JANUARY 2023

HealthNews DIGEST

Aster HOSPITALS & CLINICS
We'll Treat You Well

Dr. Sherbaz Bichu

CEO & Specialist Anaesthetist
Aster Hospitals & Clinics

As we leave behind 2022 and enter in 2023, the world coming back to its normal ways compared to where we were 2 years back. The future certainly looks brighter and healthier. While the healthcare community has always been respected for their contributions to the society, the world also witnessed their strength and courage in those testing times. We are all grateful that those difficult times seem to be behind us and now we can shift our focus back to providing value-based healthcare to our patients.

With the 5th edition of Aster HealthNews Digest going out, I want to thank all our doctors and medical professionals for their support this past year and hoping that they continue to do extraordinary and exemplary contributions in this year as well.

Wishing you all a very happy, healthy, and successful 2023.

Dr. Ramanathan V

Medical Director
Aster Hospitals & Clinics, UAE

Being the Medical Director at Aster Hospitals and a Paediatrics and Neonatology Consultant, I can very well understand and relate to the challenges that the doctors go through in their daily routines. Between OP clinics, scheduled surgeries, late night emergencies and reassuring patients, it is extremely difficult to take out time to draft multiple pages of cases with a single motive of sharing and imparting their clinical knowledge amongst their peers. I'm delighted that we have such doctors at Aster who share this goal and support us in our endeavour of sharing clinical knowledge through HealthNews Digest.

I welcome you all to the 5th edition of Aster HealthNews Digest and hope that it'll benefit all our readers in making better clinical decisions.

Happy 2023 to everyone!

Removal of Interlocking Nail Femur Implant

Successful Removal of 12-years-old Interlocking Nail Femur Implant at Aster Cedars Hospital, Jebel Ali

Dr. Hardik Pawar
Orthopaedics (Specialist)

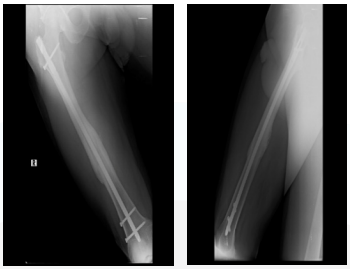
PRESENTATION

- 45 year old male
- History of surgery of right thigh femur 12 years back
- No family history of medical illness
- Admitted with:
  - On-off pain in the right thigh from past 6 months

FINDINGS

During Examination:

- Linear multiple healed surgical scars on right thigh and near knee joint lateral aspect
- Tenderness over right proximal femur and mild tenderness over knee supra patellar region
- Patient was limping due to pain



Pre-operative X-ray showing Femur anteroposterior and lateral views. Right United Fracture of Femur Shaft with Intramedullary Nail In Situ.

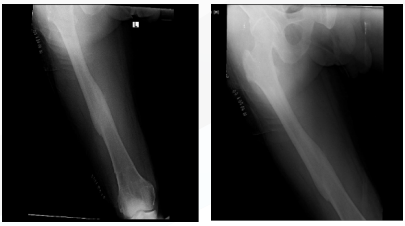
DURING PROCEDURE

- Under general anaesthesia, painting and draping was done in sterile manner.
- 4 cm incision was taken on lateral aspect of distal femur.
- Distal screws were removed first followed by proximal screws removal at around 7 cm of incision.
- Nail tip identified excessive callus around nail and was removed with osteotome.
- Nail was removed with nail extractor using conical bolt and extraction rod.

- Wound was washed and closed in layers.
- Sterile dressing was applied.

POST PROCEDURE

Patient tolerated the procedure well and post-surgery x-ray showed good results.
He was absolutely pain-free on the day of discharge and was able to walk comfortably post-surgery day 1.



Post-surgery x-ray

Removed Nail Femur Implant

DISCUSSION

Intramedullary nailing is the most common treatment for displaced diaphyseal fractures of the femur and tibia. Intramedullary nails used for fixation of femoral fractures may require removal for a variety of reasons. Some recommend that all such nails should be removed after fracture healing, whereas others prefer to remove only those that cause symptoms. [1,2,3]

Regardless of the reason, removal of an intact femoral nail can be difficult and time-consuming.

Pre-operative planning and evaluation is necessary for this surgery. Specific removal surgeries are difficult to enumerate. We have found a new universal extraction tool (TraumaCare LLC) that allows safe, quick, easy, and predictable removal of Unbroken Ante Grade Femoral Nails.

This tool contains screw extraction set and universal nail extractor kit with different sizes of conical bolts and extraction rod with slotted hammer.

These are very helpful for successful removal of nail and interlocking bolts.

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Atopic Dermatitis (Eczema)

A complex case of Adult Atopic Dermatitis (Eczema) treated with IL-13 Inhibitor effectively at Aster Clinic, Al Qusais, Dubai

Dr. Nameer Abdul Majeed
Specialist Dermatology / Cosmetology
Aster Clinic, Al Qusais (Damascus St.)

PRESENTATION

- 22 year old male
- Multiple well-defined scaly plaques on extremities and trunk
- Severe body itch with scaling
- Tendency to bleeding and pain following excoriation
- Generalized xerosis skin
- Complaints of sleep deprivation, irritability, and depression

FINDINGS

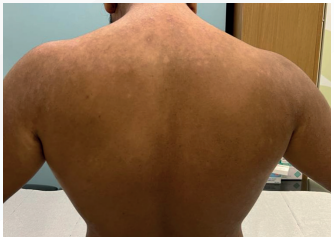
During Examination:

- Severe generalized xerosis, widespread eczematous, erythematous scaly lesions over back, chest and extremities associated with excoriations
- BSA (Body Surface Area) – 15% involvement
- EASI (Eczema Area and Severity Index) – 22 (EASI is an investigator tool used to measure the extent (area) and severity of atopic dermatitis. EASI-75 is a 75% improvement in this score from the start of the trial).
- IGA (Investigator's Global Assessment) – 3 (IGA is a tool used to provide a clinical trial investigator rating of overall disease severity at a particular time point)

Baseline Images:

Chest


Lower Extremities




Trunk, Back

TREATMENT

IL-13 inhibitor was given as an initial dose of 600 mg subcutaneous followed by 300 mg administered every other week. These are available as pre-filled injections.

Before and after images of Clinical Progress after 14 weeks of treatment


Chest



Lower Extremities


Trunk, Back

SUMMARY

- Tralokinumab was well tolerated with no ocular complaints and no lab monitoring was required
- Overall reduction of itch after 3 weeks
- EASI-75 achieved by week 8
- No specific complications after loading dose
- Real clinical practice revealed that remarkable improvement in Atopic Dermatitis signs and symptoms achieved at week 14 could be maintained despite stopping the medication

DISCUSSION

Atopic Dermatitis, also called Atopic Eczema, the most common inflammatory skin disease worldwide, presents as generalized skin dryness, itch, and rash.

Approximately 230 million people around the world have atopic dermatitis and the lifetime prevalence is >15% especially in wealthier countries.

It typically affects people with an 'atopic tendency' clustering with hay fever, asthma, and food allergies. All races can be affected; some races are more susceptible to developing atopic dermatitis, and genetic studies are showing marked diversity of the condition's extent (heterogeneity) between populations.

Atopic dermatitis usually starts in infancy, affecting up to 20% of children. Approximately 80% of children affected develop it before the age of 6 years. All ages can be affected.

Although it can settle in late childhood and adolescence, the prevalence in young adults up to 26 years of age is still 15–5%.

Atopic dermatitis results from a complex interplay between environmental and genetic factors. The symptoms can appear anywhere on the body and vary widely from person to person.

It is a chronic, inflammatory skin disease characterized by intense itch and eczematous lesions, that can result in skin barrier dysfunction and immune dysregulation.

Research has shown that moderate-to-severe atopic dermatitis can take a physical, psychosocial, and emotional toll on patients, and there is a significant unmet need for well-tolerated and effective treatments.

Tralokinumab is a high affinity, human monoclonal antibody developed to specifically bind to and inhibit the interleukin (IL)-13 cytokine, which plays an important role in the immune and inflammatory processes underlying atopic dermatitis symptoms. It is the latest biologic injectable approved for the treatment of atopic dermatitis in the UAE. Since it's a human monoclonal antibody, there are less chances of developing auto antibodies and resistance to the drug.

The majority of patients who saw benefit from Tralokinumab at 16 weeks showed considerable improvement in all 3 scores (BSA, EASI and IGA) and maintained their response at 52 weeks with continued Tralokinumab dosing.

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Glue VenaSeal Closure for Varicose Vein

Painful Varicose Veins of Bilateral Lower Extremities treated with Glue VenaSeal Closure successfully at Aster Hospital, Al Qusais

Dr Senthilnathan T.T.
Vascular Surgery (Specialist)

PRESENTATION

CASE 1

- 53 year old male
- Medical history of Varicosities in both lower limbs for one year
- Admitted with:
  - Severe pain and swelling in both lower limbs
  - Varicose veins with complications (tortuous veins, blackening hyperpigmentation, bleeding venous ulcer)

CASE 2

- 34 year old male
- No medical history
- No family history of medical illness
- Admitted with:
  - Severe pain and swelling in both lower limbs
  - Varicose veins with complications (tortuous veins, blackening hyperpigmentation)

FINDINGS

During Examination:

CASE 1

- Tender and tense legs
- Hyperpigmented gaiter area
- Varicose veins with Lipodermatosclerosis
- Bleeding venous ulcer of size 3x4cm in medial malleolar gaiter area)

CASE 2

- Tender and tense legs
- Varicose veins with incompetent perforators

Pre-operative images showing venous ulcer and hyperpigmentation

DURING PROCEDURE

- Under general anesthesia, with ultrasound guidance, access was taken by making a puncture in the Great Saphenous Vein (GSV) with 18G Needle and 7F sheath was inserted in both the legs.
- Gun with glue VenaSeal catheter system was kept ready.
- The catheter was kept 5 cms away from the sapheno-femoral (SF) junction and the gun was shot to deliver the glue into the GSV sequentially to perform the VenaSeal closure on both the lower limbs.
- Additionally, Stab Avulsion Phlebectomy procedure was also performed on the incompetent perforators of both legs.

Gun with Glue VenaSeal Catheter System to perform the Closure

POST PROCEDURE

Patient tolerated the procedure well, mobilized and discharged on the same day. Advised for follow-up visit post 48 hours of treatment for first-time dressing change.

DISCUSSION

The Glue VenaSeal closure system is a non-thermal, minimally invasive procedure to treat superficial venous insufficiency. This glue is widely used in the vascular system to seal the varicose veins without washout. The glue's high viscosity and rapid polymerization help in the sealing process, induce inflammation and results in long-term fibrotic occlusion. No heat gets generated; hence, no tumescent is required for the procedure. The vein glue closure system has documented high anatomic success and closure rates. The procedure is comfortable and results in less bruising in comparison to other methods like RF Ablation and Laser Ablation.

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Two Wandering Fibroids

An Interesting Case of Laparoscopic Removal of Two Wandering Fibroids at Aster Hospital, Mankhool

Dr. Sejal Devendra Surti
Laparoscopic Gynaecology (Specialist)

PRESENTATION

- 42 year old female
- Medical history of laparoscopic myomectomy and breast cyst removal
- No family history of medical illness
- Admitted with:
  - Complaints of lower abdominal pain and mass in the umbilical region with pain for 2 months
  - Regular cycles with severe dysmenorrhea and passage of clots
  - P1L1 patient with lower segment cesarean section delivery, 22 years ago

FINDINGS

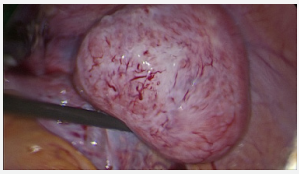
During Examination:

- Swelling in umbilical area – 2x1 cm
- Bulky uterus
- Ultrasound showed 45x34 mm broad ligament fibroid with scar endometriosis
- MRI advised diffuse adenomyosis, fibroids and scar endometriosis

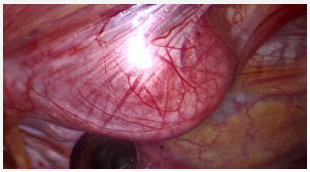
DURING PROCEDURE

The patient underwent laparoscopic hysterectomy, bilateral salpingectomy, and removal of fibroids under General Anesthesia.

- On laparoscopy, findings noted: Uterus bulky, fibroid of 4x4 cm was found in the lateral wall of right iliac region with 3x3 cm lobulated fibroid in the infraumbilical region.
- A stepwise hysterectomy was performed.
- The right iliac region fibroid was removed, and specimens were removed from the vagina.
- A small skin incision was made in the infraumbilical region and myoma was removed.



Fibroid in the Right Iliac Region



Fibroid in the Umbilical Region

POST PROCEDURE

The patient tolerated the procedure well and was in a stable and satisfactory condition at the time of discharge.

DISCUSSION

Uterine Fibroid is one of the most common benign tumors seen in women, with a prevalence of 4.5 to 68%. The International Federation of Gynaecology and Obstetrics (FIGO) leiomyoma classification system classifies fibroids into eight subtypes. Type-8 is the subtype that recognizes the parasitic fibroid as an extra-uterine variant. These fibroids do not have any direct attachment to the uterus, and they receive auxiliary vascular supply from other abdominopelvic structures to which they get attached.

Parasitic fibroid can be primary, secondary, or iatrogenic. Kelly and Cullens made the first reference to parasitic fibroid in 1909. There are hypotheses regarding the pathogenesis of this rare clinical condition. One theory says these parasitic fibroids are detached pedunculated subserous fibroids that wander off and are attached to non-uterine tissues. Hence, they are also named wandering fibroids.

Another theory suggests that parasitic fibroids occur due to iatrogenic seeding of leftover tissue of the fibroids during myomectomy or hysterectomy, especially during morcellation.

Another rare condition is Leiomyomatosis Peritonealis Disseminata (LPD), in which multiple leiomyomas get implanted on the peritoneal surface. Usually, these parasitic fibroids are asymptomatic or have pressure-related symptoms. They create a dilemma for the clinicians because of the rarity of this atypical condition. A detailed medical history and radiological investigations would help to reach the correct diagnosis. The management of the parasitic fibroid is usually surgical, either by laparoscopy or open surgery.

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Dr. Abdul Rehman
General & Laparoscopic Surgery (Specialist)

Dr. Manish Srinivasa Murthy
Anaesthesia (Specialist)

Diaphragmatic Hernia

Laparoscopic Management of Adult Diaphragmatic Hernia, A Rare and Technically Challenging Case at Aster Hospital, Al Qusais

CASE REPORT

A 33 year old female presented with progressive shortness of breath of 2 months duration and her symptoms worsened on lying down. She had recovered from Covid-19, 6 months back. She was evaluated by the physician with a CT scan that suggested a posterolateral diaphragmatic hernia.

CT scan showing herniation of omental fat and large bowel through a posterolateral diaphragmatic defect with collapse of left lower lobe of lung.

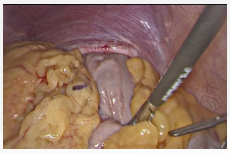
PRE-OPERATIVE EVALUATION

The patient was evaluated by a team of pulmonologist, cardiologist, and anesthetist for fitness for laparoscopic surgery, in view of the collapse of the left lower lobe and possible hemodynamic changes during pneumoperitoneum. Team headed by Dr. Manish Srinivasa Murthy (Anesthetist) opted for double lung ventilation approach after careful consideration.

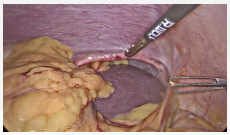
INTRA-OPERATIVE PROCEDURE

During laparoscopy, it was noticed that there was 5x5cm posterolateral defect with the left hemidiaphragm with entire transverse colon, splenic flexure, descending colon, greater omentum, upper pole of spleen as contents. The contents were gently replaced into the abdominal cavity from the thoracic cavity after releasing the omental adhesions. Since the diaphragm was deficient posteriorly, we had to mobilize the diaphragmatic attachments to the prevertebral muscles. The defect was closed with sutures and a dual layered of 12 cm mesh was placed. Left sided chest drain

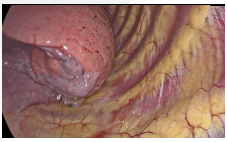
was placed to ensure adequate lung expansion.



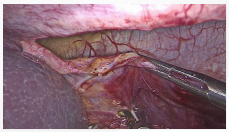
Intraoperative pic showing reduction of colon from the thoracic cavity



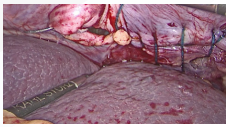
Intraoperative pic showing upper pole of spleen herniating into the thoracic cavity



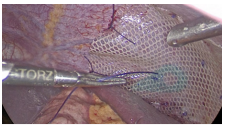
Intraoperative pic showing left lung via the defect



Intraoperative pic showing mobilization of the posterior muscular attachments of the left hemidiaphragm



Intraoperative pic showing closure of the defect with intracorporeal suturing



Intraoperative pic showing placement of composite mesh over the defect

POST PROCEDURE

Patient was started on orals on 1st POD and actively mobilized. Chest x-ray done on 3rd POD confirmed lung expansion. The ICD was removed, and patient was discharged on the same day. Chest X-ray done after 6 weeks of surgery showed no recurrence and the patient was comfortable.

Chest X-ray after 6 weeks of surgery showing no recurrence

DISCUSSION

Diaphragmatic Hernias can be congenital or acquired. Congenital variety results when there is incomplete formation of the diaphragm during embryogenesis, with an incidence of 1 in 2500 births and usually present early in life. Adult diaphragmatic hernia is mostly acquired and usually result from a direct penetrating injury, or blunt abdominal trauma such as road traffic accidents or falls. Exact cause of diaphragmatic hernia in this case is unclear, although there have been case reports of diaphragmatic hernia after covid pneumonia. (1)

The pathophysiology of acquired diaphragmatic hernias includes circulatory and respiratory depression secondary to decreased function of the diaphragm, intrathoracic abdominal contents leading to compression of the lungs, shifting of the mediastinum, and cardiac compromise. These should always be repaired.

Minimally invasive techniques for diaphragmatic repair are recommended especially with advances in technology and surgical skills. It is possible with laparoscopic, thoracoscopic, robotic-assisted or combined approaches. However, the success of these minimally invasive approaches is highly surgeon-dependent, and laparotomy remains more common in this setting.

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