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INDUS ALIVE

Year 8 Vol.14, MARCH-APRIL 2024, CHANDIGARH

A Health & Wellness Magazine by INDUS HOSPITALS, Mohali, (Pb.) India

Committed to building better Healthcare

The latest techniques and treatments to ensure an Active, Healthy & Independent Lifestyle

Social Activities

Free Medical Checkup Camp organised by Indus Hospitals

Specialities	Doctor Name	Qualifications	OPD Days
Anesthesia & Pain Management	Dr. SPS Bedi	MBBS MD	Mon to Sat
	Dr. Arjun Joshi	MBBS MD	Mon to Sat
	Dr. Devinder Grewal	MBBS MD	Mon to Sat
Cardio Thoracic Vascular Surgery	Dr. Ashwani Bansal	MBBS MS MCh	Mon to Sat
Colorectal Surgery	Dr. Pankaj Garg	MBBS MS	On Call
Critical Care & Emergency Medicine	Dr. Jogesh Aggarwal	MBBS MD	Mon to Sat
ENT Surgery	Dr. Potluri Praneeth	MBBS MS	Mon to Sat
Family Medicine	Dr. Sakshi Grover	MBBS DNB	Mon to Sat
Gastroenterology Surgery	Dr. BS Bhalla	MBBS MS	Mon & Wed
Gastroenterology	Dr. Rajan Mittal	MBBS MD DM	Mon to Sat
General Surgery	Dr. Anil Kr Sharma	MBBS MS	Mon to Sat
Gynaecology & Obstetrics	Dr. Jasmine Kang Rana	MBBS DNB	Mon to Sat
Internal Medicine	Dr. Kanwar Singh Bhinder	MBBS MD	Mon to Sat
Internal Medicine	Dr. Mayank Sharma	MBBS MD	Mon to Sat
Joint Replacement & Sports Medicine	Dr. B. Harna	MBBS, MS, DNB	Mon to Sat
Microbiology & Transfusion Medicine	Dr. Parminder Kaur Gill	MBBS MD	Mon to Sat
Nephrology & Dialysis	Dr. Narinder Sharma	MBBS MD DNB	Mon to Sat
Neurology	Dr. Ruchi Jagota	MBBS MD DM	Mon to Sat
Neurosurgery	Dr. Rajnish Kumar	MBBS MS MCh	Mon to Sat
Nutrition & Dietetics	Dt. Niyati Tejaswini	Msc	Mon to Sat
	Dt. Gauri	MSc.	Mon to Sat
Oncology (Orthopedics)	Dr. Rajat Gupta	MBBS MS DNB	On Call
Oncology (Radiation)	Dr. Vinod Nimbran	MBBS MD	Tue | Thu | Sat
	Dr. Kamalpreet Kaur	MBBS DNB	Mon to Sat
Medical Oncology	Dr. Deepak Singla	MBBS MD DM	Mon to Sat
Oncology (Surgical)	Dr. Ashwan Kallianpuri	MBBS MS MCh	Mon to Sat
	Dr. Ashwani K Sachdeva	MBBS MS MCh	Mon to Sat
Orthopedics & Joint Replacement	Dr. VPS Sandhu	MBBS MS	Mon to Sat
Pathology	Dr. Ankush Nayyar	MBBS MD	Mon to Sat
Pediatrics, Neonatology & Hematology	Dr. Kushagra Taneja	MBBS MD	Mon to Sat
Pediatrics Surgery	Dr. Abhishek Gupta	MBBS MS MCh	Mon to Sat
Pediatrics Neurology	Dr. Mukul Malhotra	MBBS MD DNB	Mon | Wed | Fri
Pediatrics Cardiology	Dr. Amitoz Singh Baidwan	MBBS DNB FNB	Mon to Sat
Plastic & Reconstructive Surgery	Dr. Ritwik Kaushik	MBBS MS MCh	Tue | Thu | Sat
Psychiatry, Behavioral & Drugs Rehabilitation	Dr. Prannay Gulati	MBBS MD	Mon to Sat (1st & 3rd Thu Outside)
	Dr. Vikas Bhateja	PhD(Cognitive Psy.) M.phil (Cl. Psy)	Mon to Sat
Counseling Psychologist	Mrs. Sarnit Chopra	MA PGDFCG	Mon to Fri
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Radiology	Dr. Bhavneet Singh	MBBS MD, DNB	Mon to Sat
	Dr. Jaspreet Singh	MBBS MD, DNB	Mon to Sat
Renal Transplant Surgeon	Dr. Rajan Sharma	MBBS MS MCh	Mon to Sat
Skin, Laser & Cosmetic Medicine	Dr. Ramandeep Kaur	MBBS MD	On Call
Urology	Dr. Prashant Bansal	MBBS MS DNB	Mon to Sat
Vascular Surgery	Dr. Vishal Attri	MBBS MS	Mon to Sat (Every Fri Outside)

From us to you

Throughout the year we generate awareness around specific conditions and diseases that people struggle with daily. Indus Healthcare is committed to bring today's most pressing health issues to the forefont for public awareness.

In this issue of Indus Alive you will find various topics related to health issues, their management and follow-up.

Looking forward for your feedback and suggestions.

feedback@indushospital.in

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GERD

Gastroesophageal Reflux Disease

Gastroesophageal reflux disease (GERD) continues to be among the most common diseases seen by gastroenterologists, and primary care physicians. GERD is the condition in which there is reflux of gastric contents into the esophagus. This causes symptoms and/or complications. It is characterized by mucosal injury seen at endoscopy and/or abnormal esophageal acid exposure demonstrated on a reflux monitoring study.

The pathophysiology of GERD includes a poor function of esophagogastric junction; the antireflux barrier composed of the LES and crural diaphragm, coupled with impaired esophageal clearance and alterations in esophageal mucosal integrity.

Typical symptoms of GERD include heartburn and regurgitation. Heartburn is the most common GERD symptom and is described as substernal burning sensation rising from the epigastrium up toward the neck. Regurgitation is the effortless return of gastric contents upward toward the mouth, often accompanied by an Acid or bitter taste.

Chest pain, indistinguishable from cardiac pain, may present in addition to Heart burn and regurgitation or as the only symptom. The symptoms of GERD are nonspecific and may overlap or confused with other disorders such as rumination, achalasia, eosinophilic esophagitis (EoE), reflux hypersensitivity, functional disease, cardiac or pulmonary disease, and para esophageal hernia.

Extra esophageal manifestations of GERD can include laryngeal and pulmonary symptoms such as hoarseness, throat clearing, and chronic cough and conditions such as laryngitis, pharyngitis, and pulmonary fibrosis. GERD might exacerbate asthma also in some cases.

The diagnosis is based on a combination of symptom presentation, endoscopic evaluation of esophageal mucosa, reflux monitoring, and response to therapeutic intervention. Heartburn and regurgitation remain the most sensitive and specific symptoms for GERD, although not as reliable as one might believe. A systematic review found a variable sensitivity of heartburn and regurgitation for erosive esophagitis (EE) (30%-76%), with the specificity ranging from 62 to 96%. Upper endoscopy is the most widely used for evaluating the esophageal mucosa. For patients with GERD symptoms who also have alarm symptoms such as dysphagia, weight loss, bleeding, vomiting, and/or anemia, endoscopy should be performed as soon as feasible. The endoscopic findings of EE and Barrett's esophagus are specific for the diagnosis of GERD. Esophageal manometry can be used to assess motility abnormalities associated with GERD. A recently approved device for evaluation of GERD uses a catheter-based balloon lined by sensors that measure mucosal impedance during endoscopy.

Management of GERD requires a multifaceted approach. Common recommendations include weight loss for overweight patients, elevating the head of the bed, tobacco and alcohol cessation, avoidance of late night meals and bedtime snacks, staying upright during and after meals, and cessation of foods that potentially aggravate reflux symptoms such as coffee, chocolate, carbonated beverages, spicy foods, acidic foods such as citrus and tomatoes, and foods with high fat content.

The backbone of pharmacologic therapy for GERD are medications that are directed at neutralization or reduction of gastric acid. Agents in this class include antacids, H2RA, and PPIs. PPIs are superior for heartburn and regurgitation relief, as well as improved healing compared with H2RAs. The addition of bedtime H2RA has been suggested for patients on PPIs with persistent nocturnal symptoms. Use of prokinetic agents has shown to increase LES pressure, enhance esophageal peristalsis, and augment gastric emptying.

GERD that fails to respond to medical therapy is valid indication for antireflux procedures, but one that requires meticulous pre procedure evaluation to achieve good surgical outcomes. Fundoplication, especially Nissen fundoplication, is widely regarded as the "gold standard" among the antireflux procedures for its efficacy in improving the physiologic parameters of GERD such as LES pressure and esophageal acid exposure time.

Laparoscopic antireflux surgery (LARS) has become the standard operative approach to fundoplication, essentially replacing open antireflux surgery. LINX Reflux Management System, a necklace of titanium beads with magnetic cores that encircles the distal esophagus to bolster the LES and prevent reflux, was developed as a less invasive and more readily reversible GERD treatment than fundoplication.

A number of endoscopic devices for treating GERD have been introduced. Presently, the only endoscopic GERD treatments still widely available are radiofrequency antireflux treatment (Stretta; Restech, Houston, TX) and TIF (endogastric solutions).

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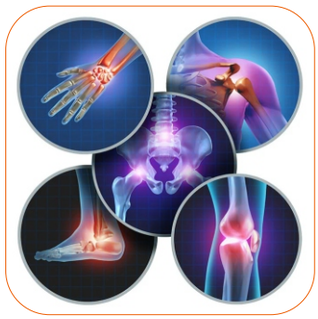
Are You Suffering from :

- Stroke & Paralysis
- Cerebral Palsy
- Parkinson's Disease
- Spinal Cord Injury
- Frozen Shoulder
- Cervical & Mascular Pain
- Back Pain & Stiffness
- Sciatica
- Prolapsed Intervertebral Disc (PIVD)
- Knee Pain
- Sports Injury



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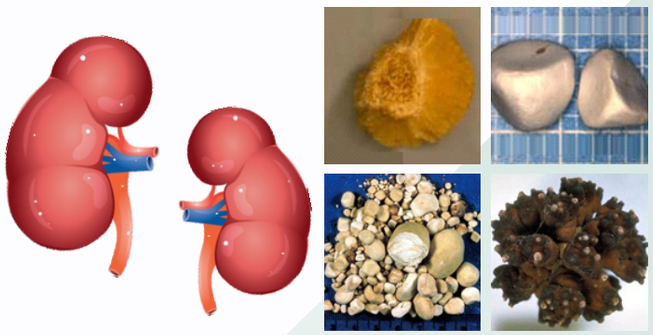
Kidney Stone EDUCATION



Human body possesses two Kidneys, one each on right and left side of abdomen. They act as a filter for blood, removing waste products from the body and making urine.

WHAT IS KIDNEY STONE?

- The Kidney Stones are solid concretions or calculi (crystal aggregations) formed in the kidneys from dissolved urinary minerals.
- Historically, it is not a new world disease. Stones have been found in Egyptian mummy - 4800 BC.

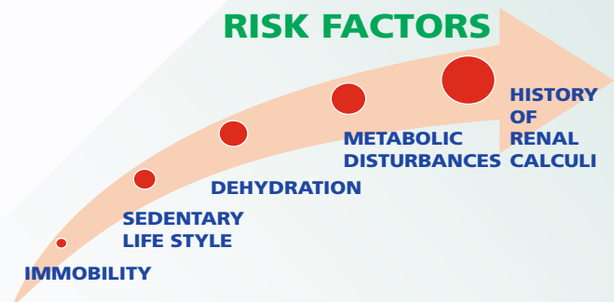
PREVELANCE:

- 1 in 10 persons develop Kidney stones in life time.
- 5 - 10 % population is affected, 50 % of them have recurrence in next 5 t0 10 yrs.
- It accounts for approximately 7-10 of every 1000 hospital admissions.
- Men are more commonly affected than women (approx. 3 times more!!!).
- It is more prevalent in hot and dry areas.
- Diet and Hereditary factors also play a role.
- Uncommon before age 20.
- Peak incidence in 4th - 6th decade.
- Prevalence and incidence directly correlate with weight and BMI.

WHAT CAUSES KIDNEY STONES?

- Reasons can be different - wrong eating habits, overuse of certain drugs and medicines, genetic abnormalities, etc.
- Most important cause is poor intake of oral fluids.
- Genetics, diet, fluid intake, work environment, and even geographical location are all factors which influence the formation of stones.
- Kidney stones form when urine has too many crystal-forming chemicals and/or not enough substances that protect against crystal formation. If the crystals do not rapidly pass through the urinary tract, they can grow and form stones. When the volume of urine is too low, stone-forming materials become concentrated, helping to promote stones.
- Stones form when urine becomes supersaturated, due to one of the following reasons

1. Decreased urine volume
2. Abnormal urine pH
3. Absence of inhibitors
4. Infection



WHAT HAPPENS TO A KIDNEY STONE, ONCE FORMED?

- Once a stone is formed, it cannot be dissolved by ANY MEANS.
- It will fall from its origin and pass through the system and come out of urine; or it may get stuck up at any point in the system and may require intervention or surgery.
- When a stone breaks loose from the place it formed on, it falls into the urine collecting system and may attempt to pass through into the bladder.
- Small stones, less than 5mm in size, usually pass through.
- Those above 10 mm usually do not.
- Between 5-10 mm, a patient may require medical treatment/intervention to promote stone expulsion (known as MET or Medical Expulsive Therapy).
- Whenever a stone attempts to pass, it can produce extreme pain/bleeding and/or obstruction of the kidney it is passing from.
- Pain is what most often signals stone disease to a patient.

TREATMENT

- Stones which do not fall and cause symptoms need treatment.
- Treatment modalities include MET, Endoscopic surgery and Open Surgery.
- Modalities are chosen as per patient and stone status, stone burden, stone location and other various factors.
- All modalities are safe in Experienced Hands. Please consult your Urologist for all stone related issues.

CAN KIDNEY STONES BE PREVENTED?

- Yes, kidney stones can be prevented! During the last many years, treatment plans incorporating diet, fluids, and medications have been developed to prevent or stall the formation of new stones.
- The primary treatments have been proven in controlled clinical trials. Your preventative treatment may consist of fluid, diet, and/or medications. It is then up to you to follow your treatment every day. Fluid and diet changes are just as essential as any medications your doctor may prescribe. Stopping your treatment will cause your chemistries to go back to a stone forming state within DAYS.

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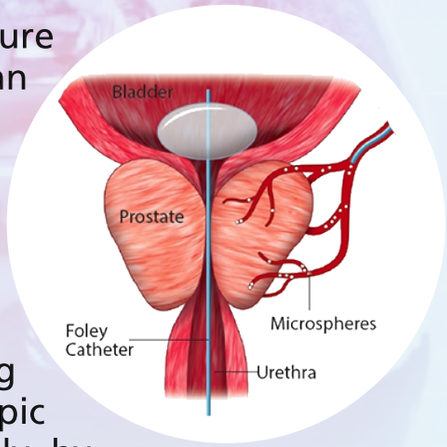
PAE (Prostatic Artery Embolisation)



Prostatic Artery Embolisation is a cutting-adge procedure performed to help improve urinary symptoms caused by an enlarged prostate without the risk of sexual side effects.

Prostate Artery embolisation is performed through a small puncture in the groin a catheter is inserted through the artery and directed towards the prostate.

Once the catheter is positioned in the prostatic artery supplying blood to the prostate tiny particles called microspheres are injected that plug up the artery blocking blood flow. A solution containing thousands of microscopic plastic beads is injected. These block the blood supply by shutting down blood flow to the prostate. All this is accomplished through a tiny quarter inch hole in the groin.

The procedure can take any where from 1 to 3 hours, depending on the location & size of the prostatic arteries. PAE blocks blood flow to the areas of the prostate that are most affected by benign prostatic hyperplasia (BPH) resulting in death or necrosis of isolated areas.

How Successful is PAE

PAE has high success rate with over 90% men experience relief with in 6 months & **100% relief in 1 year,** unlike other treatments that may have unwanted side effects like **retrograde ejaculation meaning semen does not come out and his partner does not get sexual satisfaction. PAE also does not effect sexual performance.**

What happens to Prostate after PAE ?

Following PAE, the prostate gland is starved of its blood supply and therefore shrinks down in size. This allows the urethra to open up and urine to flow normally .

Is PAE Safe ?

PAE is 100% safe as compared to all other procedures like- Laser TURP or Bipolar TURP

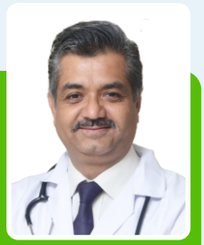
After other Procedures patients has to take Dutasteride tab 0.5 mg life long to prevent the prostate cells from multiplying and growing in to cancer cell.

Prostate Cancer :

About 1 in 8 men will be diagnosed with prostate cancer during his life time about 6 cases in 10 are diagnosed in men after 65 or older. **After PAE there is no risk of developing prostate cancer.**

No medications are required to be taken after PAE unlike.

Patients who has not got done PAE. They have to take medication life long, even if he has undergone laser TURP or Biploar TURP.



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