



SPARSH
HOSPITAL

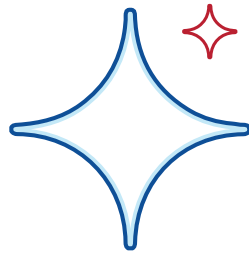
THE TOUCH OF LIFE



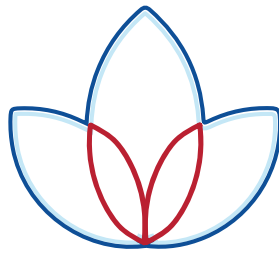
SPARSH CLINICAL DIARIES

AN INSIDER LOOK

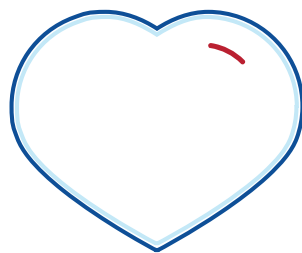
MAY
2026



FAITH



HOPE



LOVE

TABLE OF CONTENTS

PAGE NO.

Acute Inferior Wall Myocardial Infarction with Hemodynamic Instability Successfully Managed with Emergency Primary PCI	06
Disseminated Tuberculosis Presenting as Pyrexia of Unknown Origin in a Patient with Chronic Kidney Disease	08
Emergency Foreign Body Removal from the Airway in an 8-Year-Old Child	11
Successful Management of Type II Achalasia Cardia with Per Oral Endoscopic Myotomy (POEM)	13
Successful Endovascular Management of a Complex Abdominal Aortic Aneurysm in a 56-Year-Old Patient	15
Long-Term Complete Remission in Extensive-Stage Small Cell Lung Cancer with Maintenance Immunotherapy	18
Multidisciplinary Management of Severe Polytrauma with Thoracolumbar Fracture, Cervical Myelomalacia and Open Bimalleolar Ankle Fracture Following Road Traffic Accident	20
Biological Reconstruction of a Large Tibial Defect in a Child with Osteofibrous Dysplasia Using Vascularized Fibular Transfer	22
Laparoscopic Management of Sigmoid Colon Adenocarcinoma Presenting as Recurrent Subacute Intestinal Obstruction	25
Right Temporal Glioblastoma Presenting with New-Onset Seizure	27
MICRA VR2 Leadless Pacemaker Implantation in a High-Risk Patient with Symptomatic Bradycardia	29

TABLE OF CONTENTS

PAGE
NO.

Complex Two-Stage Hip Reconstruction in a Neglected Post-Septic Hip Sequela	32
Synchronous Glomus Tympanicum with Cerebellopontine Angle Schwannoma Managed Without Pre-operative Embolisation	34
Total Clavicle Reconstruction Following Wide Excision of a Massive Chest Wall and Clavicular Tumour	36
Transcatheter Aortic Valve Implantation Complicated by Acute Left Main Coronary Occlusion: Successful Bailout Coronary Intervention	39
Uterine Fibroid Embolisation: Success Depends on Accurate Angiographic Assessment and Technique	41
Complex Kidney Transplant Restores Quality of Life Through Multidisciplinary Care	43

INFANTRY ROAD
CASE IN POINT



SPARSH

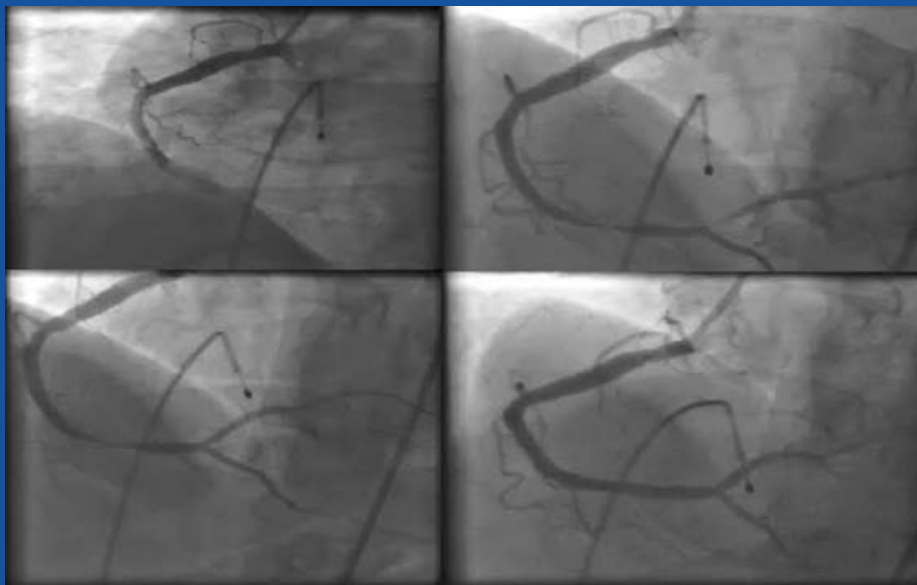
ORTHOPAEDICS • PLASTIC • MAXILLO FACIAL

CASE - 1

Acute Inferior Wall Myocardial Infarction with Hemodynamic Instability Successfully Managed with Emergency Primary PCI

CLINICAL PRESENTATION

A middle-aged male presented with sudden onset severe chest pain following a syncopal episode and fall shortly after exiting a hospital lift. He was immediately evaluated, and initial assessment revealed rapidly worsening hemodynamic status with progressive hypotension, indicating significant cardiovascular compromise.



INVESTIGATIONS & DIAGNOSIS

ECG and clinical evaluation confirmed an Acute Inferior Wall Myocardial Infarction (IWM). The patient subsequently developed hypotension and hemodynamic instability requiring inotropic support. Coronary angiography revealed an acute occlusion of the Right Coronary Artery.

FINAL DIAGNOSIS

Acute Inferior Wall Myocardial Infarction (IWM) with Cardiogenic Instability secondary to Right Coronary Artery Occlusion.

TREATMENT

The patient was immediately shifted to the Cardiac Catheterization Laboratory following rapid clinical deterioration and escalating inotropic support requirements. Emergency coronary angiography revealed an acute occlusion of the Right Coronary Artery. A primary percutaneous coronary intervention (PCI) was performed successfully, restoring coronary blood flow and achieving effective myocardial reperfusion. The procedure was completed without complications, following which the patient was transferred to the Coronary Care Unit (CCU) for intensive monitoring and further management.

POST-OPERATIVE OUTCOMES

Following successful revascularization, the patient was monitored closely in the Coronary Care Unit (CCU). Over the subsequent hours, his hemodynamic status improved steadily, allowing gradual reduction and eventual discontinuation of inotropic support. He remained clinically stable throughout recovery and was discharged home after two days of observation in the CCU and ward, with no major complications.

CLINICAL SIGNIFICANCE

This case highlights the importance of rapid recognition and activation of STEMI pathways in patients presenting with acute coronary syndromes and evolving cardiogenic instability. Timely primary PCI remains the gold standard for reperfusion and can significantly improve outcomes even in hemodynamically compromised patients.

CLINICAL EXPERT



Dr. (Prof) Ranjan Shetty

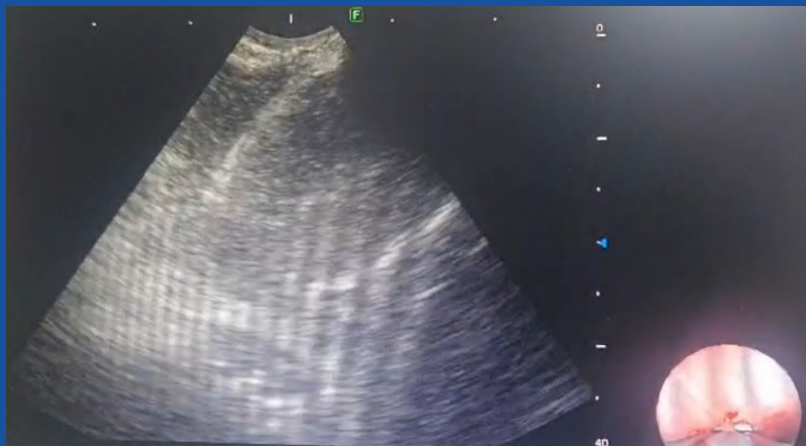
Lead Consultant –
Cardiologist & Medical Director

CASE - 2

Disseminated Tuberculosis Presenting as Pyrexia of Unknown Origin in a Patient with Chronic Kidney Disease

CLINICAL PRESENTATION

A 60-year-old male presented with a six-week history of pyrexia of unknown origin, generalized weakness, fatigue, unintentional weight loss, and reduced appetite. His medical history was significant for chronic kidney disease on maintenance dialysis and hypertension. Despite persistent constitutional symptoms, the initial clinical and radiological findings appeared disproportionate to the severity of his presentation, prompting further evaluation.



INVESTIGATIONS & DIAGNOSIS

A comprehensive diagnostic workup was undertaken. PET-CT imaging revealed mediastinal lymphadenopathy, minimal right pleural effusion, and features suggestive of pericarditis. Subsequent CT chest demonstrated homogeneously enhancing mediastinal lymphadenopathy. Based on imaging findings, the differential diagnosis included tuberculosis, lymphoma, and sarcoidosis. Given the non-specific radiological appearance and the patient's ongoing symptoms, tissue diagnosis was pursued. Endobronchial Ultrasound-Guided Transbronchial Needle Aspiration (EBUS-TBNA) of the mediastinal lymph nodes was performed, which revealed caseating granulomatous inflammation.

FINAL DIAGNOSIS

Disseminated Tuberculosis presenting with Mediastinal Lymphadenopathy and Tuberculous Pericarditis in a patient with Chronic Kidney Disease on Dialysis.

TREATMENT

Following confirmation of the diagnosis, the patient was initiated on a modified renal-safe Anti-Tubercular Therapy (ATT) regimen along with oral corticosteroids, considering the presence of pericardial involvement and underlying renal impairment. Treatment was planned in coordination with the multidisciplinary team to ensure optimal disease control while accounting for the patient's dialysis-dependent status.

POST-OPERATIVE OUTCOMES

The patient demonstrated significant clinical improvement following initiation of therapy. Fever resolved completely, appetite improved, and there was a marked reduction in fatigue and generalized weakness. Progressive recovery in overall functional status was observed, with improvement in nutritional intake and quality of life.

CLINICAL SIGNIFICANCE

This case highlights the diagnostic challenges associated with pyrexia of unknown origin, particularly in patients with multiple comorbidities. It underscores the importance of correlating radiological findings with clinical progression, especially when imaging findings alone do not fully explain the patient's symptom burden.

In tuberculosis-endemic regions, mediastinal lymphadenopathy warrants tissue confirmation whenever feasible, as imaging findings may overlap with lymphoma, sarcoidosis, and other granulomatous disorders. The case also demonstrates the value of EBUS-TBNA as a minimally invasive diagnostic tool and reinforces the importance of multidisciplinary collaboration in managing complex presentations of extrapulmonary and disseminated tuberculosis.

CLINICAL EXPERT



Dr. Venkatesh B. C

Sr. Consultant Pulmonologist

YESHWANTHPUR
CASE IN POINT

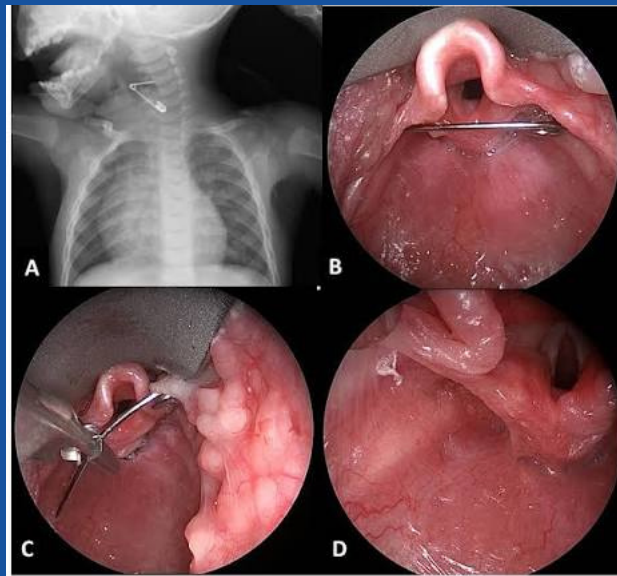


CASE - 3

Emergency Foreign Body Removal from the Airway in an 8-Year-Old Child

CLINICAL PRESENTATION

An 8-year-old child presented to the Emergency Department at SPARSH Hospital, Yeshwanthpur, with a sudden onset of severe cough and wheezing. There was no prior history of asthma, allergy, or chronic respiratory illness. The acute nature of symptoms, coupled with signs of airway obstruction, raised a strong clinical suspicion of foreign body aspiration. Given the potential for rapid respiratory deterioration in pediatric airway emergencies, urgent evaluation was initiated.



INVESTIGATIONS & DIAGNOSIS

Initial chest radiography demonstrated findings suggestive of airway obstruction. To further characterize the pathology and identify the location of the obstruction, a CT scan of the chest was performed. Imaging revealed findings highly suggestive of a foreign body lodged within the bronchial tree, resulting in partial airway obstruction.

The diagnosis of foreign body aspiration was established based on the clinical presentation and radiological findings. Prompt intervention was deemed necessary to prevent progression to complete airway obstruction, respiratory failure, or long-term pulmonary complications.

TREATMENT

Recognizing the urgency of the situation, the Adult and Pediatric Interventional Pulmonology teams were immediately mobilized. An emergency bronchoscopy was planned and performed under general anesthesia.

Bronchoscopic evaluation confirmed the presence of an aspirated foreign body obstructing the airway. Using advanced bronchoscopic retrieval techniques, the foreign body was successfully extracted, resulting in immediate restoration of airway patency. The procedure was completed safely without any intraoperative complications.

POST-OPERATIVE OUTCOMES

Following successful foreign body removal, the child demonstrated immediate clinical improvement with complete resolution of wheezing and respiratory distress. Airway patency was restored, and respiratory parameters normalized rapidly.

The post-procedural recovery was uneventful, with no evidence of residual airway obstruction or procedure-related complications. The patient remained clinically stable throughout the observation period and was subsequently discharged in good condition with complete symptomatic recovery.

CLINICAL SIGNIFICANCE

Foreign body aspiration is a potentially life-threatening emergency in children and can frequently mimic common respiratory conditions such as asthma. This case underscores the importance of maintaining a high index of suspicion in children presenting with sudden-onset cough, wheezing, or unexplained respiratory distress, particularly in the absence of a prior respiratory history.

The case highlights the critical role of prompt imaging, multidisciplinary collaboration, and timely bronchoscopic intervention in achieving successful outcomes. Early diagnosis and definitive airway management are essential in preventing serious complications, including recurrent infections, chronic lung damage, and respiratory compromise.

CLINICAL EXPERTS



Dr. Ganesh Pratap
Consultant Pulmonologist,
Allergy & Asthma specialist



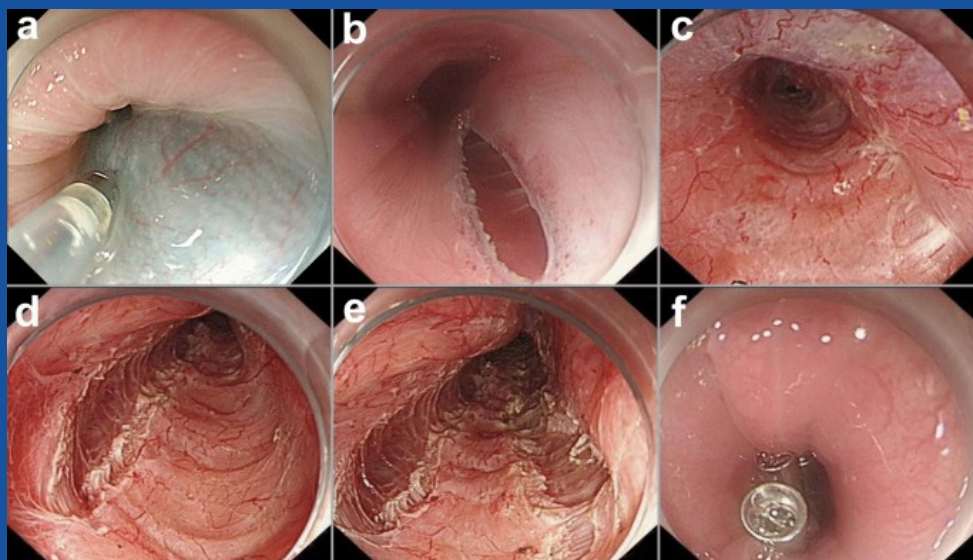
Dr. Rohan R Naick
Consultant Pulmonologist

CASE - 4

Successful Management of Type II Achalasia Cardia with Per Oral Endoscopic Myotomy (POEM)

CLINICAL PRESENTATION

A 30-year-old woman presented with a three-month history of intermittent dysphagia, predominantly for liquids rather than solids. She did not report any alarm symptoms such as weight loss, gastrointestinal bleeding, persistent vomiting, or chest pain. On admission, the patient was clinically stable with normal vital parameters and an unremarkable systemic examination. The symptom pattern raised suspicion for an underlying esophageal motility disorder, warranting further evaluation.



INVESTIGATIONS & DIAGNOSIS

The patient underwent a detailed gastroenterological evaluation. Upper gastrointestinal endoscopy revealed a dilated and tortuous esophagus with significant liquid stasis in the distal esophagus. Resistance was encountered while negotiating the lower esophageal sphincter (LES), accompanied by a characteristic "give-way" sensation. The stomach and duodenum were normal. Further assessment with esophageal manometry confirmed Type II Achalasia Cardia. Routine laboratory investigations, including liver function tests, renal function tests, coagulation profile, and serological studies, were within normal limits. Based on the clinical presentation, endoscopic findings, and manometric confirmation, a final diagnosis of Type II Achalasia Cardia was established.

TREATMENT

Under the care of Dr. Irshad Ali H, the patient underwent Per Oral Endoscopic Myotomy (POEM) on 24 April 2026. The procedure involved creation of a mucosal entry point in the esophagus followed by formation of a submucosal tunnel extending beyond the gastroesophageal junction. A targeted myotomy was performed to divide the dysfunctional muscle fibers of the lower esophageal sphincter, thereby relieving the obstruction to esophageal emptying. The mucosal entry site was subsequently closed using endoscopic hemostatic clips. The procedure was completed successfully without any intraoperative complications.

POST-OPERATIVE OUTCOMES

The patient had an uneventful recovery following the procedure. A gastrograffin swallow study performed 24 hours post-procedure demonstrated no evidence of contrast leak or extravasation. She was gradually advanced from liquid to soft oral feeds and tolerated the diet well. No post-procedural complications were observed, and her dysphagia improved significantly. The patient remained clinically stable throughout her hospital stay and was discharged with dietary advice, medications, and follow-up recommendations.

CLINICAL SIGNIFICANCE

Achalasia Cardia is a rare esophageal motility disorder characterized by impaired relaxation of the lower esophageal sphincter and loss of normal esophageal peristalsis. Type II Achalasia is associated with favorable outcomes when treated with definitive therapeutic interventions. This case highlights the effectiveness of Per Oral Endoscopic Myotomy (POEM) as a minimally invasive treatment option capable of providing rapid symptom relief and excellent clinical outcomes. Accurate diagnosis through endoscopy and esophageal manometry, combined with advanced therapeutic endoscopy expertise, enabled successful management without complications and facilitated early recovery.

CLINICAL EXPERT



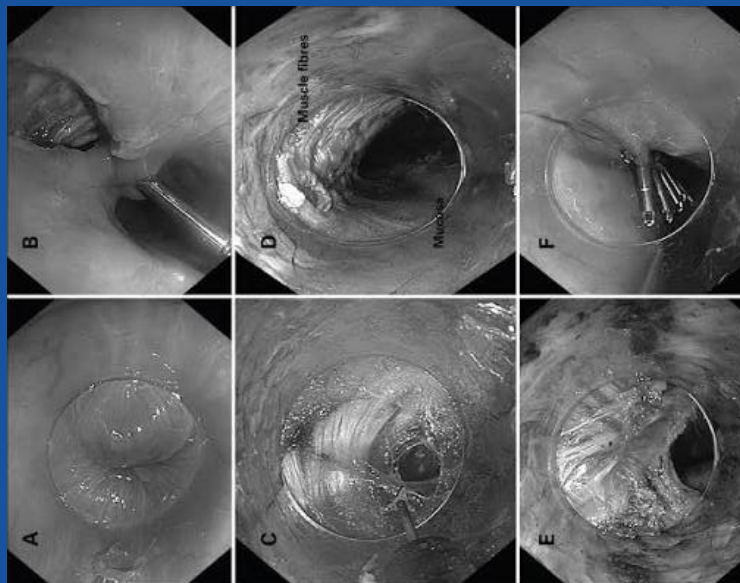
Dr. Irshad Ali H
Consultant Gastroenterologist

CASE - 5

Successful Endovascular Management of a Complex Abdominal Aortic Aneurysm in a 56-Year-Old Patient

CLINICAL PRESENTATION

A 56-year-old male presented with persistent abdominal pain and recurrent episodes of vomiting that had been ongoing for several weeks. Given the persistence of symptoms and their impact on daily activities, the patient sought medical evaluation for further assessment.



INVESTIGATIONS & DIAGNOSIS

A detailed clinical evaluation followed by advanced imaging studies revealed the presence of a complex **Abdominal Aortic Aneurysm** (AAA). The aneurysm involved not only the main abdominal aorta but also extended to several of its major branch vessels, making it a highly complex vascular condition. Due to the risk of progressive enlargement and potential rupture, timely intervention was deemed necessary.

Final Diagnosis

The patient was diagnosed with a complex abdominal aortic aneurysm involving the abdominal aorta and multiple branch vessels, carrying a significant risk of life-threatening complications if left untreated.

TREATMENT

Considering the complexity of the aneurysm and the benefits of a minimally invasive approach, the patient underwent **Endovascular Aneurysm Repair (EVAR)**. The procedure was performed through a small pinhole access in the groin. Using advanced imaging guidance, catheters and specialised endovascular devices were carefully navigated through the vascular system to the affected segment of the aorta. A specialised stent graft was then deployed to reinforce the weakened arterial wall, reconstruct the diseased vessel segment, preserve blood flow through the involved branches, and effectively exclude the aneurysm from circulation.

POST-OPERATIVE OUTCOMES

The procedure was completed successfully without major complications. The aneurysm was effectively excluded, normal blood flow was restored through the reconstructed vessel, and the immediate risk of rupture was significantly reduced. Owing to the minimally invasive nature of the intervention, the patient experienced reduced post-procedural discomfort, early mobilisation, and a shorter recovery period compared to what would typically be expected following open surgical repair.

CLINICAL SIGNIFICANCE

Abdominal aortic aneurysms are often clinically silent and may remain undetected until they enlarge significantly or rupture, resulting in a life-threatening emergency. Complex aneurysms involving branch vessels present additional technical challenges and have traditionally required major open surgery. This case demonstrates the effectiveness of advanced endovascular techniques in managing complex vascular pathologies through minimally invasive methods. Such approaches can offer appropriately selected patients the benefits of lower procedural risk, reduced surgical trauma, shorter hospital stay, and faster return to routine activities while achieving durable clinical outcomes.

CLINICAL EXPERT



Dr. Naveen C

Lead Consultant - Interventional Radiology

RR NAGAR
CASE IN POINT

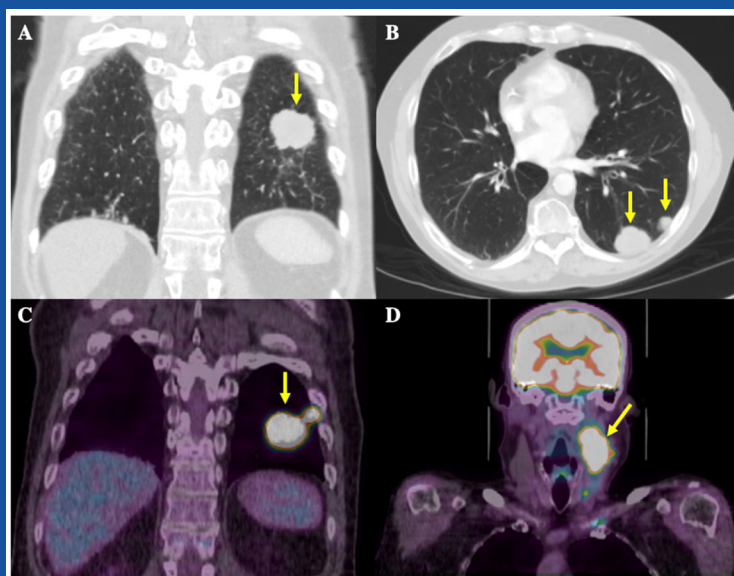


CASE - 6

Long-Term Complete Remission in Extensive-Stage Small Cell Lung Cancer with Maintenance Immunotherapy

CLINICAL PRESENTATION

A 59-year-old male with a history of coronary artery disease (post-PTCA), hypertension, diabetes mellitus, and hypothyroidism presented with extensive-stage small cell lung cancer (SCLC) with nodal metastases. Baseline cardiac evaluation showed a left ventricular ejection fraction (LVEF) of 40–50%.



INVESTIGATIONS & DIAGNOSIS

The patient was diagnosed with extensive-stage small cell lung cancer with nodal metastases in September 2021. Initial staging and subsequent PET-CT evaluations were performed to assess treatment response and disease status. Serial PET-CT scans demonstrated progressive improvement, eventually showing complete metabolic remission with no significant FDG-avid lesions.

FINAL DIAGNOSIS

Extensive-Stage Small Cell Lung Cancer (ES-SCLC) with Nodal Metastases, achieving sustained complete metabolic remission following chemo-immunotherapy, thoracic radiotherapy, prophylactic cranial irradiation, and long-term maintenance immunotherapy.

TREATMENT

The patient underwent a multimodal treatment approach consisting of four cycles of carboplatin, etoposide, and atezolizumab, followed by thoracic radiotherapy and prophylactic cranial irradiation (PCI). Subsequently, he received two additional cycles of carboplatin, etoposide, and atezolizumab before transitioning to maintenance immunotherapy with atezolizumab. Owing to his excellent clinical and radiological response, maintenance therapy was continued with periodic reassessment, ultimately completing 48 cycles of atezolizumab while remaining under close oncological surveillance.

POST-OPERATIVE OUTCOMES

The patient achieved a complete metabolic response on PET-CT evaluation, with subsequent scans demonstrating sustained remission and no evidence of active disease. More than three years after the initial diagnosis, he continues to remain disease-free with no significant FDG-avid lesions detected on follow-up imaging. The treatment was well tolerated overall, with only mild peripheral neuropathy noted during the course of therapy, which was managed conservatively. The patient remains on follow-up with an excellent clinical status and durable disease control.

CLINICAL SIGNIFICANCE

Extensive-stage small cell lung cancer is typically associated with aggressive disease biology and limited long-term survival. This case highlights the evolving role of immunotherapy in achieving durable disease control. The patient's sustained complete remission beyond three years demonstrates the potential benefits of combining chemotherapy, radiotherapy, and maintenance immunotherapy in carefully selected patients. It also underscores the importance of long-term surveillance and individualized treatment planning in advanced thoracic oncology.

CLINICAL EXPERTS



Dr. Mansi Khanderia
Senior Consultant
Medical Oncology



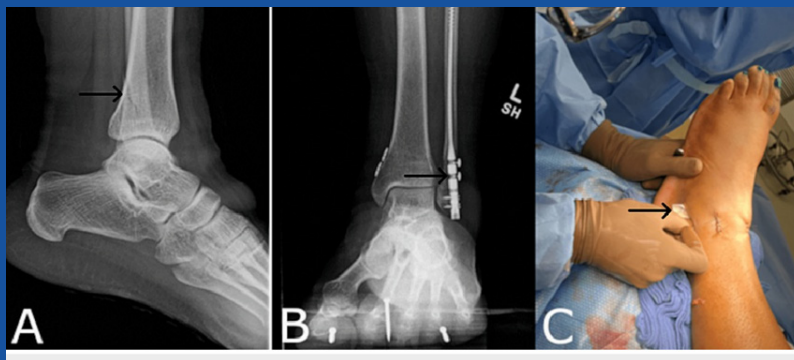
Dr. Vishakha Panicker
Associate Consultant
Medical Oncology

CASE - 7

Multidisciplinary Management of Severe Polytrauma with Thoracolumbar Fracture, Cervical Myelomalacia and Open Bimalleolar Ankle Fracture Following Road Traffic Accident

CLINICAL PRESENTATION

An 84-year-old male was brought following a road traffic accident in which he was a pillion rider on a two-wheeler. He presented with severe low back pain and bilateral lower limb pain. His medical history was significant for diabetes mellitus, hypertension, and smoking. On examination, he was conscious and alert with a right frontal subgaleal hematoma and left upper limb weakness (Grade 4/5). The right lower limb was immobilized due to a severe ankle injury.



INVESTIGATIONS & DIAGNOSIS

MRI of the spine demonstrated a D12 oblique vertebral fracture with paravertebral hematoma, extensive degenerative spine disease, cervical myelomalacia/cord edema, and intracanalicular hemorrhage. CT brain revealed a thin posterior interhemispheric acute subdural hematoma without significant mass effect. Imaging also identified an ectatic abdominal aorta and a right iliac artery aneurysm with intraluminal thrombus. X-rays confirmed an open type IIIA bimalleolar fracture of the right ankle along with a lacerated wound over the left ankle.

FINAL DIAGNOSIS

Severe polytrauma following a road traffic accident, comprising an unstable D12 vertebral fracture with thoracolumbar instability, cervical myelomalacia, thin posterior interhemispheric acute subdural hematoma, open type IIIA bimalleolar fracture of the right ankle, and bilateral lower-limb soft tissue injuries, in a patient with diabetes mellitus, hypertension, and underlying vascular abnormalities including a right iliac artery aneurysm and ectatic abdominal aorta.

TREATMENT

Following multidisciplinary evaluation and stabilization in the intensive care unit, the patient underwent posterior spinal stabilization with D10, D11, L1, and L2 pedicle screw fixation and fusion for the unstable D12 fracture. Simultaneously, orthopedic management included wound debridement of both ankles, open reduction and internal fixation of the medial malleolus using cannulated screws, and closed reduction with K-wire fixation of the lateral malleolus. During the hospital course, the patient developed acute respiratory failure with severe hypercapnia and deteriorating sensorium, necessitating endotracheal intubation and ventilatory support. Owing to prolonged ventilator dependence, a tracheostomy was performed. Comprehensive critical care management included antibiotics, anticoagulation, blood transfusion, glycemic control, nutritional support, respiratory care, and intensive physiotherapy.

POST-OPERATIVE OUTCOMES

The patient demonstrated gradual neurological and respiratory recovery following surgical intervention. He was successfully weaned from ventilatory support and transitioned to tracheostomy care. Despite developing ventilator-associated infection with multidrug-resistant *Acinetobacter baumannii* and subsequent wound-related concerns, these complications were effectively managed with targeted antimicrobial therapy and supportive care. At discharge, the patient was conscious and alert with stable neurological status, improving motor function, and satisfactory healing of surgical wounds. He was discharged with ongoing rehabilitation, tracheostomy care, nutritional support, and physiotherapy recommendations.

CLINICAL SIGNIFICANCE

This case highlights the successful multidisciplinary management of severe polytrauma in an elderly patient with multiple comorbidities. The coexistence of thoracolumbar instability, cervical cord pathology, traumatic brain injury, open orthopedic injuries, and critical care complications posed significant treatment challenges. The case underscores the importance of coordinated care involving neurosurgery, orthopedics, critical care, endocrinology, rehabilitation, and nursing teams. Timely spinal stabilization, aggressive critical care support, and structured rehabilitation enabled neurological preservation, recovery from respiratory failure, and favorable functional outcomes despite the complexity of injuries and advanced age.

CLINICAL EXPERTS



Dr. Abhilash Bansal
Senior Consultant
Neurosurgeon and
Spine Surgeon



Dr. Chetan Nagaraja
Consultant -
Orthopaedic Surgeon



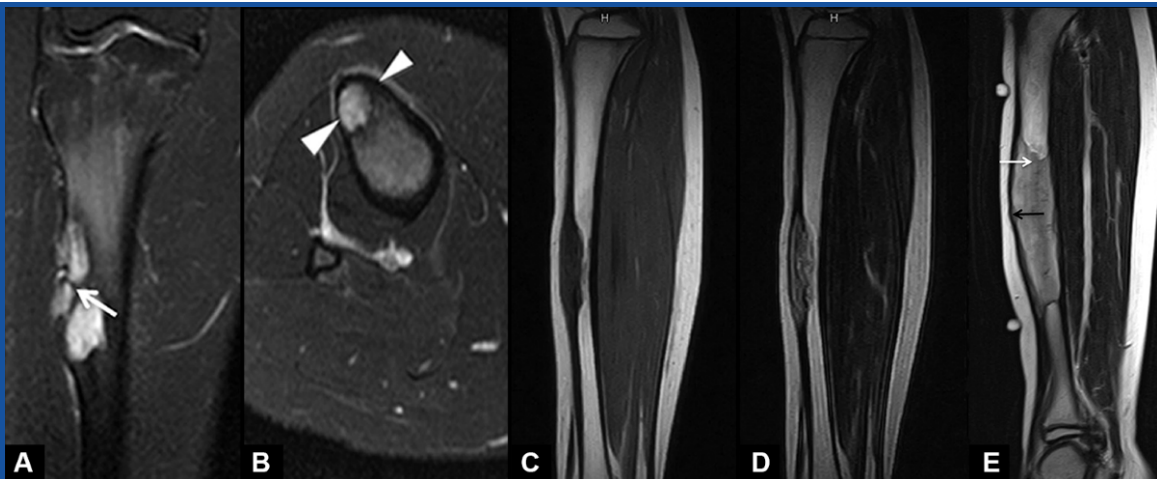
Dr. Shyam Sundar C M
Consultant Endocrinology
and Diabetology

CASE - 8

Biological Reconstruction of a Large Tibial Defect in a Child with Osteofibrous Dysplasia Using Vascularized Fibular Transfer

CLINICAL PRESENTATION

A 5-year-old boy presented with a progressively worsening deformity of the left leg over a period of 18 months. The condition was associated with intermittent pain and occasional episodes of fever. The child had no significant past medical history. Clinical evaluation revealed a deformity involving the left leg, significantly affecting the structural integrity of the tibia and fibula



INVESTIGATIONS & DIAGNOSIS

Detailed clinical and radiological evaluation demonstrated extensive involvement of the left tibia and fibula by a fibro-osseous lesion, resulting in progressive deformity. Surgical planning revealed a substantial segment of diseased bone requiring resection. Intraoperative assessment confirmed a markedly deformed tibia without evidence of soft tissue extension of the tumour.

FINAL DIAGNOSIS

Osteofibrous Dysplasia involving the left tibia and fibula, resulting in progressive deformity of the left leg and necessitating segmental resection with biological reconstruction.

TREATMENT

The patient underwent en bloc intercalary resection of the affected segment of the left tibia along with tumour excision. The resultant approximately 14 cm tibial defect was reconstructed using a combined biological reconstruction technique comprising an allograft from the bone bank and a microvascularized osteocutaneous fibular flap harvested from the contralateral leg. The vascularized fibula, along with a skin paddle measuring 13 × 3.5 cm, was transferred and anastomosed to the recipient peroneal vessels. Skeletal stabilization was achieved using screws and a titanium reconstruction plate under fluoroscopic guidance. The procedure was performed jointly by the Orthopaedic Oncology and Plastic & Reconstructive Surgery teams.

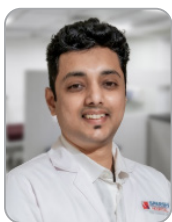
POST-OPERATIVE OUTCOMES

The patient tolerated the procedure well, and the postoperative course was uneventful. Serial assessments demonstrated excellent flap perfusion with progressive reduction in swelling and tenderness. Surgical wounds healed satisfactorily, and both donor and recipient sites remained healthy. The patient was discharged in stable condition with advice for limb elevation, physiotherapy, and regular follow-up.

CLINICAL SIGNIFICANCE

Management of extensive osteofibrous dysplasia in young children presents a significant reconstructive challenge due to the need for complete tumour excision while preserving limb function and growth potential. This case demonstrates the successful use of biological limb salvage through intercalary resection and reconstruction using a vascularized fibular transfer combined with structural allograft support. The technique provides immediate structural stability, promotes biological incorporation, and offers long-term durability, making it an effective option for large skeletal defects in the paediatric population. The successful outcome highlights the importance of multidisciplinary collaboration between orthopaedic oncology and reconstructive microsurgery teams in achieving optimal functional and reconstructive outcomes.

CLINICAL EXPERTS



Dr. Suraj Hindiskere
Lead Consultant -
Musculoskeletal Oncology



Dr. Gunasekar Vuppalapati
Sr. Consultant - Aesthetics,
Plastic Surgery &
Reconstructive Surgery



Dr. Deepak K L Gowda
Sr. Consultant - Aesthetics,
Plastic Surgery &
Reconstructive Surgery

YELAHANKA
CASE IN POINT

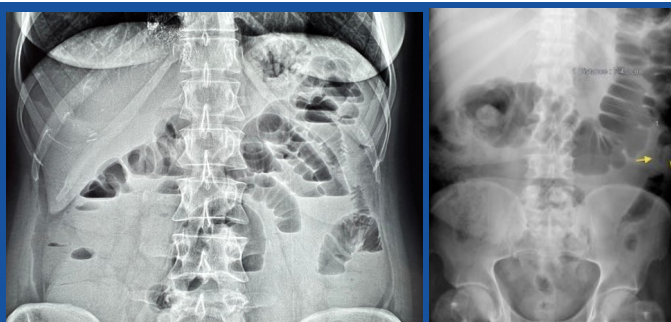


CASE - 9

Laparoscopic Management of Sigmoid Colon Adenocarcinoma Presenting as Recurrent Subacute Intestinal Obstruction

CLINICAL PRESENTATION

A 57-year-old male presented with recurrent episodes of subacute intestinal obstruction with intermittent symptomatic relief. There was no history of significant weight loss, bleeding per rectum, or altered bowel habits. Clinical examination revealed a soft abdomen with no palpable abdominal mass; however, a small incidental supraumbilical abdominal wall defect was noted. Colonoscopic evaluation demonstrated a stricturing lesion in the sigmoid colon, and biopsy was obtained for histopathological assessment.



INVESTIGATIONS & DIAGNOSIS

Contrast-Enhanced CT (CECT) abdomen demonstrated a mass lesion involving the sigmoid colon without significant lymph node enlargement. Subsequent PET/CT revealed metabolically active asymmetric circumferential wall thickening of the distal sigmoid colon (SUV 8.8), suggestive of a primary neoplastic lesion. Mild adjacent soft tissue stranding and a few small mesocolic lymph nodes (SUV 1.8) were noted, while no evidence of distant metastatic disease was identified.

Histopathological examination of the colonoscopic biopsy confirmed adenocarcinoma of the sigmoid colon. Following multidisciplinary evaluation, the patient was planned for definitive surgical management.

FINAL DIAGNOSIS

Moderately Differentiated Adenocarcinoma of the Sigmoid Colon, Stage pT3 N0 Mx (AJCC 8th Edition).

TREATMENT

The patient underwent laparoscopic anterior resection with primary colorectal anastomosis. Intraoperatively, complete oncological resection was achieved with adequate proximal and distal margins. Histopathological examination of the resected specimen revealed an ulcerated tumour measuring 4.5 × 3.5 × 1 cm. All resection margins were free of tumour, with the closest margin measuring 2.5 cm. A total of 11 lymph nodes were harvested and examined, all of which were negative for metastatic involvement. There was no evidence of lymphovascular invasion (LVI) or perineural invasion (PNI).

POST-OPERATIVE OUTCOMES

The patient had an uneventful postoperative recovery following minimally invasive surgery. Histopathology confirmed an R0 resection with complete tumour clearance. The final pathology demonstrated a moderately differentiated adenocarcinoma infiltrating through the muscularis propria into the pericolic tissue, with all 11 harvested lymph nodes negative for tumour involvement. The patient was discharged in stable condition with plans for structured oncological surveillance and multidisciplinary follow-up.

CLINICAL SIGNIFICANCE

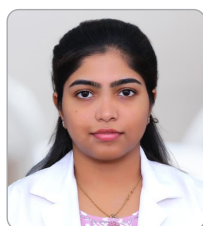
This case highlights the importance of considering colorectal malignancy in patients presenting with recurrent subacute intestinal obstruction, even in the absence of classic alarm symptoms such as weight loss or rectal bleeding. Comprehensive staging with CECT and PET/CT enabled accurate assessment of disease extent and appropriate surgical planning.

The successful use of a laparoscopic approach facilitated complete oncological resection while minimizing surgical morbidity. Histopathological findings of pT3N0 disease with negative margins and absence of adverse pathological features underscore the importance of individualized discussions regarding adjuvant therapy and surveillance strategies in Stage II colon cancer.

CLINICAL EXPERTS



Dr. Chandramouli M S
Senior Consultant
General, Laparoscopic,
GI & Colorectal Surgery



Dr. Pravalika Srinivas
Registrar General Surgery

CASE - 10

Right Temporal Glioblastoma Presenting with New-Onset Seizure

CLINICAL PRESENTATION

A 57-year-old female presented with complaints of giddiness and nausea since the morning. While at work, she experienced sudden dizziness and generalized weakness and was brought to the hospital. During hospitalization, she developed a sudden episode of loss of consciousness associated with generalized limb stiffening, hurried breathing, up-rolling of the eyes, tongue bite, followed by post-ictal confusion and drowsiness. There was no prior history of seizures. The patient was a known case of hypertension on regular medication.



INVESTIGATIONS & DIAGNOSIS

Neurological examination revealed a drowsy and confused patient with preserved movement in all four limbs and stable vital signs.

MRI Brain (Plain + Contrast) demonstrated a heterogeneous enhancing mass lesion in the right lateral temporal lobe measuring $5.1 \times 3.3 \times 3.9$ cm, involving the cortex and subcortical white matter. The lesion showed areas of necrosis, hemorrhage, mild diffusion restriction, surrounding vasogenic edema, mild right uncal herniation, and a 3 mm midline shift. Perfusion imaging suggested a predominantly hypovascular lesion.

Radiological findings were suggestive of a high-grade glioma, likely glioblastoma.

FINAL DIAGNOSIS

Glioblastoma, IDH-wildtype, CNS WHO Grade 4 – Right Temporal Lobe.

TREATMENT

The patient underwent comprehensive neuro-oncological evaluation, surgical intervention, and histopathological confirmation of the lesion, followed by multidisciplinary treatment planning.

POST-OPERATIVE OUTCOMES

The patient showed neurological stabilization with improvement in sensorium and was subsequently planned for further oncological management and follow-up care.

CLINICAL SIGNIFICANCE

This case highlights the importance of evaluating new-onset seizures in adults, particularly when associated with focal neurological lesions. Early neuroimaging and multidisciplinary intervention are critical in achieving timely diagnosis and management of high-grade gliomas.

CLINICAL EXPERT



Dr. Avinasha KM

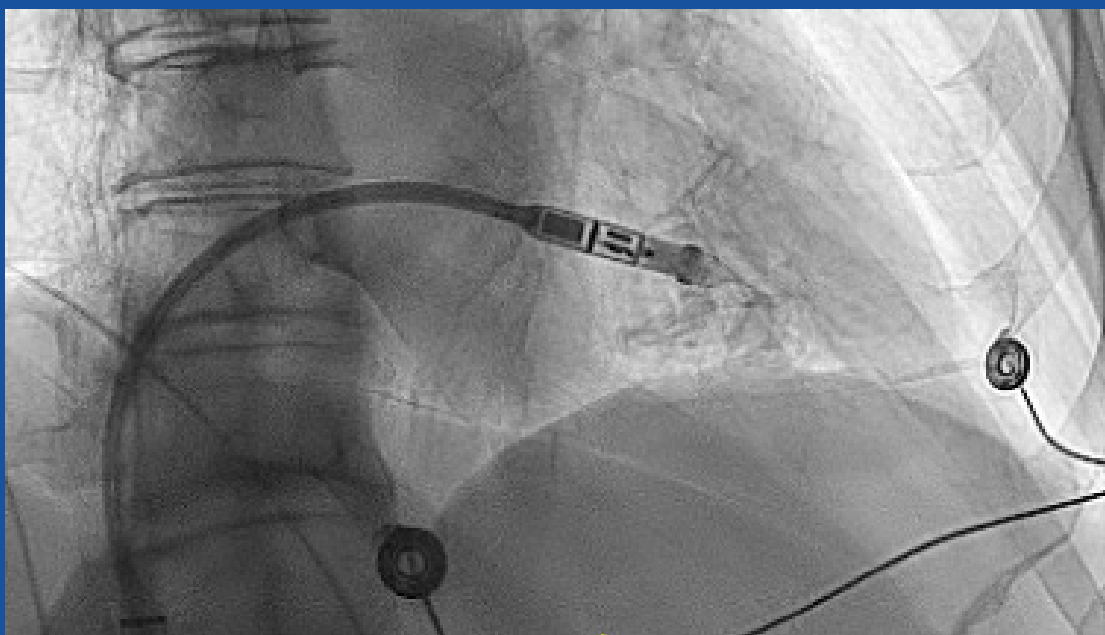
Senior Consultant Neuro & Spine
Surgeon Interventional Neurosurgeon

CASE - 11

MICRA VR2 Leadless Pacemaker Implantation in a High-Risk Patient with Symptomatic Bradycardia

CLINICAL PRESENTATION

A 62-year-old gentleman presented with recurrent episodes of giddiness. Initial cardiac evaluation revealed atrial fibrillation with a slow ventricular response/AV block, with a heart rate of only 30–35 beats per minute. The patient was also a known diabetic with elevated inflammatory markers (CRP), placing him at increased risk for device-related infections.



INVESTIGATIONS & DIAGNOSIS

Electrocardiogram (ECG) demonstrated atrial fibrillation with a slow ventricular rate associated with significant bradycardia. Clinical assessment and laboratory investigations revealed elevated CRP levels and underlying diabetes mellitus, making conventional transvenous pacemaker implantation a higher-risk option due to the potential for pocket and lead-related infections.

FINAL DIAGNOSIS

Symptomatic Bradycardia secondary to Atrial Fibrillation with Slow Ventricular Response / AV Block.

TREATMENT

After comprehensive evaluation, the patient underwent implantation of a MICRA VR2 Leadless Pacemaker. Given the elevated infection risk, a leadless pacing system was chosen over a conventional pacemaker. The capsule-sized device was implanted directly into the right ventricle through a minimally invasive transcatheter approach, eliminating the need for transvenous leads and a surgical pocket.

POST-OPERATIVE OUTCOMES

The procedure was completed successfully without complications. The patient's heart rate was effectively restored, resulting in resolution of symptoms and significant improvement in functional status. The leadless system also minimized infection risk and enabled a smoother recovery with enhanced patient comfort.

CLINICAL SIGNIFICANCE

This case highlights the growing role of leadless pacing technology in patients at high risk for device-related infections. The MICRA VR2 Leadless Pacemaker offers several advantages, including a minimally invasive implantation technique, reduced risk of infection, improved patient comfort, and an expected battery longevity of up to 17 years. Such innovations continue to expand treatment options and improve outcomes for complex cardiac patients.

CLINICAL EXPERT



Dr. Nutan Kumar

Consultant Interventional Cardiologist

HENNUR ROAD
CASE IN POINT

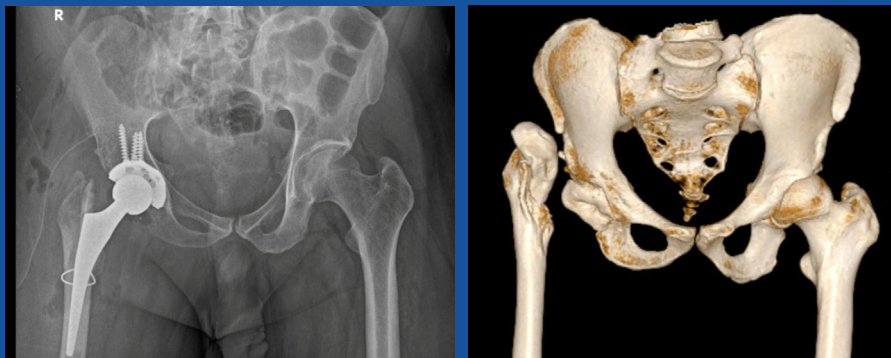


CASE - 12

Complex Two-Stage Hip Reconstruction in a Neglected Post-Septic Hip Sequela

CLINICAL PRESENTATION

A 36-year-old civil engineer presented with chronic right hip pain, severe functional limitation, limp, and an approximately 6–7 cm limb length discrepancy. The condition was a consequence of childhood septic arthritis of the hip, which had resulted in complete destruction of the native hip joint. The patient had previously undergone Girdlestone arthroplasty and continued to experience significant disability affecting mobility, daily activities, and professional responsibilities.



INVESTIGATIONS & DIAGNOSIS

Comprehensive clinical assessment was performed, supported by radiographs and CT imaging. The evaluation revealed extensive post-septic hip destruction, significant limb length discrepancy, and complex anatomical challenges requiring a staged reconstructive approach.

FINAL DIAGNOSIS

Neglected post-septic sequelae of the right hip with complete destruction of the native hip joint, severe limb length discrepancy, and functional disability following Girdlestone arthroplasty.

TREATMENT

A planned two-stage reconstruction strategy was undertaken.

Stage I: Debridement and placement of an antibiotic spacer to address residual infection risk and optimize the surgical bed.

Stage II: Complex revision total hip replacement following confirmation of infection control. The procedure focused on restoring hip stability, correcting limb length discrepancy, and achieving optimal biomechanical alignment.

POST-OPERATIVE OUTCOMES

The postoperative course was uneventful, with satisfactory wound healing and no immediate complications. The patient commenced assisted ambulation and demonstrated steady functional recovery. Near-equalization of lower-limb lengths was achieved, significantly improving gait mechanics and mobility. The reconstruction is expected to facilitate independent ambulation, enhance quality of life, and support return to full vocational activities.

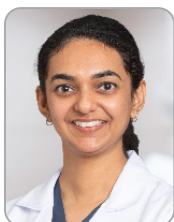
CLINICAL SIGNIFICANCE

This case highlights the challenges associated with neglected post-septic hip sequelae and demonstrates the value of a carefully planned staged reconstruction strategy. Successful management requires meticulous preoperative planning, detailed assessment of bone and soft-tissue deficiencies, and restoration of hip biomechanics, limb length, and soft-tissue balance. A multidisciplinary approach is critical to achieving durable implant stability, improved function, and long-term patient outcomes.

CLINICAL EXPERTS



Dr. Sharan Shivaraj Patil
Chief Orthopaedic Surgeon



Dr. Shrishti Patil
Consultant - Orthopaedics &
Joint Replacement Surgeon



Dr. Suraj Hindiskere
Lead Consultant -
Musculoskeletal Oncology



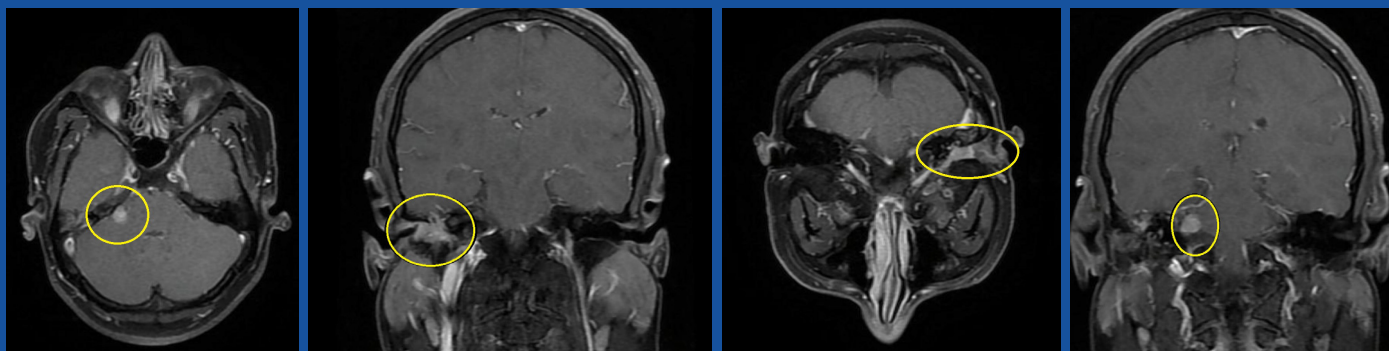
Dr. Lakshmisha N

CASE - 13

Synchronous Glomus Tympanicum with Cerebellopontine Angle Schwannoma Managed Without Pre-operative Embolisation

CLINICAL PRESENTATION

A middle-aged patient presented with progressive pulsatile tinnitus, hearing loss, and intermittent ear fullness on the affected side. Otoscopic examination revealed a reddish vascular mass within the external auditory canal. There were no lower cranial nerve deficits at presentation. Pure tone audiometry demonstrated sensorineural hearing loss.



INVESTIGATIONS & DIAGNOSIS

Contrast-enhanced MRI and CT of the temporal bone revealed an enhancing lesion occupying the middle ear cavity with extension into the mastoid and Eustachian tube. An additional synchronous lesion was identified in the cerebellopontine (CP) angle, making the presentation particularly unusual. Radiological findings were suggestive of an extensive glomus tympanicum with an associated CP angle lesion.

FINAL DIAGNOSIS

Extensive Glomus Tympanicum (Paraganglioma) with a synchronous Cerebellopontine Angle Schwannoma.

TREATMENT

Following multidisciplinary evaluation, a decision was made to proceed with surgical excision without pre-operative embolisation. The patient underwent transmastoid excision under general anaesthesia. Meticulous microsurgical dissection, early control of feeding vessels, bipolar coagulation, and careful tumour handling enabled safe and complete resection of the lesion. Despite the vascular nature of the tumour, total intraoperative blood loss was less than 20 mL, and no blood transfusion was required.

POST-OPERATIVE OUTCOMES

The postoperative course was uneventful. Complete tumour excision was achieved without facial nerve weakness, lower cranial nerve deficits, or other neurological complications. The patient remained neurologically intact throughout the hospital stay and was discharged in stable condition following satisfactory recovery. Histopathological examination confirmed paraganglioma consistent with glomus tympanicum.

CLINICAL SIGNIFICANCE

This case represents a rare presentation of extensive glomus tympanicum occurring synchronously with a cerebellopontine angle schwannoma. It highlights the importance of comprehensive radiological assessment and meticulous surgical planning in complex skull base lesions. The successful excision of a highly vascular tumour without pre-operative embolisation and with minimal blood loss demonstrates that selected cases can be safely managed through precise microsurgical techniques in experienced hands, while achieving excellent neurological and oncological outcomes.

CLINICAL EXPERT



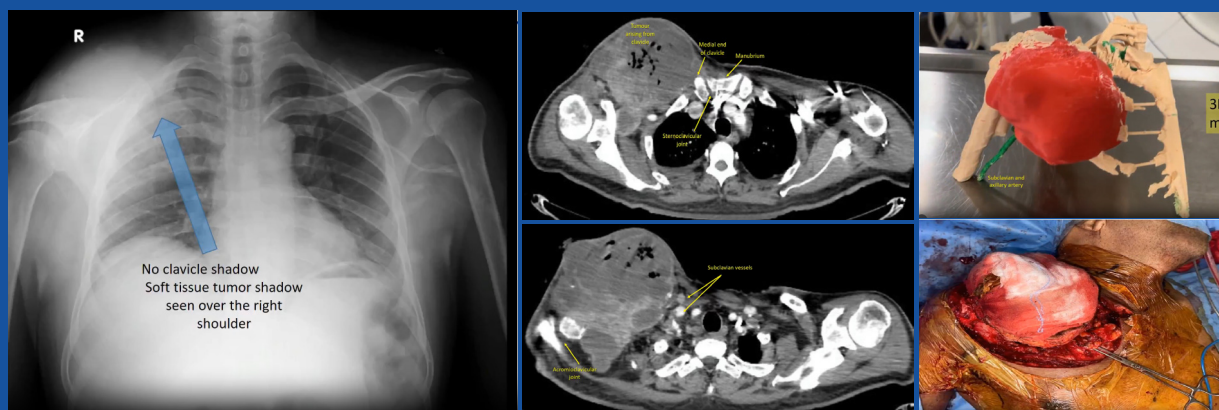
Dr. Vidya Bhushan R
Senior Consultant –
Head & Neck Oncology

CASE - 14

Total Clavicle Reconstruction Following Wide Excision of a Massive Chest Wall and Clavicular Tumour

CLINICAL PRESENTATION

A patient presented with a massive tumour measuring approximately 21 × 17 cm involving the right upper anterior chest wall, supraclavicular region, and clavicle. The lesion demonstrated extensive skin involvement with fungation in two areas and was associated with significant restriction of right shoulder movement. The size and extent of the tumour resulted in considerable functional impairment and posed major reconstructive challenges following oncological resection.



INVESTIGATIONS & DIAGNOSIS

Comprehensive clinical and radiological evaluation demonstrated a large locally advanced tumour involving the clavicular region with extension into adjacent soft tissues and overlying skin. Multidisciplinary assessment concluded that complete oncological clearance would require wide tumour excision with total claviclectomy, resulting in a complex composite defect involving bone, soft tissue, and skin.

FINAL DIAGNOSIS

Locally advanced clavicular and anterior chest wall tumour with extensive soft tissue and skin involvement requiring wide excision with total claviclectomy and immediate composite reconstruction.

TREATMENT

The patient underwent wide excision of the tumour with total claviclectomy to achieve oncological clearance. Given the anticipated functional and structural deficit, immediate reconstruction was performed using a vascularised free fibular flap. The harvested fibula was shaped and fixed between the manubrium and acromion to recreate the clavicular strut and restore shoulder girdle stability. Simultaneously, soft tissue reconstruction was carried out using a free flap with microvascular anastomosis to recipient vessels in the neck and chest region. Careful fixation and soft tissue coverage enabled restoration of skeletal continuity while protecting vital neurovascular structures.

POST-OPERATIVE OUTCOMES

The postoperative period was uneventful, with successful flap survival and stable clavicular reconstruction. Adequate soft tissue coverage was achieved, and the reconstructed clavicle provided structural support to the shoulder girdle. Early postoperative assessment demonstrated satisfactory wound healing, preserved shoulder contour, and restoration of chest wall integrity.

CLINICAL SIGNIFICANCE

Total clavicle reconstruction following oncological resection is rarely performed due to the technical complexity of recreating both skeletal and soft tissue anatomy. This case demonstrates the feasibility of combining oncological surgery, microsurgical reconstruction, and orthopaedic oncology principles to achieve limb preservation and functional restoration.

Reconstruction of the clavicle plays an important role in maintaining shoulder biomechanics, protecting the subclavian vessels and brachial plexus, preserving upper limb function, and improving cosmetic outcomes. The successful use of a vascularised fibular graft highlights the value of multidisciplinary collaboration in managing extensive musculoskeletal oncological defects.

This represents a rare and highly complex reconstructive achievement, showcasing advanced microsurgical and orthopaedic oncological expertise.

CLINICAL EXPERTS



Dr. Anand K
Chief Consultant
Plastic & Reconstructive Surgery



Dr. Gautham M
Consultant
Plastic & Reconstructive Surgery



Dr. Gururaj Hosahalli
Consultant
Plastic Surgery



Dr. Suraj Hindiskere
Lead Consultant
Musculoskeletal Oncology

SARJAPUR ROAD
CASE IN POINT

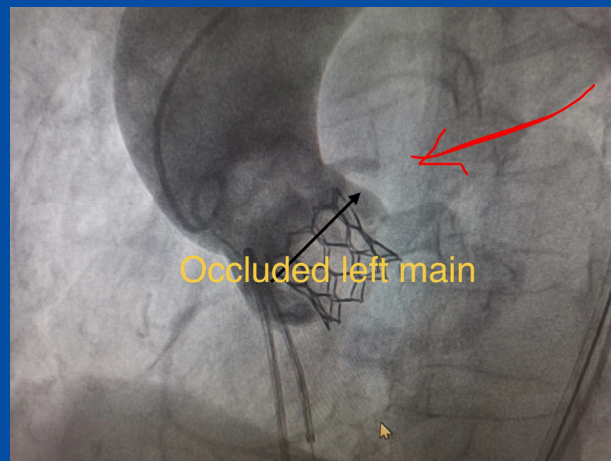


CASE - 15

Transcatheter Aortic Valve Implantation Complicated by Acute Left Main Coronary Occlusion: Successful Bailout Coronary Intervention

CLINICAL PRESENTATION

A 78-year-old frail female weighing 38 kg presented with symptomatic severe calcific aortic stenosis. Given her advanced age, frailty, and elevated surgical risk, Transcatheter Aortic Valve Implantation (TAVI) was planned as the preferred treatment strategy.



INVESTIGATIONS & DIAGNOSIS

Pre-procedural evaluation confirmed severe symptomatic calcific aortic stenosis. CT angiographic assessment demonstrated significant vascular calcification and small-calibre femoral arteries, suggesting potential challenges for valve delivery. Despite these anatomical limitations, the patient was deemed suitable for TAVI following multidisciplinary evaluation.

FINAL DIAGNOSIS

Severe Symptomatic Calcific Aortic Stenosis in a High-Risk Elderly Patient Undergoing Transcatheter Aortic Valve Implantation (TAVI).

TREATMENT

The patient underwent TAVI via transfemoral access. Although valve delivery was successfully achieved, the procedure was complicated by acute left main coronary artery occlusion secondary to embolisation of calcific debris with associated thrombosis. This resulted in sudden haemodynamic compromise requiring immediate intervention.

Emergency coronary angiography confirmed left main coronary obstruction. Prompt bail-out coronary intervention was performed to restore coronary blood flow, while simultaneous haemodynamic support and resuscitative measures were instituted. Through coordinated multidisciplinary management, successful revascularisation was achieved and the complication was effectively resolved.

POST-OPERATIVE OUTCOMES

The patient demonstrated progressive haemodynamic recovery following restoration of coronary flow. No further procedural complications were encountered. She was transferred to the ward in stable condition and continued to improve clinically, with successful valve function and satisfactory recovery.

CLINICAL SIGNIFICANCE

Coronary artery obstruction following TAVI is a rare but potentially catastrophic complication associated with significant morbidity and mortality. Acute left main coronary occlusion requires immediate recognition and rapid revascularisation to prevent adverse outcomes.

This case highlights the importance of meticulous procedural planning, vigilance for unexpected complications, and the role of multidisciplinary teamwork in managing complex structural heart interventions. Successful bailout intervention and favourable recovery underscore the value of prompt decision-making and coordinated cath lab response in high-risk TAVI procedures.

CLINICAL EXPERTS



Dr. S Venkatesh
HOD and Lead Consultant -
Interventional Cardiology



Dr. Aditi Dattagupta
Consultant
Interventional Cardiology



Dr. Prasanna B S
Consultant
Anaesthesiology



Dr. Sandeep Koti V
Senior Consultant
Anaesthesiology



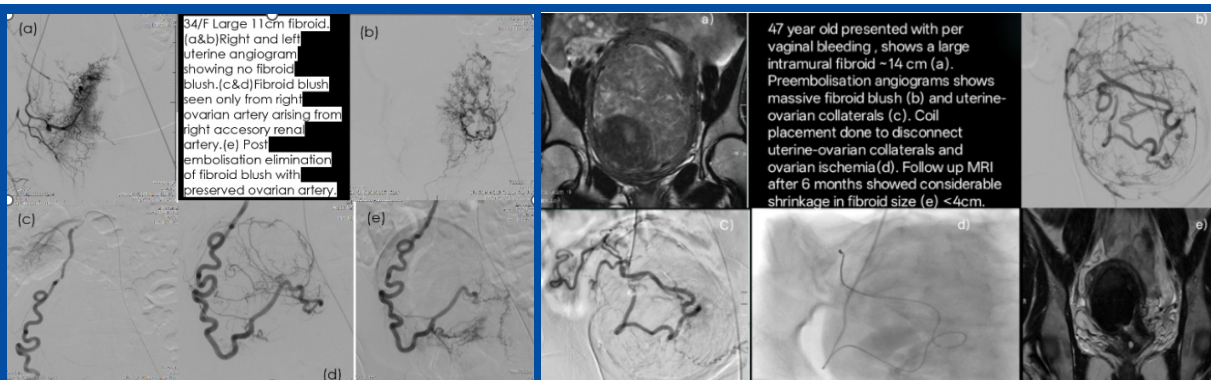
Dr. Shanmukh Hiremath
Senior Consultant
Cardiothoracic and
Vascular Surgery (CTVS)

CASE - 16

Uterine Fibroid Embolisation: Success Depends on Accurate Angiographic Assessment and Technique

CLINICAL PRESENTATION

A 34-year-old female (P2L2) presented with complaints of abdominal bloating, heaviness, and lower abdominal discomfort. Imaging revealed a large uterine fibroid measuring approximately 10–11 cm arising from the right fundal region of the uterus. The patient had a history of multiple abdominal surgeries, including cholecystectomy, appendectomy, and two caesarean sections. Given the increased risk of adhesions associated with repeat surgery and her preference to avoid another operative procedure, she opted for a minimally invasive uterus-preserving treatment approach.



INVESTIGATIONS & DIAGNOSIS

Initial ultrasonography demonstrated a large uterine fibroid, which was further characterised on MRI as an 11 cm broad-based subserosal fibroid arising from the right superolateral aspect of the uterus. The patient was evaluated for Uterine Fibroid Embolisation (UFE/UAE) as a suitable alternative to surgery.

During the procedure, angiographic assessment of both uterine arteries demonstrated normal myometrial vascularity without a definitive fibroid blush. Recognising the atypical vascular pattern, a diagnostic aortogram was performed, revealing an aberrant arterial supply to the fibroid originating from an accessory right renal artery through the ovarian artery.

FINAL DIAGNOSIS

Large symptomatic subserosal uterine fibroid with an uncommon isolated ovarian artery blood supply arising via an accessory right renal artery.

TREATMENT

The patient underwent Uterine Fibroid Embolisation through an endovascular approach. Following identification of the aberrant vascular anatomy, the ovarian artery supplying the fibroid was selectively cannulated despite significant vessel tortuosity and vasospasm. Superselective embolisation of the fibroid feeder vessels was performed using embolic particles while carefully preserving ovarian perfusion and minimising non-target embolisation.

Accurate identification of the fibroid's blood supply was critical in ensuring complete devascularisation and achieving the intended therapeutic outcome.

POST-OPERATIVE OUTCOMES

The procedure was completed successfully without complications. At one-month follow-up, imaging demonstrated approximately 2 cm reduction in fibroid size. The patient reported significant improvement in symptoms of abdominal bloating and pelvic congestion, while maintaining normal menstrual cycles. Further fibroid shrinkage is anticipated during subsequent follow-up.

CLINICAL SIGNIFICANCE

Uterine Fibroid Embolisation is an established minimally invasive alternative to hysterectomy and myomectomy for women seeking uterine preservation. However, procedural success depends heavily on accurate angiographic evaluation and identification of variant vascular anatomy.

This case highlights the importance of recognising uncommon ovarian artery collateral supply to uterine fibroids. Failure to identify such vascular variations can result in incomplete fibroid devascularisation, inadequate symptom relief, treatment failure, or inadvertent ovarian ischaemia. The case demonstrates how experience, meticulous angiographic assessment, and advanced endovascular techniques can significantly influence clinical outcomes and ensure successful fibroid embolisation.

CLINICAL EXPERTS



Dr. Gurucharan S. Shetty
Senior Consultant -
Interventional Radiology



Dr. Geetha S
Senior Consultant -
Obstetrics & Gynaecology



Dr. Mayuri Parakh
Consultant
Obstetrics & Gynaecology

CASE - 17

Complex Kidney Transplant Restores Quality of Life Through Multidisciplinary Care

CLINICAL PRESENTATION

A patient with end-stage kidney disease (ESKD) secondary to long-standing diabetes and hypertension presented with progressive renal failure after years of dialysis. The patient had exhausted multiple vascular access sites and was experiencing recurrent dialysis-related complications, significantly affecting quality of life. Due to the complexity of the case, the patient was referred to the multidisciplinary transplant team at SPARSH Hospital, Sarjapur, for further evaluation.



INVESTIGATIONS & DIAGNOSIS

The patient underwent a comprehensive pre-transplant assessment, including blood group compatibility, HLA typing, crossmatch testing, cardiac evaluation, CT angiography for vascular mapping, laboratory investigations, and infectious disease screening. A multidisciplinary team comprising transplant surgeons, nephrologists, urologists, interventional radiologists, anaesthesiologists, and transplant coordinators reviewed the case and confirmed the patient as a suitable candidate for kidney transplantation.

FINAL DIAGNOSIS

The patient was diagnosed with end-stage kidney disease requiring renal transplantation. The presence of complex vascular access issues and multiple co-morbidities made the case high risk, necessitating meticulous pre-operative planning and multidisciplinary coordination.

TREATMENT

A living donor kidney transplant was successfully performed following detailed surgical planning and individualized perioperative management. The multidisciplinary team ensured comprehensive care throughout the patient's journey, including immunosuppression planning, dialysis access management, intensive care support, and close post-operative monitoring to optimise graft function and minimise complications.

POST-OPERATIVE OUTCOMES

The patient demonstrated immediate graft function with satisfactory urine output and progressive improvement in renal parameters. Recovery was uneventful, eliminating the need for further dialysis. The patient was mobilised early, discharged in stable condition, and enrolled in a structured long-term follow-up programme to monitor graft function and overall health.

CLINICAL SIGNIFICANCE

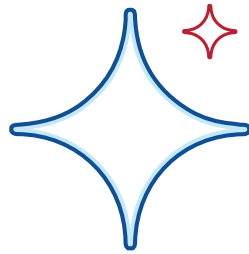
This case highlights the importance of a multidisciplinary approach in successfully managing high-risk kidney transplant patients. Comprehensive evaluation, collaborative clinical decision-making, and coordinated perioperative care enabled a successful transplant outcome while significantly improving the patient's quality of life. It also reflects SPARSH Hospital, Sarjapur's commitment to delivering advanced transplant care for complex renal conditions.

CLINICAL EXPERT

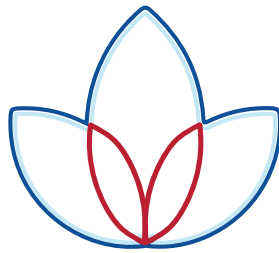


Dr. Rajkiran K. Deshpande

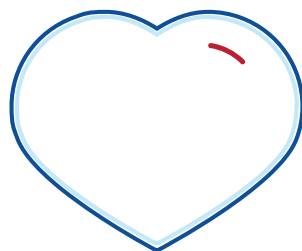
Consultant- Transplant Surgeon
(Kidney, Pancreas-Solid organ/Islets cell &
Dialysis access surgeon)



FAITH



HOPE



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Laboratory Medicine

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Interventional Radiology

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ENT

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Dermatology

Cosmetology & Cosmetic Surgery

Plastic & Reconstructive Surgery



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