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KIMS-SAVEERA HOSPITAL

MEDICAL TIMES

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

"Medicine is a Science of Uncertainty and an art of Probability"

INDEX

Reviving a Collapsed Lung
Landmark Case of Airway Recanalization.

Anantapuram, 04th April 2025 : A 64-year-old male, an active smoker, presented with progressive shortness of breath of one year duration, which had worsened significantly over the last 20 days. He has developed fever and persistent cough. Clinical examination revealed absent breath sounds over the left lung, raising strong suspicion of major airway obstruction.

Investigations

CT Scan: Total collapse of the left lung due to an endobronchial growth in the left main bronchus (LMB)

Bronchoscopy: Revealed a friable tumor mass occluding more than 75% of the LMB, with complete obstruction of both LUL and LLL bronchi.

The Challenge

Endobronchial tumors causing near-total airway obstruction are life-threatening, often leaving patients with only palliative options. Achieving airway recanalization in such cases is technically demanding and requires a multi-modal interventional approach.

The Procedure

The patient underwent Rigid Bronchoscopy with Multi-modality Debulking, performed under general anesthesia.

Steps included:

- Mechanical coring of the tumor using rigid bronchoscope tip
- Tumor extraction with forceps
- Argon Plasma Coagulation (APC) for hemostasis
- Fogarty balloon technique for clearing obstructed segments
- Cryotherapy (1.7 mm probe) for precise tumor removal

The Outcome

Post-procedure, complete recanalization of the left main bronchus, left upper and lower lobe bronchi was achieved. The collapsed lung re-expanded successfully, restoring airway patency and significantly improving patient's breathing.

The extracted tumor fragments measured several centimeters, showcasing the extent of airway compromise.

Significance

This Case Highlights:

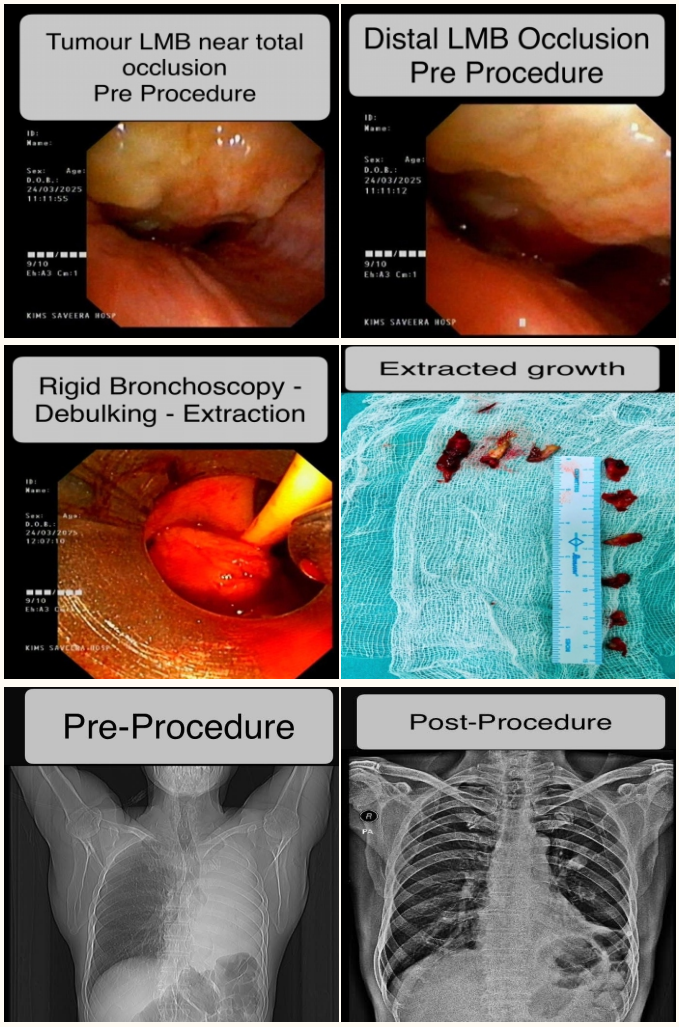
- The role of advanced interventional pulmonology in managing central airway obstruction.
- The potential to restore lung function and improve quality of life in patients previously considered inoperable or palliative.
- The equipment, expertise and innovation at KIMS Saveera Hospital, helped in treating complex pulmonary diseases.

At the Department of Interventional Pulmonology, KIMS Saveera Hospital, Anantapur, cutting-edge bronchoscopic interventions are redefining possibilities in advanced lung care.

Case Highlights in Images

1. Pre-procedure bronchoscopy: LMB near-total occlusion & LUL narrowing.
2. Distal LMB occlusion visualized.
3. Intra-procedure rigid bronchoscopy with tumor extraction.
4. Extracted growth specimens.
5. Post-procedure: Complete airway recanalization achieved.

This remarkable case is a testament to how interventional pulmonology bridges the gap between diagnosis and therapy, offering patients a new lease of life.



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Penile Fracture

Anantapuram, 10th April 2025 : A 59-year-old male presented to the ER with complaints of pain and swelling of penis after a road traffic accident. A team of Consultant Urologists examined the patient and he was referred to Radiology department for imaging and further evaluation.

Dr. Madhu Madhava Reddy and Dr Deepa, Consultant Radiologists took up the case.

Initially, Retrograde Urethrography was performed, which revealed contrast extravasation into penile soft tissues indicating a distal penile urethral disruption.

High resolution ultrasound of penis revealed breach in the hyperechoic tunica albuginea of corpora cavernosum as well as corpora spongiosum along with a hematoma in penile soft tissues.

For further evaluation, an MRI Pelvis was done which revealed breach in Buck's fascia, Tunica albuginea of corpora cavernosum, corporaspongiosum along with fracture of penile urethra traversing. A hematoma was also noted adjacent to corpora spongiosum.

Demographics :

- Penile fracture or rupture is a rare event, however one that requires emergency diagnosis and intervention.
- It is a rupture of the tunica albuginea of the corpora cavernosa or spongiosum caused by trauma in accidents or rarely during sexual intercourse.
- Breach in tunica albuginea and involvement of urethra needs to be reported in depth for surgical exploration and repair.

Radiological Features :

Ultrasound

The tunica albuginea is usually seen as a hyperechoic linear band in the penis covering the corpora cavernosa and the corpus spongiosum. A hypoechoic breach in this band of fibrous tissue may be seen especially along the penile longitudinal axis. An associated collection or hematoma may also be seen alongside the breach.

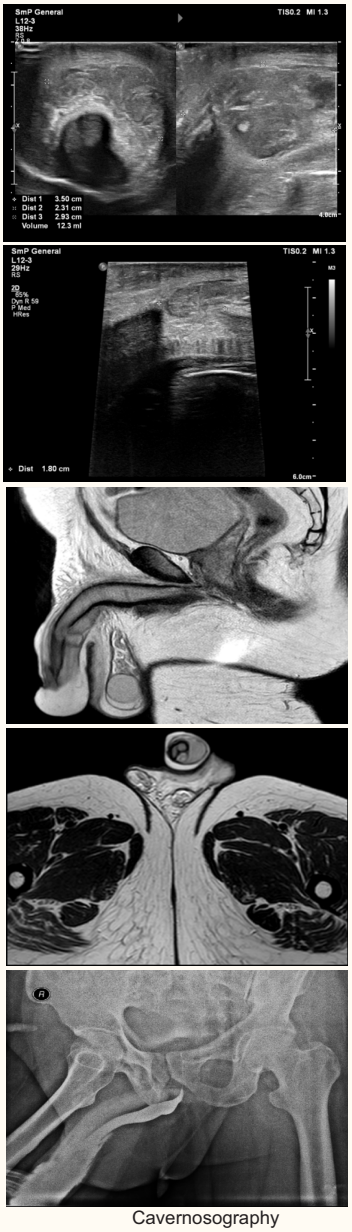
MRI

Tunica albuginea is a hypointense band on all sequences. A tear can be seen as T2 hyperintense breach. MRI can accurately determine if the fracture is transversely or longitudinally oriented. It can also accurately depict the depth and extent of the tear.

Fluoroscopy

Cavernosography: This invasive interventional procedure is often avoided but may depict the tear in corpora cavernosa.

Retrograde urethrography: Urethral rupture or post-traumatic stricture can be depicted by this imaging.



Cavernosography

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Locally Advanced Cystadenoma Left Lobe of Liver. First Ever Liver Resection in Anantapur

Anantapuram, 06th May 2025 : A 60-year-old female reported to KIMS Saveera Hospital with history of recurrent attacks of pain abdomen, vomiting and loss of weight. She was evaluated outside and found to have large tumor arising from left lobe of liver.

Dr Shahid, Consultant Surgical Gastroenterologist examined the case in detail and subjected her to routine and special tests to evaluate the mass.

CECT was suggestive of liver mass Infiltrating the proximal body of stomach.

Patient was counseled and was taken up for explorative laparotomy. Intra operatively it was found that the Liver mass was completely infiltrating proximal part of stomach. Hence decision was made to excise tumor in Toto. Left lateral segment of the liver along with total gastrectomy was done as the tumor had invaded the stomach and could not be separated. Esophago-jejunostomy was done to provide passage for food.

Patient withstood the procedure well and the post operative stay was uneventful. She recovered well and was discharged after 10 days in stable condition.

The mass was sent for biopsy and it was reported as benign cystadenoma of liver.

Discussion

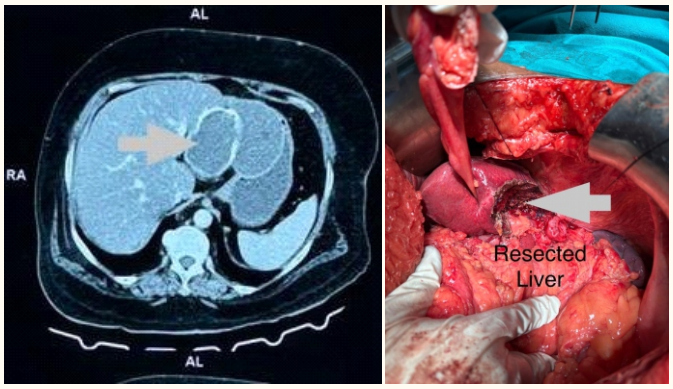
Mucinous cystic neoplasm is a unique subset within the hepatic cyst differential and includes the subgroup of mucinous cystic neoplasm, also referred to as biliary cystadenomas (BCA) and biliary cystadenocarcinomas (BCAC). The incidence of intrahepatic BCAs is reported to be 1 in 2,00,000, seen more often in women than in men.

BCAs are seen predominantly in middle-aged women between 40 to 50 years old. Approximately 85% of reported cases arise from the intrahepatic biliary system. They are slow-growing lesions and have been reported to reach sizes up to 30 cm.

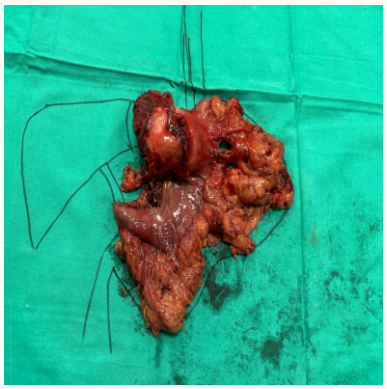
They can present with relatively nonspecific abdominal symptoms and are usually an incidental finding on imaging. Radiologic features of this neoplasm are often suggestive but tend to overlap with other cystic lesions leading to a differential. BCAs are considered to be pre-malignant. No published guidelines on appropriate therapy of BCAs currently exist due to the limited number of reported cases. Percutaneous ablation and unroofing techniques of BCAs are ineffective and have been shown to have recurrence rates up to 80%. Complete surgical resection is the management of choice given the risk of malignant transformation and recurrence. Enucleation of BCAs is recommended only in those cases where complete surgical resection is not possible.

Although only a few reports have demonstrated malignant transformation, current consensus on the best treatment is complete surgical resection.

The diagnosis of hepatic cystadenomas has its basis in a combination of ultrasound, computed tomography (CT), magnetic resonance imaging (MRI), in addition to clinical information. These lesions are typically intrahepatic, solitary, slow-growing, multiloculated cystic tumors filled with a clear mucinous fluid. BCAs are often present within hepatic segment 4.



Mucinous Cystadenoma in left Lobe of Liver



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Hereditary Pancreatitis.
A Very Rare Disorder of Pancreas Filled With Stones.

Anantapuram, 26th May 2025 : A 17-year-old student had been suffering from recurrent abdominal pain since childhood. She was completely evaluated at AIG Hyderabad. A gene mapping was done and it was diagnosed as a case of very rare pancreatic disorder called Hereditary Pancreatits with stones in pancreas. She underwent endoscopic procedures multiple times, which gave her pain free episodes for short period of time. The pain recurred frequently. She was advised to have surgery for permanent cure. She came to KIMS Saveera for definitive treatment.

Dr Shahid, Consultant Surgical Gastroenterologist, examined her. After complete assessment of her condition including fitness for anesthesia, she was subjected to surgery. Frey's Lateral Pancreato-Jejunostomy (LPJ) was performed on her. She withstood the surgery well and the post operative period was uneventful. She was discharged on day 7 without any complications in a pain free condition.

Discussion

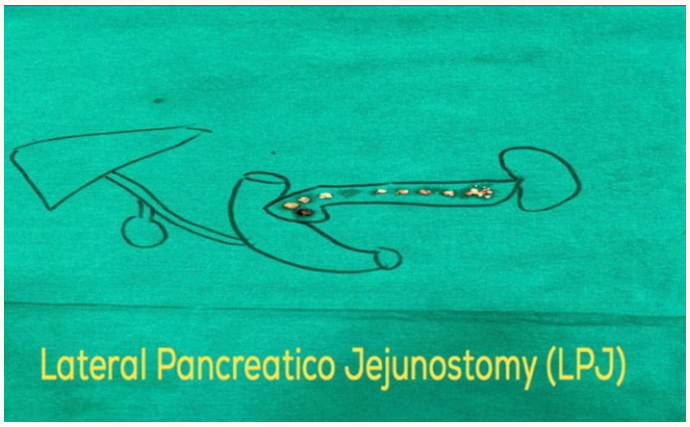
Hereditary Pancreatits is a distinct and uncommon subtype of pancreatitis and is a rare autosomal genetic disorder. Its global prevalence remains unclear, although population-based studies from France, Denmark and Australia have shown rates of 3 cases in 10,00,000 population. Clinically, HP typically manifests in childhood, with recurrent episodes of pancreatitis, abdominal pain, diarrhea, and both exocrine and endocrine pancreatic insufficiency, independent of common risk factors such as alcohol use, gallstones, or trauma. Mild diabetes develops in 10% to 25% of affected individuals.

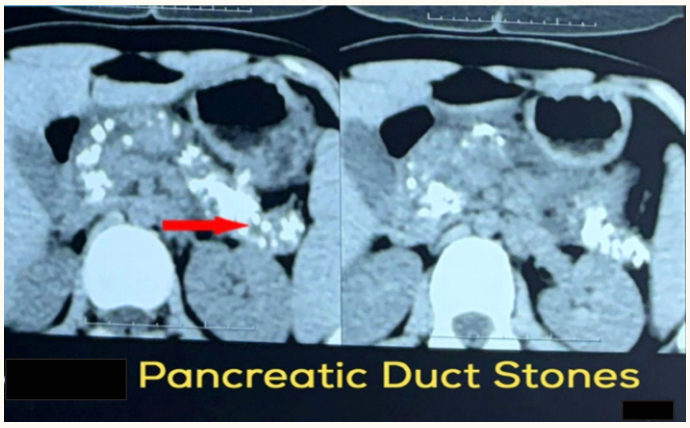
Diagnostic criteria include (1) recurrent pancreatitis from early childhood; (2) at least two affected relatives; (3) the presence of pancreatic ductal stones; and (4) exclusion of other known causes such as alcohol, gallstones, trauma, drugs, infections, or metabolic disorders. The diagnosis is confirmed by genetic study of patient and the parents.

The pathogenesis of HP involves genetic mutations affecting the regulation of pancreatic digestive enzymes. These mutations promote the premature activation of trypsinogen within the pancreatic ducts, leading to inflammation and autodigestion.

Interactions with environmental triggers often play a role. Patients tend to present at an early age (prior to the second decade of life) and have a significantly increased risk for the development of pancreatic adenocarcinoma. Patients with HP may develop sequelae of chronic pancreatitis such as strictures and fluid collections as well as exocrine and endocrine insufficiency.

Management of patients with HP involves avoidance of environmental triggers, surveillance for pancreatic adenocarcinoma, medical therapy for endocrine and exocrine insufficiency, pain management, and endoscopic or surgical treatment for complications.





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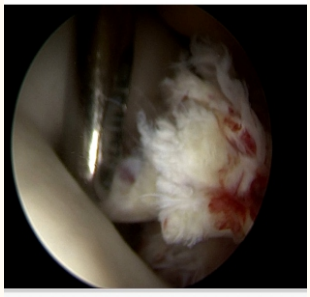
Arthroscopic ACL Reconstruction with Meniscal Repair in a 28-Year-Old Female.

Anantapuram, 28th May 2025 : A 28-year-old software professional, presented with repeated episodes of knee instability and pain following a sports injury six months ago. She complained of difficulty in running, climbing stairs, and engaging in recreational activities. Clinical examination suggested anterior cruciate ligament (ACL) insufficiency. MRI findings confirmed complete ACL rupture with a bucket-handle tear of the medial meniscus.

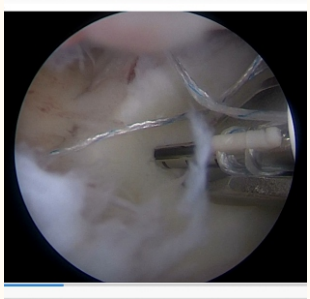


Preoperative Work

Routine preoperative investigations were carried out, including blood work and anesthesia clearance. After counseling, arthroscopic ACL reconstruction using Hamstring autograft with simultaneous meniscal repair was planned. This approach aimed to restore stability, preserve meniscal function, and prevent long-term degenerative changes.

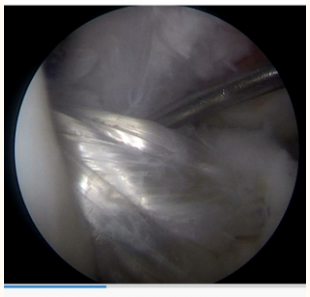
Details of Intervention Done

Under arthroscopic guidance, hamstring tendons were harvested and prepared as grafts. Tunnels were created in the femur and tibia, and the graft was passed and fixed with bio-absorbable interference screws. Meniscal repair was performed using all-inside suture techniques to preserve meniscal tissue. The stability of the reconstructed ligament and the repaired meniscus was checked and confirmed before closure. The minimally invasive procedure ensured minimal morbidity and rapid



Postoperative Recovery and Physiotherapy

Postoperatively, the patient was mobilized with the knee in a brace. Early range of motion exercises were started within days, progressing to quadriceps strengthening and balance training. Gradual return to weight-bearing was allowed under physiotherapy supervision. At six weeks, she was walking without support and had regained good knee stability. Sports-specific rehabilitation was initiated at three months.



Result

By six months, the patient had returned to full physical activity, including recreational sports. Her knee was stable, pain-free, and follow-up imaging confirmed intact graft and healing meniscus repair. She expressed great satisfaction with the outcome, as she could resume her professional and active lifestyle without limitations.

Significance of the Procedure in Such Cases

ACL reconstruction with simultaneous meniscal repair is a gold-standard treatment in young active individuals with combined injuries. This approach not only restores knee stability but also preserves meniscal tissue, preventing early arthritis. Compared to meniscectomy or conservative management, this combined arthroscopic procedure ensures long-term joint preservation, rapid recovery, and safe return to sports.

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Redefining Mediastinal Lymph Node Sampling with Cryo Technology. New Technology yields, Better Quality Biopsies from Deep Inside the Chest.

Anantapuram, 29th May 2025 : At KIMS Saveera Hospital, Anantapur, Interventional Pulmonology team is constantly pushing the boundaries of what's possible. This time, we've done something never before seen in Rayalaseema using Cryo-technology to take larger, better quality biopsies from lymph nodes deep inside the chest.

Why This Matters

When someone has enlarged lymph nodes inside the chest, doctors need a sample to clinch the diagnosis to confirm if it is cancer, tuberculosis, sarcoidosis or something else. Until now, the only practical way was to use a thin needle (called EBUS-TBNA) to suck out a few cells. This gives useful information but often, tiny fragments may not be enough for all the required advanced tests.

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.

How We Did It

1. We used EBUS (Endo Bronchial Ultra Sound) to guide us directly to the lymph node.
2. After creating a tiny opening, we slid the 1.1 mm Cryoprobe into the node.
3. We froze the tissue for a few seconds.
4. When withdrawn, the probe brought back a solid, intact biopsy core, with no bleeding in the area.

The image show:

- The EBUS ultrasound view
- Cryo probe at work
- The blackish tissue cores retrieved much larger than a typical needle sample

What It Means for Patients

- More accurate diagnosis – especially for lymphoma, sarcoidosis and lung cancers
- Fewer repeat procedures – one big sample can answer many questions
- Personalized treatment – because bigger tissue allows molecular testing and individualized drug matching

A 1st of its kind in Rayalaseema

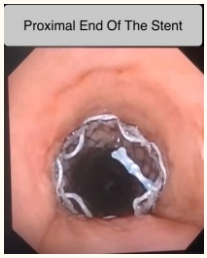
This is the first time that a Cryo-biopsy of mediastinal lymph nodes has been performed in our region. It shows that our patients can now get world-class diagnostics at Anantapur itself.

Why are We Excited?

This isn't just about technology. It's about giving our patients the best chance at the right diagnosis and treatment, faster and at an affordable cost. Interventional Pulmonology team at KIMS Saveera Hospital is capable of writing the next chapter in lung care right here in Anantapur.

Bigger tissue. Better answers. Fewer worries.

That's the advantage of having EBUS-guided Cryo-Biopsy at KIMS Saveera Hospital.



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Balloon Kyphoplasty in a 72-Year-Old Male.

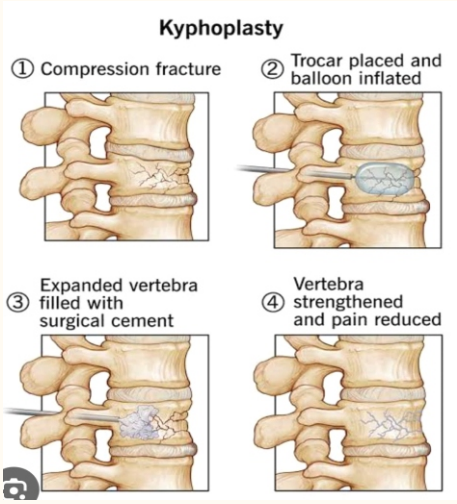
Anantapuram, 02nd June 2025 : A 72-year-old male, presented with severe back pain and inability to stand or walk without support. The pain was progressive over the last few weeks, leaving him bed-bound. Clinical examination and radiological studies revealed an osteoporotic compression fracture of the D12 vertebra. His condition was complicated by advanced osteoporosis, which made conventional fixation procedures risky and less effective.

Preoperative Work

Detailed investigations were conducted including blood work, bone mineral density scans, and spinal MRI. The imaging confirmed a wedge compression fracture at D12 with collapse of vertebral height. Given his age, poor bone quality, and severe pain, the team planned for a minimally invasive balloon kyphoplasty procedure. This approach was selected over traditional fixation because it provides rapid pain relief, restores vertebral height, and is safer in elderly osteoporotic patients.

Details of Intervention Done

The procedure was performed under anesthesia. Through a small incision, working cannulas were introduced into the collapsed vertebra under fluoroscopic guidance. A balloon tampon was then inserted and inflated, which elevated the compressed vertebral body and restored its height. Following deflation, the created cavity was filled with bone cement, which stabilized the fracture and strengthened the vertebra. The procedure was completed with minimal blood loss and without complications.



Postoperative Recovery and Physiotherapy

Remarkably, the patient reported significant relief of back pain within hours of surgery. He was mobilized on the very next day, walking independently with minimal discomfort. Physiotherapy sessions were initiated to improve his posture, strengthen para-spinal muscles, and encourage safe mobility. Early rehabilitation played a crucial role in restoring his confidence and preventing further complications of immobility.

Result

The outcome was excellent. By the time of discharge, the patient was walking comfortably without severe pain. Follow-up X-rays confirmed good cement filling and vertebral height restoration. His quality of life improved significantly, as he could now resume routine daily activities without dependence on others.

Significance of the Procedure in Such Cases

Balloon kyphoplasty is a breakthrough treatment for elderly patients suffering from painful osteoporotic compression fractures. Compared to conservative management with bed rest and painkillers, kyphoplasty provides immediate and sustained pain relief, restores spinal alignment, and enables early mobilization. In high-risk patients and in elderly patients, this minimally invasive approach is far superior to conventional open fixation procedures, ensuring safety, rapid recovery, with durable results.

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Postpartum Spontaneous Pneumomediastinum with Cortical Vein thrombosis. Exploring a rare intersection of Pulmonary and Cerebral Complication.

Anantapuram, 09th June 2025 : An 18-year-old female, (P1, L1) presented on postoperative day 1. She underwent emergency lower segment cesarean section (LSCS) at a local hospital for second- stage arrest of labour. She developed severe shortness of breath of acute onset, tachypnea, and tachycardia. She was referred to KIMS Saveera Hospital in a critical condition for further management.

On arrival, the patient was in respiratory distress and was intubated in the emergency room. A CT chest revealed pneumo-mediastinum with extensive surgical emphysema. CT abdomen with contrast suggested a possible cervical laceration with a clot in the upper vagina. Cardiothoracic surgeon's opinion was sought, and a right-sided intercostal drain (ICD) was placed. She was started on intravenous antibiotics, fluids, low-dose steroids, and ventilatory support. The Consultant Obstetrician reviewed the surgical wound, and dressing was done. 2D echocardiogram was normal. Patient was extubated on day 3 of ICU stay. A repeat CT of chest showed partial resolution of pneumomediastinum, and she was shifted to the ward with minimal oxygen support, following which the ICD was removed.

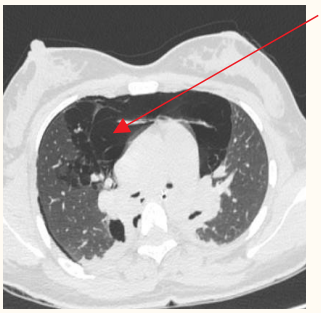
In the ward, the patient developed a Generalized Tonic-Clonic Seizure (GTCS) followed by confusion, irritability, and breathlessness, necessitating re-intubation and transfer to the ACCU. She was found to have developed supraventricular tachycardia (SVT), which reverted with antiarrhythmics. Cardiology evaluation and repeat 2D echocardiography revealed severe biventricular dysfunction. Electrolyte correction and inotropic support with Dobutamine and Noradrenaline were initiated. The patient had recurrent fever spikes, and antibiotics were escalated to Meropenem and Clarithromycin. CT chest showed bilateral pneumonia. MRI brain was suggestive of Posterior Reversible Encephalopathy Syndrome (PRES) with subacute cortical vein thrombosis. EEG showed intermittent generalized slow-wave discharges. Neurology consultation was sought, and dual antiepileptic therapy (levetiracetam and lacosamide) was initiated. Anticoagulants were added for thromboembolic prophylaxis.

Blood cultures were sterile, Persistent cardiac dysfunction and neuromuscular weakness delayed weaning from ventilator, necessitating bedside tracheostomy. The patient received intensive physiotherapy, high protein parenteral nutrition, and vitamin D3 and B12 supplements. Gradual improvement was observed with successful weaning and tracheostomy decannulation. A follow-up HRCT chest on 04th June, 2025 showed complete resolution of Pneumomediastinum and repeat 2D echocardiography demonstrated normal biventricular function.

The patient was able to tolerate oral feeds, maintained SPO_2 of 98% on room air, and was discharged in stable condition after 21 days of ICU stay with mild proximal muscle weakness attributed to critical illness neuropathy and myopathy.

This case highlights an uncommon and potentially life threatening complication postpartum pneumomediastinum (Hammans Syndrome) followed by multisystem involvement with complex ICU course. Spontaneous pneumomediastinum (also known as Macklin's syndrome) is presence of free air in themediastinum without any obvious cause such as trauma, surgery or mechanical ventilation.

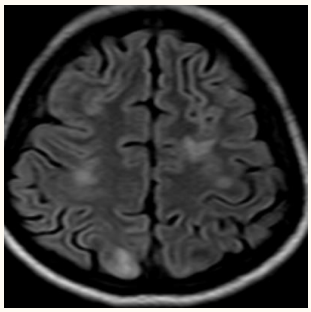
Macklin's effect explains the spontaneous alveolar rupture, with air dissecting along the bronchovascular sheath air into mediastinum.



Pneumomediastinum

Resolving Pneumomediastinum

Normal mediastinum



Hyper intense areas in bilateral parietal and right occipital cortex- Acute infarcts.

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Bilateral TKR in grade 4 Arthritis in an Old Lady with Osteoporosis.

Anantapuram, 11th June 2025 : A 67-year-old female, had been enduring severe pain in both knees for several years. Over time, the pain had worsened to the extent that she could not walk even short distances without support. She also developed progressive bowing of both legs. Her quality of life was severely compromised. When she presented to our hospital, the deformity was so severe that her legs had begun curving inward.

Preoperative Work

Clinical examination and radiological imaging confirmed the diagnosis of Grade 4 osteoarthritis of both knees the most advanced stage of the disease, where the joint cartilage is completely worn away, leading to bone-on-bone contact and deformity.

On assessment:

- Right knee showed a varus deformity of 20° with fixed flexion, deformity (FFD) of 15°
- Left knee showed a varus deformity of 15° with FFD of 10°
- Given the severity of her deformities and her inability, the team decided that bilateral total knee replacement was the best option.

Details of Intervention Done

The team of Consultant Orthopedists Dr. Pradeep Batta and Dr. Sai Sujeeth performed a bilateral total knee replacement in a single sitting. This is a technically challenging procedure, especially in elderly patients with such severe deformities.

During surgery:

The damaged knee joint surfaces were carefully removed. Advanced prosthetic implants were placed to replace the diseased bone and cartilage. Precise bone cuts and alignment corrections were performed to restore the natural axis of both legs. Special care was taken to balance the ligaments around the knee, which is crucial to ensure stability and long-term success. Both knees were successfully replaced with modern implants designed for durability and natural movement.

Postoperative Recovery and Physiotherapy

The patient recovered smoothly after surgery. Pain management was optimized, and she was encouraged to start moving with the help of physiotherapists from the very next day. Early mobilization is a key part of successful knee replacement recovery.

She was gradually trained in: Walking with support, bending and straightening exercises of the knee, quadriceps strengthening and stair climbing techniques.

With dedicated physiotherapy sessions, she was now able to move independently with support within just a few days.

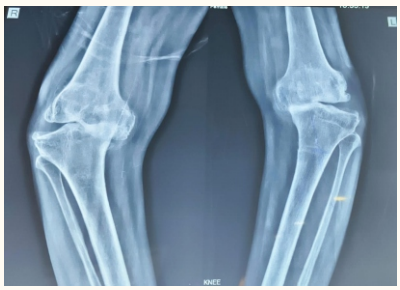
Result

By the time of discharge, the patient was walking comfortably with pain-free knees. The bowing deformities were fully corrected, and she could stand upright with restored balance. At follow-up, she continued to show excellent progress, with steadily improving knee function and improved muscular strength around the knee.

Significance of the Procedure in Such Cases

Bilateral total knee replacement is considered one of the most effective treatments for patients with advanced osteoarthritis and severe deformities. In elderly patients it not only relieves long-standing pain but also corrects structural deformities, restores joint function, and greatly improves quality of life.

This procedure is particularly significant in cases with severe varus deformity, where surgical precision is crucial to restore normal limb alignment and prevent further complications.



Varus Deformity Before Surgery

After Surgery

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Arthroscopic Repair of Supraspinatus Tear in a 55-Year-Old Female

Anantapuram, 11th June 2025 : A 55-year-old homemaker, presented with persistent pain in her right shoulder, difficulty lifting her shoulder, and disturbed sleep due to shoulder discomfort. Her condition has gradually worsened over the last year, limiting her ability to perform routine household chores.

Clinical examination revealed weakness in abduction and tenderness over the shoulder. MRI scans confirmed a full-thickness tear of the supraspinatus tendon.

Preoperative Work

Comprehensive evaluation included blood tests, anesthesia clearance, and radiological assessment. MRI confirmed a rotator cuff tear involving the supraspinatus tendon with retraction, while the rest of the cuff was intact. After detailed examination and counseling, team of Consultant Orthopedists Dr Pradeep Batta, and Dr. Sai Sujeeth, planned for arthroscopic repair of the supraspinatus tendon. This minimally invasive approach was preferred due to reduced operative tissue trauma, faster recovery, and lower postoperative pain.

Details of Intervention Done

The procedure was carried out arthroscopically. Small portals were created around the shoulder joint, and an arthroscope was introduced. The torn edges of supraspinatus tendon were identified and prepared. Anchors with high-strength sutures were placed in the humeral head, and the tendon was re-attached securely to its anatomical footprint. The repair was tested for stability and found satisfactory. The surgery was performed with minimal blood loss and without complications.

Postoperative Recovery and Physiotherapy

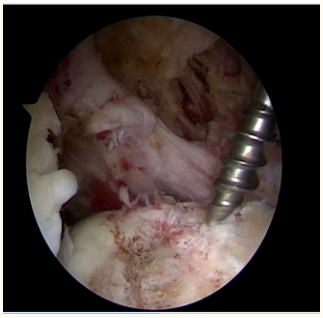
Postoperatively, the arm was supported in a sling. Pain was well controlled, and early passive mobilization exercises were initiated. Physiotherapy progressed in phases: first focusing on passive range of motion, followed by active assisted exercises, and later strength training. Gradually, the patient regained shoulder mobility and strength. Adherence to physiotherapy played a key role in her successful recovery.

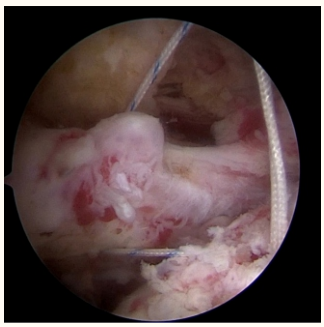
Result

Within three months, the patient had regained near-full range of motion in the right shoulder with significant pain relief. She resumed her routine household activities and reported improved sleep without shoulder discomfort. Follow-up imaging confirmed a well-healed tendon repair.

Significance of the Procedure in Such Cases

Arthroscopic supraspinatus repair is a highly effective procedure in restoring shoulder function in patients with rotator cuff tears. Compared to open repair, arthroscopy offers smaller incisions, less pain, faster rehabilitation, and excellent visualization of the joint structures. In middle-aged active homemakers like this patient, timely surgical intervention prevents progression of the tear, restores function, and significantly improves quality of life.





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Complex Polytrauma Surgery in a 40-Year-Old

Anantapuram, 25th June 2025 : A 40-year-old male, was admitted following a high-impact road traffic accident. He sustained multiple fractures involving the pelvis, right femur, and tibia, along with soft tissue injuries. On arrival, he was found to have fracture right talus and metacarpal bones of right hand. He was in severe pain and unable to move his lower limbs. Initial stabilization was carried out in the emergency department with fluid resuscitation, splinting, and pain management.

Preoperative Work

The team of Consultant Orthopedists at KIMS Saveera Hospital, Dr Pradeep Batta and Dr Sai Sujeeth did a comprehensive trauma evaluation, including CT scans, X-rays, and ultrasonography to rule out associated internal injuries. The patient was found to have a complex pelvic fracture, a comminuted femoral shaft fracture, and an open tibial fracture. Laboratory investigations, blood typing, and cross-matching were arranged to prepare for surgery. Given the severity of injuries, a staged surgical approach was planned, prioritizing life-saving and limb-saving interventions.

Details of Intervention Done

The patient underwent multiple procedures in a single operative session. External fixation was applied to stabilize the pelvis initially. Intramedullary nailing was performed for the femoral shaft fracture, and thorough debridement followed by external fixation was done for the open tibial fracture. Soft tissue injuries were addressed simultaneously to minimize infection risk. The procedures were technically demanding due to the multiplicity of injuries and blood loss risk, but were successfully completed with a multidisciplinary team effort.

Postoperative Recovery and Physiotherapy

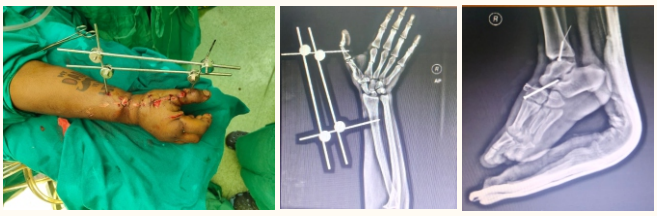
Postoperatively, the patient was shifted to the ICU for monitoring. Pain control, blood transfusions, and antibiotics were provided. Once stabilized, physiotherapy was initiated, focusing initially on breathing exercises and upper limb strengthening. Gradual weight-bearing was introduced under supervision, and the patient steadily regained mobility. Nursing care and infection control measures were critical in the early recovery phase.

Result

The patient showed remarkable progress over the following weeks. He was able to sit, stand with support, and later walk with the aid of crutches. Fracture healing was confirmed radiologically at follow-up, and the soft tissue wounds healed without major complications. He expressed great satisfaction at regaining independence after such a severe injury.

Significance of the Procedure in Such Cases

Polytrauma cases demand a coordinated multidisciplinary approach. In cases like this, prompt stabilization and staged surgical management are critical to survival and functional recovery. Modern fixation techniques combined with aggressive physiotherapy enable patients with complex injuries to regain mobility and return to productive life. This case highlights the importance of timely intervention and comprehensive care in polytrauma management.



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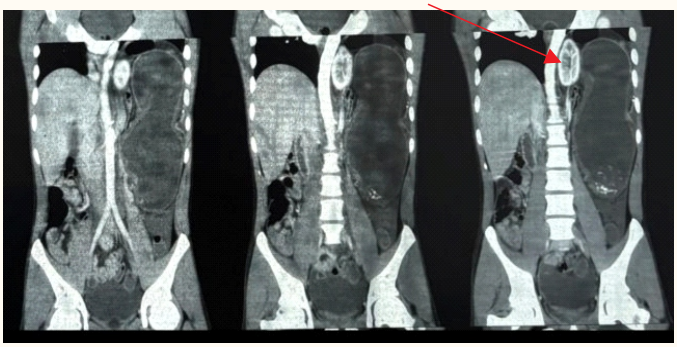
Rare Case of Diaphragmatic Hernia - With Left Kidney Stomach & Colon in the Left Chest Cavity

Anantapuram, 03rd July 2025 : A 20-year-old male reported at KIMS-SAVEERA Hospital with complaints of severe upper abdominal and lower chest pain and difficulty in breathing. He had been having persistent vomiting for last 3 days. He was examined and evaluated thoroughly by Consultant Surgical Gastroenterologist Dr Shahid. After initial evaluation a CT scan of the abdomen was ordered which showed a congenital diaphragmatic hernia on the left side causing his stomach, spleen left kidney and parts of the intestines to protrude into the thoracic cavity through the gap in diaphragm.

Normally the diaphragm acts as a complete barrier separating the contents of the thorax from those of the abdomen. There would be small gaps through which the esophagus and the major blood vessels pass. However, in this case, due to an incomplete development, there was a wide gap in the diaphragm through which the contents of the abdomen have moved into the chest cavity leading to compression of the left lung, which resulted in breathlessness and pain in upper abdomen and lower chest.

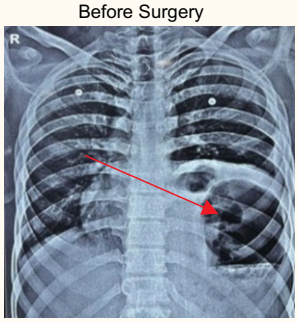
After initial evaluation and counseling, case was taken up for surgery. During the surgery the team noted early signs of tissue gangrene in the abdominal organs, prompting an emergency surgical intervention. Surgeons repositioned all the displaced organs back to their original location. The spleen had got twisted and blood supply to the organ was severely compromised and had to be removed. The diaphragm was repaired in two layers, and the gap was closed. Post-surgery, the patient was monitored in the ICU for 2 days. After he showed steady recovery, he was discharged on the 5th day in stable condition.

Treatment of such conditions needs the availability of experienced and qualified Surgical Gastroenterologist, anesthetists and the supporting intensive care team. KIMS Saveera Hospital has all the required equipment and consultants for such a challenging task and so was able to give permanent relief to the patient.



Enlarged Stomach and left kidney in left Chest

Before Surgery



Stomach and colon shadow in left chest heart shadow shifted to right

After Surgery

Stomach and colon retracted back into abdomen heart shadow shifted back to left side

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Caecal Volvulus
Rare Cause of Intestinal Obstruction

Anantapuram, 03rd July 2025 : A 60-year-old male presented at the Emergency Department with a history of upper abdominal pain of 3 days duration. The pain was sudden in onset, colicky in nature, off and on, associated with frequent vomiting of bile-stained vomitus. He also had abdominal distension and absolute constipation.

The case was examined by Dr Shahid, Consultant Surgical Gastroenterologist. After initial examination and assessment, patient was subjected to CECT abdomen, which showed distended cecum, ascending colon and ileo-caecal twist. Bowel was showing early gangrenous changes. He was taken up for surgery. Intraoperatively there wasan axial torsion of the cecum, ascending colon, and terminal ileum around the mesenteric vascular pedicles. Ileocecal segment was found necrosed and unviable. Right Hemicolectomy was performed, where part of large bowel was excised.

Post operative recovery was uneventful, and he was discharged in a stable condition after 7 days.

Discussion:

Caecal volvulus (CV) is a rare cause of intestinal obstruction, the incidence being 2- 5 cases per million annually. It causes approximately 1-1.5% of all intestinal obstructions. It is more common in certain regions known as the "volvulus belt" in the Middle East, India, South America, Africa, and Russia, where colonic volvulus accounts for around 50% of colonic obstructions.

The clinical symptoms and signs are exceedingly variable. However, common symptoms are acute onset of severe abdominal pain, constipation, obstipation, nausea, and vomiting associated with abdominal distension and exaggerated or silent bowel sounds. Due to its infrequent occurrence and nonspecific clinical symptoms and signs, a definitive diagnosis of caecal volvulus is often delayed.

Signs of caecal volvulus on CT scan include caecal distention greater than 10 cm, caecal apex location, distal colon decompression, and presence of the whirl, ileocecal twist. Surgery is the only treatment for this condition. Surgical procedures range from simple detorsion to the right hemicolectomy. Resection (limited or right hemicolectomy) is mandatory for gangrenousor a grossly distended, thin-walled cecum. Simple detorsion, rectopexy, and cecostomy seem less effective and more morbid options than resection and anastomosis of viable bowel.

Cecal Volvulus - Forming Closed Loop Obstruction

Right Hemicolectomy Specimen with Cecal Volvus

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Left Total Hip Replacement in a 69-Year-Old with Failed PFN Fixation

Anantapuram, 26th June 2025 : A 69-year-old male, presented with severe pain in his left hip and inability to walk without support. He had undergone a previous surgical procedure, a proximal femoral nailing (PFN) for fracture management. However, over time, the fixation failed, and the cephalic screw had penetrated into the acetabulum, causing significant destruction of the joint surface.

He was unable to bear weight on the affected side and had become almost immobile, depending on others for daily activities. His condition not only caused severe physical discomfort but also led to loss of independence, severely affecting quality of life.

Preoperative Work

The patient underwent a comprehensive evaluation, including detailed radiographs and CT scans of the pelvis and hip. Imaging confirmed failed PFN with cephalic screw penetration into the acetabulum along with severe arthritic changes. Routine blood work, anesthesia fitness, and cardiac assessment were done to ensure operative safety. Given the advanced damage to the acetabulum and failure of fixation, the team of Consultant Orthopedists, consisting of Dr Pradeep Batta and Dr Sai Sujeeth, decided on a left total hip replacement (THR) as the definitive treatment. This option was chosen to relieve pain, restore mobility, and reconstruct the damaged joint.

Details of Intervention Done

Under anesthesia, the failed implant was carefully removed. Intraoperatively, it was noted that the acetabulum had been damaged by the penetrating screw. To reconstruct the acetabular defect, morcellized graft was harvested from the patient's own femoral head and packed into the acetabular cavity. Following reconstruction, a cementless acetabular cup and femoral stem were implanted with precision. Trial reductions confirmed stability, and the definitive prosthetic components were fixed in place. The hip joint was restored with correct limb length and alignment.

Postoperative Recovery and Physiotherapy

The patient had an excellent recovery after surgery. Pain was effectively managed, and physiotherapy was started on the first postoperative day. He was gradually mobilized with the help of a walker and trained in hip strengthening and gait exercises.

With progressive rehabilitation, he regained confidence and mobility. Careful physiotherapy ensured safe return of function while preventing complications such as dislocation.

Result

At the time of discharge, the patient was walking comfortably with support. At follow-up, he reported significant pain relief, restored hip function, and improved ability to perform daily activities independently. Radiographs showed a well-seated hip prosthesis and satisfactory reconstruction of the acetabulum.

Significance of the Procedure in Such Cases

Total hip replacement is a highly effective solution in cases of failed internal fixation of the hip where the joint has been damaged beyond repair. In this case, acetabular penetration by the cephalic screw created a complex scenario, but the use of morcellized autograft from the femoral head allowed successful reconstruction and restoration of joint integrity.

Compared to revision fixation, which carries high failure rates in elderly osteoporotic patients, hip replacement provides a definitive and durable outcome, restoring mobility and quality of life. This case highlights the value of advanced reconstructive techniques in managing failed hip fixations.

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Spot Diagnosis of Neurocysticercosis in the Emergency Department A Case Report ▪

Anantapuram, 7th Aug 2025 : A 64-year-old female was brought to ER at around 11:20 Am on 8-7-25 with history of 3 seizure like episodes followed by right sided weakness

The seizures were associated with clenching of hands, up rolling of eyes, Tongue bite, and post episodic sleepiness

There is no history of fever, or vomiting or trauma

Patient had no known co-morbidities. Attendants gave history of pork consumption in the past.

On arrival in ER, patient was conscious, well oriented and her vitals were as follows

HR- 80 bpm, BP- 100/70 mm Hg, RR- 20 breaths, SPO2 of 96% on RA

She was afebrile and her GRBS was 101 mg/ dl

Heart sounds -S1, S2 +, with bilaterally equal air entry with no added breath sounds.

Abdomen was soft on palpation with no tenderness or mass

CNS- examination was normal with intact mental functions. Motor power was normal with slight weakness in right upper limb. (grade IV +)

Patient was shifted for MRI for further assessment

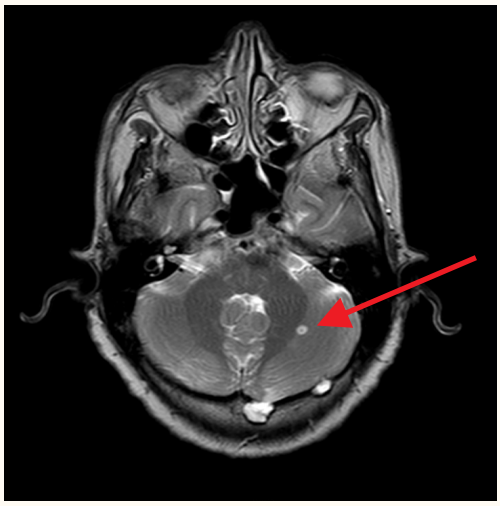
MRI showed- Multiple bilateral cerebral and left cerebellar granulomas, a few of them being calcified. Peri-lesional edema is noted around the ones in the right temporal, left parietal and left thalamic areas. Small vessel ischemic changes were noted in bilateral peri-ventricular white matter. Rest of the cerebral parenchyma was normal in signal intensity and morphology.

Impression: Multiple bilateral cerebral and cerebellar granulomas with calcification. Perilesional edema is noted around the ones in right temporal, left parietal and left thalamic – Suggestive of Neurocystisercosis.

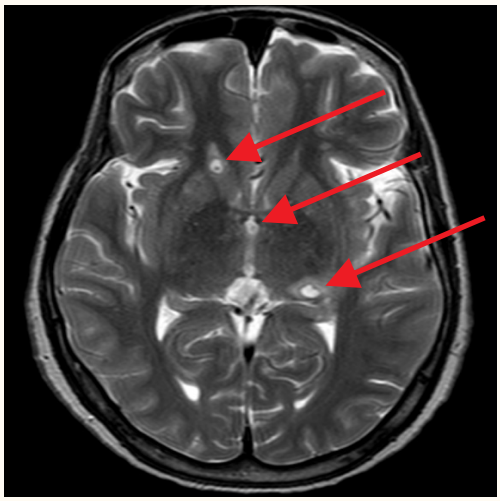
Patient was started on Inj. Levipil 2 gm, Inj Dexamethasone 8 mg, IV antibiotics, IV fluids and other symptomatic medications.

ECG, 2D Echo, Chest X-Ray where within normal limits.

Neurologist consultation was and the patient was transferred to him further management.



Calcified Granuloma in Cerebellum



Calcified Granulomas in Cerebrum

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Classical Autonomic Storming in Scorpion Sting: Prompt Recognition & Treatment with Prazosin in ER

Anantapuram, 10th Aug 2025 : A 24-year-old male was brought from Renimakulapalli village to the Emergency Department with history of Scorpion sting over right flank while working in the farm at around 4 PM.

Patient had 5-6 episodes of vomiting and complains of giddiness since then. He has excessive sweating and palpitations and complains of severe pain over the sting site.

There is no history of chest pain or shortness of breath or pain abdomen.

Patient was initially taken to a nearby hospital, from where he was directed to KIMS Saveera Hospital for further management.

On arrival to emergency department the patient was agitated but conscious and oriented. He had profuse sweating.

Vitals were monitored which showed

HR- 111 bpm, BP- 100/60 mm Hg, SPO2- 98% on room air, RR- 26 cpm, GRBS -194 mg/dl

Temp-98.2' F

His heart sounds were normal and bilateral air entry present with no added sounds.

Abdomen was soft and non-tender with no palpable mass

Swelling around a single sting mark over right flank region was noted

As the patient was being evaluated, within few minutes, his BP suddenly shot up to 190/110 mm Hg. His ECG showed inverted waves.

He was started on tablet Prazosin 2.5mg and was managed with antibiotics, analgesics and other supportive medications in ER.

Patient's BP settled to 100/60 mm Hg and his symptoms improved gradually.

Blood parameters were within normal limits except for elevated Total Leucocyte Count of 19,900 with neutrophil predominance of 90%

General physician was consulted, and patient was shifted to critical care for further management.

During the course of stay in ICU, he was monitored and was under close observation.

Patient improved very well and was discharged in a hemodynamically stable condition.

This case illustrates the use of Alfa Blockers in Autonomic storm in a case of scorpion sting.

Autonomic storming is a condition of Hyper-adrenergic reaction and high angiotensin activity to Scorpion venom. This results in sudden shooting up of blood pressure because of alfa activity of adrenergic agents, which will be followed by a drop in BP. There will also be hyperglycemia as a result of same adrenergic reaction. Cardiac changes involve T wave abnormalities and sometimes enzyme elevation.

Keeping in view the above consequences of scorpion venom, this patient was closely monitored throughout his stay in hospital and was discharged in a stable condition from the ward.

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Breaking Barriers in Airway Management: Successful Stenting of Trachea in a secondary tumor.

Anantapuram, 14th Aug 2025 : A 75-year-old female with carcinoma of the esophagus presented to our emergency department with severe stridor and respiratory distress. Her condition was rapidly worsening, with imminent risk of airway collapse.

Dr. Yashovardhan Mangisetty, Consultant Interventional Pulmonologist, attended on the patient and evaluated the case

Diagnostic Findings

Bronchoscopy revealed a critical tracheal obstruction, with over 75% narrowing of the mid-trachea due to malignant infiltration. The obstructed lumen explained her stridor and acute respiratory compromise.

The Intervention

The patient was immediately taken up for Rigid Bronchoscopy under general anesthesia.

Under C-arm fluoroscopic guidance, a covered self-expandable metallic stent (16 × 60 mm) deployed precisely across the narrowed tracheal segment.

The Outcome

- Immediate resolution of stridor
- Restoration of airway patency and improved ventilation
- Patient stabilized successfully post-procedure

This intervention not only relieved life-threatening airway compromise but also allowed better symptom control and quality of life in a patient with advanced malignancy.

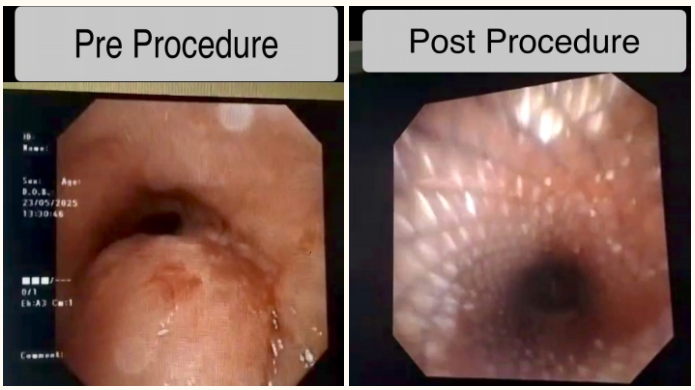
Why is this Case Special?

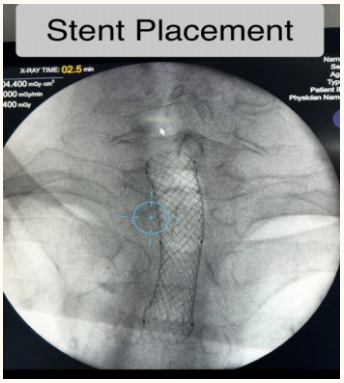
This marks the first successful tracheal stent placement procedure in Rayalaseema for malignant airway obstruction -a major milestone in pulmonology in this region. It reflects the availability of state-of-the-art interventional pulmonology services at KIMS Saveera Hospital Anantapur, ensuring that patients no longer need to travel far, for complex airway procedures.

Image Highlights

1. Pre-procedure bronchoscopy: critical tracheal narrowing
2. Post-procedure airway lumen restoration
3. X-ray: Stent in situ under C-arm guidance

This case exemplifies how timely airway intervention can be lifesaving, transforming an emergency into a success story through skill, precision, and technology.





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Severe Respiratory Distress Due to Bilateral Pneumothorax & Subcutaneous Emphysema: Life Saving bilateral ICD Intervention in ER

Anantapuram, 20th Aug 2025 : A 51-year-old male was brought to Emergency department with complaints of shortness of breath since morning. He had severe bouts of cough with retching in the morning followed by swelling of eyelids on both sides and swelling over chest region

There was no history of hypertension. He had pulmonary tuberculosis 20 years ago and had no details of treatment available now with him.

On examination the patient was conscious and well oriented

His vitals were:

HR-127 bpm, BP- 170/100mmHg, SPO2- 97% in room air, Respiratory rate was 26/minute

Temp- 98.6 degrees F, GRBS was- 148 mg/dl

Heart sounds were normal, and the breath sounds were decreased on both sides.

Patient was found to have generalized diffuse swelling over the face, neck, chest and extending onto the abdomen. On palpation over the swelling, crepitus was felt suggestive of subcutaneous emphysema

An emergency HRCT was done which showed “Over inflation with areas of air trapping. A few fibrotic lesions in both lungs with partial loss of volume. Areas of traction bronchiectasis in right middle bilateral upper lobes with mediastinal shift to right. Patchy areas of ground glass like opacification in right lower lobe – due to early bronchopneumonia. Small right pneumothorax extensive pneumomediastinum with surgical emphysema of lower neck chest wall and upper abdominal wall. Diffuse wall thickening (6.5 mm) of distal 2/3 of thoracic esophagus. There was also diffuse thickening of the distal oesophagus with features suspicious of a small hiatus hernia and intramural air, raising the possibility of oesophageal pathology.

Because of the bilateral pneumothorax, he and his family were counselled, and the patient was taken up for an emergency procedure in the department itself. Under strict aseptic precautions, bilateral inter costal drains were inserted and connected to an underwater seal drainage system with high-flow oxygen support. The ICD position was confirmed by and confirmed with air column and repeat x-ray.

In view of severe subcutaneous emphysema, multiple releasing nicks were given in the chest wall and the drains were regularly milked. He was then shifted to ICU for close monitoring Blood parameters showed elevated leucocyte count 25,000 TLC with neutrophil predominance of 92% ECG, 2D Echo and other parameters were within normal limits.

He was managed with supplemental oxygen via mask, intravenous antibiotics, nebulization, analgesics, IV fluids and other supportive medication.

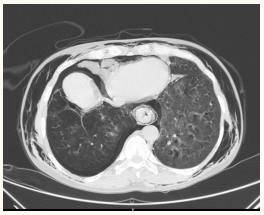
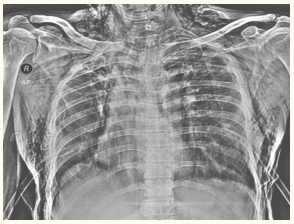
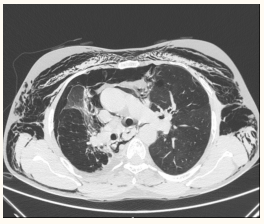
Consultant Pulmonologist, Consultant Medical Gastroenterologist and Consultant Physician were called in, and case was shifted to critical care.

In ICU, he was treated with intravenous antibiotics, antacids, inhalational bronchodilators, mucolytics and supportive medications. Serial chest X-rays showed gradual improvement in the pneumothorax. Once the left side resolved, the left ICD was removed, while the right ICD was retained. Meanwhile, he was kept nil per mouth due to suspected esophageal pathology and was started on total parenteral nutrition for support. A medical gastroenterology opinion was taken and an upper GI endoscopy was performed, which showed features suggestive of achalasia cardia.

Over the next few days, the patient showed steady improvement. His respiratory distress gradually subsided, the subcutaneous emphysema reduced significantly, and chest X-rays confirmed resolving pneumothorax. With complete resolution and closure of bronchopleural fistula, the right-sided ICD was also removed. Oral feeding was restarted cautiously with clear liquids, which he tolerated well

After stabilization, he was shifted from ICU to the ward. He remained stable on room air, was mobile and was able to take oral fluids. His condition continued to improve, and after ensuring stability, he was discharged home.

At the time of discharge, he was comfortable, breathing well on room air, with no respiratory distress. He was advised to continue medications, take only clear fluids/liquids for a few days, avoid strain, and to follow up regularly with Pulmonology and Gastroenterology teams.

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CVJ Anomalies with Basilar Invagination
A Rare Case Presentation

Anantapuram, 26th Aug 2025 : A 16-year-old female presented with insidious onset of neck pain.

Patient was referred to Radiology for a CT scan of head and neck.

CT SCAN revealed unfused posterior arch of C1, occipitalization of the atlas on right side, occipito-atlantal synostosis, and a short concave clivus. Block vertebrae of C2–C3 and partial fusion of C4–C5 were also present, along with mild rightward angulation of the odontoid and atlanto-axial asymmetry. Basal angle was increased.

The findings were consistent with a condition called Platybasia. The odontoid projected 12 mm above McGregor's and Chamberlain's lines, confirming basilar invagination, though McRae's line remained normal.

After the initial findings the team of Consultants Radiologists Dr Sri Krishna and Dr Harish Reddy took up the case for further evaluation. An MRI was done to rule out basilar imagination and nerve compression.

MRI of brain showed no tonsillar herniation or cervicomedullary compression.

Basal angle on CT scan was 152o (Normal value 143 o) and on MRI 137 o -(Normal value 129 o)- due to Platybasia.

As per McGregor's line and Chamberlain's line, odontoid is 12 mm above these lines suggesting basilar invagination. As per McRae line, odontoid tip is below this line.

Discussion:

Basilar Invagination: This is a condition of congenital upward displacement of vertebral elements into a normal foramen magnum with normal bone

Frontal image

- Digastric-line : the tip of the odontoid process is normally located 11-21 mm below this line
- Bimastoid-line: the tip of the odontoid process projects normally not more than 10 mm above this line

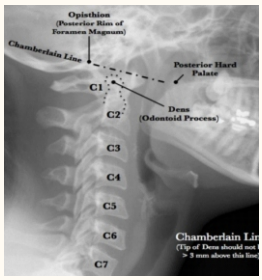
Lateral image

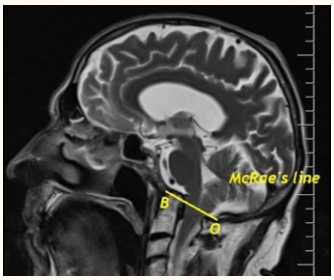
- McRae-line: Connecting basion to opisthion
- The tip of the odontoid process normally projects below this line, therefore, basilar invagination is diagnosed when the tip crosses this line
- Chamberlain-line: connecting the posterior border of hard palate and opisthion
- The tip of the odontoid process projects normally not more than 3 mm above this line
- McGregor-line: connecting the posterior edge of the hard palate to the most caudal point of the occipital curve
- The tip of the odontoid process projects normally not more than 5 mm above this line

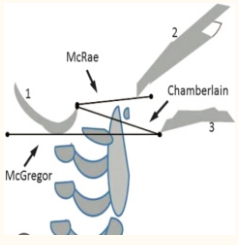
DEMOGRAPHICS:

Developmental anomalies of the craniovertebral junction (CVJ) are uncommon and may present in varied combinations. Their recognition is crucial as they may predispose to atlanto-axial instability, basilar invagination, and neurological compromise.

The coexistence of multiple CVJ anomalies with associated spinal developmental variants in a single patient is rare. CT provides excellent delineation of osseous fusion anomalies with craniometric indices. MRI is essential for assessing neural structures and rule out any brainstem compression. Klippel-Feil syndrome is a complex heterogeneous entity that results in cervical vertebral fusion.







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Consultant - Radiologist

Specialist Collaboration and Teamwork Ensure Safe. Management of 39-Week Pregnant Woman with Raised Bilirubin.

The maternity team, along with the Medical Gastroenterology and Nephrology teams at KIMS Saveera Hospital, recently managed a complex case of a 39-week pregnant woman presenting with raised bilirubin levels. Early involvement of multiple specialists played a crucial role in ensuring a safe outcome for both mother and baby

.Anantapuram, 28th Sep 2025 : A 30-year-old primigravida was referred at 39 weeks of gestation with hyperbilirubinaemia, raised creatinine levels, pre-labour rupture of membranes, and lower abdominal pain. She also had a history of cough and cold for one week. She was otherwise healthy and had received regular antenatal care at a local hospital in Anantapur.

On examination, her vitals were stable. General examination showed yellowish discolouration of the sclera. Abdominal examination revealed a term-size irritable uterus, cephalic presentation, and good fetal heart rate. Liquor appeared reduced clinically. There was no active leak on speculum examination. Vaginal examination showed early labour with thick meconium-stained liquor. Fetal monitoring demonstrated concerning features, and an emergency caesarean section was planned. Meanwhile, an urgent opinion was sought from the Medical Gastroenterology and nephrology teams.

Investigations and Intraoperative Course

Laboratory investigations showed deranged coagulation profile, abnormal liver function, and renal function tests suggestive of acute liver injury and acute kidney injury.

The patient underwent emergency caesarean section with blood products on standby. Intraoperatively, the procedure was complicated by atonic postpartum haemorrhage, which was controlled successfully with uterotonics and supportive measures.

Postoperative Multidisciplinary Care

Postoperatively, she was co-managed by the Nephrology and Gastroenterology teams. She was started on ursodeoxycholic acid, NUSAM (S- Adenosyl – L – Methionine), Lactulose and few injections of Vitamin K were given. Perioperatively. nephrotoxic and hepatotoxic drugs were carefully avoided.

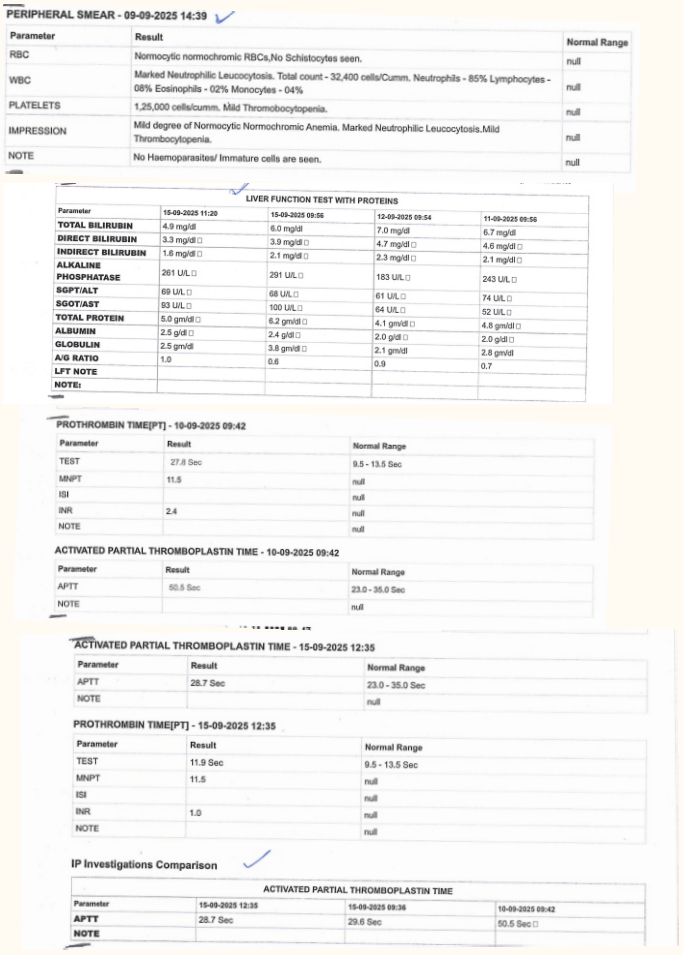
On second post operative day, her renal parameters and coagulation profile improved but there was persistent rise in bilirubin levels. Further evaluation showed severe hypoproteinaemia. Ultrasound of abdomen showed normal liver with moderate ascites. Diagnostic ascitic tap was advised. She was screened for Hepatitis A, B, C, D, E, Leptospira, Weil-felix, Dengue, Malaria, peripheral smear for Schistocytes etc.. Which were all negative.

She was given albumin infusion as albumin levels were very low and had oedema in dependent parts which was managed with magnesium sulphate dressings.

The patient gradually improved with conservative management and was discharged home on postoperative day 8 in stable condition. Her blood results were all with in normal range at the time of discharge.

Key Learning Point

This case highlights the critical importance of early specialist involvement in managing complex medical conditions during pregnancy and parturition. Raised bilirubin at term in this scenario could be either infective or pregnancy induced and timely multi-disciplinary input was essential in guiding investigations, optimising intraoperative care, and ensuring safe recovery.



PERIPHERAL SMEAR - 09-09-2025 14:39

Parameter	Result	Normal Range
RBC	Normocytic normochromic RBCs,No Schistocytes seen.	null
WBC	Marked Neutrophilic Leucocytosis. Total count - 32,400 cells/Cumm. Neutrophils - 85% Lymphocytes - 08% Eosinophils - 02% Monocytes - 04%	null
PLATELETS	1,25,000 cells/cumm. Mild Thrombocytopenia.	null
IMPRESSION	Mild degree of Normocytic Normochromic Anemia. Marked Neutrophilic Leucocytosis.Mild Thrombocytopenia.	null
NOTE	No Haemoparasites/ Immature cells are seen.	null

LIVER FUNCTION TEST WITH PROTEINS

Parameter	15-09-2025 11:20	15-09-2025 09:56	12-09-2025 09:54	11-09-2025 09:56
TOTAL BILIRUBIN	4.9 mg/dl	6.0 mg/dl	7.0 mg/dl	6.7 mg/dl
DIRECT BILIRUBIN	3.3 mg/dl	3.9 mg/dl	4.7 mg/dl	4.6 mg/dl
INDIRECT BILIRUBIN	1.6 mg/dl	2.1 mg/dl	2.3 mg/dl	2.1 mg/dl
ALKALINE PHOSPHATASE	261 U/L	291 U/L	183 U/L	243 U/L
SGPT/ALT	69 U/L	68 U/L	61 U/L	74 U/L
SGOT/AST	93 U/L	100 U/L	64 U/L	52 U/L
TOTAL PROTEIN	5.0 gm/dl	6.2 gm/dl	4.1 gm/dl	4.8 gm/dl
ALBUMIN	2.5 g/dl	2.4 g/dl	2.0 g/dl	2.0 g/dl
GLOBULIN	2.5 gm/dl	3.8 gm/dl	2.1 gm/dl	2.8 gm/dl
A/G RATIO	1.0	0.6	0.9	0.7
LFT NOTE				
NOTE:				

PROTHROMBIN TIME[PT] - 10-09-2025 09:42

Parameter	Result	Normal Range
TEST	27.8 Sec	9.5 - 13.5 Sec
MNPT	11.5	null
ISI		null
INR	2.4	null
NOTE		null

ACTIVATED PARTIAL THROMBOPLASTIN TIME - 10-09-2025 09:42

Parameter	Result	Normal Range
APTT	50.5 Sec	23.0 - 35.0 Sec
NOTE		null

ACTIVATED PARTIAL THROMBOPLASTIN TIME - 15-09-2025 12:35

Parameter	Result	Normal Range
APTT	28.7 Sec	23.0 - 35.0 Sec
NOTE		null

PROTHROMBIN TIME[PT] - 15-09-2025 12:35

Parameter	Result	Normal Range
TEST	11.9 Sec	9.5 - 13.5 Sec
MNPT	11.5	null
ISI		null
INR	1.0	null
NOTE		null

IP Investigations Comparison

ACTIVATED PARTIAL THROMBOPLASTIN TIME

Parameter	15-09-2025 12:35	15-09-2025 09:36	10-09-2025 09:42
APTT	28.7 Sec	29.6 Sec	50.5 Sec
NOTE			

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Aneurysmal Subarachnoid Hemorrhage Managed with Endovascular Coiling: 1st of its Kind in Anantapur

Anantapuram, 13th Sep 2025 : A 47-year-old female, a known hypertensive of six years, presented to the outpatient department with history of sudden onset of severe holo-cephalic headache since morning, accompanied by nausea, giddiness, photophobia, and neck spasm. This was followed by a an episode of loss of consciousness lasting for 10–15 minutes, with bowel and bladder incontinence and post-ictal confusion. There was no history of tongue bite, cranial nerve involvement, limb weakness, sensory abnormalities, gait disturbance, or recent febrile illness.

At the time of examination, the patient was afebrile, conscious, coherent, and oriented to time, place, and person. She was moderately built and nourished, with pallor and pedal edema present. Vitals were normal, BP was 150/90 mm Hg; Neurological examination: was essentially normal, except for severe neck rigidity. A provisional diagnosis of cerebral venous sinus thrombosis (CSVT) / Subarachnoid hemorrhage (SAH) / PRES was made, and she was subjected to further investigations.

MRI Brain: Intraventricular subarachnoid hemorrhage with obstructive hydrocephalus and periventricular CSF seepage. MRV Brain: Negative for (CSVT). CT Brain with Angiography: Intraventricular SAH with mild obstructive hydrocephalus. A 6 × 3 mm aneurysm with a 1.5 mm narrow neck was identified arising from the cavernous portion of the left ICA, just caudal to the anterior clinoid process. Hypoplasia of the A1 segment of the right ACA was noted as a developmental variant.

Based on the examination and image reports, a final diagnosis of Subarachnoid Hemorrhage (SAH) secondary to ruptured internal carotid artery aneurysm was made.

Management and Outcome

The patient and her attendants were counseled about the advantages and disadvantages of various therapeutic procedures in this case. Consultant Interventational Neuro Radiologist Dr. K. Ashoka Kumar was consulted. it was suggested that endovascular coiling of the aneurysm was treatment of choice.

Dr Ashoka kumar took up the case immediately and did endovascular coiling of bilateral paraclinoidal internal carotid artery aneurysms under neuro interventional guidance. The procedure took almost four hours. The postoperative period was uneventful. Follow-up CT brain showed resolution of hydrocephalus and no new hemorrhage. The patient demonstrated complete neurological recovery with supportive medical therapy.

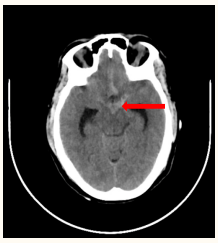
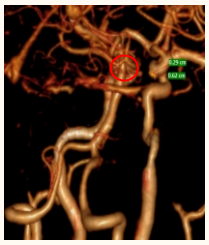
Discussion

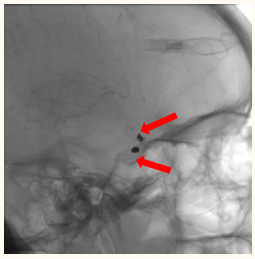
Subarachnoid hemorrhage (SAH) accounts for approximately 5–10% of all strokes and is most commonly caused by rupture of a cerebral aneurysm. It presents with sudden severe headache, often described as a 'thunderclap headache.'

Imaging modalities such as CT and MR angiography are indispensable in identifying aneurysms and associated complications like hydrocephalus. Traditionally, surgical clipping was the mainstay of treatment. However, endovascular coiling has emerged as a minimally invasive, effective alternative that reduces re-bleeding rates and improves recovery times. Treating this condition by endo-vascular coiling requires the expertise of an interventional - neuroradiologist. Dr. Ashok Kumar Consultant Interventional Neuro Radiologist is highly qualified and is experienced in this field. Very good imaging system including Digital Subtraction Angiography and good Cath Lab helped in successful management of this case at KIMS Saveera Hospital. This procedure is the 1st of its kind in Anantapur.

Conclusion

This case underscores the importance of early detection and endovascular management in aneurysmal SAH. The expanding availability of interventional neurology services in smaller healthcare centers represents a major advancement in reducing



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Complex Reconstruction of a Grade 3B Compound Fracture in an 18-year-old.

Anantapuram, 13th Sep 2025 : A 18-year-old male, sustained a high-velocity injury resulting in a compound Grade 3B injury of the left thigh. On arrival, he was found to have an open comminuted fracture of the left distal femur with intra articular extension and associated Hoffa's fracture of the femur. The wound was severely contaminated with soft tissue loss and exposed bone fragments. The injury carried a high risk of infection, non-union, and permanent disability if not managed urgently and appropriately. The patient was in severe pain and was unable to move the affected limb.

Preoperative Work

Emergency resuscitation was carried out as per ATLS protocol, including stabilization of airway, breathing, and circulation. Broad-spectrum intravenous antibiotics were administered to reduce the risk of infection.

Radiological evaluation with plain X-rays and CT scan confirmed the extent of comminution and the intra-articular extension of the fracture. Preoperative planning was critical, as the goals were to achieve thorough wound debridement, anatomical reduction of the articular surface, restoration of limb length, and temporary stabilization to allow soft tissue healing.

The surgical team of Consultant Orthopedists Dr Pradeep Batta and Dr Sai Sujeeth discussed the staged approach with the patient and his family, emphasizing that further procedures may be needed after initial stabilization.

Details of Intervention Done

The patient was taken to the operating room on an emergency basis. A thorough debridement of the wound was performed to remove all devitalized tissue and contaminants, reducing the risk of deep infection.

The articular surface was carefully reconstructed using cortical screws to restore joint congruity, which is vital for good knee function. Following this, distal femoral nailing was performed to provide stable fixation and maintain limb length and alignment despite the comminution.

Special attention was paid to preserving as much viable soft tissue as possible, given the Grade 3B nature of the injury. The wound was covered temporarily, with plans for secondary procedures depending on healing.

Postoperative Recovery and Physiotherapy

Postoperatively, the limb was immobilized using an extension splint to protect the fixation and promote soft tissue healing. The patient was kept non-weight-bearing on the affected limb. Pain control, infection prophylaxis, and wound care were strictly monitored.

Physiotherapy was initiated for the non-injured limb and general conditioning to maintain overall strength and mobility. Early quadriceps setting exercises and ankle pump movements were encouraged on the operated side to prevent stiffness and maintain circulation.

Result

At this stage, the primary goals of surgery were successfully achieved:

- Articular surface was reconstructed.
- Limb length and alignment were maintained.
- Fracture was stabilized adequately for the initial stage.
- Although the patient remains in a non-weight-bearing phase, the early outcomes are promising. The risk of joint collapse and deformity has been minimized with accurate reduction and stable fixation.

Significance of the Procedure in Such Cases

Grade 3B compound distal femur fractures with intra-articular extension are among the most challenging injuries in orthopedics. The combination of severe contamination, comminution, and involvement of articular surface often leads to poor functional outcomes if not addressed correctly.

In this case, the staged approach ensured that immediate threats of infection and deformity were controlled, simultaneouslyreconstructingthe joint surface and maintaining limb length. The first-stage surgery lays the foundation for future procedures, which may include definitive reconstruction or bone grafting as required.This case highlights the importance of early aggressive debridement, precise articular reduction, and stable fixation in salvaging both the limb and joint in complex compound injuries.



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Trauma & Arthroplasty Surgeon
Consultant - Orthopaedician

Surgical Excision of a Left Parietal Spetzler–Martin Grade II Arteriovenous Malformation Following Acute Hemorrhage

Anantapuram, 22th Sep 2025 : A 43-year-old male, previously healthy, presented with acute-onset severe headache, repeated vomiting, and altered sensorium of 3 days duration. There was no known history of hypertension, diabetes, or previous neurological symptoms. He was initially treated at a local hospital and later referred to our tertiary care center.

On admission, the patient was drowsy but arousable (GCS E3V5M6) and hypertensive (BP 180/100 mmHg). There were no focal neurological deficits, and systemic examination was unremarkable.

A non-contrast CT brain revealed a left parietal intraparenchymal hematoma with mild mass effect and rightward midline shift. CT angiography demonstrated a compact left parietal AVM (≈ 2.5 cm) supplied by posterior sylvian and parietal cortical arteries and draining superficially into the transverse sinus. Based on its small size (< 3 cm), non-eloquent location, and superficial venous drainage, the lesion was classified as Spetzler–Martin Grade II. Routine investigations were within normal limits.

The case was planned for staged management. Initially the patient was managed conservatively in the neurosurgical ICU for one week for neurological stabilization, blood pressure control, and reduction of cerebral edema. After three weeks, an elective left parietal craniotomy with complete microsurgical excision of the AVM was performed. The intraoperative course was uneventful.

A postoperative CT angiogram confirmed complete resection with no residual nidus or new hemorrhagic changes. The patient remained neurologically intact and was discharged in stable condition. Follow-up at one month showed normal neurological function.

Discussion

The Spetzler–Martin grading system remains the cornerstone for evaluating AVM surgical risk, incorporating lesion size, location, and venous drainage pattern. Grade II AVMs—small, in non-eloquent regions, with superficial drainage—carry low operative risk and excellent prognosis when managed by microsurgical resection.

In this case, early diagnosis by CT angiography facilitated accurate grading and treatment planning. Given the acute hemorrhage, initial conservative management was appropriate for stabilizing systemic and neurological parameters before surgical intervention. Elective surgery after edema resolution enabled a safer and more controlled resection. Literature supports this staged management strategy, reporting reduced perioperative morbidity and improved functional outcomes when surgery is delayed until after initial stabilization in ruptured AVMs (1,2).

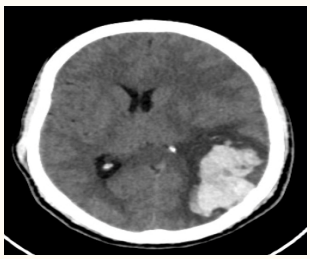
Multidisciplinary coordination among neurosurgery, neuro-anesthesia, and intensive care teams was crucial to the patient's recovery. The case demonstrates how individualized, grade-based, and staged intervention can optimize outcomes in AVM-related intracerebral hemorrhage. KIMS Saveera Hospital at Anantapur has all the required specialists and equipment to manage such cases.

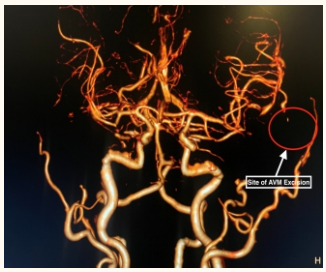
Conclusion

Prompt neuroimaging, grading-based risk stratification, and carefully timed surgical intervention are critical for successful management of ruptured cerebral AVMs. For Spetzler–Martin Grade II lesions, elective microsurgical excision following initial stabilization can result in excellent neurological recovery with minimal morbidity.

Imaging and Intraoperative Findings

Preoperative images: Non-contrast CT showing Left Parietal AVM and CT angiogram brain demonstrating AVM nidus with feeders and draining veins





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MCh (Neuro Surgery)
Consultant - Neuro Surgeon

A Rare Microbiome Causing Lung Diseases at Anantapur: New Insights in Diagnostics

Anantapuram, 30th Sep 2025 : Diagnosing rare microbiome-related diseases is always challenging clinical scenario because it affects patient's life style, hindering their daily professional and personal activities. It includes a thorough clinical evaluation and robust advanced diagnostic techniques. KIMS Saveera Hospital has a large modern laboratory, highly accurate, adhere to turn around time, accredited by highly prestigious NABL, fully equipped with state-of-the-art instrumentation and reports are approved by highly qualified senior consultants.

A tremendous variety of microbes causing lung infections, patients who were suffering from a multitude of treatment failures in various hospitals, come here for evaluation. For these Patients multimodal approach is adapted with infectious diseases and microbiology team. We present here rare microbiome over the past one month.

Case report 1: A 66 year old male patient who is known active smoker, diabetic since long years presented with respiratory symptoms, GCS was too low and on MV & dense consolidation in right upper and mid zones. Organism isolated: Nocardia, gram positive bacteria with branching filamentous & acid fast bacilli were further confirmed by culture and real time HRMA method. Infections: Nocardia can cause pulmonary infection (most common), primary cutaneous infection and also dissemination to other sites.

Case report 2: An elderly aged female patient with OAD & MR and with a long history of biomass fuel occupational exposure presented lung manifestations for a long time. Alveolar infiltrates multiple soft tissue dense lesions in the right lung and complete consolidation of left lower lobe with a small cavitatory lesion was noted. Organism isolated: Actinomycetes, gram-positive bacteria with filamentous branching which was confirmed by real time HRMA method. Infections: Pulmonary actinomycosis, abscesses and draining sinuses in soft tissues.

Case report 3: Middle aged adult male patient, who is a known DKA with respiratory symptoms and on Mechanical Ventilation. CT Showed bilateral dense and a small cavitatory lesion in lung. Organism isolated: Rhizopus species. Rapid and simple KOH showed broad, ribbon-like hyphae with infrequent septations and wide-angle branching. Infections: Zygomycosis affects people with weakened immune systems like those with diabetes, neutropenia, or organ transplant recipients.

Case report 4: A known case AKI & HTN admitted in critical situation under ICU with clinical manifestations of shortness of breath, fever and cough. This middle aged adult male had a large patch of interstitial pneumonitis in right upper lobe and small patches of interstitial pneumonitis in right lower lobe.

Dr. A. Geethanjali
MBBS, MD (Microbiology)
Consultant - Microbiologist

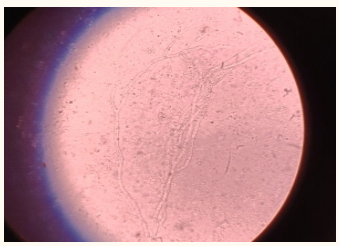
Organism isolated: Coronoavirus 229E and Corona virus NL63. These viruses were detected accurately by Real time PCR assay. Infection: In infants, young children, the elderly, and in immuno-compromised, these viruses can lead to more severe illnesses, including bronchiolitis and pneumonia.

Case series: Hospitalization is highest in elderly patients (≥ 65 yr), infants and those with preexisting obstructive lung disease or other cardiopulmonary disorders. Viral infections are the leading cause of community-acquired pneumonia (CAP).

Radiological findings: Bilateral patchy extensive interstitial pneumonitis with multiple radiological presentations including ground glass opacities, homogenous opacifications, tree-bud patterns, centrilobular nodules.

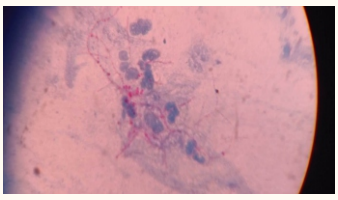
Microbiological findings: Out of 12 patients evaluated by real time PCR assay 6 Influenza A, 3 Respiratory Syncytial virus, 2 Streptococcus pneumoniae and one Rhino virus were observed. Infections: Severe viral pneumonia can manifest as sepsis and respiratory distress requiring intensive care. These viruses contribute to the global burden of respiratory diseases.

Lung microbiota plays an important role in many diseases including LRTI and pneumonia. The emergence of these pathogens is a rising concern, with diagnostic and therapeutic challenges resulting from their atypical presentation and drug resistance. The Department of Laboratory Medicine at KIMS Saveera Hospital assists doctors and patients in making optimal decisions based on the latest diagnostic studies, using cutting-edge instrumentation. Antimicrobial stewardship team of KIMS Saveera Hospital takes the input from lab and in discussion with concerned clinicians start the appropriate therapy as per the standard treatment guidelines.



Zygomycosis in KOH

Gram Stain of Nocardia



AFB Stain of Nocardia

Ground glass opacities

Human Bite : The Art of Reconstruction and Rehabilitation

Anantapuram, 30th Sep 2025 : Plastic Surgeons encounter numerous cases of Bite Injuries, including human bites. Each case presents unique challenge in reconstruction. Recently, We had the opportunity to treat two patients who suffered severe bite injuries to ear and lip. In this article, we share our experience and insights on successful reconstruction of these complex injuries.

Case 1: Ear Bite Injury

A 52-year-old male presented to KIMS Saveera Hospital, with a severe bite injury to his ear, resulting in a significant loss of tissue. The patient's wound was thoroughly cleaned and debrided, and a reconstruction plan was devised. A staged reconstruction was performed, starting with a local flap Eave's Retro Auricular Flap with cartilage graft, followed by a Flap division to restore the ear's natural shape. The patient's wound healed well, and the aesthetic outcome was satisfactory.

Case 2: Lip Bite Injury

Another patient, a young adult male, suffered a severe bite injury to his Lower lip, resulting in a significant defect involving about central 2/3rd of the lower Lip. The patient's wound was thoroughly cleaned and debrided, and a reconstruction plan was devised. A lip reconstruction was performed using a combination of local flaps as Step Ladder Flap of lower Lip to restore the lip's natural shape and function. The patient responded well to the surgery, and the functional and aesthetic outcomes were satisfactory.

Takeaways:

1. Prompt treatment : Timely intervention is crucial in managing human bite injuries. Early treatment helps prevent infection, promotes healing, and improves outcomes.
2. Thorough debridement : Debridement is essential in removing dead tissue, bacteria, and other contaminants, promoting a clean wound environment.
3. Staged reconstruction : In complex cases, staged reconstruction may be necessary to achieve optimal outcomes. This approach allows for tissue healing, reduces the risk of complications, and improves aesthetic and functional results.
4. Multi-disciplinary Care : Human bite injuries often require a multi-disciplinary approach, involving plastic surgeons, infectious disease specialists, and other healthcare professionals.

Conclusion :

Human bite injuries can be challenging to manage, but with prompt treatment, thorough debridement, and staged reconstruction, optimal outcomes can be achieved. As a plastic surgeon, it is essential to stay up-to-date with the latest techniques and approaches to provide the best possible care for patients with complex injuries. By sharing our experience of these two cases, KIMS Saveera Hospital aims to highlight the importance of proper management and reconstruction of human bite injuries, by qualified plastic surgeon..

Showing the Two staged Reconstruction of Ear using Eaves Retro Auricular Flap and Cartilage Graft

Showing the reconstruction of Lower Lip using Step Ladder Pattern Flap

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MBBS, MS (General Surgery),
Gold Mediallist
M.Ch (Plastic Surgery)
Consultant - Plastic &
Reconstructive Surgeon

KIMS-SAVEERA HOSPITAL

Academics / Training Programs for Doctors :

- DrNB Cardiology - 1 Seat
- DNB Radiology – 2 Seats
- DNB Anaesthesia – 3 Seats
- DNB Emergency Medicine - 2 Seats
- IDCCM- Indian Diploma of Critical Care Medicine (ISCCM) - 2 Seats
- FCCCM - Fellow of College of Critical Care Medicine (CCEF) – 4 Seats
- Fellowship in Critical Care Medicine (Medversity) - 4 Seats
- Fellowship in Clinical Cardiology (Medversity) - 4 Seats
- Fellowship in Emergency Medicine (Medversity) (FEM) – 4 Seats

Diploma Courses in Paramedical Subjects :

- Bsc. Nursing - 50 Seats
- Diploma in Cardiology Technician (DCARDIO) – 2 Seats
- Diploma in Cath lab Technician (DCLT) - 2 Seat
- Diploma in Medical Imaging Technician (DMIT) – 5 Seats
- Diploma in Anesthesia Technician (DANS) - 10 Seats
- Diploma in Medical Lab Technology (DMLT) - 10 Seat
- Diploma in Perfusion Technician (DPFT)- 3 Seats
- Diploma in Medical Sterilization Management & OT (DMST) - 10 Seats
- Diploma in Ophthalmic Assistant (DOA) – 5 Seats

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