



Bapuji Education Association (R)

# SSIMS TIMES

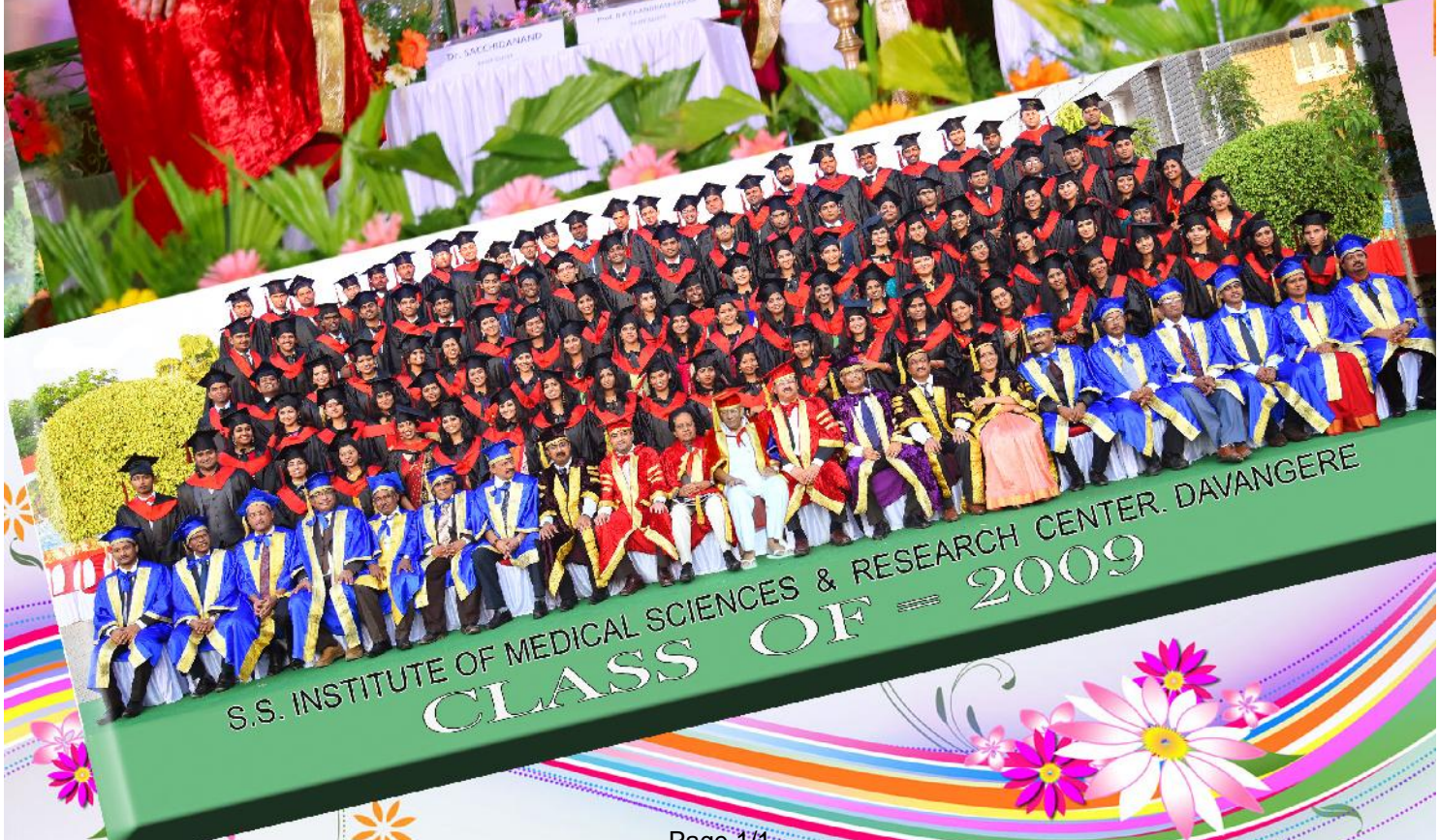


S.S. Institute of Medical Sciences & Research Centre,  
NH-4, Bypass Road, Davangere-577005

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**Republic Day -2015**



**Guest Lecture by Dr Rajashekhar, JNMC, Belgaum**

**Blood Donation Camp**



**Hearing Aid Distribution Programme**



**Guest Lecture**



**Youth Red Cross Activities**

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Views and opinions expressed in this newsletter are not directly that of the editor or the editorial board. For any clarification, author of the article is to be contacted.

## *Editorial*

### **Dear Colleagues**

Tuberculosis is second only to HIV/AIDS as the greatest killer worldwide due to a single infectious agent. It is a leading killer of HIV-positive people causing one fourth of all HIV-related deaths. It is unfortunate that in India even today one person dies every two minutes due to this menacing disease. WHO's End tuberculosis Strategy envisions a world free of Tuberculosis with zero deaths, disease and suffering. It set targets and outline actions for governments and partners to provide patient-centered care, pursue policies and systems that enable prevention, care and further innovations needed to end the epidemic and eliminate tuberculosis.

On World Tuberculosis Day 2015, WHO calls on governments, affected communities, civil society organizations, health-care providers, and international partners to join the drive to roll out this strategy and to reach, treat and cure all those who are ill today.

On the occasion of world tuberculosis day, health awareness programme were organized by Department of Community Medicine for the public. There was workshop on Tuberculosis during this occasion. It is the time to speed up our efforts to find, treat and cure all people with Tuberculosis.



***Dr. Sathisha Aithal***

*Editor*

## **REPORT : DEPARTMENTAL ACTIVITIES**

### **DEPARTMENT OF ANATOMY**

Dr.A.V.Angadi, Professor and Head, delivered a open hall lecture on “Body donation” and Dr.Veeresh Itagi, Assistant Professor on “Organ donation”, during body donation awareness and usefulness programme conducted on 10<sup>th</sup> January 2015, at Sri Shivakumaraswamy Mahamantapa, arranged by SHIVAGOSHTI in association with inner wheel Rotary Club, Taralabalu Badavane, Davangere.

First year M.B.B.S Students Ms.Meghana K.S and Ms. Jasna Karim have been

selected for short term studentship in the subject of Anatomy under ICMR Project.

### **DEPARTMENT OF COMMUNITY MEDICINE**

- Anti-Leprosy day observation at Primary Health Center, Lokikere on 30<sup>th</sup> January 2015. A health education programme for school children and teachers was organized.

Dr. Sharankumar Holyachi and Dr.Rachana, Assistant Professors, Dr.Sindhu, Post-graduate, Mr. Ashok, MSW and interns posted in the Department of Community Medicine, along with the Lokikere PHC staff participated in the programme. It was an interactive session where queries raised by the students and class teachers

were answered by the faculty and Interns.

Anti-Leprosy day observation at Urban Health Center, Bashanagar on 31<sup>st</sup> January 2015. Dr. Malatesh Undi and

Dr. Rachana, Assistant Professors and interns posted in the department of Community Medicine, participated in the health education programme.

- Workshop on “Disaster Prevention and management” was organized at First Grade Degree College, Davangere on 26<sup>th</sup> February 2015. Dr. Aswin Kumar, Dr. Malatesh Undi and Dr. Rachana, Assistant Professors, participated as resource persons in the programme.

Dr. B.A. Varadaraja Rao, Professor and Dr. Ravi Kumar, postgraduate student, coordinated the placement of overseas students from Medical School University of Scheffield, United Kingdom, under the SSC programme from 10<sup>th</sup> March 2015 to 31<sup>st</sup> March 2015. Students were trained in Community Medicine and allied subjects for a period of one month.

Interns posted in the department of Community Medicine performed a role play on Tuberculosis as part of World Tuberculosis Day observation conducted on 25<sup>th</sup> March 2015. Dr. Ratnaprabha and Dr. Sharankumar Holyachi, Assistant Professors, Dr. Yamuna and Dr. Sindhu, postgraduates, Mr. Ashok, MSW along with Lokikere PHC staff participated in the programme.

- Workshop for ASHA and ANM's on Tuberculosis was conducted at Primary Health Center, Lokikere as part of World Tuberculosis Day observation on 26<sup>th</sup> March 2015. An interactive training workshop was organized for Accredited Social Health Activists (ASHA's) and Auxiliary Nurse Mid-wives (ANM's) of Lokikere PHC area. Dr. Sharankumar Holyachi, Assistant Professor, Dr. Sindhu, Post-graduate, Mr. Ashok, MSW and interns posted in the department of Community Medicine along with the Lokikere PHC staff, participated in the programme.

## DEPARTMENT OF PAEDIATRICS

### Dr. N.K. Kalappanavar

Medical Director, Prof & Head

- Participated as national trainer during HOPE [Handling of office Pediatric Emergencies] meeting held at Bangalore on 3<sup>rd</sup> January 2015.

- Participated as faculty for a session on “Pneumonia in children” during '52<sup>nd</sup> National IAP Conference from 21<sup>st</sup> to 25<sup>th</sup> January 2015 held in New Delhi “Pneumonia in children” during '52<sup>nd</sup> National IAP Conference from 21<sup>st</sup> to 25<sup>th</sup> January 2015 held in New Delhi

Delivered talk on “Anaphylaxis and Paediatrics emergencies” during south zone TOT on Hope [Handling office Paediatrics emergencies] at Bangalore on 08<sup>th</sup> March 2015.

Moderated the panel discussion on “Approach to respiratory distress in children” during annual CME of Mangalore IAP on 15<sup>th</sup> March 2015.

### Dr. B.S. Prasad

Principal & Prof of Paediatrics

- Chief guest and spoke on “Application of Biotechnology in Medicine & Health Care” during Biotechnology workshop's closing ceremony function at BIET College, Davangere held on 24<sup>th</sup> January 2015.

- Coauthor for a research paper titled “Structural and functional outcome in premature babies with Retinopathy of Prematurity at 6 months follow up” and got published in volume 4, issue 4, 2015 of global journal of research analysis.



## DEPARTMENT OF PATHOLOGY

**12-01-15:** “Tips for better learning in pathology for Post Graduates”. PGs in Pathology were given tips on how to learn Pathology in better & interesting way. The meeting was addressed by Dr Md Shariff, Associate Professor in Pathology, Yenapoya Medical college, Mangalore along with Dr Atul Ranade, Assistant Professor of pathology, RCSM Govt Medical College, Kohlapur and Dr Suresh K K, Professor, Pathology, JJMMC, Davangere. All PGs of pathology and staff members attended the meeting.

**17-01-2015:** “Approach to liver biopsy” Guest lecture by Dr Sarada, Professor & Head, Dept of pathology, Trichy Medical college, Tamilnadu, for PGs in the dept of Pathology.

**02-02-2015:** KCIAPM conducted a slide seminar on 1-2-15. Dr Shweta Pai, 2<sup>nd</sup> year PG under the guidance of Dr Shashikala P presented a slide & won the best presenter award. Dr Laxmi Ronada, Dr Reddy Kavitha also attended the slide seminar held at API Bhavan, Vasant Nagar, Bangalore.

**04-02-2015:** Interdepartmental case discussion between the Department of Surgery & Pathology with a clinical diagnosis of Hollow viscous perforation with peritonitis with a final diagnosis of TB intestine was discussed. Dr Ganesh, 1st year postgraduate in surgery and Dr Kavita G U, Professor, Pathology presented the case.

**5<sup>th</sup> Feb to 7<sup>th</sup> Feb, 2015:** International CME in Pathology, Histopathology and Cytopathology held at Nursing college, Goa hosted by Goa Medical college. Poster was presented by Dr Chethan Sagar titled “Bethesda VI-A Thyroid malignancy a case report.”

**14<sup>th</sup> and 15<sup>th</sup> Feb, 2015:** IAC-KC conference 2015, 3rd annual conference held at Bellary, Dr Reddy Kavitha, 1<sup>st</sup> year PG presented a poster on

“ Cytological diagnosis of thyroid neoplasms- An experience”,

**27-02-2015:** A voluntary blood donation camp was organized by Jain college of engineering, Davangere in association with Indian Red Cross Society. A total of 138 units were collected. Dr Shashikala P, Prof and Head, SSIMS & RC, PGs Dr Ankur Majumder, Dr Chethan Sagar S, interns, paramedical staff attended the camp.

**03-03-2015:** A voluntary blood donation camp was organized by SSIMS & RC at Haveri with Youth Red cross. A total of 49 units were collected. PGs Dr Chethan Gowda, Dr Laxmi Ronada, interns Dr Devadatta Basu, Dr Nikhil, Dr Akash, paramedical staff Mr Nagabhushan Reddy, Mr Laxmipathy, Mrs Rathna attended the camp.

**20-03-2015:** Joint blood bank inspection was conducted by CDSCO, Bangalore and Drugs controller, Davangere. Mr Mahesh N A, Drug inspector CDSCO and Mr Manjunath conducted the inspection.

**25-03-2015:** Dr Shashikala P , Professor and Head, Dept of Pathology, SSIMS & RC conducted a CME on Dermatopathology titles “Dermopath primer 2015” at Bareilly, Uttar Pradesh organized by SRMSIMS college. She spoke in 2 sessions on Basic dermatopathology- Epidermis and lesions and also conducted a quiz and slide seminar for PG delegates. Dr Kavitha GU , Professor of Pathology also attended the CME and spoke on Histology of Dermis.



## DEPARTMENT OF DERMATOLOGY VENEREOLOGY & LEPROSY

Presentations at Indian association Dermatologists, Venereologists, &  
 Leprologists (IADVL) DERMACON 2015 at 12th to 15th Feb 2015 - Mangalore

SI No	Name of the Topic	Presentation	Name of Presenter	Name of the Guide/Other Authors	Venue & Date
1	DEATH WAITS FOR NONE: A RARE CASE OF NEONATAL PURPURA FULMINANS	E- POSTER	Dr. Harshavar Dhana K N	Dr. Jagannath Kumar V (Prof &HOD),	12th to 15th Feb 2015- Mangalore
2	GIANOTTI- CROSTI SYNDROME A REPORT OF THREE CASES				
3	A COMPARATIVE STUDY BETWEEN LEVAMISOLE WITH PUVASOL AND PUVASAL ALONE IN THE TREATMENT OF VITILIGO.				
4	A CLINIC-MYCOLOGICAL STUDY OF DERMATOPHYTOSIS IN A TERTIARY CARE CENTRE	ORAL	Dr. Harshavar Dhana K N	Dr. Jagannath Kumar V (Prof &HOD),	12th to 15th Feb 2015- Mangalore
1	URTICARIA PIGMENTOSA IN A CHILD RARE CASE REPORT	E- POSTER	Dr. Harika C	Dr. Jagannath Kumar V (Prof &HOD),	12th to 15th Feb 2015- Mangalore
2	ERYTHRODERMA: A STUDY OF ETIOLOGY , CLINICAL FEATURES AND HISTO- PATHOLOGY IN 15 CASES	E- POSTER	Dr. Harika C	Dr. Jagannath Kumar V (Prof &HOD),	12th to 15th Feb 2015- Mangalore
3	APLASIA CUTIS CONGENITA- RARE CASE REPORT	E- POSTER	Dr. Harika C	Dr. Jagannath Kumar V (Prof &HOD),	12th to 15th Feb 2015- Mangalore
4	COMPARATIVE STUDY OF THE VARIOUS TREATMENT MODALITIES FOR VERRUCA	E- POSTER	Dr. Harika C	Dr. Jagannath Kumar V (Prof &HOD),	12th to 15th Feb 2015- Mangalore
5	PLICA POLONICA IN A PATIENT WITH MAJOR DEPRESSION	E- POSTER	Dr. Harika C	Dr. Jagannath Kumar V (Prof &HOD),	12th to 15th Feb 2015- Mangalore
6	LATE ONSET LYMPHANGIOMA CIRCUMSCRIPTUM: FROGSPAWN ON THE SKIN.	E- POSTER	Dr. Harika C	Dr. Jagannath Kumar V (Prof &HOD),	12th to 15th Feb 2015- Mangalore
7	LEWANDOWSKY- LUTZ DYSPLASIA IN A RETRO POSITIVE INDIVIDUAL	E- POSTER	Dr. Harika C	Dr. Jagannath Kumar V (Prof &HOD),	12th to 15th Feb 2015- Mangalore

8	CLINICAL STUDY OF MORPHOLOGICAL VARIANTS AND PREVALENCE OF CO MORBIDITIES IN PSORIASIS.	E- POSTER	Dr.Harika C	Dr.Jagannath Kumar V (Prof &HOD),	12th to15th Feb 2015- Mangalore
1	A RARE PRESENTATION OF A NON-MELANOMA SKIN CANCER.	E- POSTER	Dr. Madhuri N	Dr.Jagannath Kumar V (Prof &HOD),	12th to15th Feb 2015- Mangalore
2	A CASE REPORT ON GIANNOTI CROSTI SYNDROME	E- POSTER			
3	A RETROSPECTIVE STUDY OF 119 SKIN BIOPSIES	E- POSTER			
4	A CASE OS PSEUDOXANTHOMA ELASTICUM: A RARE CASE REPORT	E- POSTER			
5	A CASE OF JOB'S SYNDROME: A RARE CASE REPORT	E- POSTER			
6	ALLERGIC CONTACT DERMATITIS TO KUMKUM: A CASE STUDY	E- POSTER			
1	CUTIS MARMORATA TELENGICTATICA CONGENITA IN AN ADOLESCENT MALE	E- POSTER	Dr.Harish M	Dr.Jagannath Kumar V (Prof &HOD),	12th to15th Feb 2015- Mangalore
2	HYPOMELANOSIS OF ITO IN A FEMALE CHILD	E- POSTER	Dr.Alekya P	Dr.Jagannath Kumar V (Prof &HOD),	12th to15th Feb 2015- Mangalore

## DEPARTMENT OF MEDICAL EDUCATION

13<sup>th</sup> Feb & 2<sup>nd</sup> & 3<sup>rd</sup> March 2015: Dr Renu Lohitashwa, Assistant professor, Department of Physiology attended the “Short course in Educational methodology” organized by College Development council, RGUHS, Bangalore. The course was conducted from February to April 2015 on distance learning

mode with contact programs & online assessment.

22-04-2015 : Guest lecture on “What ails modern medicine” (Was education appropriate) Speaker: Dr H B Rajashekhar M D. FRCP (Edinburgh), Sr Prof Emeritus, JNMC, Belgaum.



## YOUTH RED CROSS

22-01-2015: A voluntary blood donation camp held at Rajesh clinic, Harapanahalli, which was organized by SSIMS & RC and Indian Red Cross Society. A total of 45 units were collected. Blood bank officer, PGs Dr Udayshankar S K, Dr Laxmi Ronada, interns Dr Srusti, Dr Shruthi, Dr Dilip Kumar, Dr Nikhil, technicians Mr Ismail, Mr Karibasavaraju, nursing staff Mr Harish attended the camp.

23 to 24-1-2015: A first aid training programme was organized for students of TUV RHEINLAND NIFE ACADEMY PVT LTD. by youth red cross wing of SSIMSRC IN ASSOCIATION WITH Indian Red cross Davangere. Dr Shashikala P, Dr Aswin kumar, Dr Sharan kumar, Dr Ratna prabha, Dr Malatesh, Dr Rajeev swamy, Dr Kiran Shankar, Dr Ravikumar, Dr Uday attended and conducted the programme.

26-01-15: A voluntary blood donation camp was organized by Indian red cross society and SSIMS & RC at CCH, Davangere. Dr Shweta J H, Blood bank officer along with PGs Dr Chethan sagar S with 4 interns, technicians attended the camp. A total of 25 units of blood were collected.

13-02-2015: A voluntary blood donation camp was organized by JCI Kottur, in association with Indian Red Cross Society. A total of 33 units were collected. Blood bank officer along with Postgraduates Dr Udayshankar, Dr Reddy Kavitha, interns Dr Dilip, Dr Srusti, Dr Archana, paramedics Devraj, Laxmipathy attended the camp.

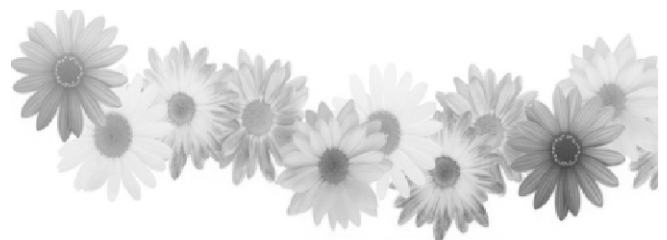
14-02-2015: A voluntary blood donation camp was organized by BIET, Davangere in association with Indian Red Cross Society. A total of 113 units were collected. Dr Shashikala P, Prof and Head, Pathology, SSIMS & RC, PGs Dr Chethan K, Dr Shwetha Pai, interns Dr

Santosh, Dr Akash, Dr Girish, paramedics Kotresh, Arun Kumar attended the camp.

10-03-2015: A voluntary blood donation camp was held at DRM science college, Davangere in association with SSIMS&RC. A total of 48 units were collected. Dr Shashikala P inaugurated the function and conducted the camp along with Dr Kavita GU, PGs Dr Reddy Kavitha, Dr Sujoy, interns Dr Dikshit, Dr Kishan, Dr Subhashini as well as paramedical staff.

## STUDENT SELECTED COMPONENT (SSC) PROGRAMME

Three students from Sheffield University, England (UK) Amogh Patil, Benjamin Cumberland and Alexandra Cannin visited our college under the Student Selected Component (SSC) programme. They were here for a period of one month 11-3-2015 to 10-4-2015. Department of Community Medicine along with Department of Paediatrics co-ordinated this programme. Dr. B .S. Prasad Professor and Director of Neonatology mentored this programme. Dr. B.A Vardaraja Rao Professor was chief coordinator of this programme along with Dr. Bheemayya Badesab Professor and Head, Department of Community Medicine . Dr. Latha Malur supervised the programme and Dr. Ravikumar, postgraduate student, department of Community Medicine was PG coordinator for this programme.. The students were also taken for field visit to places of public health importance as part of their training programme. An interaction programme was also organised for the benefit of our students on the last day of their visit.



**INFORMATIVE ARTICLE**

**HYPONATREMIA: THIAZIDE DIURETIC ARE THE CULPRIT**

Dr. K. SIDDAPPA, Professor,  
Dr. Peersab.K.Pinjar, Associate professor,  
Dr.Virupaksha .K.L, Assistant Professor,  
Dr.Harsha Vardhan,postgraduate,Department of  
general Medicine

Thiazide diuretics include all diuretics believed to have a primary action to inhibit NaCl reabsorption in the distal convoluted tubule and have been used in the management of hypertension. These agents decrease blood pressure (BP) when administered as monotherapy

- 1) Enhance the efficacy of other antihypertensive agents
- 2) Reduce hypertension related morbidity and mortality.

However, the use of thiazide diuretics is often limited by concerns about some metabolic change e.g; hyponatremia hypokalemia and insulin resistance. Virtually all cases of severe diuretic-induced hyponatremia have been due to a thiazide-type diuretic

**MECHANISM OF ACTION**

Thiazide diuretics inhibit NaCl reabsorption in the distal convoluted tubule, the main diluting site of the nephron. Thus, thiazide diuretics interfere with maximum dilution of urine because sodium (Na<sup>+</sup>) excretion is increased along with diminished free-water excretion. Loop diuretics inhibit NaCl reabsorption in the thick ascending limb of the loop of Henle. The reabsorption of NaCl without water in the medullary thick ascending limb is normally the primary step in the generation of the hypertonicity in the medullary interstitium, and loop diuretics mainly impair urinary concentration and limit water retention and development of hyponatremia.

**EPIDEMIOLOGY OF TIH**

Systolic Hypertension in the Elderly Program (SHEP), which focused on older patients, hyponatremia was observed in 4.1% of patients treated with chlorthalidone versus 1.3% in the control group. The risk factors of TIH are old age, women, reduced body Mass and concurrent use of other medications that impair water excretion.

**CLINICAL FEATURES OF**

**HYPONATREMIA, MILD (130-135 mmol/l)**

Anorexia, headache, nausea, vomiting, lethargy

**MODERATE (125-129 mmol/l)**

Personality changes, muscle cramps, muscular weakness, confusion, ataxia

**SEVERE (<125 mmol/l)**

Drowsiness, diminished reflexes, convulsions, coma, death

**CONTRIBUTORY FACTORS**

1. Excess free-water intake. Increased water intake, Low salt intake
2. Reduced free-water clearance, Reduced renal capacity to excrete free-water, Stimulation of vasopressin release, Ingestion of other drugs that impair free-water clearance
3. Renal Na<sup>+</sup> and/or K<sup>+</sup> loss

**PATHOGENESIS OF TIH**

Thiazide diuretic would not lead to hyponatremia unless impairment in water excretion exists. Thiazide diuretic do not inhibit concentrating ability. They do impair diluting ability in many ways.

- 1) They inhibit electrolyte transport at cortical diluting sites there by raising minimum urinary osmolarity
- 2) Reduces gfr and enhance reabsorption of sodium in proximal nephron diminishing fluid delivery to distal diluting sites resulting in water

retention independent of serum osmolarity

3) Thiazide induced volume depletion may also contribute to genesis of hyponatremia in some cases

**Data from Patients (n=14)**

Gender (M/F)	0/14
Age (years)	60-87
Serum Na <sup>+</sup> (mEq/L)	106-128
Serum osmolality (mOsm/kg)	221-256
Serum K <sup>+</sup> (mEq/L)	2.2-4.5
Serum Cl <sup>-</sup> (mEq/L)	70-86
Urine osmolality (mOsm/kg)	215-584
Urine Na <sup>+</sup> (mEq/L)	15-194
BUN (mg/dL)	7-18
Serum creatinine (mg/dL)	0.4-1.1
Serum uric acid (mg/dL)	1.5-4.9

**TREATMENT:**

The acute management of TIH is more determined by the presence or absence of neurologic symptoms than by the Na<sup>+</sup> level per se.

1) Discontinuing thiazides, regular diet (usually supplemented with K<sup>+</sup>), restricting water, administration of furosemide and either isotonic saline or, if the hyponatremia is severe or symptomatic, hypertonic saline.

2) In patients with hypovolemic TIH, in whom vasopressin secretion stimulated normal saline infusion is appropriate because it will restore volume and suppress vasopressin release.

In patients with severe manifestations such as seizures or coma, initiation of treatment with hypertonic saline to assure rapid onset of response is recommended. We treated our patients with TIH using either isotonic or 3% hypertonic saline.

In patients with euvolemia or hypervolemia-associated hyponatremia, who tend to have lower serum levels of uric acid, BUN, and

creatinine, normal saline will not restore free-water clearance or serum Na<sup>+</sup> concentration. In such patients, hypertonic saline will predictably raise serum Na<sup>+</sup> concentration and is preferable. Administration of furosemide in addition to the hypertonic saline can increase free-water clearance and thus hasten the increase of the serum Na<sup>+</sup> concentration while avoiding volume overload.

In asymptomatic or minimally symptomatic patients, stopping the offending diuretic and restricting water intake to <1 L/day is usually all that is needed

**PREVENTION OF TIH**

The first step is awareness that it can happen, particularly in the elderly, female, or small individuals.

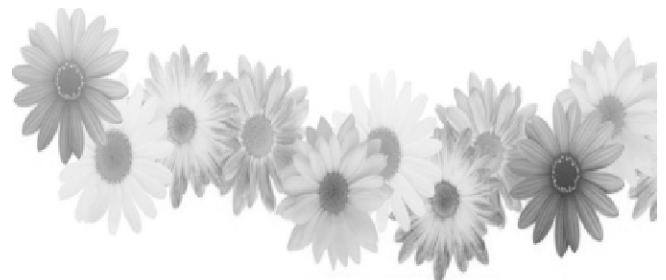
In susceptible individuals, the serum Na<sup>+</sup> may fall in hours of diuretic ingestion, and severe hyponatremia can develop within 2 days. Therefore in susceptible patients, serum Na<sup>+</sup> should be measured within one day after beginning therapy.

If the serum Na<sup>+</sup> level falls more than a few mEq/L, the diuretic should be stopped. If there is little or no change in the serum Na<sup>+</sup>, it should be rechecked 1-2 days later to be sure the level is stable.

Identifying patients with excessive fluid intake and counseling them to reduce their intake would be extremely helpful and cost-effective

When prescribing thiazides, low doses should be prescribed.

APPEAL:-To all my friends kindly judiciously use diuretics as anti hypertensives.



## CASE REPORTS

### Bronchoscopy for Lung collapse in the ICU

**Dr. Shiva Kumar K. P1, Dr. Kiran.B.R2, Dr. Priyanka3, Dr. Y. V .Rao3**

Associate Professor1, Assistant Professor2, Postgraduates3

Professor and Head of the department: **Dr. Arun Kumar Ajjappa**

Department of anaesthesiology, Critical Care and Pain medicine.

#### Abstract:

Fibro-optic bronchoscopy has become a common place procedure in ICUs. This article presents a case of a chronic bronchitis patient who had undergone awake fibro-optic bronchoscopy procedure, for retained secretions and atelectasis.

The patient was a 72-year-old man with history of difficulty in breathing and presented to the emergency department. He was then brought to the medical ICU. Over the next 6 hours, he developed progressive hypoxemia and CXR showed left lung collapse.

Emergent awake fibro-optic bronchoscopy was performed, and a large mucus plug obscuring the Left Upper Lobe bronchus and Left Lower Lobe bronchus was removed. Follow-up CXR after 6hrs demonstrated significant improvement and good oxygenation in arterial blood gas analysis. Later he was observed for two days and was discharged after rehabilitation.

This case report emphasis on improvement of patient with lung collapse after awake fibro-optic bronchoscopy in ICU patients.

#### Key words:

Retained secretions, Lung collapse, Fibro- optic bronchoscopy, significant lung improvement in CXR and good oxygenation in arterial blood gas analysis.

#### Introduction:

Lung collapse is a frequent complication seen in the ICU. Concern over prolonged lung collapse is that it may worsen hypoxemia through shunting and may predispose the patient to nosocomial pneumonia. Traditionally, the treatment of lung collapse in ICU patients has

focused on suctioning with adjuncts such as chest physiotherapy and bronchoscopy.

Recently, newer modalities such as kinetic beds, therapy with mucolytic agents, mechanical vibration therapy delivered through hand-held devices, and vests to manage lung collapse have been added to the physician's armamentarium. However, little research has been aimed at helping the practitioner choose among the incongruent therapies for their patients.

#### Case report:

Here was the patient aged about 72 years complained of fever and difficulty in breathing came to emergency medicine department. Emergency physician examined vitals like heart rate 110/min, BP 130/90, Spo2 90 percent. Nebulization given in casualty and patient was shifted to medical ICU with oxygen by face mask. In medical ICU after 6 hours patient suddenly developed breathlessness, oxygen saturation dropped down to 80 with 5 liters of oxygen and CXR showed left lung collapse.

#### PROCEDURE:

After patient attender written informed consent awake fibro- optic bronchoscopy done.

Preparation and procedure:

- Under strict aseptic conditions, 2ml of 4% lignocaine was injected trans-tracheally.
- Bilateral superior laryngeal nerve blocked using with 5ml of 2% lignocaine on each side.
- 10% lignocaine sprayed in each puff in tonsillar fossa and posterior pharyngeal wall.
- Mouth gag was placed and flexible fibre optic bronchoscope passed oral cavity and

glottis

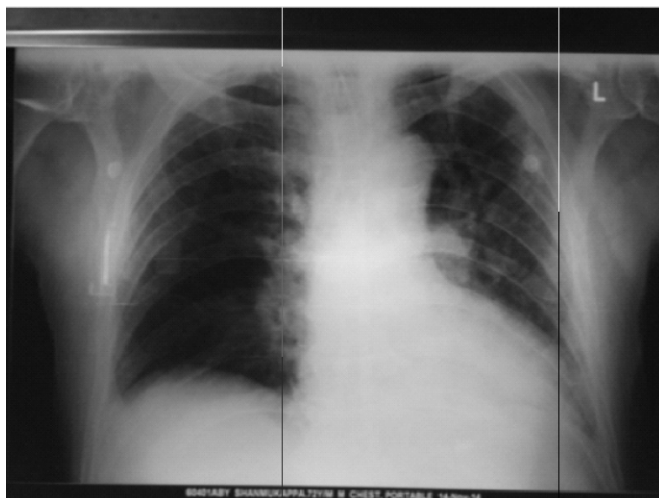
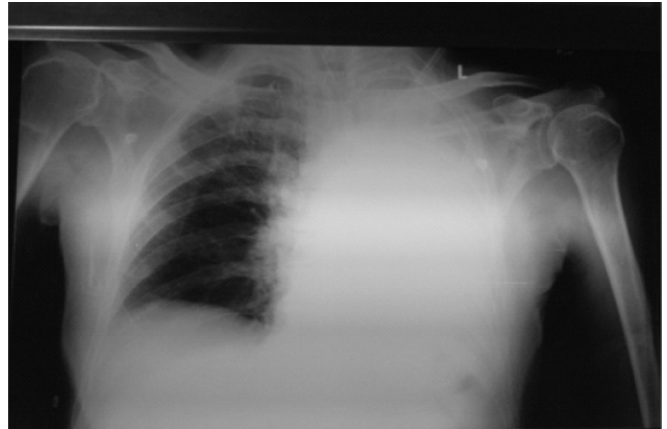
- Carina could be appreciated, then bronchoscope was passed further to left bronchus, there thick mucus secretions was found which was suctioned after flushing with 5ml of normal saline and sodium bicarbonate solution.

- Bronchoscope further proceeded towards lower lobe 2 bronchi appreciated and occluded with thick mucus secretions which were suctioned after flushing with 5ml of normal saline and sodium bicarbonate solution.

- As the bronchoscope was further proceeded patency of air way could be established

**Advised:**

- Propped up position
- 5 liters of oxygen by facemask.
- Injection hydrocortisone 100mg iv.
- Nebulization with budicort , asthalin and mucomix 4thhrly
- Withhold the feeding for 6 hrs.
- Chest X ray.
- Follow-up CXR after 6hrs demonstrated resolution of the atelectasis. His pulmonary status improved .Later observed for two days and then discharged to rehabilitation.
- Following bronchoscopy :



**Discussion:**

- The use of bronchoscopy for collapse and for clearing retained secretions has become common place in the ICU over the last 30 years. For example, in a review<sup>1</sup> of the bronchoscopies performed in the Mayo Clinic ICUs from 1985 to 1988, 90 of 179 (50%) had been performed for the resolution of atelectasis. Similarly, 188 of 297 bronchoscopies (63%) performed in the University of California Davis ICUs from 1979 to 1980 were for atelectasis resolution.<sup>2</sup>

- A study from 1974 by Lindholm and colleagues<sup>3</sup> investigated 52 patients who had undergone 71 fibro-optic bronchoscopy (FOB) procedures in ICUs in Sweden and Pittsburgh. Sixty-six percent of their patients were receiving mechanical ventilation at the time of the FOB, although no other patient information

the FOB, although no other patient information was provided. When secretions were seen on FOB, then 43 of 53 patients (81%) demonstrated improvement on the follow-up chest radiograph (CXR). If secretions were not seen on FOB, then only 4 of 18 patients (22%) demonstrated improvement.<sup>3</sup>

Snow and Lucas<sup>4</sup> documented their experiences in the surgical ICU of Case Western Reserve Hospital. They performed 76 bronchoscopies on 51 patients, with 35 performed due to lobar atelectasis and 8 performed due to sub segmental atelectasis. Those patients with lobar atelectasis fared significantly better, with 89% achieving resolution on follow-up CXR compared with 56% of those with subsegmental atelectasis.

**Conclusions and Recommendations:**

Bronchoscopy for atelectasis appears to be effective in patients who demonstrate lobar or segmental atelectasis. Drawing further conclusions about its use is not justified given the lack of consistency in study designs. There is not enough evidence to determine whether bronchoscopy is more effective than alternate mechanisms of airway clearance in the intubated ICU patient, as only Marini and colleagues directly compared bronchoscopy to an alternate method of clearance. Their study demonstrated that the results of bronchoscopy may be equivalent to those of an aggressive chest physiotherapy regimen.

Although bronchoscopy is a commonly performed procedure for the treatment of atelectasis in the ICU, the literature does not support its indiscriminate use. Success rates in the most favorable patient populations may reach 79 to 89%. However, those patients with subsegmental disease have significantly lower success rates that may not justify its use. Additional studies are needed to further delineate the proper role of bronchoscopy in the ICU.

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**A RARE CASE REPORT- ISOLATED UNILATERAL PULMONARY AGENESIS**

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**ABSTRACT:-** To bring into light the varied presentation of isolated unilateral pulmonary agenesis and its significance in routine clinical practice as they are often misdiagnosed as cases of pleural effusion and collapse. Diagnosis of this rare case as in our case alters the course of management as this condition is most often associated with other congenital anomalies (reportedly around 50%) and family history which have to be addressed.

**INTRODUCTION:-**

Pulmonary agenesis is a rare congenital anomaly and still rarer is it to be unilateral and isolated presentation without any associated anomaly. Most of the cases present in early infancy or in childhood with symptoms of shortness of breath. But its less likely to be asymptomatic till adult life and manifest as only few episodes of breathlessness in the adult age, which probably could be because of its sole

Manifestation of pulmonary agenesis and nothing else. Few cases of isolated unilateral pulmonary agenesis have been reported but most of them couldn't make it more than childhood. Surviving until adult age without any symptoms is a very rare presentation and has not been reported till now which gives a significant importance to our present case.

**CASE REPORT :-**

64yr male, ATHLETIC Winner in various running competition and other activities but had no symptoms till his adult age. Was admitted with the complaints of fever breathlessness and cough of 7 days duration , he was a known case of Type 2 Diabetes Mellitus on Oral Hypoglycaemic Agents and INSULIN. On routine investigation Blood and urine check up were normal ,CXR PA revealed right hemithoraxopacification which initially was thought to be due to pleural effusion secondary to TB and treated accordingly. Repeat CXR PA didnt show any resolution of the symptoms and clinically it was a picture of right sided fibrosis and collapse. In view of resolution of the symptoms but persistence of radiological picture a review with signs and pull of the trachea to the same side other differentials like pulmonary hypoplasia , agenesis were thought of . Following which pulmonary arteriogram was done which revealed absence of right pulmonary artery. Bronchogram revealed agenesis of the right lung and gross deviation of trachea to right side. Contrast entered into a blind pouch on right side at the level of tracheal bifurcation on bronchial pattern was not visualized further and left side was normal. Following which he was treated symptomatically with regular follow up as and when required.

**DISCUSSION:-**

Pulmonary agenesis is characterized by failure of development of lungs in utero. Various

etiologies have been hypothesized , one of them being abnormal blood flow in the dorsal aortic arch during 4th week of gestation. Other various etiologies that were proposed were abnormal thoracic cavity or abnormal fetal breathing movements or abnormal amniotic fluid volume or abnormalities of fetal lung and lung fluid pressure. Probability of overlap of all etiologies can be considered .

Presentation of the patients can be immediate difficulty in breathing with respiratory distress in form of cyanosis , intercostal recession with tachypnea , acid base disturbance and a well known VACTERL syndrome. In pulmonary agenesis the lung is absent as are bronchi , airways and pulmonary vasculature. The right and left sides are affected equally but the prognosis is worse if the right side is involved because of right is more lobed than left and also associated severe congenital malformations . The affected side has reduced volume and patients have homogenous opacification of the entire lung with mediastinal shift to the same side. Compensatory overinflation of the opposite lung and herniation are associated findings.

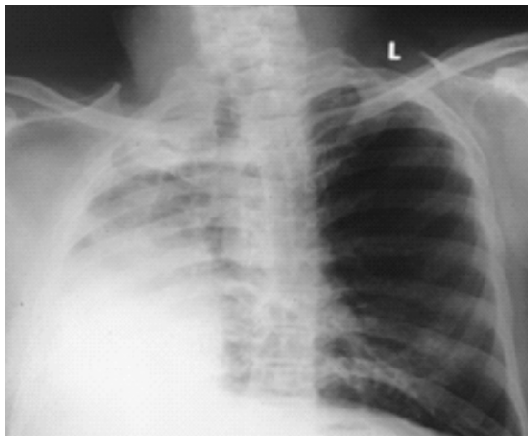
Primary isolated bilateral hypoplasia is rare and familial occurrence exceptional. Pulmonary agenesis is a rare congenital anomaly which occurs in 1 per 15000 pregnancies. Pulmonary hypertension complicates lung agenesis because of a combination of factors: normal blood volume passing through reduced lung tissue , hypoxemia leading pulmonary vasoconstriction and any associated left to right shunting cardiac lesion. Cardiac defects occur in 50% of patients . Pulmonary agenesis is differentiated from lung aplasia by the absence of the carina in the latter. Lung agenesis is less common than aplasia and about 75% of cases affect the left side and it is lethal in half of all patients.

Very few cases have been reported with Lung agenesis without any associated anomaly. As in our present case which is a isolated pulmonary

agenesis on the Right side , who is an athletic male , asymptomatic till adult life and found incidentally. There was no history of any frequent episodes of breathlessness or cough or other respiratory complaints ; nor was there any history of cyanotic spells in the childhood . Amazingly our present case was an athlete who was a winner of various athletic events and didn't have any respiratory complaints like shortness of breath on doing these activities. Uniqueness of the present case is that per se lung agenesis is rare and especially cases surviving till adult hood is still more rare occurring as an isolated variant without any associated anomaly. The importance of the present case also lies in that of considering the differential diagnosis of pulmonary agenesis in the patients presenting with right hemithorax opacity , which in routine practice a consideration of pulmonary agenesis has to be given. As in our case which was initially treated as pulmonary kochs and later as radiological findings didn't resolve and second thought was given for different differential diagnosis was sought.

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## TURMERIC CAN PREVENT HEART FAILURE

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Traditional Indian turmeric prevents heart failure, lowers cholesterol, prevents cancers and gall stones and augments scar formation in a wound. Studies from the University of Toronto's Cardiology Division and published in the Journal of Clinical Investigation have shown that curcumin, an ingredient in the curry spice turmeric, when given orally to a variety of mouse models with enlarged hearts (hypertrophy), could prevent and reverse hypertrophy, prevent heart failure, restore heart function and reduce scar formation.

In the studies, curcumin was given to rats, who then underwent surgery or received drugs designed to put them at risk of heart failure. The rats that received curcumin showed more resistance to heart failure and inflammation than comparison groups of rats that did not get curcumin. Curcumin treatment also reversed heart enlargement. Curcumin shortcircuited the heart enlargement process, though it is not clear how it did that.

The healing properties of turmeric have been wellknown. The herb has been used in traditional Indian medicine to reduce scar formation. For example, when there is a cut or a bruise, the home remedy is to reach for turmeric powder because it can help to heal without leaving a bad scar.

Curcumin has come under the scientific spotlight in recent years, with studies investigating its potential benefits for reducing cholesterol levels, improving cardiovascular health and fighting cancer.

As an herb, turmeric should to be taken 300 mg thrice daily with meals. It has useful actions like antioxidant, antiinflammatory, anti-rheumatic,



cholesterollowering, anti-cancer and prevention of gall stones. It is also found to be useful in situations like dysmenorrhea, dyspepsia, HIV, muscle soreness, peptic ulcer disease, scabies and uveitis.

Curcuminoids act as free radical scavengers. They also inhibit leukotrienes and synthesis of prostaglandins. The antiinflammatory activity has been claimed to be comparable to NSAIDs (such as indomethacin).

Curcuminoids lower blood lipid peroxides, decrease total cholesterol and LDL cholesterol, and increase HDL cholesterol. Turmeric has also been claimed to inhibit platelet aggregation.



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