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HealthNews DIGEST

Aster HOSPITALS & CLINICS

We'll Treat You Well

Dr. Sherbaz Bichu

CEO & Specialist Anaesthetist
Aster Hospitals & Clinics

On behalf of Aster's leadership, I welcome you to the 2nd edition of the HealthNews Digest following the overwhelming response we received on the launch edition. I would like to thank and applaud all our doctors at Aster Hospitals and Clinics, who have not only delivered world-class patient care and excellent clinical outcomes but also taken out time to share their knowledge and experience with fellow practitioners.

The wide spectrum of cases highlighted in this series would act as the key medium for the convergence of clinical best practices and would further strengthen our efforts toward providing affordable, accessible, and quality care to everyone. In that direction, I encourage all our doctor fraternities to keep up the extraordinary feats in the field of medical science and to further bolster contributions to the upcoming releases of HealthNews Digest.

Dr. Ramanathan V

Medical Director
Aster Hospitals & Clinics, UAE

As the Medical Director for Aster Hospitals and Clinics, I am elated to note that the initiative to extend clinical knowledge and experience through HealthNews Digest has seen tremendous acceptance among Aster doctors and our external clinical partners alike.

I believe that medical science has made such giant strides today that it is no longer possible for doctors to practice in isolation. It is valid more today than ever before that only through collaboration and knowledge sharing can doctors provide the most advanced patient care, and platforms such as HealthNews Digest play a pivotal role in that respect.

I would like to thank everyone who has come forward and am confident that the outstanding teams of Aster doctors and our external clinical partners would continue to enthusiastically support the initiative by sharing their expertise both in terms of ensuring clinical excellence and the best possible patient care.

Replantation of Traumatic Fingers

Successful replantation of traumatic amputation of index and middle finger at Aster Hospital, Al Qusais

Dr. Rajkumar Ramachandran
Plastic Surgery (Specialist)

PRESENTATION

- 25 year old male
- No medical history
- Occupation: Chef
- Admitted with:
  - Complete amputation of index and middle fingers of right hand by noodles cutting machine
  - Acute pain and bleeding due to trauma at the injured site
  - Amputated fingers brought in the ice pack

FINDINGS

During Examination:

- Patient was found conscious and oriented with stable vitals
- Right index finger was found to be amputated at the DIP Joint level (Tamai zone 3) and middle finger amputated at Trans distal phalangeal level (Tamai zone 2)

PROCEDURE

- After resuscitation, patient was shifted to OT immediately for Surgery. Dissection was performed and the injured structures in the amputated fingers were identified under operating microscope.
- The structures identified in the index finger were flexor, extensor tendons, bone and pairs of digital arteries, digital nerves, and dorsal digital veins.
- Similar structures were identified in the middle finger as well, except for the dorsal veins since the injury was distal to the formation of digital veins.
- Patient was anesthetized. The counterparts of the above-mentioned structures were identified and tagged.
- Index finger was replanted in the following sequence:
  1. Bone was fixed with K wire
  2. Flexor and extensor tendons were repaired
  3. Digital arteries, veins and nerves were micro-anastomosed with 0-10 ethilon
- A similar pattern was performed for the middle finger except for the veins, as veins were unsuitable for reconstruction.
- It took around 11 hours to complete the replantation in both the fingers.

MICRO ANASTOMOSIS

Yellow arrow - Digital nerve
Red arrow - Digital artery

SEQUENCE OF REPLANTATION

Structures repaired	Index finger	Middle finger
Bone	Yes	Yes
Flexor tendon	Yes	Yes
Extensor tendon	Yes	Yes
Digital artery	Yes	Yes
Digital vein	Yes	Not done
Digital nerve	Yes	Yes

POST PROCEDURE

The patient recovered well postoperatively. The index finger survived uneventfully and since venous anastomosis was not done for the middle finger, patient underwent external bleed therapy in which multiple stab holes were made on the replanted middle fingertip to allow external bleed and relieve venous congestion. This procedure was done for 7 to 8 days till the neo-veins forms at the site of injury. On discharge, patient was stable and both fingers survived.

DISCUSSION

Replantation is the reattachment by microsurgical means of a completely severed part. It aims to restore the amputated part to its anatomical site, preserving the function and appearance. Outcome depends on factors intrinsic to the patient and nature of the injury. Young patients who have distal, cleanly amputated extremities have the best return of function, whereas multiple levels of injury, crush, or avulsing injuries have less. Gap in the artery/vein/nerve doesn't necessarily preclude the surgery, as it can be bridged by grafts if needed. Replantation is considered as the best option available for reconstruction of the amputated finger. Success rate is around 80% and depends mostly on the anatomical integrity in the amputated finger.

Replantation of a digit does not result in reperfusion injury. Digits can be replanted after as many as 6 hours of warm ischemia. However, with amputations involving the hand or forearm, even 2 to 3 hours of warm ischemia can result in substantial muscle necrosis that may produce systemic coagulopathy after reperfusion. Cooling of the amputated part to 4° C dramatically prolongs the time between injury and successful replantation.

Digit Replantation is a technically demanding surgery and requires an interprofessional team that includes a Microvascular Surgeon, Emergency Department Physician, trained Nurses, operating microscope, and availability of O.T. for long hours. Once the digit is reimplanted, close monitoring is required to ensure that no thrombosis, ischemia, or infection occurs. Post-surgery, patients require prolonged physical therapy to regain joint function and strength.

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Removal of Large Glass Piece from Foot

Successful removal of two months old undetected foreign body (glass piece) from foot at Aster Clinic, King Faisal, Sharjah

Dr. Jerry Jimmy Chiramel
Orthopaedic Surgeon (Specialist)

PRESENTATION

- 37 year old male
- Presented with history of pain in left foot from the last 2 months
- Stamped over a glass piece in the past and slipped over it
- Severe pain while walking
- Non-healing wound

The wound was initially sutured elsewhere. After the suture removal, wound wasn't healing properly and became a non-healing wound. The patient was on antibiotics and regular dressing but still, he was not recovering. Later, patient came to Aster Medical Centre Sharjah, King Faisal Street for further management and wound care.

On examination, a hard foreign body like sensation was found in the distal part of the wound.

An X-ray was taken that showed the presence of foreign body in lateral view of the foot.

FINDINGS

During Examination:

- Non-healing wound of 3*4 cm in size with hard sensation over the distal part of the wound
- Painful toe movements
- X-Ray detected foreign body on lateral view inferior aspect of the foot that was hampering the wound healing

X-Ray showing foreign body on lateral view of foot

DURING PROCEDURE

- Under local anesthesia, wound was opened under aseptic conditions and the glass piece was removed.
- Followed by a thorough wash and debridement, wound was closed as primary closure.

Glass piece recovered from foot

POST PROCEDURE

Patient withstood the procedure well. Wound healed properly after the regular dressing. The patient was on oral antibiotics for 7 days and suture was removed after 12 days. Post removal, immediate x-rays showed no evidence of further foreign body or pieces. The patient was able to walk pain-free without any complications.

Post-removal x-ray

DISCUSSION

Soft tissue foreign bodies or wounds associated with the foreign bodies result from blunt/abrasive or penetrating trauma. Patients may present early or late with a plethora of symptoms and signs. The foreign bodies can be divided into three groups according to their composition: (a) metallic, (b) organic, and (c) inorganic.

Metallic foreign bodies have a high atomic number and are readily visible on plain radiographs. The organic ones are of vegetative origins, like wood splinters or thorns. And inorganic materials are non-living beings like glass, plastic, or rubber. If an organic foreign body is suspected, it may be challenging to identify it on radiographs. As a result, the clinician needs to be extra diligent in wound exploration and inform the patient to return immediately if any signs of infection or foreign body develop. The organic foreign bodies are identifiable using ultrasound pre or intraoperatively. If identified preoperatively, they can also aid in their removal, and this is particularly beneficial in chronic foreign bodies where a wound is no longer present. The inorganic materials can be visible on radiographs or ultrasound, but this is variable. Usually, the glass will be visible on a plain radiograph. For deeper foreign bodies, when there is concern about their involvement with specific structures, computed tomography may be required for better visualization. The ideal time for foreign body removal is the first 24 hours after an injury to allow better evaluation of the wound's entry and exit sites and minimize the inflammatory response and scar formation.

Enhancing Healthcare Team Outcomes

Foreign bodies are common but highly varied. They range from being difficult and easy to remove, meaning they do not all require a trip to the operating theatre for their removal. The more accessible foreign bodies are removable in the emergency department; however, there needs to be adequate support from surgical specialties to get involved for more complicated retrievals.

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Repair of Type-A Aortic Dissection

Emergent repair of type-A aortic dissection with impending rupture and severe aortic valve incompetence at Aster Hospital, Al Qusais

Dr. Pradeep Nambiar
Cardio Thoracic Surgery (Consultant)

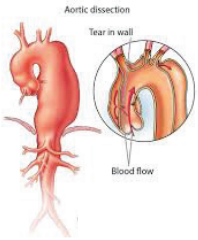
PRESENTATION

- 32 year old male
- Smoker
- History of Systemic Lupus Erythematosus (SLE) from past 15 years on Steroids
- No family history of medical illness
  Admitted with:
  - Complaint of sudden onset of chest pain and shortness of breath from one week
  - Chest pain radiating to jaw and increasing in intensity
  - Cardiac MRI showed large aneurysmal dilatation of aortic root and the ascending aorta, with a localized area of dilatation/bulging in the tubular ascending aorta at King's College Hospital, London and later referred to Aster Hospital, Dubai for further management

FINDINGS

During Examination:

- Conscious and oriented
- No pallor
- CT and HRCT scan showed dilatation of aortic root and ascending aorta
- Severe central aortic valve regurgitation, presence of hematoma in lateral aspect of ascending aorta just above the NC commissure of aortic valve
- Pulmonary artery bulging into medial aspect of aorta
- Dilated and large heart with ejection fraction of 35%



Animation of Aortic Aneurysm with Aortic Dissection

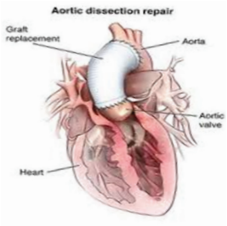
DURING PROCEDURE

- Right axillary artery exposure and sewing of 8 mm Dacron tube graft for arterial inlet of cardio-pulmonary bypass was performed.
- Less Invasive incision was made, pericardium was opened, and 150 mL of blood was found in it.
- After full heparinisation, patient was placed on cardiopulmonary bypass with arterial inflow via axillary artery and venous outflow via two stage venous cannula. Patient was cooled to 28°C.
- Findings:
  1. 100ml of blood in pericardial well and impending rupture.
  2. The Pulmonary artery had eroded the aorta and had formed the medial wall of the aorta, and the aorta was thinned out due to the long duration of Steroid treatment.
- The Native Aortic Valve was repaired by Resuspension of the commissures with 0-4 Prolene and pledgets in a standard fashion.

- The initial 1cm of the NC and right coronary leaflet was opposed together with 0-6 Prolene. Post this, excellent opposition was observed for the Trileaflet Aortic Valve.
- 26 mm Dacron tube graft was anastomosed to the proximal part of ascending Aorta with 0-4 Prolene and Teflon buttressing.
- 0-4 pledgetted reinforcement sutures were then applied and the distal aspect of the graft was anastomosed to the distal ascending aorta with 0-4 Prolene and reinforced with pledgetted 0-4 Prolene.
- The Aortic cross clamp was then removed and the heartbeat in sinus rhythm.
- Bleeding was evident from the posterior aspect of the sutured Dacron graft - native aorta junction both proximally and distally.
- Cross clamp was reapplied, the heart was rearrested and reinforcement sutures with pledgetted interrupted 0-3 Prolene was done anteriorly and posteriorly.
- The cross clamp was removed, and the patient was taken off bypass.
- After about 15 minutes of being off bypass, the heart showed global hypokinesia on TEE and the pressures dropped.
- Patient was put back on bypass after heparinisation (A piece of Saphenous vein was harvested from left leg prophylactically in case the coronary arteries needed to be grafted).
- The heart was then rested on bypass and slowly weaned of the heart lung machine with good pressures and minimal inotropes.

POST PROCEDURE

Patient tolerated the procedure well and was in a stable condition. Post CPB TEE examination showed excellent ventricular wall motion, and no Aortic Regurgitation or Stenosis was observed. Ejection fraction (EF) was measured to be 55%.



Post operative period was found uneventful and aortic valve was functioning well.

DISCUSSION

1. Post operative period was uneventful, and he was discharged on the 4th post-op day.

2. Type A aortic Dissection with SLE on long term steroids in a young male is very rare and only 5 cases have been described so far in the world and this is the 6th case. The survival in the best centers in the world is only around 25%, but we were able to give a 100% survival using a less invasive approach.

3. Patients with Systemic Lupus Erythematosus (SLE) on a long course of treatment with a history of hypertension, long-term steroid use, or SLE-related aortic pathological changes are at a high risk of developing aortic aneurysms or aortic dissections. In patients with SLE, sudden changes in the aorta can cause the SLE to rupture due to its vulnerability. In a state of cardiac tamponade, hemodynamic collapse and the effects of ongoing oral medications can easily lead to acute renal and hepatic failure, which may be severe. Antiphospholipid and other antibodies may cause pancytopenia and excessive thrombus formation; therefore, surgery with cardiopulmonary bypass (CPB) requires careful treatment planning. Conventional graft replacement is still preferred in patients with a long history of SLE treatment. Various systemic complications may occur, and multidisciplinary medical intervention should be considered.

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Dr. Hariharan Chelladurai Pandian
Neurology (Specialist)

Dr. P. Babu Balachandar
Paediatrics & Neonatology (Specialist)

Dr. Naveen Chandru
Anesthesiology (Specialist)

Neonatal Intracranial Haemorrhage

Rare presentation of Neonatal Intracranial Haemorrhage due to severe haemophilia treated successfully at Aster Hospital, Al Qusais

PRESENTATION

- First-born male infant delivered as normal vaginal delivery in Aster Hospital, Al Qusais
- Antenatal history, birth history and postnatal stay was uneventful, and child was discharged normally on day 2
- Mother started noticing abnormal movements from day 2
- Child came to Emergency Department on 5th day post-delivery with history of poor feeding, lethargy, and seizures
- Mother is the primary care giver and no family history of medical illness
- History of no trauma and physical abuse
- Possibility of Meningitis was considered and admitted in NICU

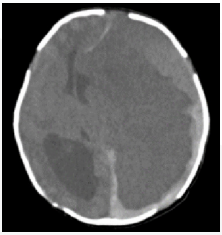
FINDINGS

During Examination:

- Child was found lethargic, pallor, poor respiratory effort, bulging anterior fontanelle, unequal pupil size, left pupils dilated and reacting sluggishly, tonic posturing and seizures
- He was mechanically ventilated in view of respiratory failure
- Empirical IV antibiotics was started
- Seizures was managed with anticonvulsants

INVESTIGATION

- Sepsis screen was negative.
- The careful examination by Pediatrician revealed unequal pupils which prompted an urgent CT scan.
- CT showed Left side Subdural Hemorrhage with midline shift to the right side with right ventricle dilated.
- Blood investigation revealed Anemia with prolonged PTT suggestive of bleeding disorder probably Factor VIII deficiency.
- Factor VIII levels were sent and FFP, PRBC transfused.
- Factor VIII transfusion was given empirically initially while awaiting levels.
- Factor VIII levels were 1%, confirming the diagnosis of severe Hemophilia A.



Pre-operative Image

DURING PROCEDURE

- The baby was diagnosed for Left Frontal Temporoparietal Acute Subdural Hematoma with mass effect and midline shift of 20 mm.
- Under general anesthesia and patient in supine position, left small skin incision over the coronal suture area was done and thick dura was identified.
- Dura was opened, gush of hemorrhagic fluid around 70-50 ml was evacuated.
- Brain looked lax post procedure.
- External Ventricular Drain (EVD) inserted into the subdural plane and connected to the EVD system to facilitate continuous drainage of the subdural hemorrhage.
- EVD was secured and tight dressing was applied.

During Procedure Image with the Amount of Blood Evacuated

POST PROCEDURE

- After evacuation, the child was continued with ventilatory support.
- For further evaluation and management of ICH with hemophilia, child was referred to Sheikh Khalifa Medical City Hospital (SKMCH), Abu Dhabi.
- SKMCH team accepted the patient and child was shifted with our Pediatrician accompanying the child. He was admitted there for 2 weeks, and no further surgical intervention was carried out.
- He was discharged in a stable condition and is on regular follow up with Aster's Paediatric Team.

DISCUSSION

Hemophilia A is an inherited bleeding disorder caused by deficiency of coagulation factor VIII. Intracranial Hemorrhage (ICH) is relatively rare in Hemophilia with incidence of 4-3 % at birth and is associated with increased morbidity and mortality. Delayed diagnosis occurs for various reasons, including vague symptoms such as irritability and fever in this case; that may be confusing with other conditions.

Even the subtle signs associated with ICH should trigger suspicion, and our Paediatric team swiftly recognized to intubate the child, took an emergency CT scan, and asked for a prompt Neurosurgical referral.

Risk factors for ICH during birth include severity of factor deficiency, prolonged second stage of labor, and use of forceps or vacuum devices for assisted delivery. But this baby's antenatal, Natal, postnatal history was uneventful.
Spontaneous ICH and bleeding can occur in case of Severe Hemophilia A, even in the absence of trauma.

In cases of suspected ICH with Hemophilia, neuroimaging is appropriate; however, infusion of factor should not be delayed while awaiting neuroimaging and Factor VIII levels.

Neonatal ICH with Haemophilia should be treated at specific centers, but still, a delay in evacuation may take a toll on their life; hence immediate surgical intervention was warranted in this case. The child needs rehabilitation and regular long-term neurodevelopmental follow-up with the Haemophilia treatment center for a better recovery.

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Multiple Fibroids Complicating Pregnancy

Pregnancy complicated by multiple fibroids treated successfully at Aster Hospital, Mankhool

Dr. Caroline Alphine Jenitha
Laparoscopic Gynaecology (Specialist)

CASE PRESENTATION

- 38 year old female, G3 A2 at 34 weeks of pregnancy
- Multiple large fibroids complicating pregnancy
- Mild bleeding per vaginum
- Anaemia due to Sickle Cell Trait
- High risk patient and was referred to Aster Hospital for delivery

FINDINGS

During Examination:

- Vitals stable, palor present
- Abdominal examination revealed uterus corresponding to 40 weeks of pregnancy with multiple large fibroids
- Per Speculum examination showed minimal blood clots and brownish discharge
- Ultrasound revealed single live foetus with estimated foetal weight of 2.2 kgs in cephalic presentation and multiple large fibroids (more than 10 in numbers) ranging in size from 10-8 cms.

COURSE IN THE HOSPITAL

- In view of suspected abruption placenta with provisional diagnosis of Threatened Preterm Labour (TPL), patient was admitted to the labour room for medical management (observation and antenatal steroids).
- Patient was stable and received two doses of steroids. After 48 hours of stay in the hospital, patient
- developed bleeding per vaginum again, and the CTG was non-reassuring.
  Adequate blood and blood products were cross-matched and kept ready. The patient was immediately
- planned for caesarean section because of increased bleeding and non-reassuring CTG.
  As delivery needed multidisciplinary care due to the complexity of the condition; specialist paediatrician, second obstetrician, and ICU team were also involved.
  Due to the complexity of the surgery and anticipated delay in the delivery of the baby, specialist
- paediatrician was involved.
- The second obstetrician was involved anticipating myomectomy before the delivery of the baby and rapid closure of myoma bed was needed.
- Under spinal anaesthesia, pfannenstiel incision was made, and abdomen was opened in layers.
- There was no access for the incision on the uterus as there were multiple large fibroids with size of 8 to 10 centimetres obscuring the complete anterior wall of the uterus. On visualizing this, second obstetrician was called, and Myomectomy was performed.

- 6 fibroids were removed to gain access and create incision on the uterus to permit the delivery of the foetus.
- Transverse incision was made over lower segment, but as the access to the foetus was difficult due to the irregular contour of the uterus and fibroids altering the shape of the uterus, transverse incision was converted to inverted T-shaped incision.
- Cephalic baby was delivered as breech and was handed over to the paediatrician. The time taken to deliver the baby from skin incision was approximately 12 minutes in comparison to 2 minutes in normal cases. Baby weighed 2.24 kg with Apgar score of 10/4 and 10/8.
- Rapid closure of the uterus started by recreating the anatomy of the uterine wall and uterus was closed in multiple layers.
- As there was severe intraoperative bleeding of more than 1000mL, blood transfusion was started during the surgery and major PPH protocol followed.
- Perfect haemostasis was obtained, intra-abdominal drain kept, and abdomen was closed in layers.
- Patient was transferred to ICU due to the need for high dependency unit.

POST PROCEDURE

After the procedure, patient was found stable and was transferred out of ICU on day one. The patient was discharged in a stable and healthy condition on day three.

DISCUSSION

It was a high-risk pregnancy case as the patient was pregnant third time with two missed abortions in the past, Sickle Cell Trait and Multiple Myomas Complicating Preterm Pregnancy with Antepartum Haemorrhage. This case was referred to Aster Hospital after multiple refusals by many other private hospitals. With the multidisciplinary team at Aster, we managed to treat the case successfully.

Some important points regarding pre-operative preparation for such cases include:

- Recognise the threat for delivery. Prepare the patient by administering antenatal steroids.
- Arrange for blood and blood products in advance.
- Counsel the patient thoroughly to anticipate delivery and possible outcomes (Myomectomy before delivery of the baby, delay in delivery of the baby, increased bleeding during caesarean section, need for blood transfusion, high dependency care and possibility of hysterectomy).
- Keep the multidisciplinary team like specialist paediatrician, anaesthetists, second obstetrician, and ICU team informed about such complex cases to get their support during/after surgery if required.

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