



MEDICAL TIMES

'A clinical knowledge sharing endeavour' by KIMS SAVEERA Hospital, Ananatapur .



**"Scalpels Treat the Body
Trust Treats the Patients"**

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Core Decompression with Bone Marrow Aspirate Concentrate (BMAC) for Avascular Necrosis of Left Femoral Head

Anantapuram, 09th Sep 2025 : A 33-years-old male presented with pain in the left hip for 3 - 4 years, associated with limp for 5 months. Pain radiated to the left groin and thigh, aggravated by walking, and relieved by rest.

Pre-operative clinical examination

Antalgic gait present.
Anterior joint line tenderness present.
Pain on forced internal rotation.
Pre-operative Range of Motion (Left Hip):
Flexion: 0°–90° (painful terminally)
Abduction: 0°–25°
Internal Rotation: 0°–10° (painful)
External Rotation: 0°–30°
Pre-operative VAS Score: 9/10

Radiological evaluation

Imaging revealed a geographic area of abnormal intensity with peripheral rim of sclerosis involving the anterosuperior aspect of the femoral head, suggestive of avascular necrosis.



Diagnosis and treatment plan

Diagnosis: Avascular Necrosis of Left Femoral Head. Patient opted for core decompression augmented with BMAC after discussion of merits and demerits.

Surgical procedure

Core decompression of the left femoral head was performed under fluoroscopic guidance. Autologous bone marrow aspirate was harvested from the iliac crest and processed using staged centrifugation (1800 RPM for 8 minutes followed by 3000 RPM for 12 minutes) to obtain concentrated BMAC. The prepared BMAC was injected into the decompressed tract. Wound closed in layers.

Follow-up and functional outcome

1 Month Post-Operative:

VAS Score: 5/10

Flexion increased upto 100° and Abduction upto 30°

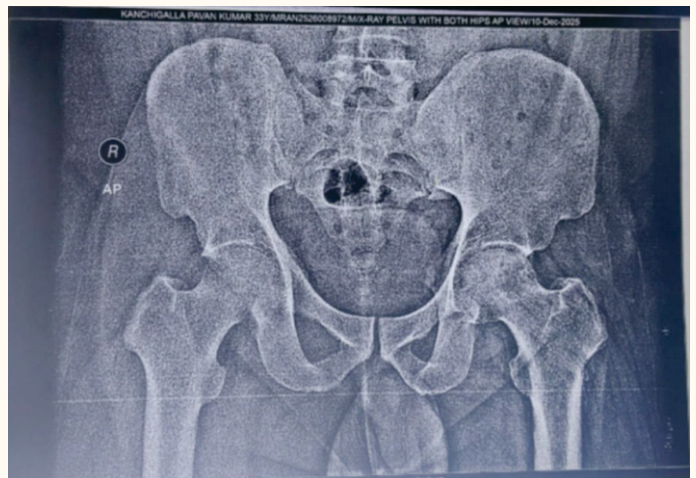
Internal Rotation increased upto 15° and External Rotation upto 35°

3 Months Post-Operative:

VAS Score: 0/10

Flexion increased upto 120° and Abduction upto 40°

Internal Rotation increased upto 25° and External Rotation upto 45°



Conclusion

Core decompression combined with BMAC reduces intraosseous pressure and enhances osteogenic potential. In this case, significant pain reduction (VAS 9 to 0) and progressive improvement in hip range of motion were observed over a 3-month follow-up period, indicating favorable early functional outcome.



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Doctors Save the Life of a 3-Year-Old Boy

Anantapuram, 04th Oct 2025 : A 3-year-old boy suffering from pneumonia developed multiple complications that put his life in danger. The dedicated team of doctors at KIMS Saveera Hospital, Anantapur, successfully treated him and saved his life after performing a series of critical medical procedures.

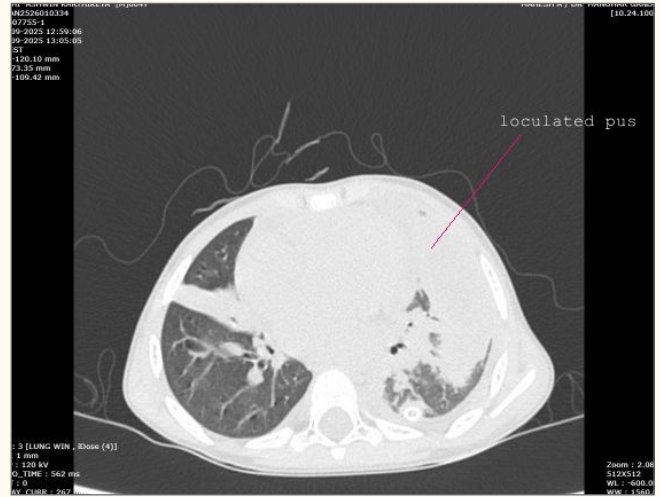
The case was handled by a team of Pediatricians consisting of Dr. A. Mahesh, Dr. C. Manohar Gandhi, Dr. Mounika, Dr. P. Giridhar, and Consultant Pediatric Surgeon Dr. Hariprasad. This team was augmented by CT Surgeon Dr. Sandeep Reddy, and Anesthesiologist Dr. C. Ravishankar.

This boy from Tadipatri was initially diagnosed with pneumonia and was being treated locally. However, his condition worsened, and he was brought to KIMS Saveera Hospital. Upon detailed examination and investigations, it was found that, along with pneumonia, there was a loculated collection of pus around his left lung.

A Video-Assisted Thoracoscopic Surgery (VATS) was immediately performed to remove the pus. Subsequently, another necessary procedure was carried out to improve the functioning of his lungs and heart, which ultimately saved his life.

Pneumonia is a common illness, especially during the winter season. Immediate medical attention is crucial when symptoms appear. Any delay in treatment can lead to serious complications such as pus formation and lung damage, which may even become life-threatening. Pneumonia can affect people of all ages from newborns to the elderly. Therefore, it's very important to recognize the symptoms early and seek proper medical care without delay.

KIMS Saveera Hospital is equipped with international standard NICU (Neonatal Intensive Care Unit) and PICU (Pediatric Intensive Care Unit) facilities to effectively handle critical health issues in newborns and children. In addition, this hospital has got the availability of super specialists of all disciplines, such as pediatric surgeon and cardiothoracic surgeon and senior anesthesiologists to support difficult procedures such as VATS in this case.



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When Breathing Becomes Difficult: A Precision Procedure that Restored Hope

Anantapuram, 07th Oct 2025 : A 55-year-old woman, diagnosed with advanced squamous cell carcinoma of the lung, had been struggling with distressing symptoms. She experienced persistent cough, difficulty in breathing, and repeated episodes of aspiration, where food or liquids accidentally entered the airway instead of the food pipe.

Further evaluation revealed the cause: She had developed a tracheoesophageal fistula.

A tracheoesophageal fistula is an abnormal connection between the windpipe (trachea) and the food pipe (esophagus). In patients with advanced cancers, tumor cells can sometimes erode into nearby structures, creating this passage.

This condition can be extremely debilitating because :

- Food and saliva keep entering the airway
- Patients experience severe coughing after swallowing
- Breathing becomes difficult
- Recurrent intractable lung infections may develop

Without proper treatment, this problem can significantly affect breathing and quality of life.

A Minimally Invasive Solution

To address this complex airway problem, our team of Pulmonologists led by Dr Yashovardhan Mangisetty Consultant Interventional Pulmonologist planned a through-the-scope Self Expanding Metallic Stent (SEMS) placement.

This advanced bronchoscopic technique allows doctors to place a specially designed metallic stent directly inside the airway using a bronchoscope, without the need for open surgery.

In this case, a 16 × 60 mm self-expanding metallic stent was carefully deployed through the bronchoscope.

The procedure achieved two critical goals simultaneously :

- Restoring the airway opening, allowing the patient to breathe more comfortably
- Sealing the abnormal fistula, preventing food or fluids from entering the airway

The entire procedure was completed smoothly in a single sitting, and the airway was immediately stabilized.

Precision in Action

Through-the-scope SEMS placement represents an important advancement in interventional pulmonology. Unlike older techniques that required more complex stent delivery systems, this method allows precise deployment under direct visualization, improving both safety and accuracy.

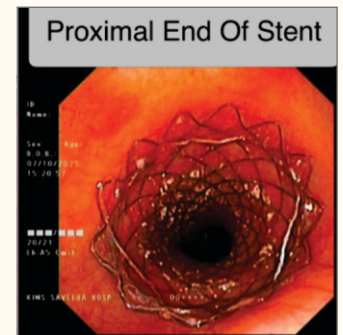
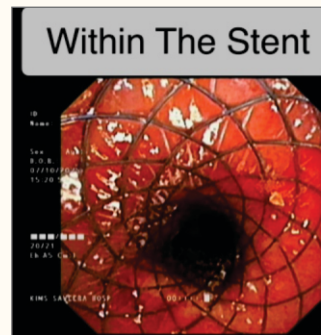
For patients with advanced airway complications, this technique can provide rapid relief of symptoms and a significant improvement in quality of life.

Cases like this demonstrate how modern bronchoscopic interventions are transforming the management of complex airway diseases. What once required highly invasive procedures can now often be managed through minimally invasive endoscopic techniques.

The Department of Interventional Pulmonology at KIMS Hospital, Ananthapur continues to adopt and perform advanced procedures aimed at improving patient care while minimizing discomfort and recovery time.

Every complex airway presents is a challenge, but with precision technology and specialized expertise, even the most difficult pathways can be restored.

Sometimes, all it takes is the right tool placed in the right place to help a patient breathe easier again.



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A Piece of Betelnut Stuck in Lungs for 6 Months

Anantapuram, 08th Oct 2025 : A 60-year-old woman, had been struggling with persistent respiratory symptoms. What began as an occasional cough gradually progressed to recurrent cough, fever, and breathlessness. Over the months, she visited multiple hospitals and received several courses of antibiotics for what was thought to be repeated lung infections as the real cause of her cough could not be found out by those hospitals.

Despite these treatments, her symptoms never truly resolved. Each episode seemed to improve briefly, only to return again. Eventually, when her breathing worsened and the fever returned, she reported to the Emergency Department at KIMS Hospital, Ananthapur seeking relief.

She was admitted under the care of Dr. Yashovardhan Consultant Interventional Pulmonologist. Because the patient had persistent symptoms for nearly a year, it was suspected that something more than a simple infection might be responsible. To investigate further, a diagnostic bronchoscopy (a procedure that allows direct visualization of the airways using a flexible camera) was performed.

As the bronchoscope was advanced into the right lung, the mystery began to unfold.

Deep within the basal segments of the right lower lobe, we discovered the unexpected cause of her repeated infections — a betel nut lodged inside the airway.

Betel nut chewing is common in many parts of our country, and occasionally a small piece may accidentally enter the airway during chewing or swallowing. If unnoticed, it can remain trapped in the bronchial tree for a long time, leading to chronic irritation, recurrent infections, and persistent cough.

In this case, the foreign body had likely been present for almost a year, silently causing repeated episodes of infection.

Once the foreign body was identified, the next step was to remove it safely.

For this, we performed a rigid tracheo-bronchoscopy, a specialized procedure that allows better airway control and enables the use of stronger instruments for extraction.

Using rigid bronchoscopy forceps, the betel nut was carefully grasped and removed from the airway. Following extraction, we performed bronchial toileting, clearing the airway of accumulated secretions and inflammatory debris that had formed around the foreign body over time.

With the obstruction removed, the lung could finally begin to heal.

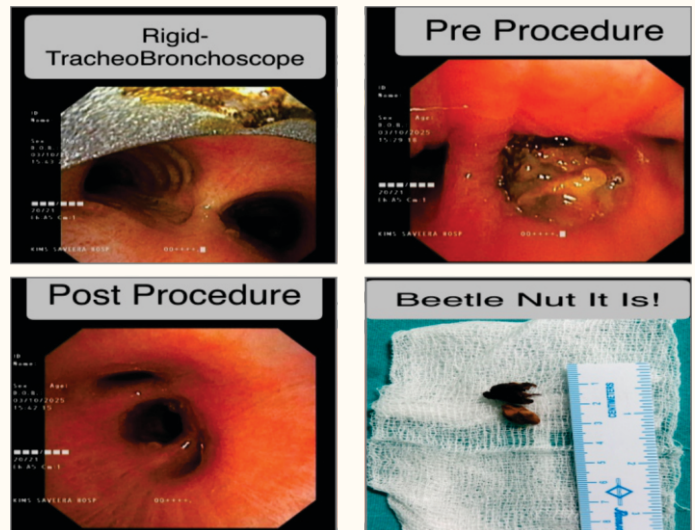
Recovery and Relief:

Soon after the procedure, the patient's breathing improved significantly. The chronic irritation that had caused months of repeated infections was finally gone.

Cases like this remind us that when respiratory symptoms persist despite repeated treatments, it is important to look deeper into the airways. Sometimes the problem is not an infection alone, but a hidden foreign body quietly causing trouble.

Modern interventional pulmonology provides powerful tools to diagnose and treat airway problems without the need for major surgery. Procedures such as bronchoscopy and rigid trachea bronchoscopy allow specialists to identify and remove airway obstructions safely and effectively. Small betelnut like foreign bodies will not be visible in routine X-rays.

At KIMS Hospital, Ananthapur, our pulmonology team continues to provide advanced bronchoscopic care, ensuring that even the most unexpected causes of lung disease can be diagnosed and treated promptly.



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Where Simplicity Meets Beauty : Lateral Supramalleolar Flap for Dorsal Foot Coverage

Anantapuram, 19th Nov 2025 : A 30-year-old female, presented with a 6 × 5 cm post-traumatic defect over the dorsum of the foot with exposed extensor tendons. The case was attended by Dr Varun Tej Consultant Plastic Surgeon, KIMS Saveera hospital, After wound preparation, a lateral supra-malleolar fasciocutaneous flap was designed on the distal lateral leg with the pivot point approximately 5 cm above the lateral malleolus.

The flap was elevated including deep fascia and rotated to cover the dorsal foot defect. The donor site was resurfaced with a split-thickness skin graft.

Abstract

Soft-tissue defects of the dorsal foot are challenging because of the thin skin and frequent exposure of tendons. The lateral supra-malleolar flap, based on the perforator of the peroneal artery, offers a reliable and aesthetically pleasing reconstructive option. We report successful coverage of a dorsal foot defect in a 30-year-old female using this flap with excellent functional and cosmetic outcome.

Outcome

The postoperative course was uneventful with complete flap survival. At one-month follow-up, the patient demonstrated stable coverage, preserved foot contour, and comfortable ambulation.

Conclusion

The lateral supramalleolar flap represents a simple yet elegant reconstructive solution, providing reliable coverage and pleasing aesthetic outcomes for dorsal foot defects without the need for complex microsurgical reconstruction.



After Surgery



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Neurosurgeons Successfully Treat Rare Arteriovenous Malformation in Brain

Anantapuram, 20th Nov 2025 : Neurosurgeons in KIMS Saveera Hospital, Anantapur successfully performed a complex, six-hour surgery to treat a rare arteriovenous malformation (AVM) in the brain of a local farmer, restoring his health and improving his quality of life.

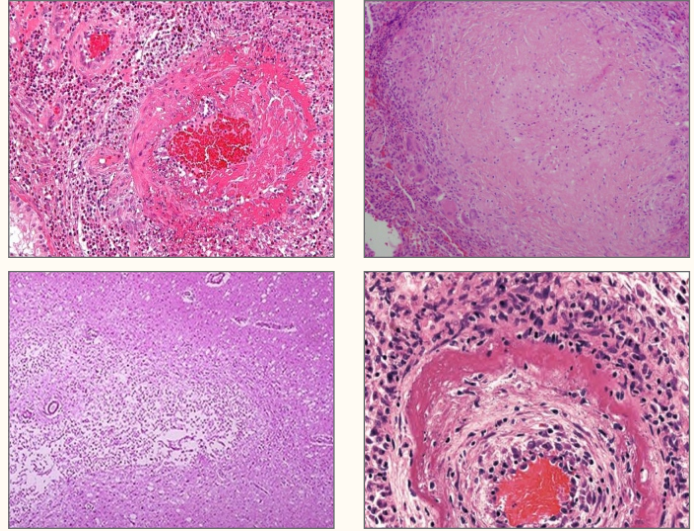
A 40-year-old male from nearby village, came to KIMS Saveera Hospital after experiencing an episode of sudden, severe headache and altered sensorium. Diagnostic imaging revealed an AVM - a rare vascular condition affecting just one in every one lakh individuals, in which abnormal connections between arteries and veins dangerously bypass the normal capillary system within the brain. "AVMs can be life-threatening if untreated, as the swollen blood vessels are at constant risk of rupture, causing internal bleeding,

In this case, the malformation was located near vital areas controlling speech and movement, making the surgery particularly challenging. A team led by Dr. C. Anil and Dr. Murali Krishna Consultant Neurosurgeons utilized advanced microsurgical techniques and real-time intraoperative monitoring to safely remove the tangled vessels and restore normal blood flow to the brain. Following the intricate procedure, the patient made a rapid and complete recovery, retaining his speech and mobility. He was discharged five days later. He was able to resume his daily activities independently.

Many patients with AVMs may not realize they have the condition until sudden, severe symptoms appear. Early diagnosis and timely surgical intervention are critical in preventing life threatening complications. Previously, patients requiring such advanced neurosurgery had to travel long distances to metropolitan cities like Bengaluru or Hyderabad. The success of this operation underscores the capabilities now available at KIMS Saveera Hospital, allowing the residents of Anantapur and the entire Rayalaseema region access to world-class brain and vascular care.

About Arteriovenous Malformation (AVM):

AVMs are usually congenital and develop when arteries connect directly to veins without the normal, pressure-buffering capillary network. This can lead to dangerously high blood flow, causing the veins to swell over time-sometimes remaining silent for years until symptoms such as headache, memory loss, neurological deficits, or bleeding arise. If undetected, such a rupture of vessels normally is life threatening and result in extremely high mortality and severe morbidity in surviving patients.



మెదడు రక్తనాళాలకు అరుదైన శస్త్రచికిత్స

అనంతపురం (వైద్యం), న్యూస్ టుడే: కణికల్లుకు చెందిన రైతు పక్కీరప్ప (47) మెదడులోని రక్తనాళాలకు అరుదైన శస్త్రచికిత్స చేసి ప్రాణాలు కాపాడినట్లు కన్సల్టెంట్ న్యూరోసర్జన్ డాక్టర్ అనిల్, డాక్టర్ మురళీమోహన్ కృష్ణ తెలిపారు. గురువారం వారు కిమ్స సవీరా ఆసుపత్రిలో శస్త్రచికిత్సకు సంబంధించిన వివరాలను వెల్లడించారు. పక్కీరప్పకు తీవ్ర తలనొప్పి రావటం, మతిమరుపు వంటి లక్షణాలతో ఆసుపత్రికి వచ్చారని వెల్లడించారు. ఆయనను పరీక్షించి సిటి యాంజియోగ్రామ్ పరీక్ష చేయగా ఆర్థెరియో వీన్స్ మాల్ పార్షిషన్ (ఏవీఎం) అనే సమస్య ఉందని గుర్తించామని తెలిపారు. సాధారణంగా రక్తనాళాల నుంచి మెదడులోకి రక్తప్రసారం జరిగే క్రమంలో మెదడులోని కీలక ప్రాంతాల వద్ద సరాలు ఉబ్బటంతో ఆయనకు మతిమరుపు



కోలుకున్న రైతు పక్కీరప్పతో వైద్యులు అనిల్, మురళీ మోహన్ కృష్ణ

లాంటి సమస్యలు వచ్చాయని వివరించారు. ఉబ్బిన సరాలు సరిగ్గా మెదడులో మాట, కదలికలను నియంత్రించే ప్రాంతంలో ఉండటంతో వాటిని ఆరు గంటలపాటు శస్త్రచికిత్స చేసి తొలగించామన్నారు. శస్త్రచికిత్స విజయవంతం తరువాత మెదడులోకి రక్తప్రసారం సాధారణంగా జరుగుతుండటంతో రోగి కోలుకున్నారని ఎలాంటి ఇబ్బంది లేకపోవటంతో డిశ్చార్జి చేసినట్లు వివరించారు.



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A case of Ventricular Fibrillation Following Acute Anterior Wall Myocardial Infarction Successfully Reverted in the Emergency Room

Anantapuram, 29th Nov 2025 : Ventricular fibrillation (VF) is a life-threatening arrhythmia typically associated with extensive myocardial ischemia. Primary VF in the setting of anterior wall myocardial infarction (AWMI) carries a high risk of mortality if not recognized and treated promptly. Ventricular fibrillation results from rapid electrical impulses arising in the ventricular myocardium or Purkinje system, producing chaotic electrical activity and loss of coordinated myocardial contraction. It is one of the most common causes of sudden cardiac death in acute myocardial infarction. Out-of-hospital sudden cardiac arrest (SCA) and SCD are often because of Ventricular fibrillation. VF is more frequently associated with anterior wall MI due to ischemia-induced electrical instability. Early recognition and defibrillation are critical to survival. This case highlights the importance of continuous monitoring, rapid team response, and standardized resuscitation protocols in the ER.

We report an uncommon case of sudden VF presenting with AWMI, successfully reverted with immediate defibrillation in the Emergency Room (ER), resulting in rapid return of spontaneous circulation (ROSC) and favorable outcome.

A 45-year-old male, with no significant past medical history presented to the Emergency Room with history of acute onset retrosternal chest pain of 2 hours duration, radiating to the left arm, associated with diaphoresis and mild dyspnea.

Initial Assessment : Vital signs: HR 98/min, BP 110/70 mmHg, RR 22/min, SPO2 96% on room air. General: Diaphoretic but alert.

Cardiac examination : S1, S2 normal, no murmurs. ECG: ST segment elevation in V1–V4 consistent with acute anterior wall STEMI.

Initial management included :

- Aspirin 325 mg + Clopidogrel/Ticagrelor loading
- Heparin bolus
- High-dose statin
- Oxygen as required
- Pain relief (nitrates avoided due to borderline BP)

The patient was connected to continuous cardiac monitoring while activation for primary PCI was initiated. In the ER, approximately 10–15 minutes after arrival, the patient suddenly became unresponsive and pulseless. Saturation started to drop significantly. The monitor showed coarse ventricular fibrillation. Immediate CPR was initiated. Defibrillation delivered with a 200 J biphasic shock.

Return of spontaneous circulation achieved within 20–30 seconds, with return of organized rhythm (sinus tachycardia) and palpable central pulses. No additional shocks were required. He continued to have a stable BP of 115–120 systolic and 76–82 diastolic. HR returned to 80 to 90/min, SpO2 remained around 98% with oxygen. The patient regained consciousness promptly without neurological deficit.

Repeat ECG: Persistent ST elevation in anterior leads. Electrolytes: Normal potassium and magnesium.

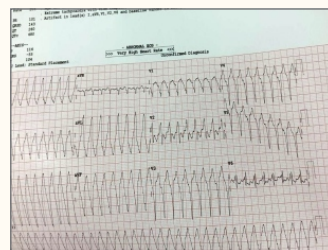
Bedside echo: LAD territory hypokinesia, no mechanical complications.

The patient was shifted for primary PCI. In Cath-lab LAD occlusion was identified and successfully stented.

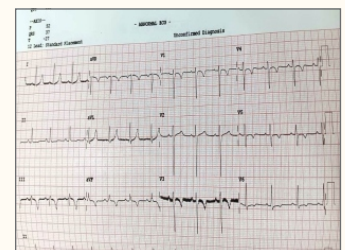
Post-PCI recovery was uneventful.

Discussion: Primary VF in anterior wall MI is not uncommon but dangerous. Most out of hospital deaths of MI cases occur due to ventricular fibrillation. It typically occurs early due to acute ischemia-induced electrical instability. Early VF in MI is usually transient and reversible with prompt defibrillation. Rapid defibrillation (<2 minutes) significantly improves survival. Continuous monitoring in high-risk STEMI patients is essential. Immediate PCI reduces ischemic burden and prevents recurrence.

Conclusion: This case highlights how preparedness and adherence to ACLS protocols dramatically improve outcomes. Rapid recognition and immediate defibrillation in this case saved his life. A coordinated ER response enabled successful ROSC, timely PCI, and favorable recovery. Early VF following MI, must be anticipated, reinforcing vigilant monitoring and team readiness.



VF Tracing



Normal rhythm after successful Defibrillation and CPR



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When Seconds Matter: A Race Against Time in a Bleeding Lung

Anantapuram, 02nd Dec 2025 : A 68-year-old woman was rushed into the Emergency department of KIMS Saveera Hospital, with massive hemoptysis. Along with this, she had a history of loss of appetite and significant weight loss, suggesting a serious underlying lung disease.

By the time she reached the emergency room, she was in severe respiratory distress. Her oxygen levels were dropping rapidly and breathing was becoming increasingly difficult. The priority was clear: secure the airway and stabilize her breathing immediately.

She was intubated in the emergency room, allowing us to take control of her breathing and move quickly toward identifying the source of bleeding. After initial therapy in Emergency department, the case was taken over by Dr Yashovardhan Mangisetty Consultant Interventional Pulmonologist.

Entering the Battlefield: Emergency Bronchoscopy

In situations like this, time is critical. The next step was to perform an emergency bronchoscopy - a procedure where a thin camera is passed into the airways to directly visualize the lungs.

As the bronchoscope entered the airway, the picture became clear - and alarming. Blood was pooled within the airways, threatening to flood the lungs and obstruct ventilation.

A CT scan had already pointed toward a likely culprit: active bleeding from the lateral segment of the right middle lobe.

Managing a bleeding lung is one of the most challenging situations in pulmonology. Not only must the bleeding be controlled, but the airway must remain clear enough to allow oxygen to reach the lungs.

Carefully, we began extracting blood clots and performing airway toileting, clearing both lungs to maintain ventilation. However, one clot was intentionally left in the right middle

lobe - temporarily acting as a natural plug to limit further bleeding from that segment.

During the procedure, the patient's oxygen saturation dropped, and her heart rate began to fluctuate. These are the moments when the entire team feels the pressure.

Managing an actively bleeding airway requires absolute coordination, calm decision-making, and rapid action. With medications, ventilation adjustments, and meticulous airway management, we were able to stabilize her breathing and circulation.

Once the patient's ventilation was secured, the next step was to address the bleeding at its source.

The patient was taken for selective bronchial artery embolization, a life-saving interventional radiology procedure that blocks the blood vessels responsible for the bleeding.

This technique allows doctors to seal the bleeding artery without the need for open surgery, making it an essential tool in the management of massive hemoptysis.

Once the embolization was successfully completed, we performed a check bronchoscopy to reassess the airways.

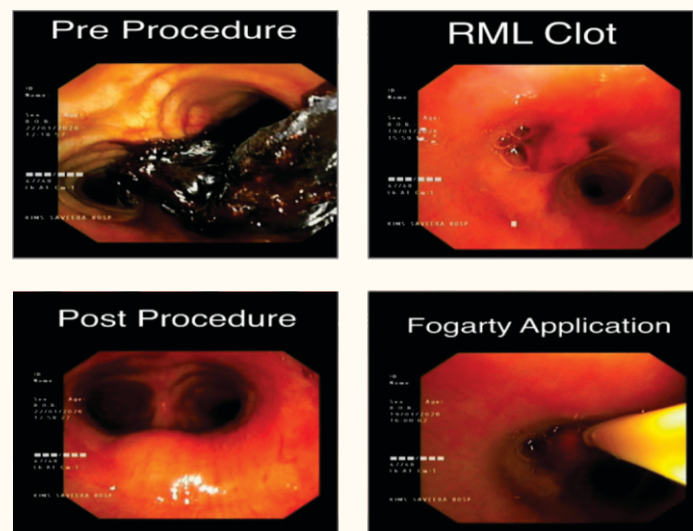
This time, the previously retained clot in the right middle lobe was carefully removed. The airway was now clear and stable.

To determine why the bleeding had occurred in the first place, we collected bronchoalveolar lavage (BAL) samples from the lungs. Laboratory analysis revealed the underlying diagnosis: active pulmonary tuberculosis. Anti-tuberculosis therapy was started promptly.

Over the next few days, the patient's condition improved steadily. With the bleeding controlled and treatment initiated, she was successfully extubated, breathing on her own again. Soon after, she was discharged home in a stable condition, continuing her treatment with close follow-up.

Massive hemoptysis remains one of the most dramatic and life-threatening emergencies in respiratory medicine. Managing it requires rapid airway control, advanced bronchoscopic skills, interventional radiology support, and coordinated teamwork.

At KIMS Hospital, Anantapur, cases like these highlight how modern pulmonology and critical care can transform a life-threatening emergency into a survivable event.



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Local Tissue, Elegant Solution: Infra-Alveolar Perforator Flap for Ear Lobule Reconstruction at Anantapur

Anantapuram, 04th Dec 2025 : An 48-year - old female, presented with a traumatic defect involving the ear lobule with adjacent soft-tissue loss. Reconstruction required tissue that matched the color, thickness, and contour of the native ear lobule while maintaining a reliable blood supply for optimal healing.

Introduction

Loss of the ear lobule, though seemingly small, can significantly affect a person's facial aesthetics and confidence. Ear lobule defects may occur due to trauma, infection, burns, or tumor excision. Reconstruction of this delicate structure requires both functional precision and aesthetic finesse.

At KIMS Saveera Hospital, Anantapur, an innovative reconstructive procedure was performed by Dr. Kammiti Varun Tez Plastic & Reconstructive Surgeon, using an infra-alveolar perforator flap to restore the ear lobule in a patient who sustained accidental trauma to the ear with a sickle during agricultural work.

Figure 1. Pre-operative image showing traumatic loss of the ear lobule following sickle injury.

The Surgical Solution

A local perforator-based flap based on the infra-alveolar perforator was designed and elevated from the adjacent facial region. This technique offers several advantages:

- Excellent vascular supply ensuring flap survival
- Good color and texture match with surrounding skin
- Minimal donor-site morbidity
- Single-stage reconstruction with restoration of natural contour

The flap was carefully transposed and sculpted to recreate the ear lobule contour, followed by meticulous suturing to achieve symmetry with the opposite ear.

Figure 2. Immediate post-operative appearance after ear lobule reconstruction using the infra-alveolar perforator flap.

Outcome

The reconstruction successfully restored the shape, projection, and aesthetic appearance of the ear lobule. The patient recovered well with healthy flap viability and satisfactory cosmetic outcome.

At one-month follow-up, the reconstructed lobule demonstrated good contour, stable healing, and pleasing aesthetic symmetry.

Figure 3. One-month post-operative follow-up showing stable lobule contour and good healing.

Advancing Reconstructive Surgery in Anantapur

This case highlights the role of perforator-based local flaps in facial reconstruction, offering reliable and cosmetically satisfying outcomes even in traumatic defects. At KIMS Saveera Hospital, Anantapur, advanced reconstructive techniques continue to provide patients with solutions that restore not only anatomy but also confidence and quality of life.



Fig.01 Pre-operative



Fig. 02 Immediate post operative



Fig.3 One month after surgery



Dr. Kammiti Varuntez

MBBS, MS (General Surgery) Gold Medallist

Mch (Plastic Surgery)

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Hunting the Hidden: How Advanced Lung Navigation Helped Us Reach the Unreachable

Anantapuram, 06th Dec 2025 : A 62-year-old gentleman walked into our clinic with persistent cough, poor appetite, and significant weight loss, it raised immediate concern. Dr Yashovardhan Mangisetty Consultant Interventional Pulmonologist attended the case and evaluated. A CT scan of his chest revealed a suspicious lesion in the apicoposterior segment of the left upper lobe, extending into a superior subsegmental region — an area that is notoriously difficult to access with conventional bronchoscopy. For pulmonologists, lesions located in such deep and peripheral parts of the lung pose a diagnostic challenge. Reaching them safely while obtaining a meaningful tissue sample requires both advanced technology and refined procedural skill.

The Cryo Advantage

With the new Cryo probe being available at KIMS Saveera Hospital, we can freeze a small area of tissue for a few seconds and then gently pull it out. This gives a chunk of tissue instead of just cells.

The bigger sample lets pathologists see the structure better, do more stains, and run genetic tests.

Mapping the Lung in Three Dimensions

Using Cone Beam CT, we created a three-dimensional roadmap of the patient's lung anatomy. This technology allows the bronchoscopist to visualize the airways and lesion simultaneously, helping us identify the exact bronchial pathway leading to the target.

In peripheral lung lesions, even a few millimeters of deviation can mean missing the lesion entirely. CBCT guidance significantly improves the accuracy of navigation, especially in small or tricky locations deep within the lung segments.

Once the pathway was confirmed, a Radial Endobronchial Ultrasound probe was introduced through the bronchoscope. This tiny ultrasound device acts like an eye within the lung, confirming the precise position of the lesion before sampling.

Cryobiopsy: Bigger, Better Tissue Samples :

After confirming the location, we performed a cryobiopsy using a 1.1 mm cryoprobe. Unlike conventional biopsy forceps, cryobiopsy freezes and retrieves a larger, well-preserved piece of lung tissue.

This technique offers several advantages :

- Higher diagnostic yield
- Better preserved tissue architecture
- More reliable analysis for modern pathology and molecular testing

In complex lung lesions, obtaining a high-quality tissue sample in the first attempt is crucial, as it reduces the need for repeat procedures.

The Role of ROSE: Instant Feedback

Another key element of the procedure was Rapid On-Site Evaluation (ROSE). During the procedure itself, the collected tissue was immediately examined by the pathology team.

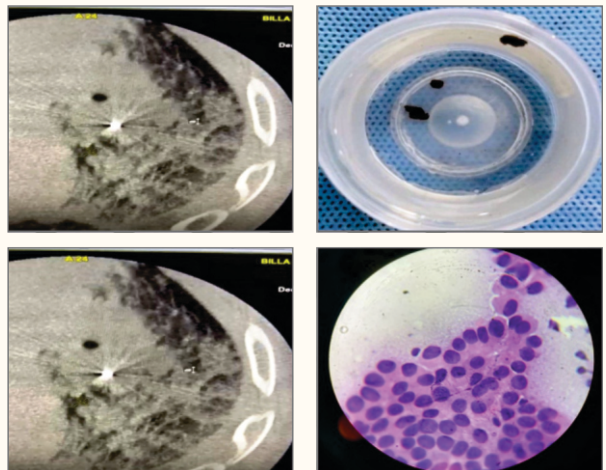
ROSE allows clinicians to quickly determine whether the sample contains abnormal or suspicious cells, ensuring that adequate tissue has been obtained. In this case, the preliminary evaluation suggested atypia, indicating that the biopsy had successfully targeted the lesion.

The patient tolerated the procedure well and was safely extubated on the table, highlighting the safety and minimally invasive nature of these advanced techniques.

Bringing Advanced Lung Care to Ananthapur

Technologies such as Cone Beam CT navigation, Radial EBUS, cryobiopsy, and ROSE are transforming the way pulmonologists diagnose lung diseases.

Our pulmonology department in Ananthapur is proud to offer these advanced diagnostic capabilities. By combining cutting edge technology with specialized expertise in interventional pulmonology, we aim to ensure that patients receive early, accurate diagnoses and world-class care closer to home.



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Complex Total Hip Replacement in a Patient with Old IMIL Nail and Malunited Fracture Neck of Femur with Proximal Migration

Anantapuram, 15th Dec 2025 : A 65-year-old female underwent IMIL nailing 14 years ago for fracture of right femur shaft. The fracture healed, but several years later she sustained another fracture in neck of femur, which remained untreated. Over time, the neck fracture malunited, and the proximal femur migrated superiorly due to mechanical imbalance and muscular pull, as a consequence of which she developed:

- Severe pain around the right hip
 - Limb shortening
 - Difficulty bearing weight
 - Reduced hip mobility
 - Pain due to proximal protrusion of the IMIL nail tip
- Her functional mobility was significantly compromised, and she relied on support for ambulation.

Clinical examination

On examination, the patient demonstrated:

- Antalgic gait and dependence on support
- Noticeable shortening of the right lower limb
- Painful and restricted hip movements, especially internal rotation
- Prominence and tenderness over the proximal femur due to nail protrusion
- No neurovascular deficits

The presence of previous surgical scars and tissue contractures indicated a challenging surgical exposure and implant removal process.

Radiological evaluation

X-rays revealed multiple deformities:

- Old IMIL nail in situ with healed femoral shaft fracture • Malunited neck of femur fracture
- Superior migration of the greater trochanter
- Verticalization of the proximal femur
- Reduced femoral o set and limb-length discrepancy • Narrow, distorted femoral canal
- High risk zone for stress fractures due to existing hardware tract

These radiological features that a standard hip signified replacement would not suffice; correction of mechanical axis and femoral length was mandatory.

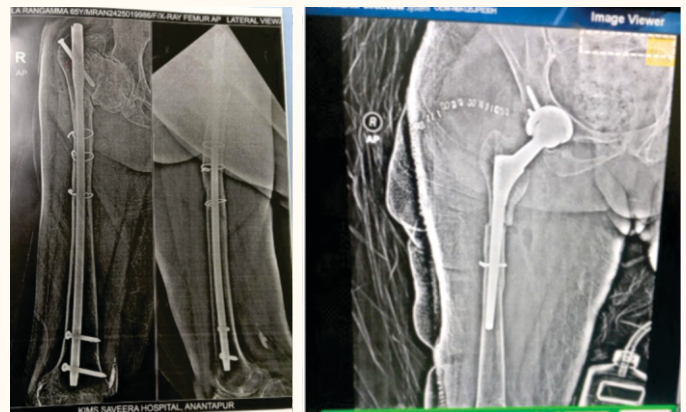
Neglected femoral neck fractures in elderly or medically underserved populations commonly progress to malunion and proximal migration. When combined with a pre-existing IMIL nail from prior trauma surgery, the anatomy becomes significantly distorted. Such cases demand high surgical expertise since extraction of old implants, correction of deformity, and joint reconstruction must occur in a controlled and safe manner. The need for long-stem implants and osteotomy adds further complexity, increasing the importance of precision in planning and execution.

Surgical management

Key technical steps included:

1. Removal of old IMIL nail
 - Technically demanding due to bone overgrowth, screw tract fibrosis, and risk of iatrogenic fracture.
 - careful dissection and fluoroscopic guidance.
2. Subtrochanteric osteotomy
 - Performed to correct proximal migration and rotational deformity.
 - High precision required to maintain alignment and avoid propagation of cracks.
3. Femoral canal preparation
 - Challenging due to distorted anatomy and narrow canal.
 - Long stem selected to bypass the old fracture zone and distribute stress evenly.
4. Acetabular component placement
 - Achieved optimal cup inclination and anteversion despite altered femoral orientation.
5. Final reduction and restoration of biomechanics
 - Limb length, o set, and soft-tissue tension were restored close to normal.

This surgery required advanced orthopedic skills, including implant extraction, osteotomy execution, deformity correction, and handling of compromised bone quality.



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Bilateral Unstable Slipped Capital Femoral Epiphysis Managed with Bilateral Modified Dunn Osteotomy

Anantapuramu 25th Dec 2025

Introduction

SCFE (Slipped Capital Femoral Epiphysis) is characterized by displacement of the capital femoral epiphysis relative to the femoral neck through the physis. Unstable slips represent a surgical emergency due to the increased risk of avascular necrosis. The Modified Dunn procedure allows anatomical reduction under direct vision while preserving the retinacular blood supply.

Case presentation

A 13-year-old male, presented with bilateral hip pain and inability to bear weight for 20 days following a fall from a two-wheeler. Pain was progressive, aggravated by movement, and associated with inability to ambulate.

Clinical examination

The patient was conscious, oriented, and hemodynamically stable. Both lower limbs were held in external rotation. Tenderness was present over both hip joints. Severe restriction of movements was noted bilaterally. Internal rotation was almost absent and painful.

Pre-operative Range of Motion:

Flexion – Severely restricted

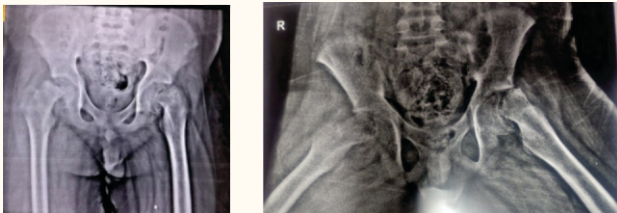
Internal Rotation – Almost nil

Abduction – Painful and limited

Neurovascular status – Intact

Radiological evaluation.

X-ray pelvis with both hips (AP and frog-leg lateral views) revealed bilateral posteroinferior displacement of the capital femoral epiphysis, widening of the physis, and failure of Klein's line to intersect the epiphysis, suggestive of bilateral unstable SCFE.



Pre-Operative work-up and planning

Comprehensive hematological and biochemical investigations were performed. Pre-anesthetic evaluation was done. Radiological images served the purpose of calculating the degree of slip by measuring the Southwick Epiphyseal shaft angle. Considering bilateral unstable slips and risk of avascular necrosis, bilateral Modified Dunn osteotomy with surgical hip dislocation was planned.

Surgical management

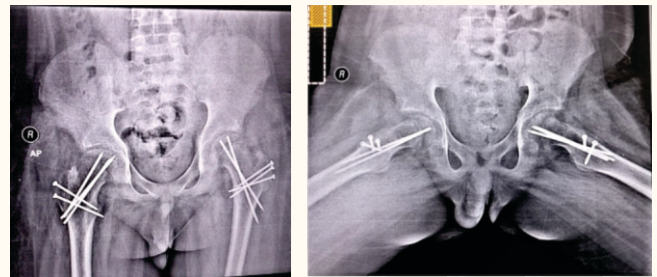
Bilateral Modified Dunn osteotomy was performed under appropriate anesthesia. Surgical hip dislocation approach was used. Retinacular vessels were carefully preserved. Anatomical realignment of the epiphysis was achieved and stabilized with internal fixation under fluoroscopic guidance.

Post-Operative Rehabilitation

Post-operative period was uneventful. Vitals remained stable and wounds healed well. Physiotherapy was initiated early with gradual mobilization. Progressive weight bearing was allowed as tolerated.

Outcome and follow-up

At follow-up, the patient demonstrated significant pain reduction and improved hip range of motion. He is currently able to bear weight and ambulate with support. No early complications such as avascular necrosis or chondrolysis were noted.



Conclusion

Bilateral unstable SCFE can be successfully managed with bilateral Modified Dunn osteotomy when prompt intervention and careful vascular preservation techniques are employed. Early rehabilitation contributed significantly to functional recovery in this case.



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Complex Multi-Ligament Reconstruction of the Left Knee Following High-Velocity Injury

Anathapuram 27th Dec 2025 : 27-year-old male presented with history of trauma resulting in severe pain, swelling, inability to bear weight, knee instability, and difficulty in knee movements on the left side. He reported repeated giving-way episodes of the knee. No distal neurovascular deficit was noted.

Clinical examination

- Tenderness over medial and lateral joint lines
- Positive Lachman test (ACL laxity)
- Positive posterior drawer test (PCL laxity)
- Valgus laxity indicating MCL injury
- Patellar apprehension due to MPFL involvement
- Restricted range of motion due to pain and inflammation

Radiological evaluation.

MRI Findings:

- ACL : Mild substance tear
 PCL : Complete tear at femoral attachment
 MCL : Complete tear at tibial attachment; medial patellofemoral ligament tear
 MPFL : Mild strain near insertion
 Meniscus : Horizontal tear in posterior 1/3rd of medial meniscus
 Impression : A high-grade Mult ligamentous knee injury requiring surgical reconstruction.

Multiligament knee injuries typically result from high-impact trauma and require precise interpretation of imaging, detailed surgical planning, and advanced arthroscopic techniques. This case highlights extensive MRI findings, surgical difficulty, and the expertise required for successful reconstruction.

Pre-Operative work-up and planning

This procedure requires a surgeon skilled in complex arthroscopy for simultaneous tunneling for ACL and PCL reconstruction and open multi ligament reconstruction techniques for MCL.

Surgical management

Procedures Performed:

- Arthroscopic ACL reconstruction
- Arthroscopic PCL reconstruction
- MCL repair (tibial side)
- Meniscus repair

Key Surgical Steps:

1. Diagnostic arthroscopy and evacuation of joint hematoma
2. ACL reconstruction using graft with anatomical tunnel placement
3. PCL reconstruction using femoral and tibial tunnels; graft secured with screws
4. MCL repair with suture anchors
5. Meniscal tear repaired using inside-out sutures
6. MPFL tension assessed and balanced

Technical Challenges

- Difficulty in maintaining tunnel orientation with bone contusions
- Avoiding tunnel convergence during ACL–PCL reconstruction
- Accurate graft tensioning in the presence of multiple reconstructions

Post operative rehabilitation

- Ice compression and elevation
- Gradual passive range of motion exercises
- Partial weight-bearing with walkers
- Quadriceps strengthening initiated early
- Close physiotherapy supervision for 6–12 months
- Pain significantly reduced within 3 days
- No wound complications
- Knee stability improved
- Range of motion progressively increasing
- Patient ambulates with support and continues physiotherapy



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A Rare Presentation of Carcinoma Cervix

Anantapuram, 19th Jan 2026 : A 70 year-old-female presented to the ER with complaints of vague lower abdominal pain of 3 months duration, which has been worsening since last 1 week. On examination, it was found to be associated with foul smelling, white discharge per vaginum.

Initially, ultrasound abdomen and pelvis was advised. It revealed a well-defined thick-walled hypoechoic lesion with internal echoes measuring 8 x 8 cm superior to uterus-like structure in continuity with its lumen. Minimal ascites was present.

MRI Pelvis was advised for detailed evaluation. It revealed :

- Enlarged uterus (7.1 x 6 x 9 cm) with endometrial cavity distended with mixed intense fluid (endometrial cavity is 4 cm in diameter) -- Hematometra.
- Diffuse, ill defined, circumferential lesion of soft tissue intensity seen involving entire cervix with irregular cervical canal narrowing / stenosis leading to proximal hematometra. This lesion was seen infiltrating entire vagina (more along the anterior wall). 4 mm long segment of anterior vaginal wall, 13 mm long segment of posterior vaginal wall. Introitus and vulva were spared.
- This lesion was seen infiltrating bilateral parametrium, not reaching up to pelvic side wall, vesico-uterine / vaginal septum with large ulcer at the anterior wall of mid vagina. Diffuse thickening of urinary bladder wall was seen with almost near complete or impending Vesicovaginal fistula formation.
- Posteriorly anterior mesorectum was infiltrated (almost 2 cm long segment). Multiple, similar morphology bilateral internal iliac, a presacral lymph nodes were seen.

Most likely Carcinoma of cervix as described with high cellularity (In view of DWI restriction and ADC reversal). FIGO stage IVA /B T3B N1 MX

- Small amount of free fluid in pelvis.
- Both ovaries could not be identified.
- Visualized pelvic bones / joints, external pelvic soft tissues are normal

Discussion Demographics :

- Average age of onset at around 45 year

Risk factors for carcinoma cervix :

- Human papillomavirus (HPV) 16 and 18 infections
- Multiple sexual partners or a male partner with multiple previous or current sexual partners
- Young age at first intercourse
- High parity
- Oral contraceptives
- Nicotine/smoking

Risk factors for carcinoma cervix :

- USG -** Hypoechoic, heterogeneous mass involving the cervix may show increased vascularity on colour Doppler.
- CT -** It is performed primarily to assess lymphadenopathy, but also has roles in defining advanced disease, monitoring distant metastasis, planning the placement of radiation ports, and guiding percutaneous biopsy.
- MRI -** The normal low signal cervical stroma provides intrinsic contrast for the high signal cervical tumor.

T1 :

- Usually isointense compared with pelvic muscles

T2

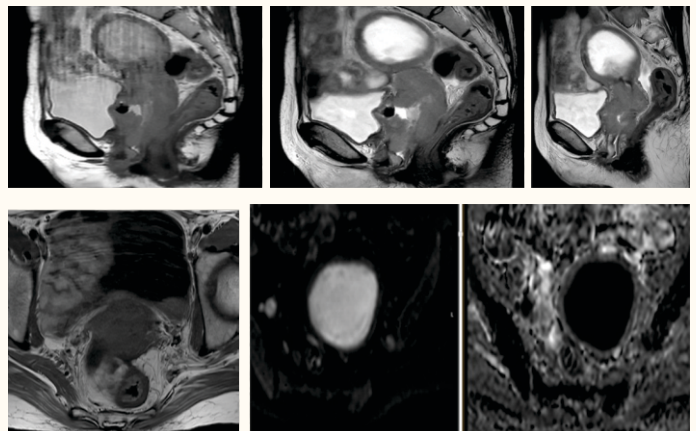
- Hyperintense relative to the low signal of the cervical stroma.
- Hyperintensity is thought to be present regardless of histological subtype 1.

T1 C+ (Gd)

- Contrast is not routinely used, though it may be helpful to demonstrate small tumors considered for trachelectomy (removing only the cervical tumor and retaining the remaining uterus).
- On contrast-enhanced T1-weighted images, tumor presents as a high signal relative to the low signal of the cervical stroma 24

PET-CT - PET-CT in conjunction with pelvic MRI is often used as an imaging strategy to stage cervical carcinoma.

In this case, the patient presented with symptoms associated with hematometra which was diagnosed on initial radiological study. However, this case highlights the importance of multimodality imaging for diagnosis and staging of cancers.



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Case Report: Complex Primary Total Knee Arthroplasty in Post-Traumatic Knee with Bone Loss

Anantapuram, 28th Jan 2026 : A 30-year-old female presented with chronic right knee pain, deformity, and inability to bear weight following a history of trauma. The patient had been non-weight bearing for six months, during which she developed progressive stiffness and functional limitation.

Clinical examination On examination, the patient was unable to ambulate without support. The right knee showed severe pain, stiffness, and instability. The pre-operative range of motion was nil(0°), with no active flexion or extension possible. Neurovascular examination was normal.

Post-traumatic osteoarthritis of the knee accounts for a significant proportion of secondary osteoarthritis cases and often affects younger patients. Management becomes challenging when associated with severe stiffness, instability, and bone loss. Complex primary total knee arthroplasty with constrained implants may be required to restore stability and function.

Radiological Evaluation

Radiographs of the right knee demonstrated advanced post traumatic knee with significant bone loss, altered joint alignment, and joint incongruity.



Pre - Operative workup and Planning

A comprehensive pre-operative workup was performed including hematological and biochemical investigations, pre-anesthetic evaluation, and detailed surgical planning. Anticipation of bone defects and ligamentous insufficiency necessitated planning for a constrained implant.

Surgical Management

The patient underwent right complex primary total knee arthroplasty. Intra-operatively, significant bone loss and instability were confirmed. Adequate bone preparation, defect management, and soft tissue balancing were performed. A constrained knee prosthesis was implanted to achieve stability and alignment.

Post - Operative Rehabilitation

Physiotherapy was initiated from postoperative day one with emphasis on early mobilization and knee range-of-motion exercises.

Outcome and Follow-Up

At early follow-up, the patient achieved knee flexion up to 40°, representing a significant improvement from nil pre-operative ROM. The range of motion was progressively improving with continued physiotherapy.

Discussion

This case highlights the role of complex primary total knee arthroplasty with constrained implants in managing young patients with post-traumatic osteoarthritis, severe stiffness, and bone loss. Early rehabilitation played a crucial role in functional recovery.

Conclusion

Complex primary total knee arthroplasty can provide satisfactory early functional outcomes in young patients with post-traumatic osteoarthritis when meticulous pre-operative planning, appropriate implant selection, and aggressive rehabilitation protocols are followed.



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Beyond the Spinal Cord - A Case of MOG-Positive Myeloradiculitis Presenting as Acute Cauda-Conus Syndrome

Anantapuram, 16th Feb 2026 : A 41-year-old female presented with sudden onset of weakness in both lower limb (Power: Rt 3/5, Lt 2/5), numbness, saddle anesthesia, and bowel & bladder incontinence.

Dr Karthik Reddy Consultant Neurologist examined the patient and after initial evaluation subjected her to investigations.

Clinical history revealed lower back pain with sharp, dragging paresthesia in both lower limbs (Left more than Right). Neurological examination confirmed lower limb paraparesis with preserved upper limb function and normal cranial nerves.

Imaging: MRI of the lumbar spine and plexus revealed an ill defined altered signal intensity and thickening of the lower dorsal spinal cord from D11 to the conus-medullaris, consistent with myelitis. Additionally, thickening and signal changes in the left lumbosacral nerve roots and sciatic nerve suggested plexitis/radiculoneuritis.

- Systemic Workup: MRI Brain and Visual Evoked Potentials (VEP) were normal, which excluded cranial or optic nerve involvement. CSF analysis was unremarkable.
- Serology: Serum anti MOG (Myelin oligodendrocyte glycoprotein) antibodies were positive, confirming the diagnosis of MOGAD

Management and Outcome:

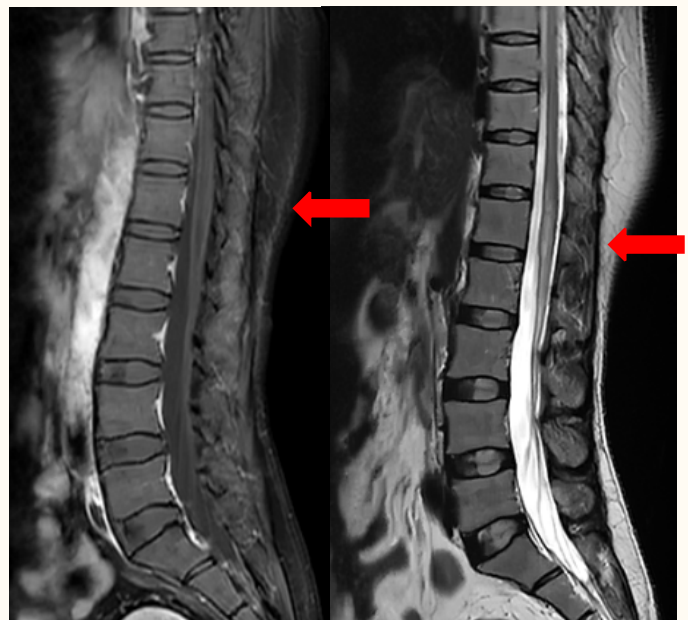
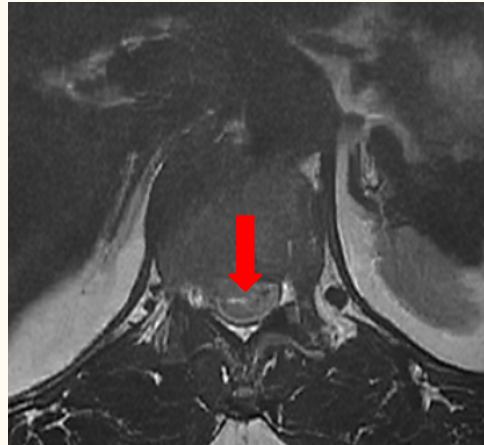
The patient was treated with high-dose intravenous Methylprednisolone and supportive physiotherapy. Significant clinical improvement was observed, radicular pain subsided, bladder sensations and control were restored, and motor power improved sufficiently for the patient to walk with support. The patient was discharged with a plan for long-term immunosuppression assessment due to the risk of future relapses.

Background:

Myelin Oligodendrocyte Glycoprotein Antibody-associated Disease (MOGAD) typically presents as optic neuritis, transverse myelitis, or acute disseminated encephalomyelitis (ADEM). The simultaneous involvement of the spinal cord (Conus Medullaris) and the peripheral nerve roots (radiculoneuritis) is an uncommon presentation that can mimic other acute poly radiculo neuropathies.

Conclusion:

This case highlights the phenotypic diversity of MOGAD. Clinicians should maintain a high index of suspicion for MOGAD in patients presenting with acute myelitis, especially when associated with radicular symptoms and conus involvement. The fact that her CSF was normal but Serum MOG was positive is a great learning point—MOG antibodies are often more detectable in the serum than in the CSF. Early identification and steroid intervention are critical for neurological recovery.



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A Rare Case of Primary Amenorrhoea with Cervical Cancer

Anantapuram, 18th Feb 2026 : 42-year-old woman presented with a history of intermittent white vaginal discharge for three months. There was no associated foul smell, pruritus, bleeding, or pelvic pain. She had been evaluated at an outside hospital where ultrasonography and CT imaging suggested a mass likely arising from the cervix. The uterus and ovaries were reported as normal on imaging. She had a known history of primary amenorrhoea, which had been evaluated earlier. Her hormonal profile, including FSH and LH levels, was normal. There was no history of cyclical abdominal pain, urinary symptoms, or bowel complaints. Her secondary sexual characteristics were normally developed, and there was no family history of primary amenorrhoea. She was otherwise fit and well. Her past surgical history included an abdominal surgery approximately 15 years earlier for a suspected fibroid uterus, though operative details were unavailable.

Clinical Examination

On examination, her BMI was 21.8 kg/m² and vital signs were within normal limits. Abdominal examination revealed a soft, non tender abdomen with no palpable masses. A Pfannenstiel scar was noted.

With informed consent, per-speculum examination revealed a blind-ending vagina. The urethral meatus was normally located. Per-vaginal examination showed healthy vaginal mucosa without infiltration or nodularity; however, a hard, globular, freely mobile mass measuring approximately 6 × 6 cm was palpable through the blind vaginal pouch.

Per-rectal examination revealed normal rectal mucosa, with the same mass palpable through the anterior rectal wall.

Management and Surgical Findings

A major limitation in this case was the inability to obtain a cervical biopsy due to the blind vaginal pouch.

Following multidisciplinary evaluation with Gynaecology and Oncology co-ordination, we have done radical hysterectomy with bilateral pelvic lymph node dissection under Spinal Anaesthesia.

Intra-operatively, the uterus was of normal size. A 5–6 cm fungating mass arising from the cervix was identified. Both ovaries and fallopian tubes appeared normal.

On cut section, the uterus showed absence of an endometrial cavity. The surgical specimen—including uterus, cervix, bilateral adnexa, upper vagina, and pelvic lymph nodes—was sent for histopathological examination.

Histopathology confirmed Stage IB2 squamous cell carcinoma of the cervix, with no lymph node involvement. The uterus demonstrated a myometrial thickness of approximately 1.5 cm, with an endometrial thickness of only 0.2 cm and scanty endometrial glands, explaining her lifelong primary amenorrhoea.

Discussion

This case represents a rare Müllerian developmental anomaly characterised by endometrial agenesis, distinct from classical Mayer-Rokitansky-Küster-Hauser (MRKH) syndrome, as the uterus was structurally present but lacked functional endometrium. The coexistence of primary amenorrhoea, blind vagina, endometrial agenesis, and invasive cervical cancer is exceptionally rare and poses unique diagnostic and management challenges—particularly the inability to obtain pre-operative biopsy. Conclusion This case highlights the importance of maintaining a high index of suspicion for gynaecological malignancy even in women with congenital reproductive tract anomalies and primary amenorrhoea.



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Consultant - Obstetrics & Gynaecologist

Defying Stroke - How Mechanical Thrombectomy Became the Ultimate Saviour in Critical Stroke

Background:

Acute ischemic stroke due to large vessel occlusion in the Middle Cerebral Artery (MCA) is associated with significant morbidity and mortality. Early recognition and prompt mechanical thrombectomy significantly improve functional outcomes, particularly in patients presenting within the therapeutic window.

Anantapuram, 23th Feb 2026 : A 37-year-old male presented with sudden onset of left upper and lower limb weakness at 4:30 AM, followed by slurred speech and dysphagia. There was no history of diplopia, visual disturbances, vomiting, seizures, fever, chest pain, or shortness of breath. He had a history of ethanol consumption and betel nut chewing.

Dr Karthik Reddy, Consultant Neurologist examined the patient. On examination, the patient was drowsy but obeying commands. Vitals were stable (BP 110/70 mmHg, HR 97/min, SpO₂ 97% on room air, GRBS 116 mg/dL). Neurological examination revealed right upper motor neuron facial palsy with bulbar weakness. Motor power was 0/5 in the left upper and lower limbs and 5/5 on the right side. There were no cerebellar signs or neck stiffness.

MRI brain demonstrated multiple varying-sized acute to subacute non-hemorrhagic infarcts in the right MCA territory with susceptibility-weighted imaging blooming of the M3 segment and sylvian branches, suggestive of thrombosis (hyperdense MCA sign) with mild mass effect. The patient needed mechanical thrombectomy. Mechanical thrombectomy of a clot in Brain requires an expert interventional radiologist. Dr Ashok Reddy, our consultant interventional radiologist was called in for this procedure and successful recanalization of the right MCA was done. The procedure was uneventful.

Follow-up CT brain showed a mild cortical gyral bleed without evidence of cerebral edema or raised intracranial tension. Two dimensional echocardiography revealed normal cardiac chamber sizes, normal left ventricular systolic function (EF 60%), trivial mitral and tricuspid regurgitation, and no pulmonary arterial hypertension. Carotid Doppler showed an eccentric fibrofatty plaque (5.2×4.3 mm) in the right carotid bulb causing approximately 60% luminal stenosis without hemodynamically significant obstruction.

The patient was managed with antiplatelet therapy, statins, and supportive care. He showed progressive neurological improvement during hospitalization.

Outcome and Follow-Up:

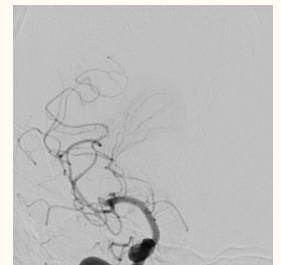
At discharge, the patient was hemodynamically stable. Speech had improved, and dysphagia had resolved. Motor power had improved to 1/5 in the left upper limb and 3/5 in the left lower limb at the time of discharge.

Conclusion:

This case highlights the importance of rapid identification and endovascular intervention in acute right MCA infarction. Endovascular intervention requires a well qualified and experienced radiologist. There are very few centers, even in cities like Hyderabad, which are equipped with the expertise and equipment required for such a procedure. KIMS Saveera Hospital has got the necessary equipment and specialists. This case reinforces the role of intervention in Cerebral infarction due to thrombosis as a standard of care in eligible patients with large vessel occlusion (LVO).



Pre procedure MRA showing
Right MCA Occlusion



Post Mechanical Thrombectomy DSA
showing Right MCA Recanalization

Note :

Performing mechanical thrombectomy in tier-2 cities presents several significant challenges, including limited public awareness, logistical constraints, lack of fully equipped and compatible Cath lab facilities, and, most importantly, the availability of trained interventional radiologists.

Despite these hurdles, we are proud to share that we have successfully conducted a mechanical thrombectomy the first of its kind in the entire district. KIMS Saveera Hospital is equipped with state-of-the-art Cath Lab with DSA (digital subtraction angiography) facility and highly specialized and well-trained doctors to handle such cases because of which this achievement was possible.



Dr. P. Karthik Reddy

MBBS, MD, DM (Neurology)
Consultant - Neurologist

Radiological Diagnosis of A rare case of Intramedullary Dermoid Cyst

Anantapuram, 02nd MAR 2026 : A 2-months-old baby with normal antenatal scans, presented to pediatric OPD with complaints of tuft of hair in lower back region. On clinical examination no sinus tract was detected, and there was no scoliosis. The patient was referred to Radiology department for ultrasonography of spine.

Dr C. Deepa Consultant Radiologist, KIMS Saveera Hospital examined the patient and performed a High resolution sonography of spine was done using high frequency linear transducer.

USG Reveals:

Anechoic cystic lesion measuring 15 x 6 mm within the spinal cord at lower thoracic level with splitting of short segment of cord into two hemi-cords just distal to the cyst at upper lumbar level.

No obvious bony septum is seen. No obvious sinus tract extending from skin to spinal canal noted. Spinal cord is seen ending at L3, L4 vertebral bodies' level.

Features are suggestive of intramedullary dermoid cyst with splitting of short segment of cord distal to syst (Short segment Diastometamyelia) MRI SPINE was suggested for further evaluation

MRI revealed :

Prominent central canal communicating with cyst at D12, L1 and is extending up to low lying tethered cord, conus at L3-L4 level. 6 x 14 mm posterior saccular dilatation of central canal at L1-L2 level with severe thinning of posterior portion of spinal cord.

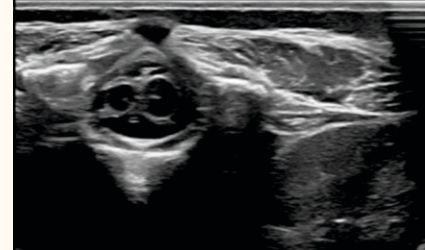
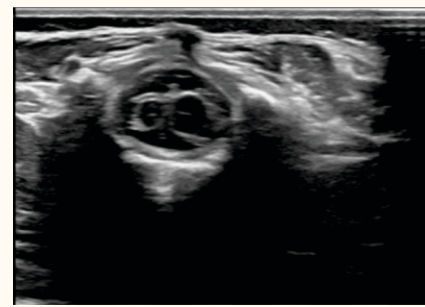
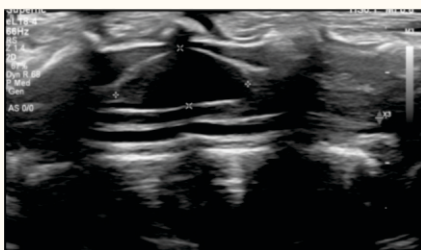
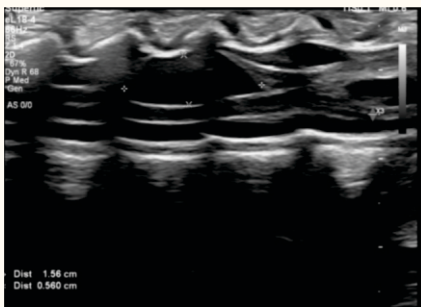
Diplomyelia is seen extending from mid L2 level / lower portion of saccular dilatation of central canal of spinal cord (left hemicord is relatively thin) and both the cords fuse together and become single cord/conus at mid L4 level.

L3, L4, L5 posterior arch defects, prominent posterior spinal subcutaneous fat, dermal sinus with fibrosis is seen extending from skin to thecal sac at L4-L5 level through spina bifida.

Some of the cauda equina nerve roots are adherent to posterior thecal sac / spinal dysraphism at posterior arches of lower lumbar region and are extending into intralesional lipoma / subcutaneous fat.

Spina bifida / dysraphism is seen at L4, L5 level with intraosseous lipoma in lamina, rudimentary spinous process.

This case is presented in view of the rarity.



Dr. C. Deepa

MBBS, MD (Radiodiagnosis)
Fellowship in Fetal Medicine
Consultant - Radiologist



Dr. Madhu Madhav Reddy

MBBS, MD, (Radiodiagnosis)
Consultant - Radiologist

Successful Cochlear Implantation in a 57-Year-Old Patient

Anantapuram, 18th Mar 2026 : A 57-year-old female presented with progressively worsening bilateral hearing loss that had reached to profound level. The patient reported significant difficulty in communication at the workplace and in daily social interactions.

Prior to presentation, the patient had used hearing aids for an adequate trial period; however, she reported no benefit in speech perception and communication. Audiological evaluation confirmed profound sensorineural hearing loss with poor aided speech discrimination scores, indicating candidacy for cochlear implantation.

After comprehensive counseling and preoperative assessment, the patient was advised to undergo cochlear implant surgery as the most appropriate rehabilitative option.

Abstract

Cochlear implantation is an established intervention for severe to profound sensorineural hearing loss when conventional hearing aids provide limited or no benefit. Although traditionally associated with pediatric and younger adult populations, cochlear implantation in older adults has shown promising outcomes. We report a successful cochlear implantation in a 57-year-old female patient.

Introduction

Severe to profound sensorineural hearing loss significantly affects communication, occupational performance, and overall quality of life. While hearing aids remain the first line of management, patients who derive minimal or no benefit from amplification require alternative rehabilitation strategies. Cochlear implantation has emerged as the gold standard for auditory rehabilitation in such cases. However, awareness and access to this intervention remain limited in several semi-urban and rural regions of India.

This report describes the successful cochlear implantation of an elderly highlighting the feasibility and effectiveness of the procedure in older individuals.

Surgical Procedure

Cochlear implantation was performed through posterior tympanotomy approach and complete electrode insertion was achieved. Intra operative telemetry confirmed the position of active electrodes. Intra operative impedance was good. The procedure was completed successfully without intraoperative or immediate postoperative complications. The patient had an uneventful recovery. After switching on of the implant patient is able to hear very well.

Discussion

This case emphasizes several important points :

Age is not a contraindication for cochlear implantation. Increasing evidence supports the safety and effectiveness of cochlear implants in older adults.

Hearing aids are not beneficial for all patients. Individuals with severe to profound sensorineural hearing loss and poor speech discrimination often require cochlear implantation for meaningful hearing restoration.

Cochlear implantation can restore communication ability, independence, and occupational functionality, thereby improving quality of life.

Conclusion

Increased awareness and accessibility to cochlear implant surgery may enable more patients with disabling hearing loss to benefit from this life-changing intervention



57 ఏళ్ల మహిళకు సవీరా వైద్యులు విజయవంతంగా కాక్లియర్ ఇంప్లాంట్ శస్త్ర చికిత్స

అనంతపురం (అనంత న్యూస్) మార్చి 18 : సంవత్సరం కాలం పాటు వినికిడి సమస్యతో బాధపడుతున్న ఓ మహిళకు కాక్లియర్ ఇంప్లాంట్ శస్త్రచికిత్సతో ఊరట కల్పించారు కిమ్స్ సవీరా ఆస్పత్రి వైద్యులు. ఇందుకు సంబంధించిన వివరాలను ఈవీన్ టీ సర్జన్ డాక్టర్ ఆర్. రాఘవేంద్ర రెడ్డి వెల్లడించారు. అనంతపురం పట్టణానికి చెందిన ఓ మహిళ (57) తీవ్రమైన వినికిడి సమస్యతో ముమ్మడి సంప్రదించారు. ఇక్కడి రాకముందు వినికిడి యంత్రాలు ఉపయోగించినప్పటికీ ఎటువంటి ప్రయోజనం కలగలేదు. వినికిడి లేకపోవడం వల్ల ఆమెకు ఉద్యోగంలో పని చేయడం మరియు ఇతరులతో సంభాషించడం చాలా కష్టంగా మారింది. తిరిగి వినికిడి పునరుద్ధరించడానికి కాక్లియర్ ఇంప్లాంట్ శస్త్రచికిత్స మాత్రమే సరైన మార్గం అని తెలియజేశారు. ఈ శస్త్రచికిత్సను మార్చి 10న విజయవంతంగా నిర్వహించారు. ప్రస్తుతం రోగి ఆరోగ్యంగా కోలుకుంటున్నారని. వయసు రీత్యా ఆమెకు ఈ సమస్య వచ్చింది. సాధారణంగా ఈ కాక్లియర్ ఇంప్లాంట్స్ చిన్న పిల్లలతో పాటు వయసుతో సంబంధం లేకుండా పెద్దవారికి కూడా చేయవచ్చని తెలిపారు. రాయలసీమ జిల్లాలో ఈ వయస్సు వారికి ఈ రకమైన శస్త్రచికిత్స చేయడం ఇదే మొదటిసారి, ఇది ఒక ముఖ్యమైన మైలురాయిగా నిలుస్తుందని డాక్టర్ ఆర్. రాఘవేంద్ర రెడ్డి తెలిపారు.



Dr. R. Raghavendra Reddy

MBBS, MS, OTO Rhino Laryngology
Consultant - ENT & Cochlear Implant Surgeon
Fellow in Sleep Surgery, Certified Allergy Specialist



Dr. Ravirala Roja

MBBS, MS, (ENT)
Jr. Consultant - ENT Surgeon

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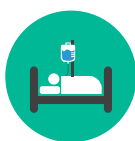


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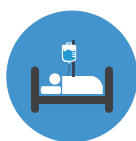
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