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HIGHLIGHTS



- Laproscopic Sacro-colpopexy: An Advanced Endoscopic Procedure
- New Era of Renal Transplant in Southern Rajasthan
- Oral Manifestations of Mucocutaneous Disorders
- Laparoscopic Trans-abdominal Pre-peritoneal approach for Inguinal Hernia Repair: Our Institutional Experience
- News that will make Your Heart Skip a Beat
- Free Cochlear Implant Programme at GMCH in Collaboration with Govt. of India

LAPROSCOPIC SACRO-COLPOPEXY: AN ADVANCED ENDOSCOPIC PROCEDURE

Dr. ANJANA VERMA¹, Dr. PANKAJ SAXENA²

¹Professor, Department of Obstetrics and Gynecology, GMCH, Udaipur.

²Professor & HOD, Department of General Surgery, GMCH, Udaipur.



Dr. Anjana Verma

Vaginal vault prolapse is a common complication following vaginal hysterectomy with negative impact on women's quality of life due to associated urinary, anorectal and sexual dysfunction. Pre-existing pelvic floor defect prior to hysterectomy is the single most important risk factor for vault prolapse. Treatment options are:

1. Pessary with limited success
2. Utero-sacral ligament suspension or sacro-spinous fixation by vaginal route
3. Abdominal or laproscopic sacro-colpopexy – preferred procedure with least recurrence rate supported by many studies. Laparoscopy needs advanced surgical and suturing skills. The choice of procedure should be based on age, co-morbidity, previous surgery, level of physical and sexual activity of the patient, and experience of surgeon.

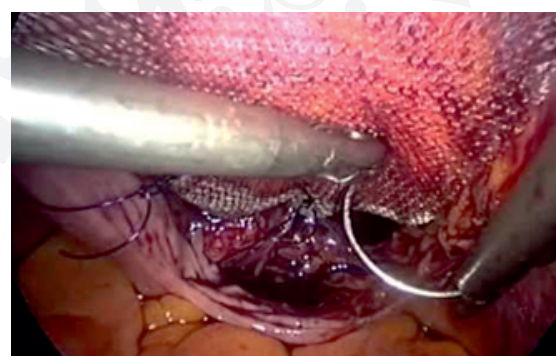
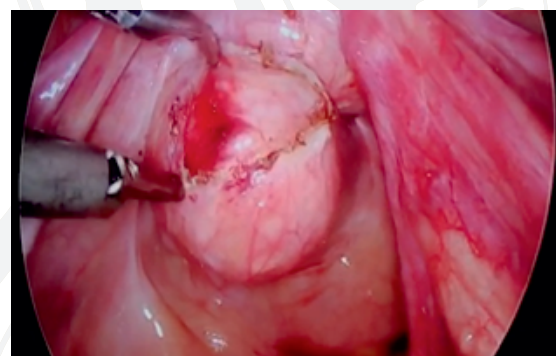
CASE REPORT

A 45 years old lady presented with vault prolapse post vaginal hysterectomy (20 years back). No significant past or present illness was identified and investigations were within normal limits. Laproscopic sacro-colpopexy was planned after counseling.

Four ports were used; one 10 mm supra-umbilical for scope, two 5 mm ports on left and one 5 mm port on right side. Vault was pushed up from below with sponge on forceps and after delineating bladder margins, peritoneum overlying vault incised, bladder dissected anteriorly till urethra and rectum posteriorly till levator ani. Peritoneum overlying sacral promontory medial to right common iliac vessels and crossing ureter was picked up and incised by sonoscissor. Retroperitoneal fat dissected to allow exposure of anterior vertebral ligament. Peritoneal incision then extended along rectosigmoid to continue till deepest part of cul-de-sac. A Y shaped prolene

mash around 15X3 cm introduced. Split part of mash was fixed anteriorly and posteriorly to vault with prolene sutures as below as possible. Mash pulled up and vertical limb was fixed to sacral promontory by a tackler. Mash was then retroperitonized using I-0 vicryl. Ports closed. Post-operative period was uneventful with excellent outcome.

Conclusion: Laproscopic repair may be challenging due to the need for extensive dissection and suturing skills, but it offers benefits in terms of minimal blood loss, lower recurrence rate and less dyspareunia.



Desk of the Dean



Dear reader,

The current issue of Spandan features clinical case reports from a variety of specialties, academic experiences, progress in medical education technologies and

community outreach programs. The University has been organizing workshops and conferences. I extend my best wishes to the Editorial Board, who have been striving to create a wider circulation and increase readership of Spandan.

Dr. F. S. Mehta, Dean

Editor's Desk



Greetings and good wishes!

The current issue of Spandan gives us an extra delight and a sense of pride as we present some outstanding clinical material that is distinctively the 'first of its kind', not only in the institute but also in the southern region of Rajasthan. Our readers will surely be appreciative of the talent

and skill of the clinicians in our institute, bringing in laurels with the first renal transplant, the first exploits in cutting edge technology in cath lab etc. I am deliberately withholding the description of other extraordinary material to keep your curiosity alive.

Wishing you a happy and enjoyable reading.

Dr. Pankaj Saxena, Editor-in-Chief

NEW ERA OF RENAL TRANSPLANT IN SOUTHERN RAJASTHAN

¹Dr Pankaj Trivedi, ²Dr Vishwas Baheti, ³Dr Gulshan Mukhiya, ⁴Dr Suraj Gupta, ⁵Dr Kishan Patel

^{1,2}Consultant Urologist, ^{3,4}Consultant Nephrologist, ⁵Post-graduate Resident in General Surgery, GMCH, Udaipur.



Dr Pankaj Trivedi

In southern Rajasthan, Geetanjali Medical College and Hospital (GMCH) has created history by starting renal transplant programme. The living kidney transplantation program in India has evolved in the past 45 years and is currently the second largest program in numbers after the USA. The prevalence of end-stage renal disease requiring transplantation in India is estimated to be between 151-232 per million. It is estimated that almost 220,000 people require kidney transplantation in India per year. Against this, currently, approximately 7500 kidney transplantations are performed at 250 kidney transplant centers in India. Of these, 90% come from living donors and 10% from deceased donors. The Indian Society of Organ Transplant reported only 783 cadaveric donors in period 1971-2015. A kidney donor can be classified as: living related, living unrelated (altruistic/emotionally related), deceased / cadaveric (brain-dead), beating or a non-beating heart donor. Prospective transplant candidates must have documented chronic renal disease defined by GFR less than 20 ml/min or serum creatinine more than 8 mg/dl.

Figure 1 shows the common indications of transplant. Our team consists of 2 Urologists, 2 nephrologists and dedicated kidney transplant unit (KTU) and staff. First renal transplant in GMCH was done on February 24th, 2019. The recipient had chronic glomerulonephritis and was on dialysis for about one year. The donor was the patient's mother. At our institute, we perform laparoscopic donor nephrectomy (LDN), which is standard of care surgery for donors with all modern equipments and armamentarium. After kidney harvesting, renal perfusion is done on bench surgery. Graft is placed in the right iliac fossa. Renal graft artery and vein anastomosis is

created with external iliac artery and vein of recipient. Leich-Gregor type- extravesical ureteric re-implantation is performed. Donor is discharged in about 3-4 days and recipient with normal serum creatinine approximately within 10 days. So far, we have performed three successful renal transplant, most recently on September 22nd, 2019.

The burden of kidney disease in India requires two strategies; on the one hand, there is a need to look at prevention and early identification of kidney disease and on the other, there is a requirement to increase the deceased donation rate. Concerted efforts from government, public and private sector hospitals along with non-government organizations are required to give momentum to improve the donation rate and take care of organ shortage.

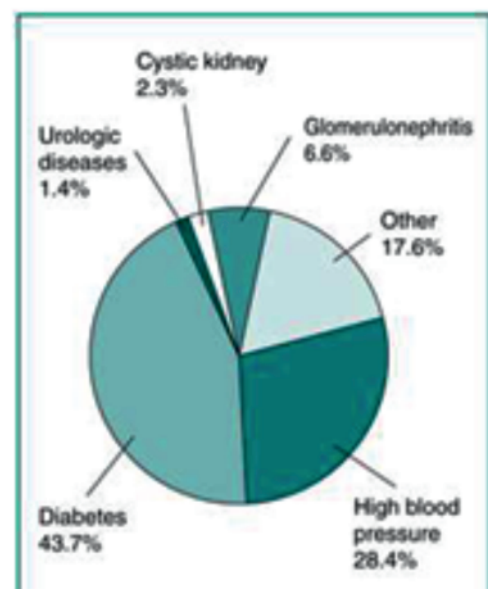


Figure 1. Major causes of ESRD and indications of transplant

ORAL MANIFESTATIONS OF MUCOCUTANEOUS DISORDERS

Dr. Anu Babu¹, Dr. Archana M S², Dr. Preeti Gupta³

Senior Lecturer¹, Associate Professor², Tutor³, Dept. of Oral Medicine and Radiology, Geetanjali Dental & Research Institute



Dr. Anu Babu

"Mucocutaneous diseases are the diseases affecting the skin and the mucosa having structural and morphological alteration in the components of skin and mucosa".

The oral cavity often mirrors systemic health and may be the initial site of presentation of an underlying disease process. Clinicians should understand that oral cavity is an integral part of human body and does not exist in isolation.

Mucocutaneous disorders can be classified based on the site of involvement as:

LESIONS AFFECTING BOTH SKIN AND ORAL MUCOSA	LESIONS AFFECTING PREDOMINANTLY SKIN WITH MINIMAL ORAL MUCOSAL INVOLVEMENT	LESION AFFECTING TYPICALLY ORAL MUCOSA WITH MINIMAL SKIN INVOLVEMENT
VESICULOBULLOUS LESIONS <ul style="list-style-type: none"> • Pemphigus • Epidermolysis bullosa • Hand foot mouth disease RED AND WHITE LESIONS <ul style="list-style-type: none"> • Lichen planus • Lupus erythematosus 	VESICULOBULLOUS LESIONS <ul style="list-style-type: none"> • Bullous pemphigoid • Recurrent herpes simplex infection • Herpes zoster 	VESICULOBULLOUS LESIONS <ul style="list-style-type: none"> • Cicatricial pemphigoid • Behcet's syndrome

PEMPHIGUS:

Classical lesion of pemphigus is a thin-walled bulla arising on otherwise normal skin or mucosa subsequently breaks but continues to extend peripherally, eventually leaving large areas of denuded skin. A striking clinical sign is **"Nikolsky's sign"**- when is pressure applied onto normal area results in the formation of a new lesion. Oral lesions often start on the buccal mucosa, in areas of trauma along the occlusal plane as a bulle which rapidly breaks and thin layer of epithelium peels away in an irregular pattern .Other sites of involvement are palate and gingiva.



FIGURE 1

LICHEN PLANUS

Skin lesions consist of pruritic erythematous to violaceous papules that have a predilection for the trunk and flexor surfaces of arms and legs associated with itching and **"Kobner's phenomenon"** (lesion aggravates with trauma). Oral lesions of lichen planus consist of both red and white components .Based on their clinical presentation OLP is classified as reticular, papular, plaque-like, erosive, bullous, erythematous. The reticular form the most commonest form of OLP is characterized by fine white lines or striae- **"Wickham striae"**. OLP confined to gingiva may be entirely erythematous, with no reticular or papular elements present (**Desquamative Gingivitis**).



FIGURE 2

LUPUS ERYTHEMATOSUS

LE is an autoimmune disorder classified as discoid lupus



FIGURE 3

erythematosus (DLE) and systemic lupus erythematosus (SLE) depending on the involvement. Lesion form **"Butterfly-like rash"** over the cheeks and nose known as **"Malar rash"**. Oral lesions comprise of white striae with a radiating orientation, and sharply

terminating toward the center of the lesions, which has a more erythematous appearance called **"Brush Border appearance"**. The most affected sites are the gingiva, buccal mucosa, tongue, and palate. Oral mucosa lesions compatible with LE may be the first sign of the disease.

BULLOUS PEMPFIGOID



FIGURE 4

Most common subepithelial blistering disease affecting the elderly individuals. BP is a blister on an inflamed base that chiefly involves the scalp, arms, legs, axilla, and groin. Oral lesions are smaller, forms slowly and are less painful when compared to pemphigus. The gingival lesions consist of generalized edema, inflammation, and desquamation with localized areas of discrete vesicle formation.

CICATRICIAL PEMPFIGOID



FIGURE 5

Conjunctival involvement leads to scarring and adhesion of bulbar and palpebral conjunctiva (symblepharon). Progressive scarring of cornea can lead to blindness. Oral lesions are seen in 90% of cases and manifest as

“Desquamative Gingivitis”.

HAND FOOT MOUTH SYNDROME

Caused by infection of Coxsackie virus A16. The disease is characterized oral vesicles and ulcers, non-pruritic macules, papules, and vesicles, particularly on the extensor surfaces of the hands and feet. 75% of the cases occur below the age of 4 years.



FIGURE 6

RECURRENT HERPES SIMPLEX INFECTION

Caused by re-activation of herpes simplex virus that remains latent in the sensory ganglia. It affects localized areas of skin and mucous membrane. The lesions are preceded by tingling or burning sensation, accompanied by edema at the site of the lesion, followed by formation of a cluster of small vesicles size ranging from 1-3mm later they break to form ulcers. Recurrent herpes infection can occur in two forms recurrent herpes labialis and intraoral herpes. Recurrent herpes labialis presents as vesicle which rupture to form ulcers and later crustation. Intraoral herpes lesions occurs chiefly on keratinized mucosa of the hard palate, gingival, tongue.

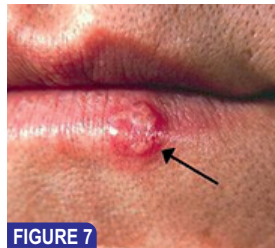


FIGURE 7



FIGURE 8

HERPES ZOSTER INFECTION

Herpes zoster infection is caused by reactivation of latent varicella zoster virus in the dorsal root ganglia associated with vesicular eruptions of skin or mucous membranes in areas



FIGURE 9

supplied by the affected sensory nerves presenting as unilateral, linear, clusters of vesicles called **“Zosteriform pattern”**. Intra-oral lesions appear as 1-4 mm white opaque vesicles seen on movable / bound mucosa sharply terminating at the midline.

BECHET'S SYNDROME:



FIGURE 10

Triad of symptoms including recurring oral ulcers, recurring genital ulcers, and eye involvement. Skin lesions resemble erythema nodosum or large pustular lesions. BD patients present with cutaneous hypersensitivity to intravenous or needle-stick (**Pathergy**). Patients experience oral lesions resembling recurrent aphthous stomatitis. Oral ulcers appear on non keratinized mucosa as round shallow ulcer with yellow pseudomembranous base and erythematous halo.

EPIDERMOLYSIS BULLOSA



FIGURE 11

Clinical course of EBA can resemble BP or MMP with widespread skin lesions or primary involvement of the oral mucosa, genital mucosa, conjunctiva, and larynx. Severe intraoral blistering with subsequent scar formation is seen.

CONCLUSION

Oral health is closely linked to the general state of health in a patient. Oral lesions of these mucocutaneous diseases form the hallmark of the disease. An oral physician plays the most important role in diagnosis and management of oral counterparts of these mucocutaneous disorders.

LAPAROSCOPIC TRANS-ABDOMINAL PRE-PERITONEAL APPROACH FOR INGUINAL HERNIA REPAIR: OUR INSTITUTIONAL EXPERIENCE

Dr. P. K. Saxena¹ and Dr. Kalpesh Patel²

¹Professor & Head, ²Post-graduate Resident, Department of General Surgery, GMCH, Udaipur



Dr. P. K. Saxena

Laparoscopic hernia repair has emerged as an effective alternative method for treating inguinal hernia. It has several significant advantages over traditional open tension free repair.

At our institute we began laparoscopic hernia repair in 2017. The first patient was a 48 year old male operated in October 2017, which was uneventful. Over a period of 2 years, we have operated on around 40 patients with inguinal hernia with average age of 52 years. Almost all patients were operated successfully, except one which required conversion to open laprotomy due to the presence of sliding hernia which is difficult to operate laparoscopically.

Almost all patients began oral intake and passed urine after 6 hours of surgery. The average duration of operation was 55.3 minutes. We observed that with experience the learning curve for the laparoscopic inguinal hernia repair shortened, that is from the first case which took 80min, the duration decreased to 30min in few later cases of laparoscopic repair. All patients were discharged within 24 hours of surgery.

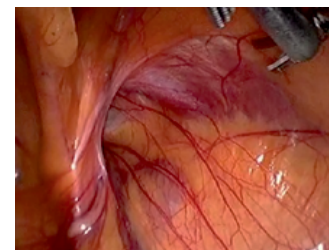


Figure 1. A laparoscopic view of patulous /defective inguinal ring.

In post operative follow up two patients developed cord seroma which necessitated ultrasound guided aspiration. Complications such as pain, port site infection, scrotal

hematoma were not encountered. There is no recurrence recorded till date in any of the operated patients.

With this experience we conclude Laparoscopic Trans-

abdominal Pre-peritoneal Approach (TAPP) hernia repair has proven to be an efficient method for the treatment of inguinal at our institute.

NEWS THAT WILL MAKE YOUR HEART SKIP A BEAT

Dr. Kapil Bhargava, Consultant Cardiologist, GMCH, Udaipur.



Dr. Kapil Bhargava

Rolling of the cardiac juggernaut started with the magnanimity of the management. In a very short time having acquired state of the art cutting edge technologies it was but a logical step that we started disseminating our skills and knowledge to all seekers and faithful.

The upshot of the story is that in the last few months the Department of Cardiology has acquired:

1. New cathlab to cut down on the waiting time and taking up serious patients immediately
2. Intravascular Ultrasound (IVUS) and Optical Coherence Tomography (OCT) for better imaging (Figure 1 & 2)
3. Fractional Flow Reserve (FFR) for physiological testing of coronary blockages (Figure 3)
4. Rotablator for drilling through calcified coronary lesions

We have been fortunate enough to be chosen as proctors for IVUS training at the national level. We have had a batch of senior cardiologists mainly from Nizam's Institute of Medical Sciences, Hyderabad who had a real hands on experience (real patients, not mannequins) with each person allotted one patient to perform the procedure on.

For the uninitiated we would like to elaborate that IVUS and OCT are intracoronary imaging techniques wherein a catheter with camera is inserted into the coronary artery and images are acquired by using ultrasound and light respectively. These images help in:

- a. Estimating the right size of the artery and hence the right size of the stent to be implanted

- b. Showing composition of the plaque (not possible by coronary angiography) whether it is lipid-rich, fibrous or calcified hence treatment depends on these findings
- c. After stent implantation whether stent is properly covering the lesions and is well-expanded or not

Thus these techniques lead to refinement of the angioplasty procedures and lead to less complications post stenting

FFR

The significance of any lesion can be found out only by functional testing of the blockage. Hence, apart from acute myocardial infarction situations all borderline lesions should be investigated by FFR and if found to be significant, only then stented. The stenting should not be done only by 'oculostenotic' reflex because to a person with a hammer with his hand all things look like the head of a nail !!

FFR is a procedure whereby a pressure wire is introduced distal to the lesion in the coronary artery and pressure is measured by a sensor and compared to the pressure in the aorta. If the ratio is less than 0.8 we proceed with the angioplasty otherwise the patient remains on medical therapy alone.

Incidentally, we have been fortunate to perform the first Trans-catheter Aortic Valve Implantation (TAVI) procedure in this part of Rajasthan and second in the state only after Jaipur. TAVI is a pragmatic approach in patients with severe valvular aortic stenosis wherein the aortic valve is implanted percutaneously (not surgically) through the femoral route and the patient is discharged the next day. Initially the procedure was indicated only in high risk patients (i.e. where surgeons refused aortic valve replacement) but is now indicated across the whole spectrum on patients from low risk to high risk.

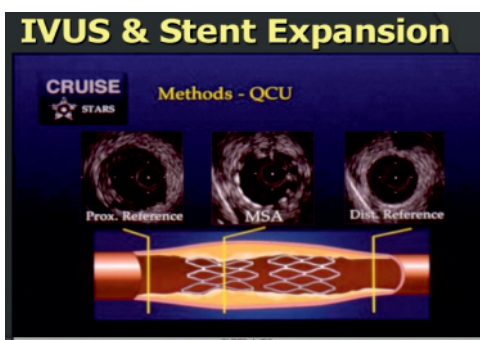


Figure 1. Intravascular ultrasound and stent expansion

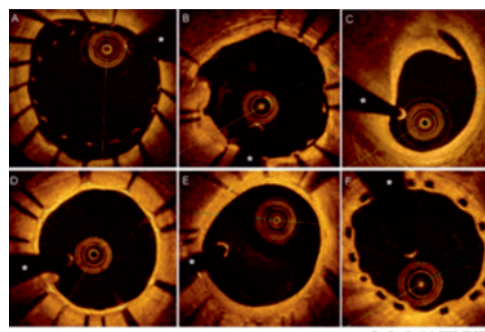


Figure 2. Optical Coherence Tomography

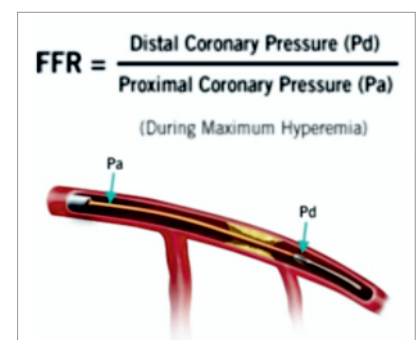


Figure 3. Fractional flow reserve

FREE COCHLEAR IMPLANT PROGRAMME AT GMCH IN COLLABORATION WITH GOVT. OF INDIA

Dr. A K Gupta¹, Dr. V P Goyal¹, Dr. Pritosh Sharma², Dr. Nitin Sharma², Dr. Gaurav Sharma⁴

Professor Emeritus, Professor, Associate Professor, Assistant Professor, Department of Otorhinolaryngology, GMCH, Udaipur.



Dr. A K Gupta

Hearing loss is the most common sensory deficit in humans today. As per WHO estimates in India, there are approximately 63 million people are suffering from significant auditory impairment; this places the estimated prevalence at 6.3% in Indian population. As per NSSO survey, currently there are 291 persons per one lakh population who are suffering from severe to profound hearing loss (NSSO, 2001). Of these, a large percentage is children between the ages of 0 to 14 years.

Hearing loss in children may be caused by a number of factors, including: genetics, exposure to noise, some infections before & after birth, birth complications, trauma to the ear, and certain medications or toxins. A common infection that results in hearing loss is chronic ear infections. Certain infections during pregnancy such as rubella may also cause problems. Hearing loss is diagnosed when hearing testing finds that a child is unable to hear 25 decibels in at least one ear. Hearing evaluation is recommended for all newborns. Hearing loss can be categorized as mild, moderate, severe, or profound.

Early identification and intervention in children is advantageous. Language development in children begins to occur from birth and is nearly complete by the age of 6 years. Language skills, speech quality, and expressive and receptive vocabulary are enhanced by exposure to aural language from as early an age as possible. Evaluation of a child younger than 1 year of age having profound hearing loss should include the following: an attempt at behavioral audiometry (i.e., VRA), bilateral OAEs, ear-specific and frequency-specific ABR or ASSR, bilateral tympanometry, and acoustic reflexes.

Half of hearing loss is preventable. This includes by immunization, proper care around pregnancy, avoiding loud noise, and avoiding certain medications. Early identification and support are particularly important in children. Rehabilitation of deaf mute child by fitting Hearing aids preferably by 6 months of age followed by speech therapy. Children who are not benefited by hearing aids are suitable candidates for cochlear implant surgery. The surgery should be done preferably between 1 to 3 years of age.

A cochlear implant is an electronic medical device that replaces the function of the damaged inner ear. Unlike hearing aids, which make sounds louder, cochlear implants bypass the damaged hair cells of the inner ear (cochlea) to provide sound signals to the brain.

Who can they help?

The cochlear implant technology can help people who:

- have moderate to profound hearing loss in both ears
- receive little or no benefit from hearing aids
- score 50% or less on sentence recognition tests done by hearing professionals in the ear to be implanted

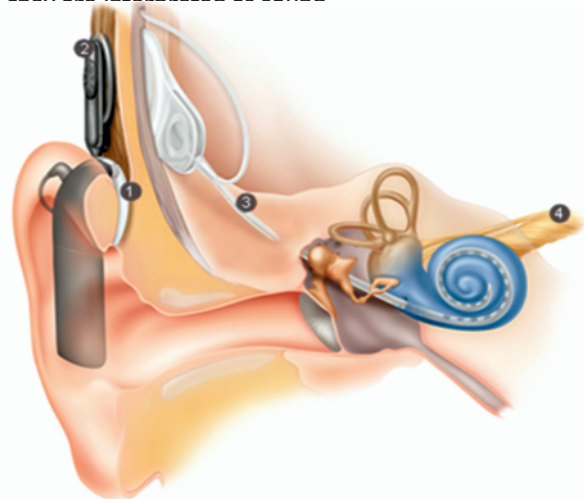
- score 60% or less on sentence recognition tests done by hearing professionals in the non-implanted ear or in both ears with hearing aids.

Many people have cochlear devices in both ears (bilateral). Listening with two ears can improve your ability to identify the direction of sound and separate the sounds you want to hear from those you don't.

How does a cochlear implant work?

Many people suffer hearing loss because their hair cells in the inner ear or (or cochlea) are damaged. The cochlear implant enables the sound to be transferred to your hearing nerve and enables you to hear. The process is described below:

1. A sound processor worn behind the ear or on the body, captures sound and turns it into digital code. The sound processor has a battery that powers the entire system.
2. The sound processor transmits the digitally-coded sound through the coil on the outside of your head to the implant.
3. The cochlear implant converts the digitally-coded sound into electrical impulses and sends them along the electrode array placed in the cochlea (the inner ear).
4. The implant's electrodes stimulate the cochlea's hearing nerve, which then sends the impulses to the brain where they are interpreted as sound.



What are the benefits of a cochlear implant?

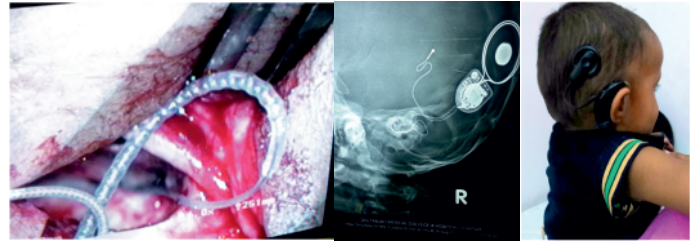
Patients with cochlear implant

- Hear better with a cochlear implant than with a hearing aid
- A previous study has shown that people with a cochlear implant achieve an average of 80% sentence understanding, compared with 10% sentence understanding for hearing aids!
- Can focus better when in noisy environments.
- Find it easier to have conversations with people across meeting tables, in restaurants and other crowded places.
- Reconnect with missed sounds that they could not hear before their cochlear implant.

- Feel safer in the world as they can hear alarms, people calling out and approaching vehicles.
- Talk and hear on the phone.
- Enjoy music.

Cochlear implant is routinely done in our department. Geetanjali Medical College is one of the six institute in Rajasthan recognized under ADIP scheme run by Government of India. Under this scheme free treatment and rehabilitation are provided to divyangjans. Total cost of performing cochlear implant surgery with post op rehabilitation is approx. 8 to 10 lakhs rupees. Universal New Born Hearing Screening

Programme is running in our department for detecting hearing impairment at birth. After implant post-operative rehabilitation is must and all facilities related to it are provided in our department.



VIGILANCE AWARENESS WEEK-2019

Organised By: Dean, Principal, GCSN, HOD's, Faculties and Students of Geetanjali School and College of Nursing

INTRODUCTION

- ❖ Central vigilance commission, the apex integrity institution of the country observes vigilance awareness week every year. This year the CVC has decided to observe vigilance awareness week with the theme of **"Integrity - a way of life"**.
- ❖ Under the banner of Geetanjali University and as per the direction of UGC- circular No. 05/08/2019 dated 02-08-2019, GCSN has organized various events on the eve of Vigilance awareness week from 28th Oct. 2019 to 2nd Nov. 2019 at GCSN.
- ❖ On 1st Nov. 2019, essay competition was organized on the theme **"Integrity - a way of life"** various students from different batches M.Sc.(N), B.Sc.(N) & GNM took part in the competition.



- ❖ On 2nd Nov. 2019, oral and E-pledge was taken by faculties and students of GCSN at Lecture theatre, GCSN in the presence of dignitaries.



By concluding Principal, GCSN motivated all students to establish an integrity club in college level and be a part of vigilant and commit to highest standards of honesty and integrity at all times and supports to fight against corruption.

REPORT ON WORLD MENTAL HEALTH DAY

Date: 10th October, 2019

The Department of Mental Health Nursing of Geetanjali College & School of Nursing has observed WORLD MENTAL HEALTH DAY on 10th October, 2019 at Examination Hall of GCSN followed by Rally in Community area on 11th October, 2019 and the theme of this year was **"FOCUS ON SUICIDE PREVENTION"**. The programme commenced at 10:00 am

with an opening ceremony followed by speech, theme based Role play was done by B.Sc. (N) III year students.

On 11th October, 2019 at 10:00am the rally on suicide prevention was planned from GCSN to Community area Nai, Udaipur. Students organized theme based role play in community area.





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To Provide Quality Diagnosis Services and Accurate Results

Introducing World's Most Advanced Technology at Geetanjali Hospital, Udaipur



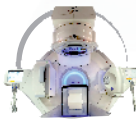
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 The wide bore design means more space and less anxiety thereby helping you feel more relaxed
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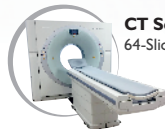
ADVANCED TECHNOLOGY BACKED BY BEST OF DOCTORS AVAILABLE



Linear Accelerator
 Elekta Vera HD
 SRS, SBRT,
 IGRT, VMAT, IMRT,
 3D CRT



1.5 Tesla MRI
 Magnetom Avanto



CT Scan Machine
 64-Slice System



4D CT Scan
 GE Optima
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Since Last 12 years, Providing World Class Health Care Services backed by Advanced Technology & Best Team of Doctors Under One Roof

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