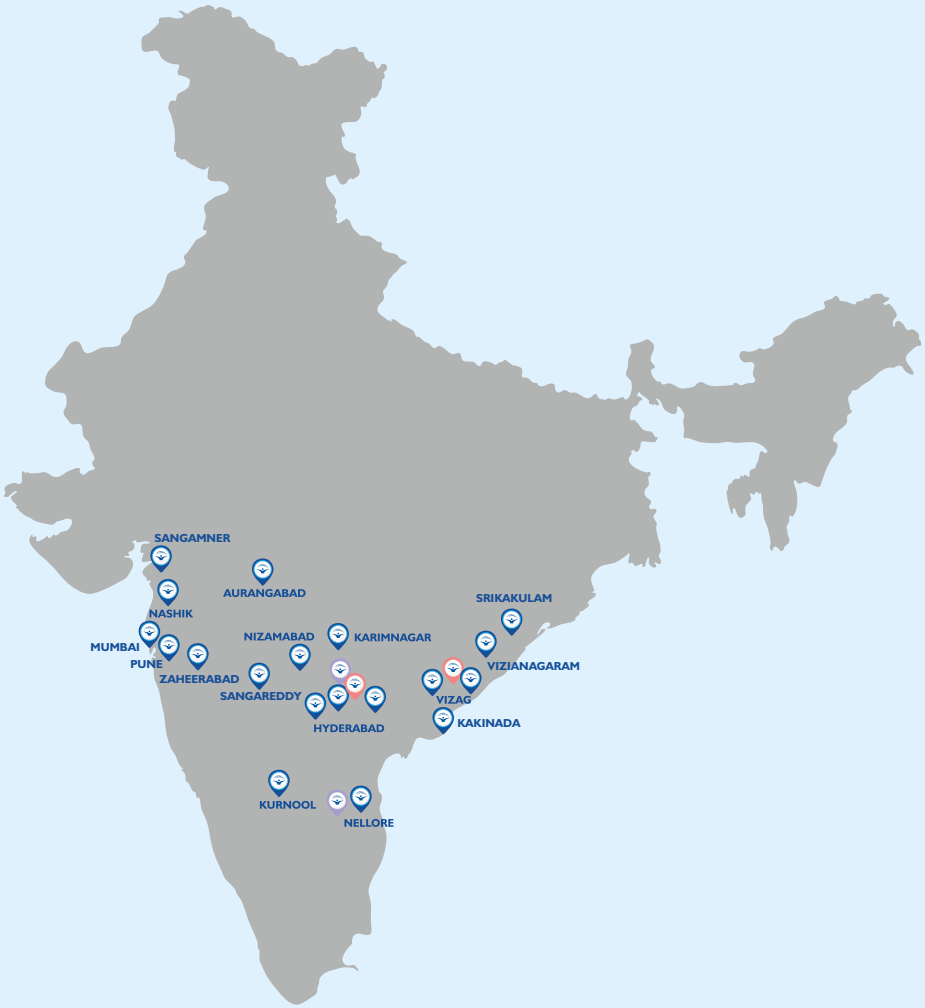
Figure 2 showing 3D CT scan of the pelvis

Figure 3 showing postoperative x-ray of the pelvis with internal fixation of the fractures

Conclusion:

The pelvic acetabulum injuries are rare injuries and difficult to operate. Careful planning of the surgery and open reduction, and perfect internal fixation are essential for good outcome of the patient. Its multidisciplinary work and involves clinical acumen with team work among orthopedics, Anesthesiologists and critical physicians. At our center, all the above departments worked hard to get the best outcomes.

Largest Emergency And Truauma Centre In The Resion



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