SEPTEMBER 2022

# HealthNews DIGEST



Aster HOSPITALS & CLINICS

We'll Treat You Well

## Dr. Sherbaz Bichu

CEO & Specialist Anaesthetist
Aster Hospitals & Clinics

On behalf of the management, I would like to offer a word of thanks to all our doctors at Aster Hospitals and Clinics, who have come forward to share and detail out the complex cases they manage. Our expert team of doctors always strive towards the best possible patient care and exceptional clinical excellence, a reflection of which has been captured through the diverse cases highlighted in this edition of HealthNews Digest. As a clinician myself, I place great value and emphasis on sharing clinical knowledge amongst the peers and its merit in improving patient care. Hence, I encourage active participation and contributions from the medical community to ensure the continuity and success of HealthNews Digest.

On a side note, I am equally elated to inform you that our 5th Aster Hospital in the UAE and 1st in the Emirate of Sharjah is now officially open and fully functional with state-of-the-art facilities and great team of doctors and staff to provide best possible medical care to the people of Sharjah and Northern Emirates.

## Dr. Ramanathan V

Medical Director
Aster Hospitals & Clinics, UAE

As the Medical Director for Aster Hospitals and Clinics, I am truly honoured and proud to be working in tandem with an outstanding team of doctors and clinicians, who form the backbone of our entire clinical excellence team at Aster Hospitals and Clinics. This is a team that is fully engaged and committed to the success of our brand promise, We'll Treat You Well; be it our patients, staff, or our external partners.

HealthNews Digest is a monthly newsletter representing some of the complex and demanding cases which were successfully managed and treated by our excellent team of doctors at Aster. We recognize the importance of ensuring that through these cases we not only highlight the issues critical to the patients, but also the ones which are informative and educative for a clinician, both at Aster and for our external clinical partners. We have also ensured that the cases we highlight are as diverse in specialities and approach as the population we cater to in the UAE.

Going forward, I also want to encourage all the doctors who are interested in being part of HealthNews Digest and share the complex cases they manage. We're equally open to highlight cases from our external clinical partners who're connected with Aster Hospitals as visiting clinicians.

Thank you all once again for your amazing support and continued efforts aimed at ensuring that we provide the best possible care to our patients.

# Two cases of Molar Pregnancy

## Complete and partial molar pregnancies treated effectively at Aster Hospital, Mankhool

**Dr. Susmita Das**
Specialist Obstetrics & Gynaecology

### INTRODUCTION

Hydatidiform Mole (HM), also known as Molar pregnancy, is one of a group of rare diseases, a complication of pregnancy that develops from abnormal proliferation of trophoblastic tissues and is classified as Gestational Trophoblastic disease. Two distinct types of HM – complete mole and partial mole have different karyotypes, gross and microscopic histopathology, clinical presentation, prognosis and its chances to progress into Gestational Trophoblastic Neoplasia (GTN). Process management is similar but with some difference in the follow up schedules due to its associated progression to GTN.

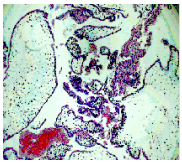
Treatment of hydatidiform disease involves removal of tissue followed by surveillance of serial Beta hCG to negative levels, or low plateau levels (quiescent GTN), or at worst increasing hCG levels (GTN). GTN includes Choriocarcinoma – with potential to metastasis and others – Placental Site Trophoblastic Tumour, Invasive Mole, and Epithelioid Trophoblastic Tumour. However, GTN invasive or metastatic, both has excellent cure rate with chemotherapy.

Presenting two cases of GTN, one with histological diagnosis of Molar Pregnancy, and the other with histological diagnosis of Partial Molar Pregnancy, where both had evacuation followed by Beta hCG follow up.

### CASE 1-HISTOLOGICAL DIAGNOSIS OF COMPLETE MOLAR PREGNANCY

A 34 year old female patient, married for 7 years attended OPD for infertility. She had a history of slightly prolonged cycles so her hormonal profile was done. Hypothyroid state and Vitamin-D deficiency was corrected. She was followed for 1 natural cycle and was found to have unruptured follicle with low progesterone on Day 21.

She started with 100 mg clomiphene on next cycle and she became pregnant. Early scan on follow up showed there was no foetal pole at 9 weeks with signs of molar features. Her Beta hCG was high and more than doubling. Then, she underwent evacuation at initial Beta HCG value of 4138515.



**Biopsy Image of Complete Mole**

Post evacuation, she was advised for a follow up with weekly Beta hCG. It started to plateau over 3rd - 6th week. She had recurrent bleeding hence she was advised for repeat scan and X-ray. Scan didn't suggest any retained products, in view of persistent GTN disease. She was then referred to medical oncology department for chemotherapy. She received 5 cycles of methotrexate and each cycle lasted for 1 week. Her follow up Beta hCG came negative for 6 consecutive months after her last cycle.

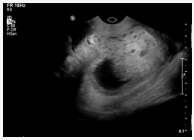


Fig 1

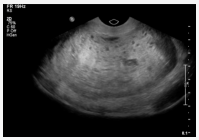


Fig 2

**Fig 1 & 2: Scans showing Snow Storm Appearance suggestive of Complete Molar Pregnancy**

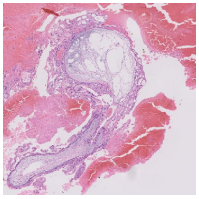
## CASE 2 - HISTOLOGICAL DIAGNOSIS OF PARTIAL MOLAR PREGNANCY

A 38 year old female patient, Para2 Living2 previous2 caesarean sections was referred to doctor's clinic at 14 weeks with a scan report suggestive of Molar Pregnancy. She was hypothyroid on 125 mcg thyronorm and no other medical comorbidities.

Her last caesarean was 5 years back. She was planned for dilatation and evacuation under general anaesthesia. Her initial Beta hCG level was 197233. She was evacuated in OT with oxytocin and under scan guidance, with an estimated blood loss of 1300 ml. Her repeated Beta hCG value was 53245 the next day.

Her histopathology report showed that it was a Partial Mole. She was advised for weekly Beta hCG levels since she had a history of recurrent bleeding during follow up with raising Beta hCG values.

Her repeat pelvic scan revealed ill-defined heterogeneous area of 9.6 x 4.7 mm.



**Biopsy Image of Partial Mole**

The patient had CT scan of abdomen, chest X-ray, and there was no metastasis found. She was then referred to medical oncology department and received chemotherapy.

## DISCUSSION

After a complete mole, 17-15% of patients develop Gestational Trophoblastic Neoplasia (GTN). Invasive disease is several folds more common in these cases than metastatic disease. After a partial mole, 1 to 4.5% patients develop GTN. Almost all patients have Invasive Disease in such cases while the metastatic disease is rare.

After the surgical evacuation / hysterectomy, Beta hCG levels are measured on weekly basis till its undetectable or the criteria for increased or plateaued level are met.

A plateaued or rising level indicates GTN, and is treated with chemotherapy later. A decreasing and undetectable hCG level is defined as a level that progressively decreases more than 10% across 4 values in 3 weeks period.

Once the Beta hCG level becomes less than 5 mIU/mL, further Beta hCG is done for 3 months for complete mole and 1 month for partial mole with negative values.

Patients with molar pregnancy are always advised to use reliable contraception during the entire interval of hCG monitoring because a new pregnancy event during this period makes it difficult or impossible to interpret the hCG results and complicate the management process. Therefore, either combined OC pills or progestin only pills or barrier methods are advised during the monitoring phase.
If the patient needs chemotherapy during this process, she is advised to avoid pregnancy for at least one year post chemotherapy.

## CONCLUSION

After evacuation of molar pregnancy, trophoblastic tissue can persist in up to 20% cases. Surveillance is essential after evacuation to exclude the presence of persistent disease. The diagnosis is based on finding the stable or serially rising serum Beta hCG rather than examination of tissue. So, patients are treated empirically with chemotherapy accordingly.

Due to their raising trend of Beta HCG levels, they usually get referred to medical oncology and receive chemotherapy on follow up visits.

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2. Gestational Trophoblastic disease (Green top Guidelines No 38) RCOG

3. Management of gestational trophoblastic disease-2021 BJOG

# Carotid Revascularization

Successful carotid revascularization of near total occlusion (99% critical stenosis) of right carotid artery using stent technology at Aster Hospital, Al Qusais

**Dr Sandeep Burathoki**
Interventional Neuroradiology (Consultant)

## PRESENTATION

- 57 year old male
- Medical history of Diabetes Mellitus and Hypertension
- Presented with Acute Ischemic Stroke 3 weeks prior to admission – MRI brain showed acute infarct at right corona radiata
- Admitted with:
  - Left upper limb weakness
  - Difficulty in speech

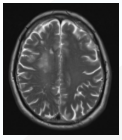
## CLINICAL EXAMINATION

- Mild weakness of left hand grip and elbow flexion
- Left nasolabial fold flattened (Cranial Nerve 7 Palsy)
- Right plantar – extensor
- Stable vital signs

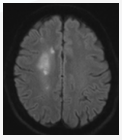
## RADIOLOGICAL INVESTIGATION

**MRI Brain**

Abnormal T2 hyperintensity at right corona-radiata showed diffusion restriction on diffusion weighted images (DWI) suggestive of acute deep watershed infarct.



T2W Axial Imaging of Brain showed Abnormal T2 Hyperintensity at Right Corona-Radiata



Corresponding DWI Imaging showed Diffusion Restriction of T2 Hyperintense Lesion

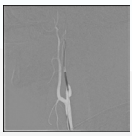
**Carotid Angiography (Digital Substraction Angiography)**

- Near total occlusion of right proximal internal carotid artery
- Delayed antegrade flow in right internal carotid artery distal to stenosis
- Poor visualization of right middle cerebral artery cortical branches

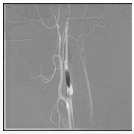
## DURING PROCEDURE

The patient was planned for Carotid Artery Stenting under Embolic Protection Device for Critical stenosis of extracranial carotid artery.

- Under general anesthesia, 6-Fr long sheath was placed at right common carotid artery.
- Pre dilatation of the critical stenosis was performed using 20/2.5 mm balloon.
- Embolic protection device was placed at distal cervical ICA.
- Self-expanding tapered stent (8-6 x 40 mm – Acculink, Abbott) was deployed.
- Post stenting dilatation of the residual stenosis was performed using 15/4.5 mm balloon.



Predilatation of Stenosis



Post Stenting Dilatation

Emboshield Embolic Protection Device used in the procedure

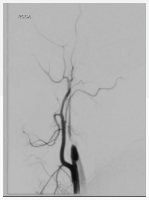
## POST PROCEDURE

Final angiogram showed complete revascularization of right carotid artery with good antegrade flow to right hemisphere (ACA and MCA territory). Patient was extubated and no procedure related complications were observed.

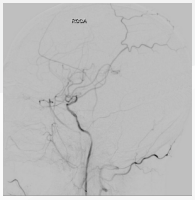
Patient was ambulated the next day and was

discharged on second day.

The patient was seen energetic and active with improved memory and concentration on follow-up after a week. His weakness of left upper limb also improved with physiotherapy.

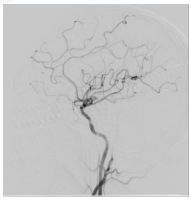


Right CCA injection showed Near Total Occlusion of Right Proximal Internal Carotid Artery with Sluggish Distal Flow



Poor Anterior Circulation of Right Hemisphere before Stenting

Final Angiogram after Carotid Stenting showed Good Revascularization of Right Carotid Artery



Significantly Improved Anterior Circulation in Right Hemisphere after Stenting

## DISCUSSION

Stroke is the second most common cause of death worldwide (Global Health Estimate, WHO, 2019) and a major cause of permanent neurological and physical disability. Approximately 18–7% of all first strokes are associated with carotid stenosis. In patients with symptomatic carotid artery stenosis of more than 60% narrowing, annual risk of ischemic stroke is more than 10%. Carotid revascularization by endovascular stenting/surgery can reduce the risk of ischemic stroke in patients with significant symptomatic stenosis.

This patient had a near total occlusion of the right internal carotid artery and presented with acute deep watershed territory infarct because of cerebral hypoperfusion. The carotid artery stenting was performed under a distal embolic protection device to increase cerebral perfusion and prevent a future stroke.

During stent deployment, the filter device is essential to prevent distal embolism and to maintain the blood flow to the brain during the procedure. In addition, the patient was on dual antiplatelet therapy.

3-D Reconstruction of Right Carotid Artery after Stenting

## CONCLUSION

Carotid Artery Stenting for symptomatic carotid artery stenosis is a life-saving procedure to prevent future stroke occurrences. The use of distal embolic protection devices is essential to prevent embolism during the procedure.

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2.https://www.neurology-asia.org/articles/neuroasia-253-(3)25-2020.pdf

# Glomus Tumour

## Rare tumour of fingers and nails removed successfully at Aster Clinic, Al Butina, Sharjah

**Dr. Manoj Kumar.P.N**
Specialist Orthopaedics, Aster Clinic, Al Butina

### CASE PRESENTATION

- 23 year old female
- History of severe pain over the tip of the right middle finger since last two years
- No family history of medical illness
- Admitted with:
  - Excruciating symptoms localized to the finger

### FINDINGS

During Examination:

- Severe tenderness localized over the right middle finger base with mild bluish discoloration
- Pulp of the finger was found normal and vascular
- Normal range of movements of distal interphalangeal joint
- Normal X-Ray and MRI resulted in lack of a specific diagnosis
- Persistent symptoms affecting daily life routine

Contrast MRI Image

### DURING PROCEDURE

A contrast MRI was later done which diagnosed the soft tissue neoplasm under the right middle fingernail base confirming the presence of Glomus Tumour. The patient was taken for surgery at Aster Hospital, Al Qusais.

- The tumour under the nail bed was accessed by raising a flap from the dorsum of the finger including the whole nail plate and proximal skin in a single layer without damaging its vascularity
- The small soft tissue lesion measuring 0.5x0.5 cm was found under the nail bed
- Excision biopsy was done, and the flap was reattached
- The tissue sample was sent for histopathological examination to confirm the diagnosis
- The histopathology report confirmed the clinical suspicion of glomus tumour

### POST PROCEDURE

Post-surgery, the dorsal skin flap including the nail healed well and the patient had good clinical relief of symptoms. At 18 months of post excision biopsy, the patient was found asymptomatic without a clinical or radiological evidence of recurrence.

3-months post-operative image

### DISCUSSION

Glomus tumors are the uncommon vascular tumors of the hand that originate from the glomus body in the dermis and account for less than 5% of all diagnosed tumors in the hand, and almost all are benign. Malignant glomus tumors, also called glomangiosarcoma, are exceedingly rare and more common in the lower extremity.

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https:/www.orthobullets.com/pathology/8075/glomus-tumor

# Post CABG Medically Resistant Angina Treatment

## Complex post CABG medically resistant angina treated successfully by angioplasty at Aster Hospital, Mankhool

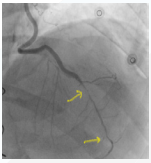
**Dr. Naveed Ahmed**
Cardiology (Consultant Interventional Cardiology)

### CASE PRESENTATION

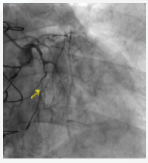
A 63-year-old male referred to Aster hospital, Mankhool in emergency with history of worsening Angina despite of medical management, presented with Angina at rest, Troponin Positive and admitted with ACS NSTEMI. He had significant history of Coronary Artery Disease and underwent CABG in the past, long standing Type-II Diabetes Mellitus, Hypertension, and Hyperlipidemia.

ECG showed evolved inferior ST-T changes, Troponin T levels at 130 pg/mL. 2-D Echo showed Mild LV Dysfunction with LVEF range at 45%, and Echocardiographic Regional Wall Motion Abnormalities (RWMA) in inferior-posterior and basal septum.

Coronary Angiogram was done via left radial artery which showed native Severe Triple Vessel Disease, occluded vein graft to OM2, patent LIMA to LAD, and diffused mid to distal LAD, RCA non dominant mid segment severe disease.



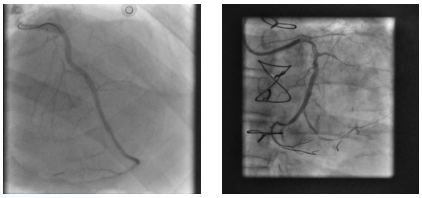
**Mid to distal LAD diffuse disease**



**Mid LCx shows 100% occlusion (CTO)**

The patient was advised aggressive medical management vs Redo CABG. In the view of diffuse disease, non-availability of grafts and high surgical risk for redo CABG, the case was turned down by the surgeon. The patient persisted to have class III-IV angina despite of maximal medical therapy. Patient decided to proceed for high risk PTCA for mid to distal LAD, CTO-LCx in view of persistent angina.

High risk PTCA was done via left radial artery with two drug eluting stents deployed in LAD via LIMA graft and two drug eluting stents in proximal to distal LCx with good results.



Good results in LAD and LCx

Follow up after 3 months showed patient Angina free and can carry out daily activities without any symptoms.

**Dr. Sudheer Salavudeen**
General And Laparoscopic Surgery (Specialist)

**Dr. Irfan Ali Shera**
Gastroenterology And Hepatology (Specialist)

# Two cases of Diverticulitis

## Diverticulitis cases with and without perforation treated by sigmoid colectomy successfully at Aster Hospital, Al Qusais

### CASE PRESENTATION

**Case 1 – Presented with Sigmoid Diverticulitis Perforation**

- 61 year old male
- Medical history of Diabetes Mellitus and Hypertension, on medications

Stage 1 – Peritoneal lavage with colostomy
Stage 2 – Sigmoid Colectomy

**Case 2 – Presented with Pain in the Left Iliac Fossa Region**

45 year old male

- No medical history
- No family history of medical illness
- Admitted with:
  - Complaints of recurrent pain in the lower abdomen
  - Recurrent episodes of acute diverticulitis with left sided colitis for last 4 years

### FINDINGS

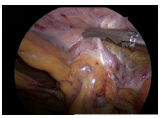
During Examination:

**Case 1**

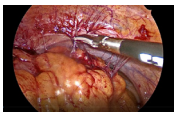
- Colostomy in situ
- Healed midline incision

**Case 2**

- No pallor, no jaundice
- No clubbing lymphadenopathy, edema
- Abdomen - soft lax, moving well with respiration
- No mass palpable, no free fluid
- Normal bowel sounds
- Tenderness in the left iliac fossa region
- CT suggestive of Sigmoid Diverticulitis
- Colonoscopy and biopsy of sigmoid colon was suggestive of segmental colitis associated with diverticulosis



**Case 1: Adhesions Post Diverticulitis Perforation**



**Case 2: Adhesions at the Site of Diverticulitis**

### DURING PROCEDURE

Both the cases were diagnosed for Diverticulitis of large intestine with and without perforation and underwent Sigmoid Colectomy Surgery.

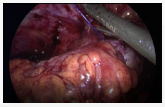
- The area was prepped and draped in the usual sterile manner.
- The patient was placed in supine position.
- The pneumoperitoneum was created using the open method at supraumbilical port.
- Two 10 mm and two 5 mm port was placed below the right side and on the left side.
- Peritoneum was opened and the free areolar space was reached. Both the ureters were identified and safe guarded.
- The dissection was carried out through the holy plane of heald, lateral ligaments on both the sides were divided and the attachments were released anteriorly.
- IMA was identified, the dissection was carried out till spleen and pancreas medially, and the attachments were cut laterally.
- 7 cm from the specimen, the bowel was divided distally with Endo GIA 60 mm staplers.
- The specimen along with bowel were brought out through a small incision and were divided with 6 cm margin.
- Handwill was fixed to the colon with 0-2 Prolene and placed inside the abdomen.
- Pneumoperitoneum was created again.

- Rectum was cleaned and circular stapler was inserted and fixed to the handwill and fired.
- Leak test was done and was found negative.
- Drain was placed towards the pelvis; loop ileostomy was performed.
- Haemostasis was attained and skin was closed with staples.

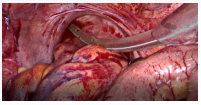
## POST PROCEDURE

The patients tolerated the procedure well without any complications and haemodynamically stable.

Normal diet was initiated eventually, were able to walk and do the stoma care themselves. Contrast Enhanced CT showed normal colon enhancement at the site of anastomosis.



**Case 1: Anastomotic Site Post Sigmoid Colectomy**



**Case 2: Drain placed at the Region of Anastomosis**

## DISCUSSION

Acute diverticulitis of the sigmoid colon is an inflammatory complication, affecting 3–1% of individuals who harbour diverticula. The spectrum of this condition is broad, ranging from uncomplicated phlegmonous diverticulitis, which almost always responds to conservative management, and diffuse faecal peritonitis, which mandates an emergency laparotomy. We advocate a practical diagnostic and therapeutic approach, emphasizing that the treatment should be tailored to the severity of the disease.

Most patients have clinically localized diseases and are treated with broad-spectrum antibiotics. Very few patients with diffuse peritonitis need an emergency laparotomy. CT scan is performed in patients who fail to improve within 48–24 hours to stage the process and document abscess formation. Small peri-colic diverticular abscesses should respond to a prolonged course of antimicrobials.

When local and systemic circumstances are favourable, a colonoscopy followed by a primary colorectal anastomosis is recommended and considered safe; otherwise, a Hartmann's procedure is advised. In addition, a "one-stage" Elective Sigmoidectomy might be an option in patients who have responded to conservative management.

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- Obstetrics & Gynaecology
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- Orthopaedics
- Pathology
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- Private rooms & semi - private rooms
- Deluxe rooms
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- 2 beds for labour, delivery and recovery
- A critical care unit comprising of 7 beds
- Day Care Unit with 9 beds
- 24 - Hour Emergency Care
- 24×7 Pharmacy

For appointments: +971 54 309 6105


OPD HOURS: MONDAY - SATURDAY, 9:00 AM - 10:00 PM

**CARE IS JUST AN Aster AWAY**

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