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## HIGHLIGHTS



# NIPAH VIRUS : WHAT WE NEED TO KNOW

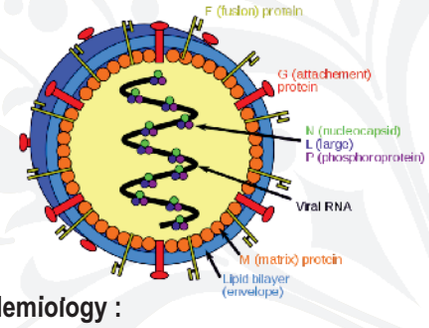
Dr. Upasana Choudhary, Assitant Professor, Dept. of Microbiology, GMCH.

Dr. Upasana Choudhary

Nipah virus (NiV) infection is a newly emerging zoonosis that causes severe disease in both animals and humans. It belong to Genera Paramyxoviridae , family Henipavirus. Outbreaks occur between December and May.

## Morphology

Nipah virus particle range in diameter from 120-500nm. It is non segmented, single stranded RNA virus. Lipid bilayer envelope with spikes having F fusion protein trimers and G protein tetramers are present.




## Epidemiology :

An outbreak of severe encephalitis occurred in pig farmers in the Perak state of Malyasia , including the village of Kampung Sungai Nipah , in September 1998. There were total 276 cases of acute Nipah virus , 106 of which were fatal. Nipah virus was isolated from respiratory secretions and urine of 8-10 patients. Subsequent outbreaks occurred in Bangladesh nearly every year since 2001 and in India During an outbreak in India in 2001 , 45-60 patients had a history of exposure to individuals infected with Nipah virus in Siliguri. In 2007 in Nadia district , 50 suspected cases were documented.

On 19 May 2018, a Nipah virus disease (NiV) outbreak was reported from Kozhikode district of Kerala, India. This is the first NiV outbreak in South India. There have been 17 deaths and 18 confirmed cases as of 1 June 2018. The two affected districts are Kozhikode and Mallapuram.

## Reservoirs and Intermediate hosts:

The natural host of the virus are fruit bats of the Pteropodidae Family, Pteropus genus. Bats were screened for the presence of anti-Nipah antibodies. Island flying foxes (Pteropus hypomelanus) and Malayan flying foxes ( Pteropus vampyrus) were found to have neutralising antibodies to Nipah Virus. Incubation period ranges from 6-11 days with a median of 9 days.Fruit bats (flying foxes) are the natural host for both Nipah and Hendra viruses. Transmission of NIV to humans may ocur after direct contact with infected pigs also.

Ecologic changes, including land use and animal husbandry practices, are probably the reason for the emergence of these two infectious diseases.Mainly healthcare workers are affected, suggesting that nosocomial transmission played an important role for its spread.

## Clinical features:

Although a subclinical infection can occur, the ratio of symptomatic to subclinical infection was approximately 3:1 during outbreaks. NiV infection in humans has a range of clinical presentations, from asymptomatic infection to acute respiratory syndrome and fatal encephalitis. Fever, headache, dizziness and vomiting were typical features with what the patient generally complains, which can mimick any viral infection. More than 50% patients had a decreased level of consciousness and brainstem dysfunction, including signs of myoclonus , areflexia, hypotonia, hypertension and tachycardia. Severely ill patients also had multisystem organ dysfunction, including sepsis, gastrointestinal bleeding and renal failure.

## Laboratory Diagnosis:

Leukopenia, Thrombocytopenia and elevated levels of alanine aminotransferase and aspartate aminotransferase were common laboratory abnormalities. CSF with elevated white blood cells or protein levels is witnessed frequently. Isolation of Nipah virus from CSF is strongly associated with mortality.

### *Diagnostic tests*

Nipah virus can be detected from urine and respiratory secretions by culture and PCR.Methods used for detection of Nipah virus infection includes Culture, serology, Electron Microscopy, Immunohistochemistry, Reverse transcriptase polymerase chain reaction (RT-PCR) and serum neutralisation test. Antibody detection by ELISA (IgG& IgM) can also be helpful.

Real time PCR is more sensitive than conventional RT-PCR. Serology is used for epidemiological purpose

## Prevention

Ribavirin is the drug of choice.Human monoclonal antibody targeting the Nipah G glycoprotein. Standard infection control practices and proper barrier nursing techniques to prevent nosocomial infections should be implemented

## References:

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2. Gerald Mandell, John Bennett, Raphael Dolin. Mandell, Douglas, and Bennett's Principles and Practice of Infectious Diseases. Elseiver publishers 2009, 7th edition ; Chapter 13: 1947-77.
3. http://www.who.int/csr/disease/nipah/en/

## Desk of the Dean

From the Dean's desk…

Dear Reader,

An intriguing joint issue of two quarters of *Spandan* is before you. In this issue, the reader will find scientific articles addressing latest research from various health care specialties. The institute has been recently awarded the NABH accreditation. It is hoped that this change will translate into enrichment of the scientific knowledge base and health care services across the region. This issue has reports on the major academic events held in the University. I wholeheartedly commend the enthusiastic and proactive efforts of under-graduate, post-graduate students and faculty members who have brought laurels to the University. The contributors deserve appreciation, as it is due to their humble and sincere efforts that *Spandan* is academically rich. I extend my best wishes and commendation to the Editorial Board for their endeavors to maintain *Spandan* as the flag bearer of Geetanjali University. Best wishes!

## Editor's Desk

### Profuse Greetings and Good Wishes

We are in a blessed period of 72nd Independence day celebrations with soaring monsoon Spirits.

With mother earth cooling down, hills getting green covers and dancing rain drops trumps me up to present before you a brand new issue of *Spandan*.

Me and my colleagues of the editorial board make sincere efforts to make it an "inclusive reporting," of all that is happening at our institution. It augers well for this great institution as we continue getting plentiful of original articles, academic events and happenings at GMCH.

It swells me with pride when our young medical graduate and Post graduate students bring write-ups, their dream, aspirations and challenges of their tumultuous journey here.

We are at the cusp of making a "quantum leap" at GMCH.

Do contribute and encourage us by giving us your critical feedback.

Happy Reading

**Editor-in-Chief**

Prof. Pankaj Saxena

## ATRAUMATIC SPLEENIC RUPTURE : A RARE SEQUEL OF DENGUE FEVER

Prof. Pankaj Saxena, Head, Department of General Surgery, GMCH.

**Introduction**

Atraumatic Splenic Rupture (ASR) is uncommon but not exceptional. The incidence, mechanisms, treatment guidelines, and prognosis are poorly defined due to heterogeneity and limited availability of comprehensive reviews.

Dengue fever (DF) is characterized by a spectrum of clinical features that ranges from asymptomatic infection to severe illness (dengue hemorrhagic fever/dengue shock syndrome). We report a non-fatal case of ASR in a young patient with dengue fever with no cutaneous and mucosal bleeding tendencies but with features of circulatory collapse due to visceral bleed.

**Case Report**

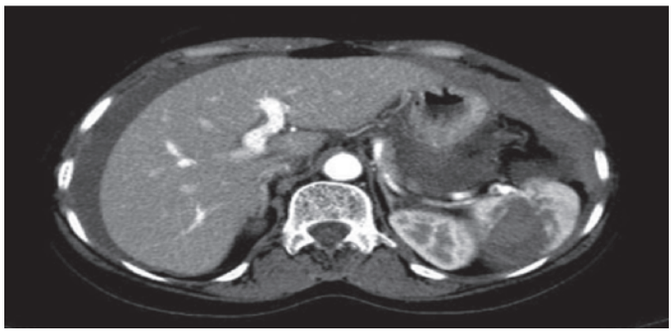
A 19-year-old male presented with an acute abdominal pain and prostration in a background of intermittent fever of 4-5 days. On examination, severe pallor, tachycardia (pulse 120/min), tachypnea and a blood pressure of 90/60 mm of Hg, generalised tenderness over the abdomen with no guarding or rigidity were noted. Ascites was present without hepatosplenomegaly. Other systemic examinations were non-contributory.

The ultrasound findings were suggestive of a possible large hematoma at the upper pole of normal sized spleen with haemoperitoneum . A CECT-abdomen showed a large heterogenous area (HU70-80) involving left subdiaphragmatic, gastrospleenic and left lumbar region, measuring approx.14 cm × 10 cm × 15.5 cm suggestive of haematoma with extravasation of contrast into haematoma. There was also gross free fluid (HU-35-50) in abdomen and pelvis suggestive of haemoperitoneum (Figure 1). These findings were consistent with splenic rupture with intra- and peri-splenic hematoma. Initial investigations revealed, hemoglobin (Hb)-5 g/dl, total leukocyte count-7.1 × $10^9$/l , platelet count -51 × $10^9$/l; prothombin Time -17 sec, international normalized ratio was 1.2, rest all routine blood investigations were normal

He had positive IgM antibodies and negative IgG antibodies against dengue. He was seronegative for malaria dual antigen, Widal test and HIV.

He was resuscitated with crystalloids and blood transfusions (2 units of packed cells; 4 units FFP and 4 units of platelets) pre and intraoperatively. He underwent splenectomy in view of the hemodynamic status. The surgical procedure was uneventful. There was no fever or bleeding tendencies in the post-operative period. Two more units of packed cells were transfused postoperatively. His follow-up hemogram improved on the 2nd post-operative day (POD) onward- from Hb 7.6 g/dl, platelet 92 × $10^9$/l to Hb-12.2gm/dl & Platelet-121×$10^9$/l on POD4. He was discharged in good state.

Macroscopic examination of the specimen showed a longitudinal rupture from the upper pole of spleen to the centre of the hilum, causing dehiscence of the splenic capsule all through the course along with overlying hematomas. Histopathology of the spleen showed normal architecture with no evidence of hyperplasia, cellular infiltrates, or haematological malignancy.



**Discussion**

Most common cause of Splenic rupture is trauma but this does not negate the possibility of ASR.

Infections associated with ASR include dengue, malaria, typhoid etc. In case of dengue the pathogenesis behind this serious complication is probably congestion of spleen and thrombocytopenia or both. Splenectomy is the treatment of choice for spontaneous splenic rupture with hemoperitoneum, but several reports also advocate a trial of initial conservative management. The therapeutic choice depends upon the hemodynamic status of the patient and cases not responding to conservative therapy must undergo splenectomy. The survival observed in these cases should be attributed to timely diagnosis and management rather than the natural course of splenic rupture, which is expected to be poor if the diagnosis is missed. We went for spleenectomy in our patient to which he responded with a good outcome.

Dr. Kusum Lata Mathur

## A SCHOOL-BASED SURVEY OF PREMENSTRUAL DYSPHORIC DISORDER-RELATIONSHIP WITH DEPRESSION, ANXIETY, SELF-ESTEEM AND QUALITY OF LIFE

Kusum Lata Mathur[1], Manu Sharma[2], Devanshi Sharma[3], Shikha Talati[4]
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[2]Assistant Professor, [3,4]Post-graduate Resident, Department of Psychiatry, GMCH.

**Introduction:**

Premenstrual dysphoric disorder (PMDD) is a severe and debilitating form of Premenstrual syndrome (PMS) affecting women in their reproductive age. There is paucity of Indian research in this area among adolescents. Aims: To determine the prevalence of PMDD in adolescent school students, and to study relationship between PMDD and anxiety, depression, self-esteem and quality of life (QOL).

**Materials and Methods:**

A cross-sectional survey was conducted on 100 adolescent students of an urban school. The Premenstrual symptom screening tool for adolescents (PSST-A), Hamilton anxiety (HAM-A) and Depression (HAM-D) Scale, Rosenberg self esteem scale (RSES) and The women's quality of life questionnaire were employed.

**Results:**

All participants reported at least one PMS symptom of minimal severity and 68% had at least one PMS symptom of moderate-severe intensity. Twenty five percent of the participants had 'moderate-to severe' PMS. None of the participants qualified for PMDD. Disruption of daily activities was reported by 35% while 22% missed school due to PMS. A statistically significant relationship was found between PSST scores and HAM-D score ($p<0.005$). No statistically significant relationship was found between PSST scores and HAM-A, RSES and Women's QOL scores.

**Conclusion:**

Although PMS and PMDD pose a difficulty, majority of adolescents do not have significant anxiety, experience positive self-esteem and good quality of life. There is a need for multi-centric and multi-disciplinary research to further elucidate the factors associated with PMS and PMDD in this population.

Dr. Geetika Milind Khachane

## THE DAUNTING CHALLENGES AND OPPORTUNITY GALORE FOR ASPIRING MEDICAL UNDERGRADUATES

Dr. Geetika Milind Khachane, Intern, GMCH.

It was a Sunday morning like every other, until it wasn't. We were waiting on my father to come back from the doctor's appointment to launch into the weekend plans, when we received a call from my father's ophthalmologist saying he was having a heart attack and had passed out in the street facing his clinic. Everything after that was a blur, of ambulances, concerned neighbours and wailing relatives. Through it all, all I remember is my mother's countenance. After a brief moment of trepidation and emotion the strength and composure with which she handled everything. In that moment she was nothing but a doctor. And that is all I ever wanted to be.

It's one thing to be determined about something and another to actually achieve it. It's a road full of scattered thorns and blooms on the way to becoming a doctor. For all the 13-lakh applicants who take the NEET pre-medical test, on an average less than 5000 actually get in. Which is ironic, considering that we have 1 doctor for every 11,000 patients in India. Retrospective to this a small country with resources far less that ours Cuba has a doctor: patient ratio of 1:170 , one of the highest in the world and has been lauded by WHO to be one of the best medical systems in the world. With Indian medical education system becoming the largest in the world, a policy change is needed particularly as the Indian reservation system creates an imbalance and inequality among students from various backgrounds, when it was designed to resolve the same. Coming to the lucky ones(or not so lucky) to be admitted , coping with the challenges of the first year, swimming and succeeding through them can be a herculean task, especially when you don't have the comforts of home cooked meal to sooth those brazen nerves.

It's not easy to maintain that mettle when the stench of formalin ambushes your nostrils. It's quite a show with already a few fainting interludes between. It's surreal, seeing the cadavers for the first time, registering the fact that this was a person not unlike us, had it not been for dedication to science or the unfortunate hand-to-mouth life they had.It stems partly from the unavailability of expert teachers and more so their willingness to teach. Safe to say I have been blessed in that regard with excellent mentorship throughout. The paucity of good patient flow at some canters is a major detrimental factor in training. Its another story when you find patients hell-bent on making a joke of you with histories straight of a Bollywood movie. Many are yet to update their technology as per the global standards. Moreover absence of adjoin and in-house post-mortem facilities often cause students to fall back to rote learning trying to grasp blindly at the fundamentals of forensic medicine.

First years' often ask themselves, 'Am I able enough?' and the final years' that, 'will I ever know enough!' And the cycle never ends. The maze of purples, violets and pinks rarely let you have an eureka moment trying to discern one histopathology slide from another. Neither does the immense data of facts and figures PSM throws at you. Its easy to lose track of our goals and burnout with lassitude trying to haggle academic excellence with the Leisure's of social life.The catacomb of tongue twisting and tying drugs make you question at every step whether this is for you, with every drug you pursue dripping out of your brain like water from leaky plumbing.This has created a widespread problem of depression leading to substance abuse among the students, in their fight to keep afloat. Truth to be told medicine is like the mighty ocean, not the calm serene, but turbulent and tempestuous waters. I sometimes find myself drowning trying to swim to across.

But it's not all grim study sessions and grey days. Medical science is all about overall personality development and holistic nurturing of an individual. We are taught the golden rules of empathy, communication and effective time management early on in life. Once we're through we'll be able to breeze through the craziest of days balancing a tray full of thing on the little pinkie finger. We get the opportunity to train under world class doctors, the very best and the brightest minds of the age. It gives the real time experience early on as to what to expect from the future. As far as India as a resource is considered it's an unparalleled where patient flow is considered. It is a goldmine of cases to review sharpening our diagnosis acumen early on. This is evident from the success of Indian doctors worldwide. The best example being the deputy director general of WHO, Dr. Soumya Swaminathan.

One cannot deny the financial stability the profession provides. Where opportunities are concerned there are no boundaries and sky is the limit. No department is unimportant, no area of science is out of reach. The sea water calls you for a dip, go into diving medicine. Intrigued by the universe, accompany the astronauts as their on-board physician. Interested in helping out your younger lot, teaching is an effective way to connect with students and guiding them through the delicacies and difficulties of the subjects. My boat would have gone under just past the shore had it not been for my revered mentors at GMCH. I am forever in debt. We have one doors to excel in the field of medical research with the world community coming together to share and discover medical breakthroughs. CME's and research presentation seminars are becoming increasingly advance nowadays with more and more of us aiming to enter research trying to find answers to the problems that plaque us. For there is no bigger mystery than the human body.

Having had the opportunity to observe the lead surgeons of my college, I observed them day after day doing the impossible and my resolve strengthened,'That this is it. This I wanna do'. After that I can chalk out my five year plan with optimistism but also with caution knowing that will ultimately face complications testing me on the way. I have been told a Whipple is hardest procedure a general surgeon performs.I hope to be trained as the master of surgery from the prestigious John Hopkins department of surgery with a few Whipple's in the bag. The quest to succeed will never overshadow the passion to help others. My work with doctors without border having taught me that for people less fortunate , a doctor is equivalent to God not only God sent. It's humbling.

Medicine is a naturally creative endeavour, committed to progressive action driven by hands in discovery. Perhaps that is what Hippocrates meant by 'art of medicine'. In words of the esteemed Dr. A.P.J. Abdul Kalam, ignited minds of youth is the most powerful resource. Who better than the ignited determined unserwable and prodigal youth to cruise the cataclysmic expanse of medicine. An arrow can be shot only by pulling it backwards. When life is dragging us back with difficulties, it means it's going to launch us into something great. That is what I tell myself. So just focus, and keep aiming. Until u can say, “Scalpel please”.

Dr. Rita Saxena

# VITAMIN D DEFICIENCY IN PREGNANT WOMEN AND ITS MATERNAL AND PERINATAL OUTCOMES

Dr. Rita Saxena[1], Dr. Anjana Verma[2], Dr. Ashish Varma[3]
[1]Assistant Professor, [2]Professor, [3]Post-graduate Resident, Department of Obstetrics and Gynecology, GMCH.

Despite its discovery a 100 year ago, vitamin D has emerged as one of the most controversial nutrient and pro-hormone of the 21st century. Its role in calcium metabolism and bone health is undisputed, yet has non classical action on glucose metabolism, immune function, bacterial infections etc. During pregnancy Vitamin D deficiency induces maternal and neonatal complications.

**Objective:**

The aim of our study was to determine the prevalence of Vitamin D deficiency during pregnancy and its consequential effect and complication in mothers and their newborn.

**Design:**

A sample size of 50 preganant mothers attending antenatal clinic with suspicion of vitamin D deficiency was picked up for the evaluation that included detailed history, physical examination and Vitamin D level estimation. The extent and severity of Vitamin D deficiency were analysed, maternal and neonatal outcome were recorded.

**Results:**

Majority of women (60%) had Vitamin D level <10ng/dl and 28% have insufficiency and 8% had sufficient levels of Vitamin D. Main symptoms were fatigue, bone and muscle pain etc and complications during pregnancy with Vitamin D deficiency were preganancy induced hypertension, oligohydroamnios and gestational diabetes mellitus. There was a six fold increase in the incidence of caessarean section and significant perinatal complications such as asphysia and low birth weight resulting in NICU admission.

**Conclusion:**

High prevelence of Vitamin D deficiency during pregancy is increasingly recognized to lead to maternal and perinatal complications. Knowledge about in and its adverse impact on mother and the newborn requires close scrutiny. Universal screening is highly recommended looking to the very high prevalence of Vitamin D deficiency.

*This research work was published in the Indian Journal of Maternal-fetal and Neonatal Medicine Vol 4, Issue 2, Jul-Dec 2017, Pages 114-119.*

Prof. Jitendra Jeenger

# C-REACTIVE PROTEIN, BRAIN DERIVED NEUROTROPHIC FACTOR, INTERLEUKIN-2 AND STRESSFUL LIFE EVENTS IN DRUG NAIVE FIRST EPISODE AND RECURRENT DEPRESSION: A CROSS-SECTIONAL STUDY

Prof. Jitendra Jeenger, Dr. Vikas Singroha, Dr. Manu Sharma, Prof. D.M. Mathur
Department of Psychiatry, GMCH

**Aims:** To assess and compare serum CRP, BDNF and IL-2 levels in patients with first episode depression (FED), recurrent depressive disorder (RDD) and healthy controls (HC). To determine the relationship between the above specified inflammatory markers, severity of depression and stressful life events.

**Method:** Consecutive drug-naïve patients with FED and RDD (N=85), and 50 HC were studied. Serum concentrations of C-reactive protein (CRP), Brain Derived Nerve Growth Factor (BDNF) and Interleukin-2 (IL-2) were measured. All participants were assessed using Mini International Neuropsychiatric Interview Plus, Beck's Depression Inventory and Presumptive Stressful Life Events Scale.

**Results:** The FED and RDD groups had statistically significant lower serum concentration of BDNF and higher IL-2 compared to the HC group, whereas no statistically significant difference was observed with regard to CRP level. No statistically significant differences were observed with regard to the severity of depression, serum concentrations of CRP, BDNF and IL-2 in the FED and RDD groups. No significant correlation was found between severity of depression and serum concentration of CRP, BDNF and IL-2 in both the groups. Serum CRP concentration was significantly higher in patients with ≥2 stressful life events. No significant difference was observed between number of stressful life events and BDNF and IL-2 in patients with depression.

**Conclusion:** FED and RDD are associated with lower serum concentration of BDNF and higher IL-2 compared to the healthy controls, whereas there appears no difference with regard to CRP level. Multi-centric studies are needed to further elucidate the role of inflammatory markers in depression.

*This paper has been accepted for publication in the Indian Journal of Psychiatry*

Dr. Rahul Ahluwalia

# INFLAMMATORY MYOFIBROBLASTIC TUMOR OF LUNG: A RARE ENTITY

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[1]Post-graduate Resident, [2]Associate Professor, [3]Professor, [4]Professor and Head,
Department of Respiratory Medicine, GMCH

A 22 year old female patient presented with complaints of right sided chest pain, shortness of breath and dry cough associated with decreased apetite and weight loss since past 6 months. Chest X-Ray PA view (Fig.1) done elsewhere suggested of a homogenous opacity in the right hemithorax with mediastinal shift to the contralateral side. Along with the chest radiograph, USG Thorax screening had been performed which suggested presence of a hypoechoic lesion with internal cystic area and calcification with no evidence of effusion. Therefore, pleural aspiration was withheld contrast enhanced CT of the thorax was advised. CT findings (Fig.2) were suggestive of a heterogeneously enhancing mass like pleural thickening on right side with a thickness of 36 mm with an underlying collapse of the right lung. The thickening infiltrating into the right main bronchus abutting the superior venacava, severely compressing the right pulmonary artery and its branches ,inferior venacava, the right superior and inferior pulmonary veins and right atrium. CT guided biopsy was performed and specimen was sent for histopathological examination.

The biopsy specimen on microscopy (Fig. 3) showed tumor cells with elongated to spindled shaped nuclei having mild to moderate nuclear atypia. The tumor cells were admixed with mixed inflammatory cells comprising of neutrophils, lymphocytes and plasma cells(as above). After detailed discussion with the histo-pathologist about the clinical features of the patient and correlation of the same with the microscopic features. Differential diagnosis of three diseases were kept:

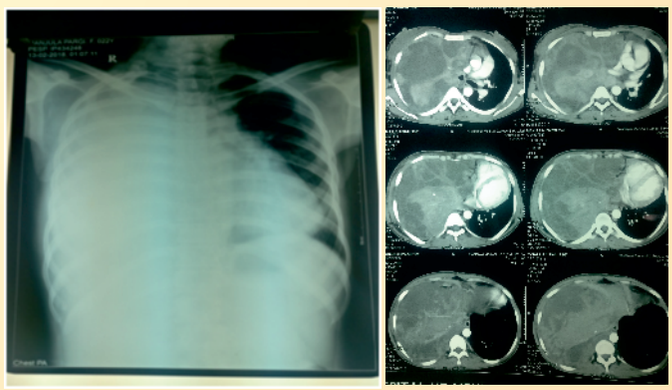


*Fig 1. (left) Chest X-Ray suggested of a homogenous opacity in the right hemithorax with mediastinal shift to the contralateral side. Fig 2. (right) CECT Thorax showing heterogeneously enhancing mass like pleural thickening on right side with a thickness of 36 mm with an underlying collapse of the right lung abutting the SVC, severely compressing the right pulmonary artery and its branches ,IVC, the right superior and inferior pulmonary veins and right atrium.*

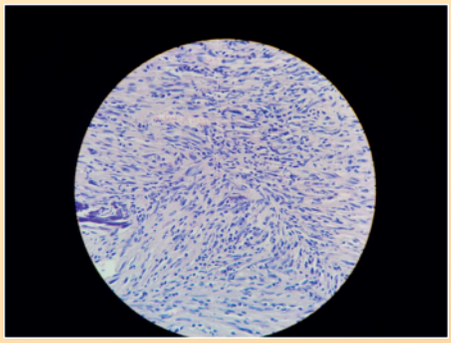


*Fig 3. Tumor cells with elongated to spindled shaped nuclei having mild to moderate nuclear atypia*

1. Inflammatory myofibroblastic tumor.
2. Solitary fibrous tumor.
3. Spindle cell mesothelioma.

Immunohistochemistry revealed Vimentin and Calponin positive markers.

Hence, the diagnosis of inflammatory myofibroblastic tumor of the lung was established. Medical oncologist's opinion was obtained and patient was subjected to chemo and radiotherapy. But, owing to the poor general condition of the patient, patient was discharged on request and couldn't be followed up.

**Discussion**

Inflammatory myofibroblastic tumour (IMT) represents an extremely rare type of inflammatory pseudo-tumour that appears most commonly in children and young individuals with a prevalence ranging from 0.04% to 0.7% irrespective of the gender and race of the world population. There has been an ongoing controversy whether an IMT is a reactive lesion or a true neoplasm. This has been revealed in a large number of individual case reports and series with subtle differences in their clinico-pathological findings and the results of the treatment provided.

The take home message is that one should always look to perform a USG thorax in a patient whose radiograph is suggestive of a pleural effusion as seen in the above case. Although very rarely one would come across such a finding, but by diagnosing the patient correctly, patient can be saved from ineffective treatment. Immunohistochemical analysis also aids in the differential diagnosis. On account of their vague biological behaviour of the tumor it would be considered beneficial to keep such patients under close observation after treatment to rule out local recurrence and malignant transformations.

## CONFERENCES & WORKSHOPS

### A workshop conducted for hands on training in laparascopic surgery

On 5th June 2018, a unique opportunity was provided to all the faculty members of the Departments of Surgery and Obstetrics & Gynaecology, along with their surgical residents to experience and develop their eye hand co-ordination, depth perception and other basic skills for Laparoscopic Surgeries.

An impeccable air-conditioned Volvo bus decked with twelve monitor consoles and *Laparo-trainer* was arranged by *Johnson & Johnson's*, along with experienced trainers and guides imparted the requisite exposure and training to a group of about 20 doctors arranged in a sequential pattern.

The event was inaugurated by the Dr. F. S. Mehta, Dean, GMCH and Dr. Pankaj Saxena, Head, Dept. of General Surgery, and received a huge enthusiastic response from surgical fraternity of GMCH.





### Prof. Gupta and Prof. Sareen awarded on Doctors' Day

Dr. A.K Gupta, Professor Emeritus, Department of ENT and Dr. Devendra Sareen, Professor & Head, Department of Pediatrics was honored on Doctors' Day 2018 by Hon. Health Minister of Rajasthan, Shri Kaslicharan Saraf. The award ceremony was held at Birla Auditorium, Jaipur. Prof. Gupta and Prof. Sareen were recognized and commended for their contributions made toward Excellence in Medical Education Research.

### Department of Pediatrics organizes Breast Feeding Week


Breast feeding week was celebrated with full enthusiasm by the departemtn of Pediatrics, GMCH, from 1st to 7th August 2018. On 2nd August a quiz competition was organized for under graduates students regarding breast feeding in the premises of GMCH .Dr. Kishore Pujari, CEO, GMCH was the chief guest. He emphasized the need for dissemination of knowledge of breast feeding by medical students. Dr. Narendra Mogra, Medical Superintendent, GMCH, presided over the function and stressed upon the need forbreast feeding awareness in rural and tribal areas.

The quiz masters were Dr .Dheeraj Diwakar and Dr. Dileep Goyal. The winners were Ms. Parul Mahla and Ms. Purva Maheshwari and runner up being Ms. Tejasvita Verma and Ms. Shivangi Shekhawat. Dr Devendra Sareen, HOD, welcomed the guests. Dr. Anubhuti Bhardwaj and Dr. Praduman Pamecha conducted the program, and Dr Deepesh Gupta delivered the vote of thanks. On this ocassion Dr. N C Sharma,Dr. D M Mathur, Dr. Arun Gupta, Dr. Sharda Goyal. Dr. Anjana Verma, Dr. Sanjay Gandhi, Dr. Chetan Mahajan, Dr. Sukanta Das and Mr. Indrapal were present in gracious attendance.

## Independence Day Celebration at GMCH

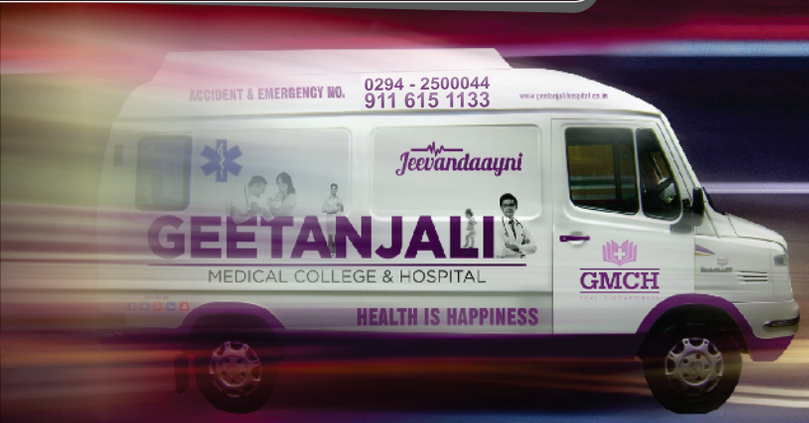
The 72nd Independence Day was celebrated with zeal and patriotism. The chief guest of the function was Shri. Ankit Agarwal, Executive Director, GMCH. The flag was hoisted by Dr. F.S. Mehta, Dean, GMCH. In gracious attendance were also present Shri. Kishor Pujari, CEO, GMCH and Dr. Narendra Mogra, Medical Superintendent, GMCH. The security personnel performed a smart parade. The students of Geetanjali College of Pharmacy presented culutral program which included skit and dance. The winners of the poster making competition held as part of the breast feeding awareness week were felicitated. The program was smoothly organized and co-ordinated by Shri. Rajeev Pandya, GM-HR, GMCH.


### Workshop on Medical Ethics for Interns

The Medical Education Unit (MEU) of GMCH organized a one-day workshop with the objective of sensitizing interns to concepts of medical ethics on August 22, 2018. The workshop was inaugurated by Dr. F.S. Mehta, Dean, GMCH. The resource persons for the workshop were Dr. Manu Sharma, Assistant Professor (Psychiatry) and Dr. Manjinder Kaur, Professor (Physiology). The members of MEU, namely, Dr. Ashsish Sharma, Dr. Arvind Yadav, Dr. Suman Parihar, Dr. Suman Sharma and Dr. Upasana Choudhary made important contributions to the content and organization of the workshop which included interactive lectures, cinemeducation and role plays. The participants expressed their gratitude and compliments for the workshop.

SPANDAN

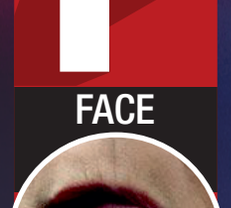
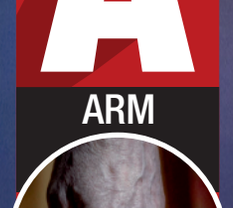
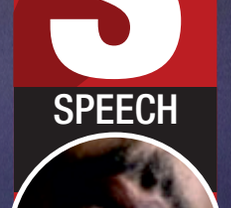
आईसीयू ऑन व्हील एम्बुलेंस 24 घण्टे उपलब्ध




गीतांजली
न्यूरोसाइंस सेंटर

**Emergency No. : 911 615 1133**

# लकवे को पहचाने

| F | A | S | T |
|---|---|---|---|
| FACE | ARM | SPEECH | TIME |
|  |  |  |   |
| लक्षण – 1 | लक्षण – 2 | लक्षण – 3 | |
| **चेहरा लटक जाना** | **बांह कमजोर होना** | **बोलने में कठिनाई** | **चिकित्सक से तुरन्त सम्पर्क करें** |
| *मरीज द्वारा रोगी से प्रश्न :* | *मरीज द्वारा रोगी से प्रश्न :* | *मरीज द्वारा रोगी से प्रश्न :* | *मरीज द्वारा किया जाने वाला कार्य :* |
| व्यक्ति को मुस्कराने के लिए कहें | व्यक्ति से दोनों हाथ उठाने के लिए कहें | व्यक्ति से कुछ बोलने के लिए कहें | 3 घण्टे के अंदर अस्पताल पहुंचाएं |

आप द्वारा समय पर की गई कार्यवाही से हमारे अनुभवी एवं प्रतिष्ठित चिसित्सकों द्वारा लकवेग्रस्त व्यक्ति का उपचार सम्भव हो सकता है

- न्यूरोलोजी एवं न्यूरोसर्जरी आई सी यू
- संक्रमण रहित सीमलेस ऑपरेशन थिएटर
- न्यूरोलोजी, न्यूरो सर्जरी, न्यूरो इंटरवेंशनल रेडियोलोजी, इंटेन्सिविस्ट (क्रिटीकल केयर विशेषज्ञ), न्यूरो एनेस्थेटिस्ट, आपातकालीन दल एवं नर्सिंग स्टाफ का अस्पताल परिसर में स्थायी निवास जिससे मिनटों में रोगी तक पहुंच
- कम्पोनण्ट सुविधा के साथ ब्लड बैंक
- 24 घण्टे सी.टी./ एम.आर.आई, केथलेब

**Geetanjali Medicity, N.H. 8 Bypass, Near Eklingpura Chouraha, Udaipur (Raj.)**
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