PARKVIEW TIMES

PARKVIEW SUPER SPECIALITY HOSPITAL

He was stared on Itraconazole oral therapy following which he and he improved clinically and his weight began to increase within weeks of the therapy being initiated.

This case was an uncommon one and multiple investigations were initially inconclusive and clinically clueless with various differential diagnosis like – Adrenal tumour, TB, metastasis, lymphoma etc.

Scan for Full Details

Our activities in 2024

Walkathon on World Diabetes Day - 2024


ABP Ananda Swasthya Samman - 2024

Fathers' Day Walkathon - 2024


CME of Dr. Shilpa Bhartia


Doctors' Day - 2024


Birthday Celebrations of Dr. V. K. Bhartia

From the Desk of the CEO...

Parkview Superspeciality Hospital, an NABH Accredited highly super-specialized hospital at Salt Lake, HB Block, is a hospital founded by doctors.

A doctor's priority is always to serve the patient at whatever cost where all else becomes secondary.

Parkview is a hospital driven by this mission - a living, breathing mission that everyone has committed to achieve.

Having just completed 6 years, Parkview has earned its stripes as one of the leading healthcare facilities in the country with a laser-sharp focus on bariatric surgery, sophisticated laparoscopic surgery, and haemato-oncology services, including bone marrow transplant.

Today, the 12th day of December, 2024, on the auspicious birthday of our Respected Founder Director, Dr.V.K.Bhartia, we have the pleasure of publishing another edition of this Newsletter – the Parkview Times, with the thought of sharing with all of you, our operational agenda and achievements and also to enable us to get into a dialogue mode with all of you for further scope of improvement in every step we take forward so that we can constantly excel.

PARKVIEW SUPER SPECIALITY HOSPITAL
Parkview Super Speciality Hospital
(A Unit of Ankush Medicare Pvt. Ltd.)
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SCAN TO LOCATE

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PARKVIEW TIMES

PARKVIEW SUPER SPECIALITY HOSPITAL

HB 36-A/4-36/A/5/1, Sec-III, Salt Lake, Kolkata - 700 106 info@parkviewhospital.in

Parkview Superspeciality Hospital

Founded in the year 2018, the hospital is the vision and dream-come-true for its Founder Director, Eastern India's most experienced Advanced Laparoscopic and Bariatric Surgeon, Dr. V. K. Bhartia.

Located in Salt Lake, Parkview is a 77-bedded, NABH Accredited highly super-specialized hospital, perhaps the only one of its kind in Eastern India, for treating blood-related diseases like leukemia, thalassemia etc. Apart from this, it also has a well-equipped BONE MARROW TRANSPLANT UNIT where several Bone Marrow Transplants have been done with 100% success rates and this has been possible only because of the leadership and guidance of its HOD, Consultant Haemato-Oncologist Dr. Shilpa Bhartia (MRCP, FRCPath). Apart from these, more than 22 thousand cases of chemotherapy have also been done here under her Cable treatment.

The other super-speciality branch here is the Minimal access / Laparoscopic surgery which is headed by Eastern India's most experienced Advanced Laparoscopic and Bariatric Surgeon, Dr. V. K. Bhartia, whose forte is to permanently cure diabetes by metabolic surgery and who has several thousands of these surgeries, with almost 100% success rate, to his credit.

For us at Parkview, the journey has just begun... a long way to go !!!

Our Founder...

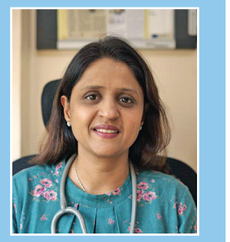
Dr. V. K. Bhartia
FRCS, FICS
Director - Bariatric & Metabolic Surgery

Eastern India's most experienced Advanced Laparoscopic and Bariatric Surgeon whose forte is to cure Diabetes permanently by Metabolic surgery.

Our Inspiration...

Dr. Shilpa Bhartia
MRCP, FRCPath (UK)
Consultant Haemato-Oncologist

An expert in her dedicated field, she's forever playing the pioneering role in creating awareness & in helping patients cope with the dreaded disease, not to mention the assurance that she provides in reducing the mental agony the disease puts on the families of these patients.



Our Mentor...

Dr. Abhishek Bhartia
MRCS (UK), EFIAGES, DIP. LAP. SURGERY (France)
HOD - General & Laparoscopic Surgery

One of the most renowned General & Laparoscopic surgeons in the city whose knowledge and determinion has given a new height and dimension to the hospital.

PARKVIEW TIMES

PARKVIEW SUPER SPECIALITY HOSPITAL

Dr. Shilpa Bhartia
MRCP, FRCPath (UK)

Case Study

A 54-year-old gentleman presented with 2 and 1/2 month history of lower back pain since May 2024. He is a known diabetic and hypertensive and has hypothyroidism for which he is under treatment.
He initially presented to the orthopaedic surgeon with the back pain and a right gluteal discomfort. He had normal bowel and bladder and no focal neuropathy. MRI of the spine was done which showed diffuse altered marrow signals in the lumbosacral spines and the visualised iliac bones with a small Para spinal soft tissue at L5 - S1. His initial blood reports showed altered albumin globulin ratio and hence serum protein electrophoresis was sent and a PET CT scan was done which showed small mildly FDG avid enhancing right paravertebral soft tissue lesion encroaching into the neural foramen.

Mild diffuse update was seen in the Bone Marrow and there was no detectable lymphadenopathy. His biochemistry work up showed a creatinine of 1.32 mg and the serum calcium of 9.62 mg, his haemoglobin was reduced to 11.7 g/dl with normal hematinics. The ESR was elevated to 113 and the total globulin was 4.9 gm. A comprehensive multiple Myeloma panel was done which showed an M spike of 41.5 g/L and immunofixation confirmed this as IGA Kappa.

Among CRAB symptoms he had kidney involvement, anaemia and bone pains and hence was suspected to have a multiple myeloma. Bone Marrow test was done which did not show plasma cells but a lymphoplasmacytic infiltrate. The Myeloma FISH panel was also normal. The bone marrow trephine showed mildly hyper cellular marrow with nodular and interstitial lymphoid infiltrate more suggestive of a low-grade B cell lymph proliferative disorder with a plasmocytic differentiation. Further immuno-histo-chemistry was done which confirmed CD 20 positivity which was significantly more than CD 138 and MUM 1. These cells were kappa chain restricted although the clinical parameters were more suggestive of multiple myeloma and specially the immuno fixation showed an IGA para protein further testing with MYD mutation was done, which confirmed positive favouring a diagnosis of IgA type Waldenstorms macroglobulinemia. As there was delay in confirmation in view of his symptoms, he was started on Myeloma-based therapy with Dara RVD protocol and received one injection of Denosumab. However, once the diagnosis of WM was confirmed, he was switched to bendamustine Rituximab protocol which he tolerated well. He is currently post third cycle of chemotherapy and an interim pet scan as planned prior to the next one. His Paraprotein is reduced to 2 gm/l and is asymptomatic.

This case highlights the importance of complete work up as the initial findings may reflect another diagnosis but a complete study including Molecular work up may change the initial diagnosis. This will result in better treatment and better patient outcomes. In this case we were able to avoid the steroids as it would worsen his diabetes and contribute to morbidity and infections.

Scan for Full Details

Dr. Sadajit Banerjee
MBBS, MD, MRCP (UK), MAMS (New Delhi)

Pancreatitis & Transamnitis in an Elderly Dengue Patient

Patient Profile:
- **Age/Sex:** 66-year-old male
- **Medical History:** Hypertension (managed with Telmisartan, Amlodipine and Chlorthiazide).
- **Presentation:**
  - Symptoms: Throbbing headache (7 days), fever (104°F), arthralgia, myalgia and crampy abdominal pain radiating to the right upper quadrant, with nausea and vomiting.
  - Examination: Drowsy, hypotensive (BP: 90/50 mmHg), tachycardic (HR: 110 bpm), tachypneic (RR: 26 rpm) and disseminated petechiae.

Initial Workup:
- Dengue NS1 borderline, malaria ruled out.
- Labs: Severe thrombocytopenia (23,000 cells/µL), elevated pancreatic enzymes (Lipase: 358 U/L, Amylase: 329 U/L), transaminitis (SGOT: 747 U/L, SGPT: 509 U/L) and hypoalbuminemia.
- Imaging:
  - **Ultrasound:** Enlarged hypoechoic pancreas, bilateral pleural effusion and hepatomegaly.
  - **CECT Abdomen:** Enlarged pancreas with irregular margins, confirming acute pancreatitis.

Diagnosis:
- Acute pancreatitis associated with dengue fever (confirmed by Dengue IgM antibodies).
- Dengue with warning signs (thrombocytopenia, petechiae, pleural effusion).

Management:
- **Supportive Care:**
  - IV fluids (normal saline) and antipyretics.
  - Temporary cessation of antihypertensive medications.
  - Nil by mouth (Day 1-5) with parenteral nutrition, transitioning to a low-fat diet once oral intake was reintroduced.
  - Ursodeoxycholic acid and pancreatic enzyme supplements during re-feeding.
- **Outcome:**
  - Fever subsided within two days; abdominal pain resolved by Day 1 of fasting.
  - Pancreatic enzymes normalized and the patient was discharged in stable condition.

Key Takeaways:

1. **Dengue-associated Pancreatitis:** Elevated pancreatic enzymes and imaging findings distinguish this from typical dengue-related gastrointestinal symptoms.
2. **No Antibiotics Required:** Blood cultures showed no growth; infection markers were normal.
3. **Relevance in Endemic Regions:** Acute pancreatitis should be considered in differential diagnoses for dengue patients with abdominal pain and enzyme elevation.

Scan for Full Details

Dr. Bodhisatwa Choudhuri
MBBS, MD (Med), MRCEM (UK), MRCP Acute Medicine, MEM, Dip Rheumatology (UK) Consultant, Critical Care & Rheumatology

Severe Rhinoviral ARDS in an Immunosuppressed Adult: First Report of a Case Associated with Tofacitinib

Introduction:
- Rhinovirus: Typically causes mild respiratory illnesses but rarely leads to acute respiratory distress syndrome (ARDS) in adults.
- Tofacitinib: A Janus kinase (JAK) inhibitor used for rheumatoid arthritis (RA), linked to increased infection risks but not previously associated with rhinoviral ARDS.

Case Summary:
- Patient: 55-year-old female with RA on long-term Tofacitinib and Methotrexate therapy.
- Symptoms: Fever, cough, shortness of breath and hypoxia.
- Diagnosis: Rapid respiratory decline with diffuse bilateral lung consolidations. COVID-19 ruled out; nasopharyngeal swab confirmed rhinovirus.
- Treatment:
  - Initiated with antibiotics, transitioned to high-dose intravenous corticosteroids after ARDS diagnosis.
  - Oxygen support with high-flow nasal oxygen and non-invasive ventilation.
  - Awake proning used to improve oxygenation.
- Outcome: Gradual improvement; discharged after 12 days. Complete recovery confirmed at 2-month follow-up.

Discussion:
- Rhinoviral ARDS is rare, particularly in adults, but immunosuppression (e.g., Tofacitinib) increases susceptibility.
- Diagnostic utility of early PCR testing to identify viral pathogens.
- Management: Supportive care with corticosteroids; no specific antiviral therapy for rhinovirus.
- Raises questions about the dual role of Tofacitinib:
  - Potential contributor to immune suppression and viral complications.
  - Therapeutic benefit in mitigating hyperinflammation (e.g., in COVID-19-related ARDS).

Conclusion:
This case highlights:
- The importance of considering viral causes in immunosuppressed patients with severe respiratory failure.
- The need for further research into the immunomodulatory effects of JAK inhibitors like Tofacitinib.
- Early recognition and supportive management as critical factors in improving outcomes.

Scan for Full Details

Dr. Abhijnan Maji
MD (Medicine), MRCP (Dublin), MRCP (Glasgow), CCEBDM

A RARE CASE OF ADRENAL HISTOPLASMOSIS - Case Study

A 50-year-old male patient with history of uncontrolled diabetes (HbA1C 11%) for the last 8 years and a known case of RCC with a history of Nephrectomy and chemotherapy 2 years back, presented with weight loss (10 kgs over the last 4 months) along with severe weakness and apathy.

On examination, his BP (Supine) was 100/60mm Hg and on standing 80/50mm Hg and he already had 3 previous consultations. He appeared to be hyperpigmented over the buccal mucosa. He was extremely weak in appearance & his reports showed a low Serum Cortisol level, high ACTH level with Serum Metanephrines within normal limits. CT Whole Abdomen revealed a right sided adrenal mass.

CT guided FNAC showed Methenamine Silver positive fungal stain consistent with Histoplasma capsulatum.