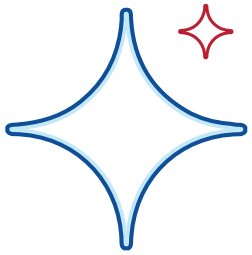


SPARSH HOSPITAL
THE TOUCH OF LIFE

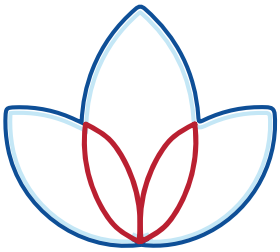
SPARSH
CLINICAL DIARIES

AN INSIDER LOOK

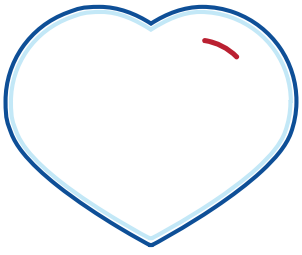
JULY
2026



FAITH



HOPE



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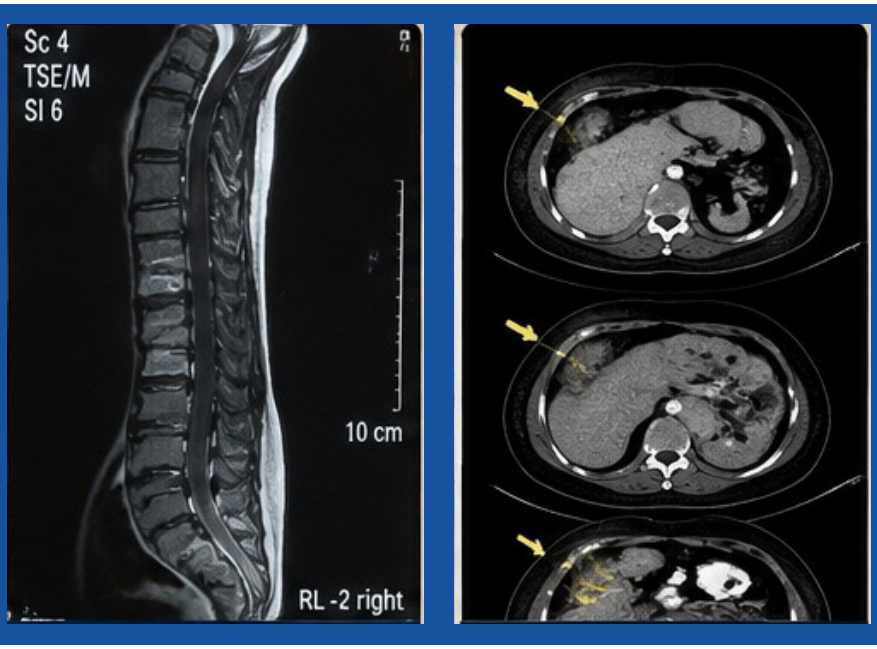

INFANTRY ROAD
CASE IN POINT
SPARSH
ORTHOPAEDICS • PLASTIC • MAXILLO FACIAL

CASE-1

Multisystem Complications of Prolonged Glucocorticoid Therapy
A Complex Multidisciplinary Case in Inflammatory Arthritis

CLINICAL PRESENTATION

A 49-year-old woman from Kenya with small-joint inflammatory arthritis on long-term dexamethasone 6 mg/day presented after three years of progressive functional decline, requiring support for standing and ambulation. At presentation, she had severe proximal muscle weakness, uncontrolled diabetes, multiple osteoporotic vertebral fractures with spinal cord involvement and sub-nephrotic proteinuria.



INVESTIGATIONS & DIAGNOSIS

Neurophysiology demonstrated sensory-motor axonal neuropathy, predominantly affecting the lower limbs. Laboratory evaluation revealed secondary adrenal insufficiency attributed to chronic glucocorticoid exposure. Renal biopsy demonstrated minimal change disease, while rheumatoid factor was positive, adding further complexity to an already multisystem presentation.

FINAL DIAGNOSIS

A complex multisystem presentation of inflammatory arthritis complicated by prolonged glucocorticoid exposure, with significant neurological, renal, metabolic, endocrine, skeletal and cardiovascular involvement.

TREATMENT

Rheumatoid therapy was revised with methotrexate and tofacitinib, while organ-specific management was coordinated across specialties. The treatment strategy incorporated targeted infection management, fluid and cardiac optimisation, endocrine replacement/support, glycaemic control and stepwise immunomodulation.

The inpatient course was further complicated by a post-biopsy renal haematoma with bleeding, sepsis, PDA and hypervolemic heart failure. Each complication required rapid specialist assessment and intervention, highlighting the need for continuous multidisciplinary coordination in a high-risk multisystem patient.

POST TREATMENT OUTCOMES

Following coordinated inpatient management, the patient achieved functional independence, with marked improvement in mobility and quality of life, and was discharged in good condition.

CLINICAL SIGNIFICANCE

This case underscores the potential for long-term glucocorticoid therapy to produce widespread morbidity, including osteoporosis, diabetes, adrenal suppression, muscle weakness and increased infection risk. More importantly, it demonstrates how early multidisciplinary review and coordinated specialty-led management can alter the trajectory of a complex, high-risk presentation.

CLINICAL EXPERT



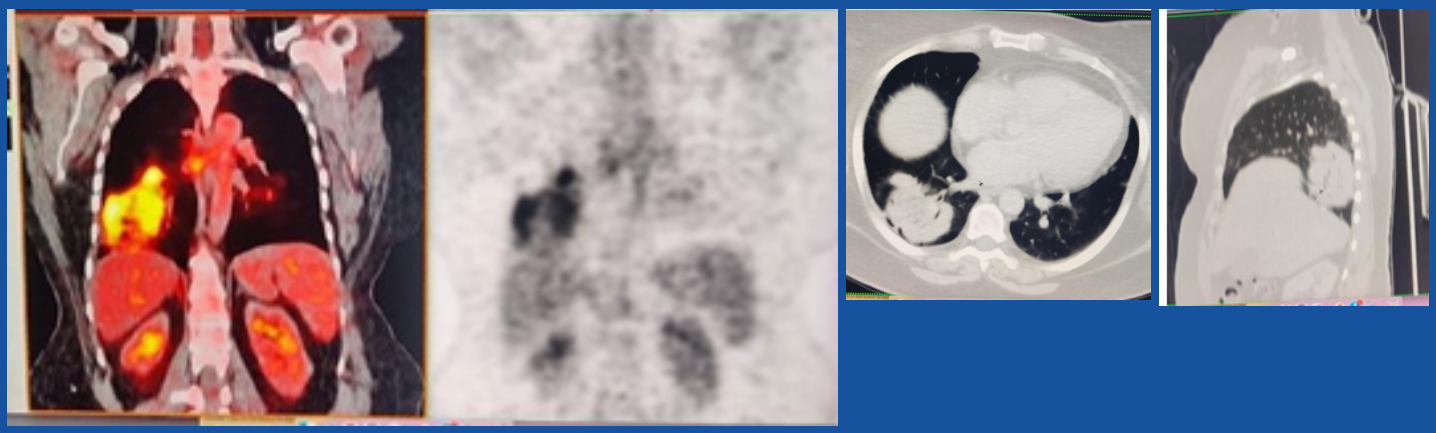
Dr. Gaurang Sudhir Deshpande
Consultant - Rheumatologist

CASE-2

Stage IIIA ROS1 Fusion-Positive Lung Adenocarcinoma: Curative-Intent Multimodality Management

CLINICAL PRESENTATION

A 52-year-old woman presented with a large right lower-lobe lung mass. Staging demonstrated a localized thoracic primary without distant metastatic disease, making her a potential candidate for curative-intent surgical management. She underwent right lower lobectomy with systematic mediastinal and hilar lymph-node dissection.



INVESTIGATIONS & DIAGNOSIS

Histopathology revealed a 10 × 7.5 × 7 cm poorly differentiated adenocarcinoma, predominantly solid in pattern, with visceral pleural and lymphovascular invasion. Six metastatic lymph nodes were identified across subcarinal, peribronchial and interlobar stations. Bronchial and vascular margins were negative, achieving an R0 resection. The final pathological stage was pT4N2M0, Stage IIIA.

FINAL DIAGNOSIS

Poorly differentiated right lower-lobe lung adenocarcinoma, pT4N2M0 Stage IIIA, with multistation N2 disease and a CD74–ROS1 fusion.

TREATMENT

Given the absence of distant metastatic disease and technical feasibility of complete resection, the patient underwent curative-intent right lower lobectomy with systematic nodal dissection. Molecular profiling subsequently identified a CD74–ROS1 fusion. Following R0 resection, she received four cycles of pemetrexed plus carboplatin as adjuvant chemotherapy. ROS1-targeted therapy was not used in the adjuvant setting after definitive local treatment and chemotherapy.

POST-OPERATIVE OUTCOMES

At approximately 10 months following completion of chemotherapy, the patient remains asymptomatic and has returned to her normal professional activity. Follow-up PET-CT demonstrates no metabolically active residual tumour, local recurrence, significant mediastinal/hilar lymphadenopathy or distant metastatic disease.

CLINICAL SIGNIFICANCE

This case highlights that Stage IIIA disease, including selected N2 presentations, does not necessarily preclude curative-intent treatment when distant metastases are absent and complete resection is technically achievable. Despite adverse pathological features including a large primary tumour, poor differentiation, visceral pleural invasion, lymphovascular invasion and multistation N2 disease, R0 resection followed by platinum-based adjuvant chemotherapy resulted in no evidence of disease at 10-month follow-up. Comprehensive molecular profiling also identified a potential targeted therapeutic option should advanced recurrence occur.

CLINICAL EXPERT



Dr. Nagesh Basavaraj
Senior Consultant -
Cardiothoracic and Vascular Surgeon



Dr. Raghunandan Madhavamurthy
Senior Consultant -
Anesthesiology



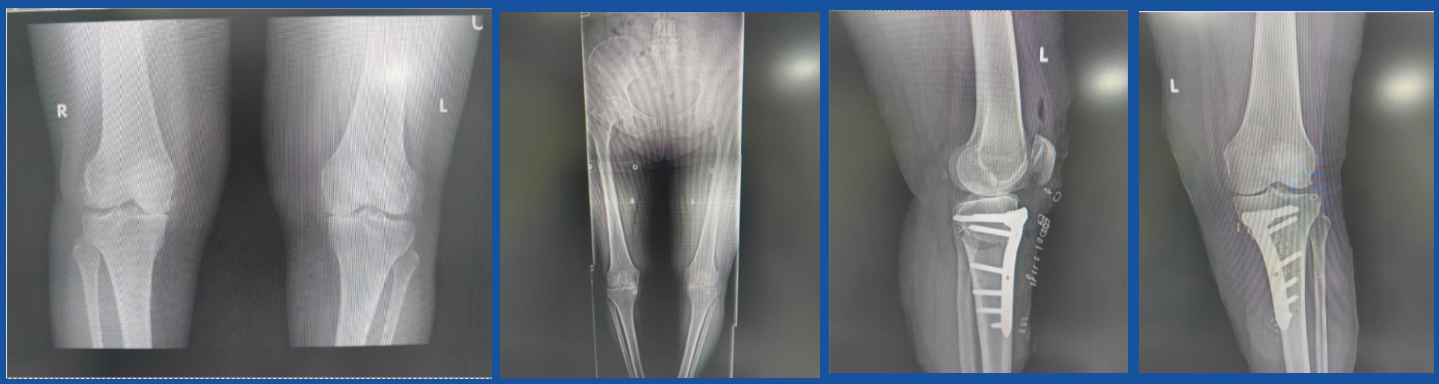
Dr. R. Ravi Naik
Senior Consultant –
Cardiac Anaesthesia

CASE-3

Joint Preservation in Varus Knee & Medial Compartment Early OA

CLINICAL PRESENTATION

A 61-year-old female with no documented comorbidities presented with predominantly left knee pain for 3 years, which had progressively worsened over the preceding 6 months. She experienced increasing difficulty with sitting, squatting and cross-legged sitting. Clinical examination revealed varus deformity and medial joint-line tenderness, with normal range of motion and no distal neurovascular deficit. The key clinical concern was not pain alone, but the combination of varus alignment, medial-compartment loading and a treatable medial meniscal lesion.



INVESTIGATIONS & DIAGNOSIS

Pre-operative imaging of the left knee demonstrated varus alignment with early medial-compartment osteoarthritic changes. The patient was also found to have a medial meniscus posterior horn tear, making both the mechanical alignment and meniscal pathology important considerations in treatment planning.

FINAL DIAGNOSIS

The final diagnosis was left knee varus deformity with early medial-compartment osteoarthritis and a medial meniscus posterior horn tear.

TREATMENT

A joint-preservation strategy was adopted, combining left arthroscopic medial meniscus posterior horn repair using an all-inside suture technique with left high tibial osteotomy (HTO) using a Tomofix 4-hole plate. The combined approach aimed to preserve the meniscal tissue while correcting the abnormal varus loading across the medial compartment.

POST-OPERATIVE OUTCOMES

Post-operative radiographs showed the HTO plate and screw construct in place, with correction of the knee alignment compared with the pre-operative imaging. Detailed functional scores, pain outcomes and long-term follow-up were not documented in the available case material.

CLINICAL SIGNIFICANCE

This case demonstrates a joint-preservation strategy in early medial-compartment OA with varus malalignment and a repairable meniscal tear. Combining meniscal repair with HTO addresses both tissue preservation and correction of abnormal medial-compartment loading. It highlights the importance of joint-preservation surgery can be considered even in patients over 50 years of age, provided there is appropriate patient selection, preserved joint status, correctable deformity, and realistic functional expectations.

CLINICAL EXPERT



Dr. Vijaykumar D
Consultant - Sports Surgery and Ankle
Foot Specialty in the Department of Orthopedics


YESHWANTHPUR
CASE IN POINT
SPARSH
SUPER SPECIALITY
HOSPITAL

CASE-4

Robotic-Assisted CABG for Coronary Artery Disease: A Minimal-Access Approach

CLINICAL PRESENTATION

A 32-year-old gentleman presented with chest pain and was evaluated for suspected coronary artery disease. Following clinical assessment, he was diagnosed with coronary artery disease (CAD) requiring surgical revascularisation with coronary artery bypass grafting (CABG).



INVESTIGATIONS & DIAGNOSIS

The patient underwent cardiac evaluation, which confirmed coronary artery disease warranting CABG. Based on the clinical and anatomical assessment, the patient was planned for a robot-assisted coronary artery bypass graft (CABG) using a minimal-access approach.

TREATMENT

The Cardiothoracic and Vascular Surgery (CTVS) team performed the robot-assisted CABG using an advanced minimal-access technique.

The procedure involved docking three robotic arms through the patient's chest, enabling robotic harvesting of the left internal mammary artery (LIMA). Following LIMA harvesting, coronary grafting was performed through a left anterior thoracic thoracotomy approach, avoiding the conventional median sternotomy.

POST-OPERATIVE OUTCOMES

The patient had an uneventful postoperative recovery and demonstrated early clinical recovery. He was discharged on postoperative day 4 and continues to remain well on regular follow-up.

CLINICAL SIGNIFICANCE

This case represents a significant milestone for SPARSH Hospitals as its first robotic cardiac surgery. It demonstrates the application of robotic technology in coronary revascularisation, combining enhanced surgical precision with a minimal-access approach.

The successful outcome and early discharge highlight the potential of robotic-assisted CABG as an approach to selected patients requiring surgical coronary revascularisation, while contributing to the institution's growing capabilities in advanced cardiac surgery.

CLINICAL EXPERTS



Dr. Ashwini Kumar Pasarad
Senior Consultant - Cardiac & Transplant Surgeon



Dr. Asher George Joseph
Consultant - Cardiothoracic & Transplant Surgeon



Dr. Shivaprakash S
Senior Consultant – Cardiothoracic & Transplant Anaesthesia | ECMO Specialist



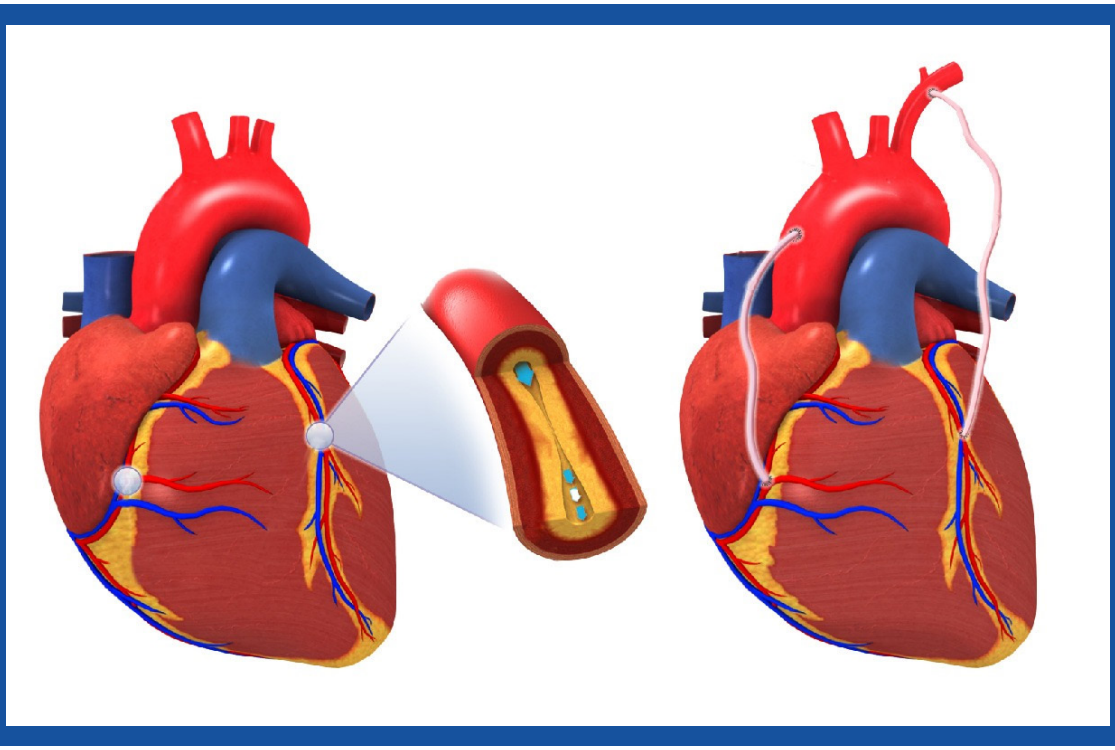
Dr. Basavaraj S Hagargi
Consultant - Cardiology

CASE-5

High-Risk CABG in a Patient from Conflict-Affected Sudan

CLINICAL PRESENTATION

A patient from a remote region of Sudan, a country affected by prolonged conflict and limited access to advanced medical care, presented with acute coronary syndrome in the setting of severe coronary artery disease. His clinical profile was further complicated by uncontrolled diabetes mellitus and chronic obstructive pulmonary disease (COPD), placing him at high perioperative risk.



INVESTIGATIONS & DIAGNOSIS

Cardiac evaluation confirmed severe coronary artery disease requiring surgical revascularisation. Given the acute presentation and multiple significant comorbidities, the patient was considered a high-risk candidate for CABG.

TREATMENT

The patient underwent Coronary Artery Bypass Grafting (CABG) under the care of the Cardiac Surgery team led by Dr. Ashwini Kumar Pasarad, Dr. Asher and Dr. Shivaprakash. Given his acute presentation and underlying comorbidities, the case required careful perioperative assessment, surgical planning and multidisciplinary management.

POST-OPERATIVE OUTCOMES

Despite the patient's high-risk clinical profile, he demonstrated an exceptional postoperative recovery. He progressed well following surgery and was able to continue his recovery with appropriate follow-up. Beyond the clinical outcome, the patient's response following treatment was particularly meaningful. Having travelled from a conflict-affected region with limited access to specialised cardiac care, he expressed profound gratitude to the treating doctors and the hospital for helping him through a critical phase of his illness.

CLINICAL SIGNIFICANCE

This case highlights the importance of timely access to advanced cardiac surgical care for patients with complex, high-risk coronary disease, irrespective of their geographical circumstances. For a patient who travelled from a remote, conflict-affected region of Sudan with acute coronary syndrome and multiple comorbidities, successful surgical revascularisation and recovery represent not only a clinical achievement, but also a deeply human story of access to care, resilience and a life regained.

CLINICAL EXPERTS



Dr. Ashwini Kumar Pasarad
Senior Consultant - Cardiac & Transplant Surgeon



Dr. Asher George Joseph
Consultant - Cardiothoracic & Transplant Surgeon



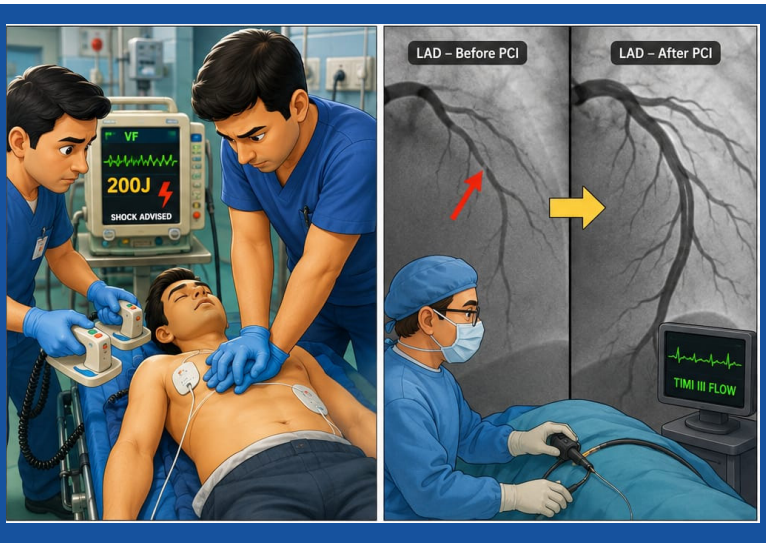
Dr. Shivaprakash S
Senior Consultant – Cardiothoracic & Transplant Anaesthesia | ECMO Specialist

CASE-6

A Successful Emergency Medicine Resuscitation with Favourable Neurological Outcome

CLINICAL PRESENTATION

A 24-year-old previously healthy male presented with acute chest pain, vomiting and profuse sweating. An ECG at a nearby hospital was suggestive of acute myocardial infarction, following which he received initial antiplatelet loading and was referred to our tertiary-care centre. There was no documented bystander CPR during the prehospital period. On arrival at approximately 17:22 hours, he was unresponsive with agonal breathing and no palpable carotid pulse. Cardiac arrest was immediately recognised and the Emergency Medicine resuscitation team activated the cardiac arrest protocol.



INVESTIGATIONS & DIAGNOSIS

The initial cardiac rhythm was shockable — ventricular fibrillation/ventricular tachycardia without a pulse. During resuscitation, the rhythm transiently changed to PEA/asystole before reverting to a shockable rhythm. Following return of spontaneous circulation, coronary angiography revealed single-vessel coronary artery disease involving the LAD.

INVESTIGATIONS & DIAGNOSIS

Out-of-hospital cardiac arrest secondary to acute myocardial infarction with LAD coronary artery disease.

TREATMENT

Immediate high-quality CPR and defibrillation were initiated, with continuous rhythm assessment. The patient received three defibrillation attempts, intravenous adrenaline, amiodarone 300 mg IV and advanced airway management with a 7.5-mm endotracheal tube. After approximately six cycles of CPR, ROSC was achieved. He was subsequently stabilised with mechanical ventilation and vasopressor support and underwent urgent coronary intervention/POBA to the LAD. Comprehensive post-cardiac-arrest care continued in the ICU.

POST-OPERATIVE OUTCOMES

The patient demonstrated progressive haemodynamic and neurological improvement. He was subsequently extubated and was able to respond appropriately to commands, demonstrating a favourable early neurological outcome. Despite the absence of documented bystander CPR and a prolonged resuscitation, he achieved successful ROSC, definitive coronary treatment and meaningful neurological recovery.

CLINICAL SIGNIFICANCE

This case highlights the critical role of a rapid, protocol-driven Emergency Medicine response in the Chain of Survival. Immediate recognition, high-quality CPR, rapid defibrillation, advanced life support, timely coronary reperfusion and coordinated post-cardiac-arrest care enabled a favourable outcome despite a high-risk presentation. It reinforces that the absence of bystander CPR does not necessarily mean the absence of a chance of survival when an effective emergency response system is in place.

CLINICAL EXPERT



Dr. Kiran P V
Consultant -
Emergency Medicine



Dr. Anand Kumar M
Consultant -
Interventional
Cardiologist



Dr. Mohammed Sajid Ali
Consultant -
Emergency Medicine

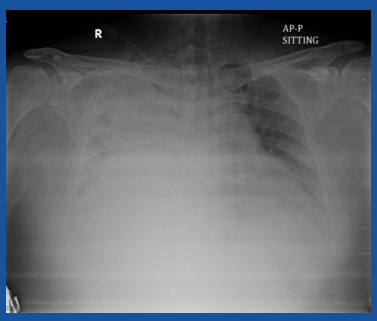

RR NAGAR
CASE IN POINT
SPARSH HOSPITAL

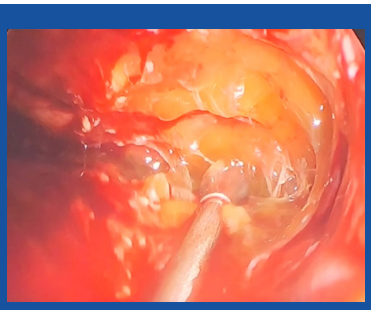
CASE-7

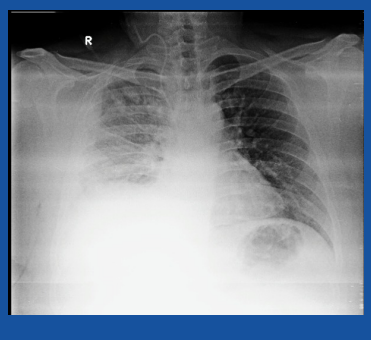
Successful VATS Decortication for Grade III Empyema in a High-Risk Patient

CLINICAL PRESENTATION

A 40-year-old male presented with acute breathlessness of one day duration and fever for ten days. His medical history was significant for severe COVID-19 infection in 2020 requiring ventilatory support with prone positioning. He was also morbidly obese (BMI 42), adding complexity to his clinical management. The patient required non-invasive ventilation (NIV) on presentation, maintaining SpO_2 of 96% on FiO_2 50%.









INVESTIGATIONS & DIAGNOSIS

Chest X-ray demonstrated extensive right-sided pleural pathology. Contrast-enhanced CT thorax revealed Grade III empyema of the right lung, characterised by multiloculated pleural collections with associated compressive atelectasis.

FINAL DIAGNOSIS

Grade III right-sided empyema with multiloculated pleural collections and compressive atelectasis.

TREATMENT

The patient was managed under the Cardiothoracic and Vascular Surgery (CTVS) team and underwent right-sided Video-Assisted Thoracoscopic Surgery (VATS) decortication. The procedure involved evacuation of the multiloculated pleural collections and decortication to relieve the trapped lung and facilitate restoration of pulmonary function.

POST-OPERATIVE OUTCOMES

The patient tolerated the procedure well. Postoperative chest X-ray demonstrated satisfactory lung expansion with resolution of the pleural collections. Recovery was uneventful, and the patient was discharged in a stable condition.

CLINICAL SIGNIFICANCE

This case highlights the role of early surgical intervention in advanced empyema, particularly in patients with significant clinical complexity. VATS decortication provided effective evacuation of multiloculated pleural collections and relief of trapped lung, resulting in satisfactory lung re-expansion and an uneventful recovery.

CLINICAL EXPERTS



Dr. Ashwini Kumar Pasarad
Senior Consultant -
Cardiac & Transplant Surgeon



Dr. Vijay C L
Consultant -
Thoracic Surgery



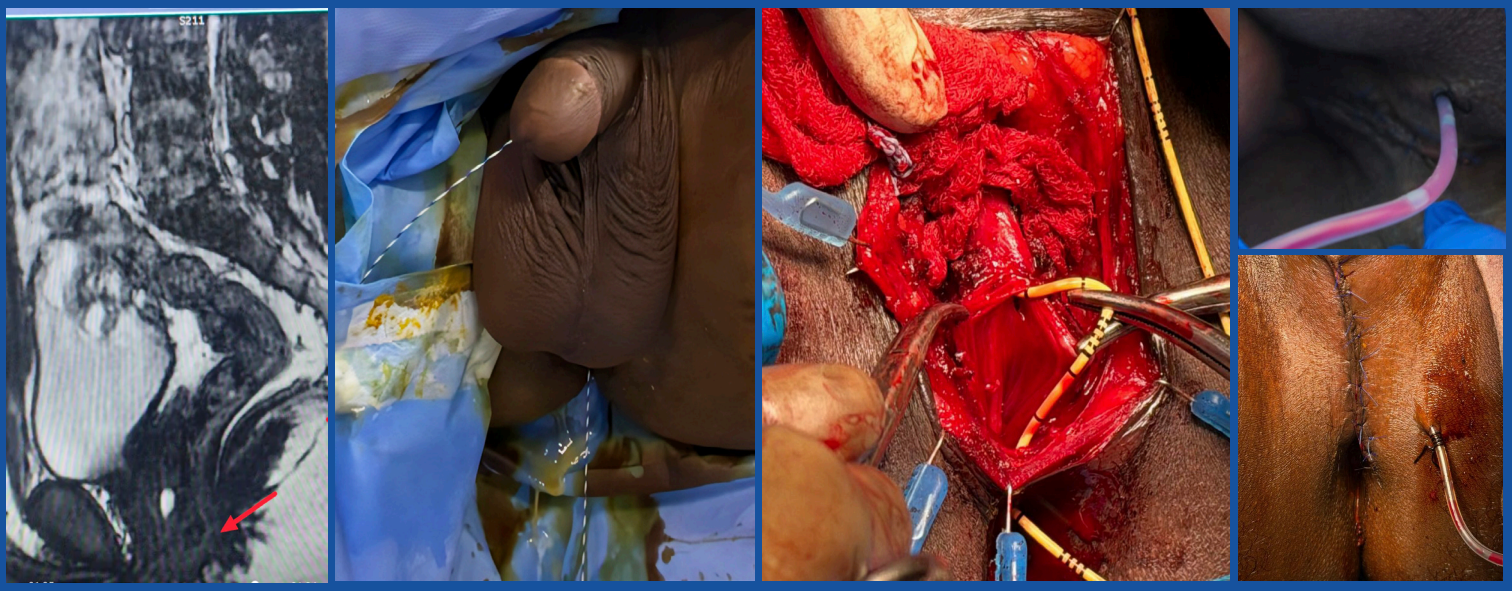
Dr. Hitesh J
Consultant -
Cardiothoracic & Vascular Surgeon

CASE-8

Complex Recto-Urethral Fistula Repaired Through a Multidisciplinary Surgical Approach

CLINICAL PRESENTATION

A 24-year-old otherwise fit male from Yemen presented with a history of passing small amounts of urine per rectum for several years. He had undergone pelvic surgery during childhood for a suspected anorectal malformation; however, details of the previous procedure were unavailable.



INVESTIGATIONS & DIAGNOSIS

CECT and MRI of the abdomen and pelvis did not demonstrate any convincing abnormality. Given the strong clinical suspicion of a fistulous communication, examination under anaesthesia, colonoscopy and cystoscopy were performed to define the anatomy and surgical roadmap. Colonoscopy was normal, while cystoscopy demonstrated a proximal urethral stricture followed by a fistulous communication between the proximal bulbar urethra and distal rectum near the anal verge. The communication was confirmed by guidewire passage from the urethra into the rectum.

FINAL DIAGNOSIS

Recto-urethral fistula associated with proximal urethral stricture, with the fistulous tract extending between the proximal bulbar urethra and distal rectum.

TREATMENT

Following multidisciplinary surgical planning, the patient underwent recto-urethral fistula repair with bilateral Dartos muscle interposition flaps and antigen-free dermis placement on 09/07/2026. Cystoscopy-guided guidewire placement was followed by VIU, opening of the fistulous tract and complete fistulectomy with excision of the intervening fibrotic tract. The urethral and rectal defects were closed separately, with bilateral broad-based Dartos muscle flaps interposed between the repair sites and antigen-free dermis placed over the repaired areas.

POST-OPERATIVE OUTCOMES

The postoperative course was uneventful. A Foley catheter was maintained for five weeks to facilitate healing of the urethral repair. On follow-up, the surgical wound remained clean and well healed. Following catheter removal, the patient was voiding normally with no evidence of recurrent fistulous communication.

CLINICAL SIGNIFICANCE

This case demonstrates the complexity of managing a long-standing recto-urethral fistula with associated urethral stricture, particularly when previous pelvic surgery has altered the anatomy and historical operative details are unavailable. Precise anatomical delineation through EUA, cystoscopy and colonoscopy, followed by complete fistulectomy, layered closure and vascularised Dartos interposition, enabled successful reconstruction. The case also highlights the value of coordinated expertise across colorectal, minimally invasive GI, urology and plastic surgery in complex pelvic reconstruction.

CLINICAL EXPERTS



Dr. Nagabhushan J S
Senior Consultant –
Surgical Gastroenterology



Dr. Neel Shetty
Senior Consultant –
Surgical Gastroenterology



Dr. Sharath C T
Consultant - Urologist



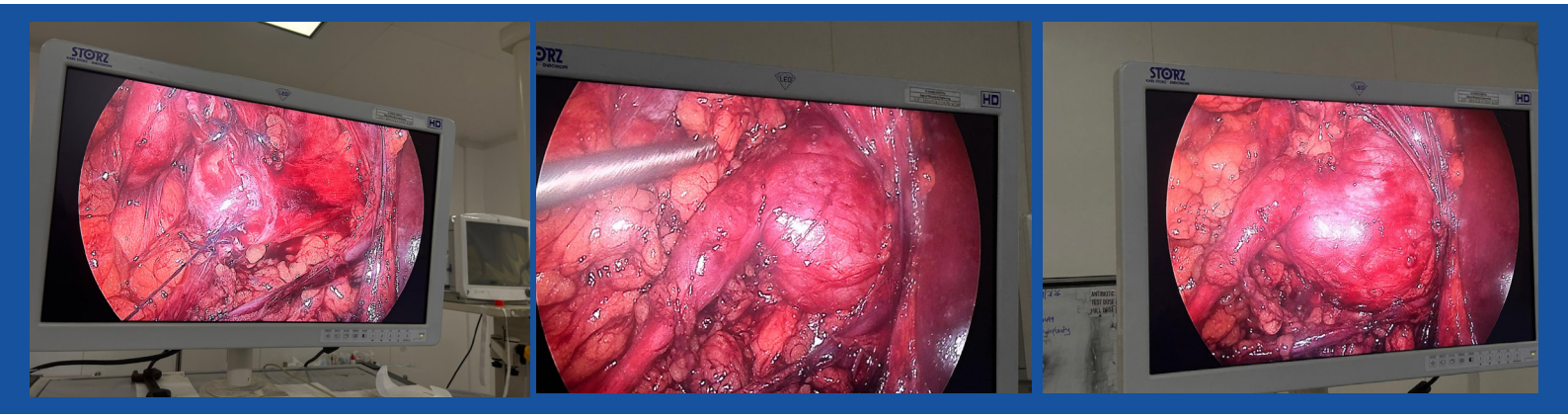
Dr. Gunasekar Vuppalapati
Sr. Consultant - Aesthetics,
Plastic Surgery & Reconstructive
Surgery

CASE-9

Congenital UPJ Obstruction in an Adult: Successful Laparoscopic Pyeloplasty with Renal Function Preservation

CLINICAL PRESENTATION

A 35-year-old male presented with a six-month history of recurrent, dull aching right flank pain, characteristically aggravated following high fluid intake, consistent with Dietl's crisis. Examination revealed mild right flank tenderness without a palpable mass.



INVESTIGATIONS & DIAGNOSIS

Ultrasonography and CT urography demonstrated severe right hydronephrosis with marked pelvic dilatation and abrupt narrowing at the ureteropelvic junction (UPJ), with no evidence of calculi or crossing lower-pole vessels. DTPA renal scintigraphy showed a severely prolonged obstructive clearance pattern, with a 20-minute clearance half-time unresponsive to diuretic administration. Split GFR was reduced to 32% in the right kidney, with compensatory hyperfunction of the left kidney at 68%.

FINAL DIAGNOSIS

Congenital intrinsic right ureteropelvic junction obstruction causing severe hydronephrosis and impaired right renal function.

TREATMENT

The patient underwent transperitoneal right laparoscopic pyeloplasty under general anaesthesia using a three-port approach. Intraoperatively, congenital intrinsic narrowing at the UPJ was identified. An Anderson-Hynes dismembered pyeloplasty was performed with excision of the stenotic segment and lateral spatulation of the proximal ureter. A 6 Fr × 26 cm Double-J stent was placed antegradely, followed by watertight pelviureteric anastomosis using continuous 4-0 Vicryl sutures.

POST-OPERATIVE OUTCOMES

The postoperative course was uneventful. The perinephric drain was removed on post-operative day 2 following minimal output, and the patient was discharged on day 3. At six-week follow-up, there was complete resolution of flank pain, and the DJ stent was successfully removed cystoscopically. A repeat DTPA scan is planned at three months to assess drainage and split renal function.

CLINICAL SIGNIFICANCE

This case highlights the importance of recognising adult congenital UPJ obstruction, which may remain clinically silent until significant renal functional impairment develops. Objective functional assessment with DTPA demonstrated compromised right renal function and guided definitive intervention. Laparoscopic Anderson-Hynes pyeloplasty provided effective relief of obstruction with an uneventful recovery and preservation of the compromised renal unit.

CLINICAL EXPERT



Dr. Sharath C T
Consultant - Urologist

YELAHANKA

CASE IN POINT



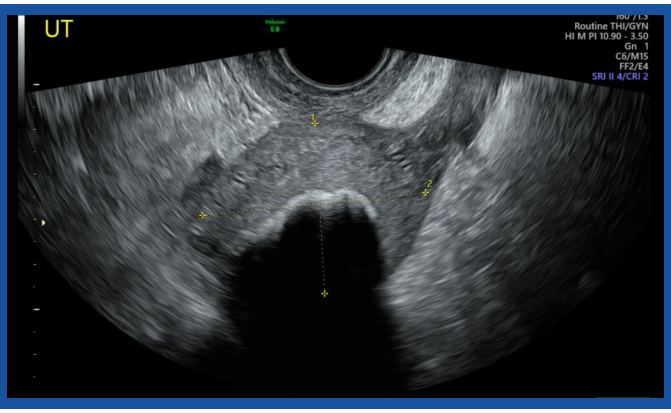
CASE-10

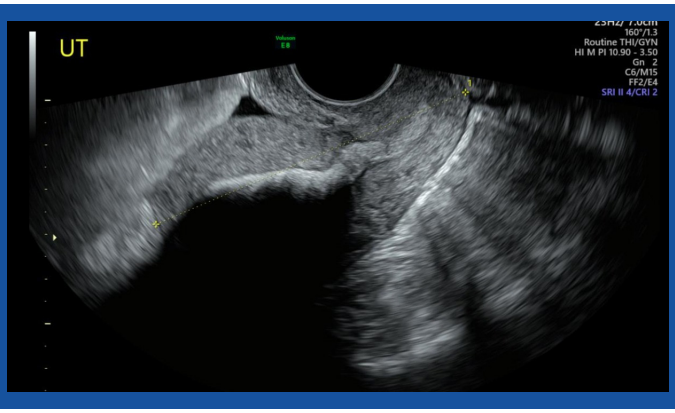
Intrauterine Gossypiboma Following Caesarean Section: A Complex Delayed Presentation Managed by Hysteroscopic Retrieval

CLINICAL PRESENTATION

A 24-year-old P2L2 presented with persistent foul-smelling, yellowish vaginal discharge, soaking approximately one pad per day, following an elective LSCS for her second pregnancy. Her postoperative course following the Caesarean section was significantly complicated. Within three hours of surgery, she developed postpartum haemorrhage and hypotension and subsequently required management at a higher centre. Her course was complicated by sepsis, shock with coagulopathy, severe anaemia, bilateral pleural effusion and Type 1 respiratory failure. She required ICU care, 2 units of PRBC and 4 units of FFP, along with higher antibiotics.

Following recovery from the acute illness, the patient continued to have foul-smelling vaginal discharge and presented for further evaluation.





INVESTIGATIONS & DIAGNOSIS

At presentation, the patient was clinically stable and afebrile. The abdomen was soft and non-tender, while examination revealed foul-smelling vaginal discharge.

In view of the persistent postoperative vaginal discharge and her history of a complicated Caesarean section, further evaluation led to the identification of a retained surgical gauze within the uterine cavity. The clinical diagnosis was P2L2 with previous two LSCS with gossypiboma in uterus.

FINAL DIAGNOSIS

Intrauterine gossypiboma following Caesarean section, presenting as a delayed postoperative complication with persistent foul-smelling vaginal discharge.

TREATMENT

The patient underwent hysteroscopy-guided removal of the retained gauze under general anaesthesia. Intraoperatively, 2 retained gauze was visualised within the uterine cavity and was found to be mildly adherent to the posterior uterine wall. It was carefully retrieved using artery forceps under ultrasound guidance.

The procedure was performed under strict aseptic precautions with the patient in lithotomy position. Following hysteroscopic removal of the retained gauze, gentle curettage was performed. A check hysteroscopy confirmed that there was no retained gauze, and the patient remained stable throughout the procedure.

POST-OPERATIVE OUTCOMES

The postoperative course was uneventful. A P/V pack was inserted and subsequently removed. The patient was discharged with oral medication, advice regarding hydration and avoidance of strenuous activity, and was advised follow-up in the Obstetrics & Gynaecology OPD.

CLINICAL SIGNIFICANCE

This case represents a challenging delayed postoperative presentation following a complicated Caesarean section. The combination of significant preceding postoperative morbidity and persistent foul-smelling vaginal discharge required careful clinical assessment and consideration of an unusual postoperative cause.

The identification of an intrauterine retained gauze and its subsequent hysteroscopic retrieval, particularly in the setting of mild adherence to the posterior uterine wall, demonstrates the value of a minimally invasive, image-guided approach. Complete removal was confirmed intraoperatively by a check scan, allowing the patient to recover without further surgical intervention.

CLINICAL EXPERT



Dr. Swetha S. Reddy
Consultant -
Gynaecologist and Obstetrician



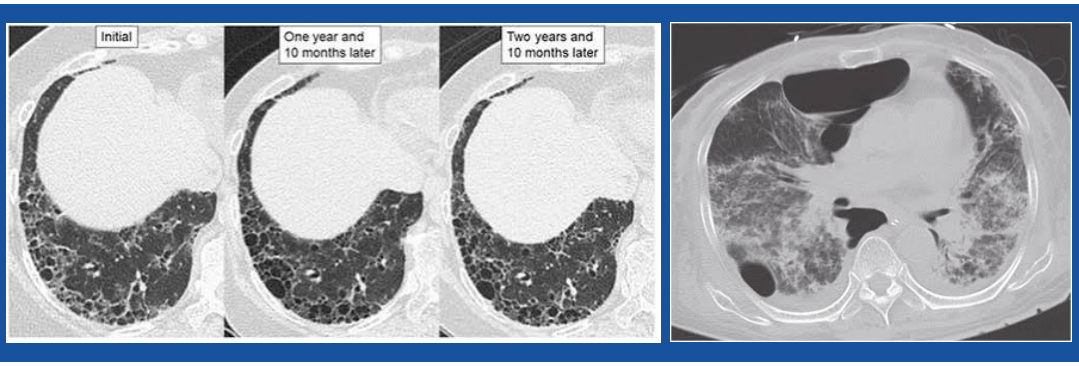
Dr. Sunitha Reddy G
Consultant -
Obstetrics and Gynaecology

CASE-11

Dual-Positive Anti-GBM and MPO-ANCA Disease Complicated by Septic Shock and Multiorgan Dysfunction

CLINICAL PRESENTATION

A 50-year-old woman with a background of rheumatic heart disease, previous infective endocarditis requiring bioprosthetic tricuspid valve replacement, and bronchiectasis was being managed for rapidly progressive acute kidney injury, severe anaemia and active urinary sediment. Her renal deterioration was associated with significant inflammatory and urinary abnormalities, prompting an extensive evaluation for rapidly progressive glomerulonephritis. Three weeks after her initial admission, she presented with severe lower respiratory tract infection (LRTI), followed by septic shock requiring prolonged intensive care management. She subsequently presented with chest pain, loose stools and breathlessness and was found to be hypotensive, requiring inotropic and non-invasive ventilatory support. Chest imaging demonstrated left lower-zone consolidation, while echocardiography revealed severe global LV dysfunction with an LVEF of 25–30%, along with right-sided chamber dilatation and RV dysfunction, necessitating intensive care management.



INVESTIGATIONS & DIAGNOSIS

Laboratory evaluation demonstrated severe renal dysfunction with active urinary sediment, including proteinuria, pyuria and numerous RBCs. Autoimmune work-up revealed positive anti-GBM antibodies with a quantitative level of 30 and markedly elevated MPO-ANCA titres of 164.95, with P-ANCA positivity and C-ANCA negativity. A kidney biopsy was pivotal in establishing the diagnosis. Light microscopy demonstrated 14 glomeruli, of which 11 showed crescents, including nine cellular and two fibrocellular crescents, with tuft necrosis in two glomeruli. Immunofluorescence showed diffuse linear IgG staining along the glomerular capillary basement membrane (3+), supporting anti-GBM disease in the presence of concomitant MPO-ANCA positivity. During her subsequent critical illness, she developed marked thrombocytopenia, severe inflammatory response and cholestatic liver dysfunction. Platelet counts fell to as low as 11,000/μL, while CRP reached 354. Liver investigations demonstrated significant cholestatic derangement, with elevated bilirubin, ALP and GGT.

FINAL DIAGNOSIS

Dual-positive anti-GBM and MPO-ANCA disease with crescentic glomerulonephritis and rapidly progressive renal failure, complicated by dialysis dependence, severe lower respiratory tract infection, septic shock, stress cardiomyopathy, profound thrombocytopenia, cholestatic liver dysfunction and multiorgan dysfunction syndrome.

TREATMENT

Following confirmation of the dual-antibody disease, the patient received pulse methylprednisolone, plasmapheresis and cyclophosphamide, alongside renal replacement therapy. She underwent multiple plasmapheresis sessions and received cyclophosphamide as part of induction immunosuppression. A temporary haemodialysis catheter was inserted and maintenance haemodialysis was continued.

She subsequently developed a lower respiratory tract infection (LRTI) with septic shock, requiring prolonged intensive care management with broad-spectrum intravenous antibiotics, antifungal therapy, inotropic support, non-invasive ventilation and sustained low-efficiency dialysis (SLED). Repeated platelet transfusions were required for severe thrombocytopenia. Cardiology and Gastroenterology inputs were sought, with concurrent management of stress cardiomyopathy, gastrointestinal symptoms and cholestatic liver dysfunction.

POST-OPERATIVE OUTCOMES

Although this was a medically managed case without a surgical intervention, the patient's response following intensive multidisciplinary treatment was significant. Septic shock resolved, vasopressor support was successfully tapered and discontinued, inflammatory markers showed a declining trend and liver function improved. Her respiratory status stabilised with oxygen supplementation, while thrombocytopenia improved from a nadir of 11,000/μL to 50,000/μL. The patient remained anuric and dialysis-dependent at discharge and required continued maintenance haemodialysis and multidisciplinary follow-up. She was transferred to an outside centre for continued conservative management at the request of the patient and family.

CLINICAL SIGNIFICANCE

Dual-positive anti-GBM and MPO-ANCA disease represents an uncommon overlap of two aggressive autoimmune renal conditions and is associated with severe renal injury and a high risk of dialysis dependence. In this case, timely serological evaluation and kidney biopsy were critical in identifying the underlying autoimmune process and enabling early initiation of aggressive immunosuppressive therapy and plasmapheresis.

The clinical challenge was compounded by the patient's significant cardiac and pulmonary comorbidities and subsequent development of severe infection, septic shock and multiorgan dysfunction. Management required simultaneous control of the autoimmune renal disease while addressing dialysis dependence, respiratory failure, stress cardiomyopathy, profound thrombocytopenia and cholestatic liver dysfunction. Despite an exceptionally guarded prognosis, coordinated multidisciplinary management resulted in resolution of septic shock, improvement in organ function, stabilisation of thrombocytopenia and successful transition out of intensive care. The case highlights the importance of early recognition, timely tissue diagnosis, appropriate immunosuppression and seamless collaboration across specialties in managing critically ill patients with rare autoimmune disease complicated by severe infection and multiorgan dysfunction.

CLINICAL EXPERTS



Dr. Girish N. S.
Lead Consultant -
Nephrology & Renal Transplant



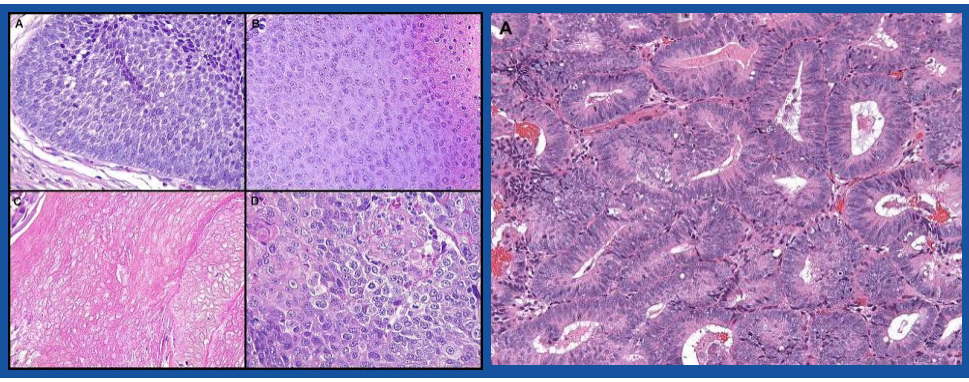
Dr. Gurram Sriharsha
Consultant -
Nephrology & Renal Transplant

CASE-12

A Rare Case Of Morular Metaplasia Mimiking Endometrial Adenocarcinoma.

CLINICAL PRESENTATION

A 31 year old female patient presented with hemorrhagic menstrual bleeding and dysmenorrhea since 1.5 years. She had previously undergone Invitro-fertilization to conceive her child who is now 3 years old.



INVESTIGATIONS & DIAGNOSIS

USG shows Endometrial thickness of 13.3 mm with cystic changes. MRI pelvis shows normal appearing endometrium no myometrial involvement. A slide and block was recevied for second opinion which was previously diagnosed elsewere as Atypical hyperplasia/ endometriod intraepithelial hyperplasia(AH/EIN) focally bordering on Endometrial endometriod adenocarcinoma (FIGO Grade 1).

On thorough evaluation of the slide and block we found multiple tiny tissue bits of polypoidal endometrial tissue with numerous closely packed endometrial glands, showing focal complexity and minimal intervening stroma lined by benign pseudodstratified columnar epithelium.Many foci of glands and stroma shows intraluminal and stromal islands of cells showing uniform round nuclei and moderate eosinophilic cytoplasm.Basement membrane is intact. No granulomas and frank invasive malignancy noted.

Immunohistochemistry was performed that shows CDX2 and CD10 diffusely immunoreactive within the morules. P53 showed normal type(wild type) expression and p63 had only focal weak expression. Ki 67 index was 1-3% within the morules. Beta catenin having focal nuclear expression in few of the morules.

FINAL DIAGNOSIS

Immunohistochemistry and morphological diagnostic features strongly favour- Extensive morular metaplasia in a hyperplastic endometrial polyp.

TREATMENT

Subtotal hystrectomy done and sent for frozen section (done elsewere) and histopathological evaluation. Frozen section also shows mild focal glandular crowding with squamous morule. No evidence of atypical hyperplasia and invasive carcinoma in sections studied. On Histopathology of whole specimen shows Polypoidal endometrium with foci of non-atypical endometrial hyperplasia . No residual metaplasia seen.

CLINICAL SIGNIFICANCE

Morular endometrial metaplasia is a rare, essentially benign, hormonally inert condition with proliferative activity; with associations with pre-malignant and malignant neoplastic changes. Immuno-histochemical tools utilizing new molecular biological advances, can simplify the diagnostic and prognostication processes which aid clinical management.

Of particular note, an EMM sub-type thought to arise from CTNNB1 (beta-catenin) gene mutation, is related to endometrioid endometrial carcinomas and other extra-uterine cancers. The higher recurrence risk of endometrial cancers which feature this mutation may warrant a hysterectomy as a treatment option in these women.

CLINICAL EXPERTS



Dr. Gale Kathleen Edward
Senior Consultant-
Pathologist



Dr. Farheen Naaz Shigli
Consultant-
Pathologist



Dr. Palaniappan Ramanathan
Senior Consultant -
Surgical Oncology



Dr. Swetha S. Reddy
Consultant -
Gynaecologist and Obstetrician

HENNUR ROAD
CASE IN POINT



CASE-13

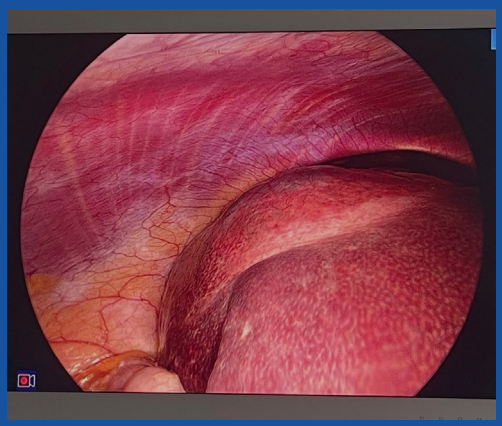
Laparoscopic Deroofing of a Giant Hepatic Cyst: Minimal Access Management of a 22 cm Cyst

CLINICAL PRESENTATION

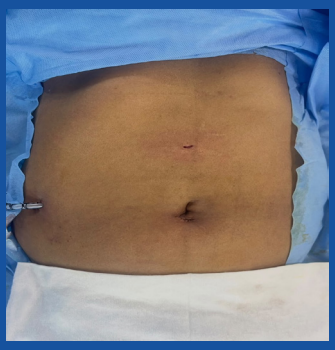
A 48-year-old female presented with upper abdominal fullness for several months, associated with abdominal pain for two weeks. Giant hepatic cysts measuring >10 cm are uncommon and are typically encountered in the 4th–5th decades, with a higher prevalence among females.











INVESTIGATIONS & DIAGNOSIS

CECT demonstrated a 22 × 18 × 14 cm simple hepatic cyst occupying the entire right lobe of the liver, with significant mass effect and displacement of the right kidney, duodenum and pancreas. There was no evidence of biliary communication or internal echoes. Liver function tests and tumour markers were within normal limits.

FINAL DIAGNOSIS

Giant simple hepatic cyst of the right hepatic lobe (22 × 18 × 14 cm).

TREATMENT

The patient underwent laparoscopic deroofing with marsupialization using a three-port technique comprising one 10-mm port and two 5-mm ports. Intraoperatively, 2.5 litres of straw-coloured fluid were aspirated. Adequate deroofing (> 80%) and marsupialization of the cyst with omental packing was performed, followed by drain placement through the right lateral port.

POST-OPERATIVE OUTCOMES

The postoperative recovery was uneventful. Oral diet was initiated four hours after surgery, and the patient was discharged on postoperative day 1. No postoperative complications were reported. Histopathology - Benign Biliary cyst

CLINICAL SIGNIFICANCE

This case demonstrates the feasibility of laparoscopic management even in a giant hepatic cyst with significant intra-abdominal mass effect and hostile anatomy. Despite the size of the lesion and displacement of adjacent structures, a minimally invasive approach enabled effective decompression and deroofing with an uneventful recovery, early oral intake and next-day discharge.

CLINICAL EXPERTS



Dr. Ramraj V. N.
Lead Consultant - Gastrointestinal, General, Minimal Access & Bariatric Surgery



Dr. Santosh M P
Senior Consultant - General, Gastrointestinal, Minimally Invasive & Bariatric Surgery



Dr. Yedin Chandra
Consultant - Gastrointestinal, General, Minimal Access & Bariatric Surgery

CASE-14

From Toe-Walking to Plantigrade: Single-Stage Reconstruction of Complex Post-Traumatic Achilles Contracture

CLINICAL PRESENTATION

A 28-year-old man presented with a severe post-traumatic right lower limb deformity following an Achilles tendon injury sustained during the conflict in Yemen. Despite undergoing multiple previous surgical procedures, he experienced persistent calf tightness and pain and was unable to place his right heel on the ground, resulting in toe-walking. Extensive scarring over the posterior aspect of the leg further exacerbated the functional deformity.

Clinical examination revealed a thick scar over the lower third of the right leg, a fixed equinus deformity, and profound disuse atrophy of the posterior compartment muscles resulting from the longstanding deformity. The patient was admitted for definitive surgical reconstruction.



INVESTIGATIONS & DIAGNOSIS

Post-traumatic equinus deformity secondary to tendo-Achilles contracture of the right lower limb with extensive posterior leg scarring.

FINAL DIAGNOSIS

Correction of the deformity following excisional scar release presented a complex reconstructive challenge: addressing the contracted Achilles tendon alone would leave a substantial soft-tissue defect requiring reliable and durable coverage.

TREATMENT

Under general anaesthesia, the patient underwent a single-stage reconstructive procedure comprising excision of the thick scar, tendo-Achilles Z-lengthening and immediate free anterolateral thigh (ALT) flap reconstruction. The tight Achilles tendon was explored and Z-lengthening was performed to correct the contracture. The posterior tibial vessels were then explored through a medial incision, and an ALT flap was harvested from the contralateral thigh to cover the posterior leg defect. Microvascular revascularisation was achieved via end-to-end anastomosis to the posterior tibial vessels (one artery and two veins). Flap perfusion was satisfactory upon completion of the procedure.

POST-OPERATIVE OUTCOMES

The patient recovered well following the procedure, with no immediate postoperative complications. The reconstructive procedure successfully corrected the equinus deformity, allowing the patient to achieve a neutral position of the ankle on table with good passive range of movements at the ankle joint. The patient was discharged in stable condition with instructions for limb elevation, splinting and non-weight-bearing ambulation during the initial postoperative period. Over the following weeks, he underwent rigorous physiotherapy and training, regaining near-normal active ankle mobility, full heel-strike capability, and a stable plantigrade gait.

CLINICAL SIGNIFICANCE

This case highlights the challenge of managing a longstanding post-traumatic Achilles tendon contracture in the presence of severe soft-tissue deficiency. Deformity correction alone would have been insufficient without addressing the overlying scarred tissue. A single-stage approach—combining tendon reconstruction with microsurgical free tissue transfer (an ALT free flap with microvascular anastomosis to the posterior tibial vessels)—simultaneously restored tendon length, corrected the equinus deformity, and provided durable soft-tissue coverage. Achieving a plantigrade foot demonstrates the value of reconstructive microsurgery, restoring not only anatomical integrity but also fundamental mobility: the ability to take a normal step.

CLINICAL EXPERTS



Dr. Anand K
Chief Consultant-
Plastic & Reconstructive
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Dr. Gautham M
Consultant -
Plastic &
Reconstructive
Surgery



Dr. Gururaj Hosahalli
Consultant –
Plastic Surgery

SARJAPUR ROAD
CASE IN POINT

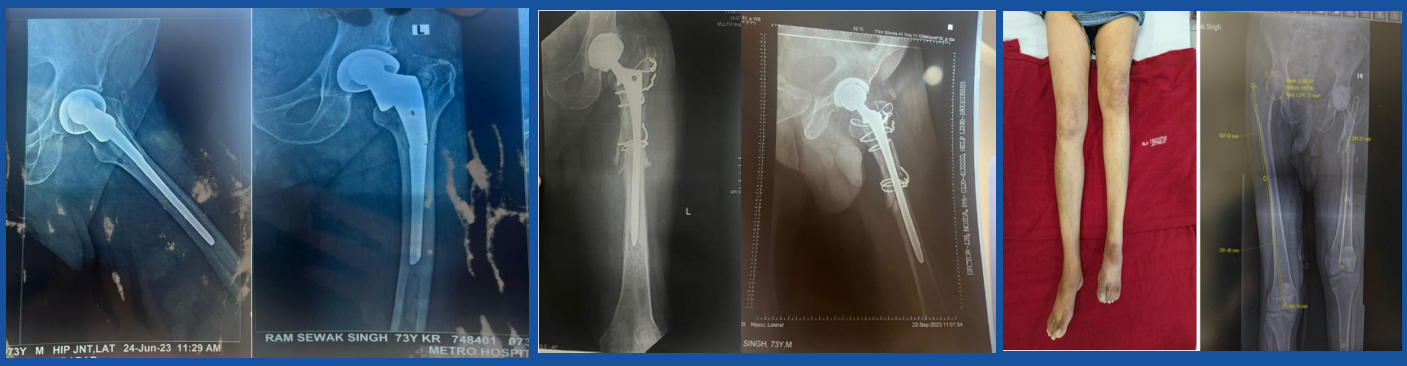


CASE-15

Complex Proximal Femoral Non-Union with Severe Limb Shortening: Reconstruction with a Megaprosthesis

CLINICAL PRESENTATION

A male patient presented with pain, deformity and inability to bear weight on the left lower limb, with significant limb shortening following previous revision hip surgery. His history included a left hip hemiarthroplasty following a fall, followed years later by implant failure and revision surgery complicated by a peri-implant fracture of the proximal femur. The fracture subsequently progressed to non-union, osteolysis and prosthetic instability, resulting in progressive limb shortening and loss of function.



INVESTIGATIONS & DIAGNOSIS

Clinical examination demonstrated a 7 cm shortened, deformed left lower limb, abnormal mobility at the proximal femur, absent transmitted movements at the hip and a positive telescopy test. Radiographs showed atrophic non-union with failed implants, broken cerclage wires within the femoral canal and suspected infection. Further assessment identified recurrent urinary tract infections requiring treatment prior to definitive reconstruction.

FINAL DIAGNOSIS

Complex proximal femoral non-union with failed revision hip arthroplasty, osteolysis, prosthetic instability and severe limb shortening, with concern for periprosthetic joint infection.

TREATMENT

Following optimisation of haematological parameters and treatment of active infections, the patient underwent the first stage of reconstruction comprising implant extraction, meticulous debridement, deep tissue sampling for culture and placement of an antibiotic-eluting articulating cement spacer. The non-viable, sclerotic proximal femoral segment was excised in total, followed by prolonged antimicrobial therapy according to the periprosthetic joint infection protocol.

After six weeks of infection work-up and optimisation, a standing scanogram demonstrated approximately 19 cm of limb shortening with inadequate viable proximal femur for conventional hip reconstruction. The definitive procedure involved removal of the cement spacer and reconstruction of the entire proximal femur using a limb-reconstruction megaprosthesis combined with total hip replacement through a Southern-Moore approach.

POST-OPERATIVE OUTCOMES

Protected assisted full weight-bearing was initiated on postoperative day 3, supported by aggressive physiotherapy that had commenced following the first-stage procedure. At six-week follow-up, serial radiographs demonstrated satisfactory osteointegration, preserved hip biomechanics and maintained range of motion. The patient, who had experienced a non-weight-bearing, severely shortened limb for almost four years, ultimately achieved a functioning hip with restored limb alignment and a normal gait following reconstruction with the limb-reconstruction megaprosthesis system.

CLINICAL SIGNIFICANCE

This case demonstrates the challenges of managing failed revision hip arthroplasty complicated by proximal femoral bone loss, non-union, suspected infection and profound limb shortening. Conventional reconstruction was not feasible because of the absence of viable proximal femoral bone. A staged approach combining infection control, radical debridement and subsequent megaprosthetic proximal femoral reconstruction with total hip replacement provided a viable solution for restoring hip stability, limb length and function.

CLINICAL EXPERT



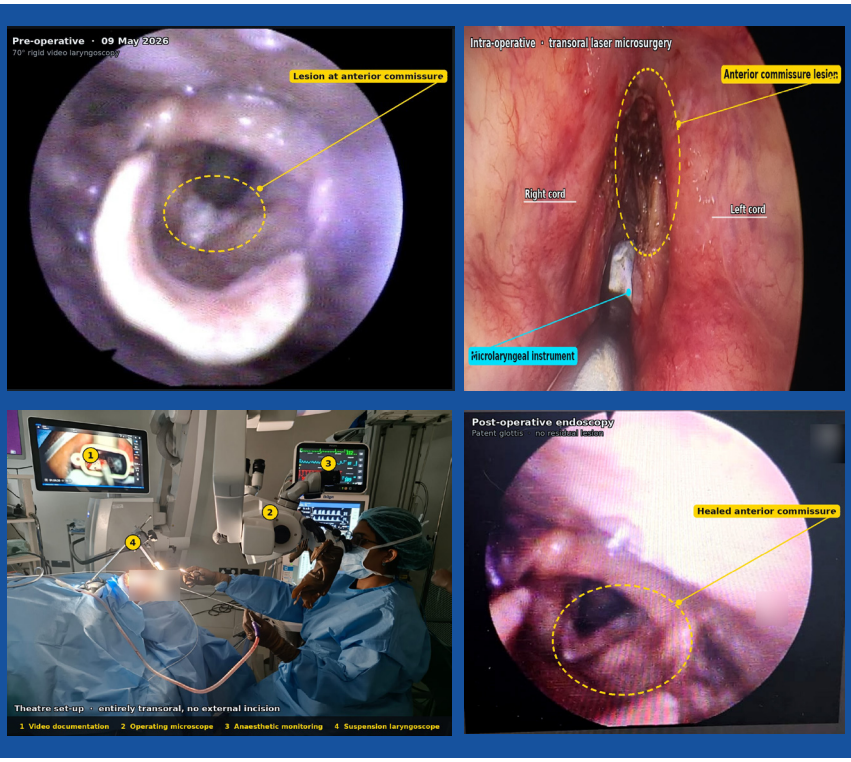
Dr. Prashanth B N Jain
Senior Consultant - Orthopaedics

CASE-16

Transoral Laser Microsurgery for Early Laryngeal Carcinoma: Voice Preservation with Same-Day Discharge

CLINICAL PRESENTATION

A 79-year-old gentleman presented with progressively worsening hoarseness of voice for six months. Diagnostic video laryngoscopy revealed a lesion involving both vocal cords at the anterior commissure. Following an initial trial of conservative medical management, interval check scopy demonstrated increase in lesion size with an anterior laryngeal web and contiguous bilateral cord involvement extending across the anterior commissure.



INVESTIGATIONS & DIAGNOSIS

Contrast-enhanced CT of the neck demonstrated a right vocal cord lesion extending across the anterior commissure to the left vocal cord, without evidence of deep invasion or nodal disease. The progressive lesion on interval laryngoscopy prompted definitive tissue diagnosis and treatment.

FINAL DIAGNOSIS

T1 microinvasive squamous cell carcinoma of the larynx, involving the vocal cords and anterior commissure.

TREATMENT

Following discussion of the available treatment options, risks and benefits, the patient underwent microlaryngoscopy with transoral laser microsurgery (TLM) under general anaesthesia. A right cordectomy with excision of the left cord and anterior commissure lesion was performed entirely through the oral cavity, with no external incision. Histopathology confirmed complete excision of the T1 microinvasive squamous cell carcinoma.

POST-OPERATIVE OUTCOMES

The patient was discharged home on the same day of surgery. Recovery has been smooth, and he remains on a standard head and neck cancer surveillance protocol.

CLINICAL SIGNIFICANCE

This case highlights the importance of investigating persistent hoarseness, particularly when lasting beyond 3–4 weeks in patients over 40, as outpatient laryngoscopy can identify laryngeal malignancy at a potentially curable stage.

It also demonstrates the role of transoral laser microsurgery in early glottic cancer, offering organ-preserving, scarless treatment through a single minimally invasive procedure, while avoiding upfront open surgery or radiotherapy and preserving future treatment options.

CLINICAL EXPERT



Dr. Diptarka Bhattacharyya
Lead Consultant – Minimal Access ENT Surgery

CASE-17

Occult Neurotoxic Snakebite Mimicking Brain Death
A Case Of Profound Neuroparalysis With Complete Functional Recovery

CLINICAL PRESENTATION

A 16-year-old previously healthy male developed sudden severe central abdominal pain with 2–3 episodes of vomiting during the early hours of the day. He subsequently developed dysphagia, ptosis with difficulty opening his eyes and slurred speech, followed by progressive respiratory distress, hypoxia, hypotension and deterioration in sensorium. A reported episode of cardiopulmonary arrest required approximately three minutes of CPR before return of spontaneous circulation.

He was subsequently transferred to a tertiary centre with GCS E1V1M1 (3/15), absent brainstem reflexes and acute respiratory failure requiring invasive mechanical ventilation.



INVESTIGATIONS & DIAGNOSIS

Initial CT brain and CT abdomen/pelvis showed no acute abnormality. The clinical differential included neurotoxic envenomation, food-borne botulism, toxic ingestion/poisoning, AIDP and other causes of acute neuromuscular paralysis. EEG demonstrated no electrographic seizure activity, making ongoing non-convulsive seizure activity less likely. Although there was no witnessed snakebite or identified snake, suspected fang marks near the right little toe provided an important clinical clue.

FINAL DIAGNOSIS

Suspected neurotoxic snake envenomation presenting as acute flaccid paralysis with bulbar involvement and respiratory failure, clinically mimicking catastrophic neurological injury.

TREATMENT

Based on the clinical picture and suspected fang marks, Polyvalent Anti-Snake Venom (ASV) was administered, with 10 vials as the initial dose followed by second and third doses of 10 vials each. This was supported by invasive mechanical ventilation, neuro-critical care and subsequent neurorehabilitation.

POST-OPERATIVE OUTCOMES

Neurological improvement was observed following treatment, with progressive recovery of proximal, distal and truncal muscle strength. The patient subsequently met weaning and extubation criteria and was successfully extubated. Continued neurorehabilitation resulted in significant functional recovery, and he was planned for discharge home.

CLINICAL SIGNIFICANCE

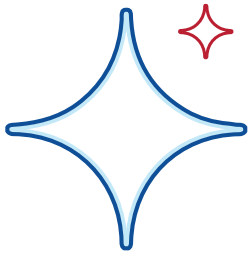
This case highlights the diagnostic challenge of neurotoxic envenomation without a witnessed bite or prominent local signs. The progression from gastrointestinal symptoms to bulbar dysfunction, ophthalmoplegia/ptosis, profound flaccid paralysis and respiratory failure, in the absence of an intracranial abnormality, should prompt consideration of neurotoxic snake envenomation.

The case also demonstrates the value of serial neurological examination, environmental and exposure history, meticulous examination for subtle fang marks and exclusion of important neurological and toxicological differentials. Early clinical suspicion allowed timely administration of ASV and prolonged ventilatory support, resulting in substantial neurological recovery.

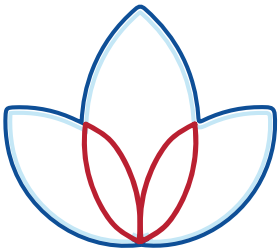
CLINICAL EXPERT



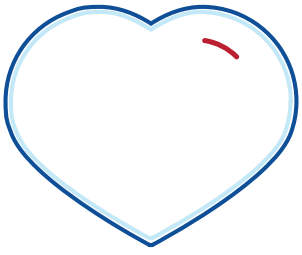
Dr. Ramkumar Jayaprakash
HOD and Lead Consultant -
Critical Care Medicine



FAITH



HOPE



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Rheumatology	Physiotherapy	Dermatology
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