SISIR PARIPALAN

KKCTH NEWS MAGAZINE APRIL 2025

From the Medical Director's desk

Greetings from Kanchi Kamakoti CHILDS Trust Hospital! Welcome to this edition of our newsletter, where we bring you the latest updates, insights, and events that inspire and inform. This platform reflects our shared commitment to excellence, compassion, ethics and innovation showcasing achievements, milestones and the collective spirit that drives us forward. It highlights the dedication and passion of our team. As always, your support and feedback is invaluable in making this journey more enriching!

Dr.Janani Sankar, Medical Director, KKCTH

HEARTY CONGRATULATIONS TO OUR CEO !!

Our CEO, Mr. S.Rengarajan was awarded the " operational efficiency "CXO Champion award" by FICCI and CXO organisation.

PROUD MOMENT FOR KKCTH!!

Dr Usha Vishwanath, Director OBG,KKCTH has been awarded the "Life time achievement" award by Parivu Charitable trust

ACCOLADES IN PEDIATRIC CANCER CARE

At the Cancer institute Registry meeting, Dr. Arathi.S, Senior Consultant Pediatric hematooncology KKCTH received appreciation from the Health minister for our institute being a part of the Pediatric cancer registry of Chennai.
Happy to note that we were the second largest contributor of data of patient numbers and outcomes.

ACADEMIC EXCELLENCE!!

Dr. Nilofer,final year pediatric post graduate won the 1st place in the TYSA final quiz held at Ahmedabad.

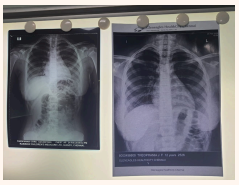
Dr.UmaThilak,Fellow,Emergency Medicine was awarded Gold medal for IAP PEM fellowships 2024

Dr.Kanmani, Fellow, Pediatric hematooncology presented on Autoimmune cytopenias and their association with Inborn errors of immunity at International conference on Inborn Errors of Immunity.

Congratulations to Dr.Siddharth Pandian,final year Pediatric Surgery post graduate for his Runner up prize in Laparoscopic suturing competition at recent PESICON at Kochi.

Congratulations to Dr Mangal, Fellow,Pediatric neurosurgery!- for winning the second prize for the Paper on Giant Cavernomas presented at AASNS 2025.

*The airway team of Kanchi Kamakoti Childs Trust Hospital has successfully managed very challenging case of a rare airway foreign body.*A 13 year old girl presented to the ER with alleged history of foreign body (LED light) stuck in the bronchus. The child was initially taken to a private hospital where foreign body removal was attempted, but could not be retrieved. She was taken to 2 other hospitals before reaching KKCTH. XRay was done which showed the foreign body stuck in right terminal bronchus. Dr.Thirunavukkarasu, Head of the department, Centre of Excellence in Pediatric airway surgery(***CEPAS***) with the support of Anaesthetists, headed by Dr.Ramesh, performed bronchoscopy and successfully removed the foreign body using telescopic bronchoscope, which was deeply seated in the right terminal bronchus. One end of the sharp edge had to cut and removed separately, skillfully the remaining bulb was removed without causing injury.



Xray before and after the procedure

Sharp airway foreign bodies are very tricky because it can make a rent in the airway and cause catastrophic complications.

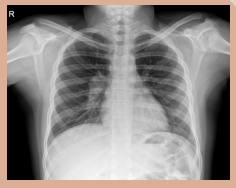
SUCCESS STORIES

Cerebral cavernous malformations (CCMS) are vascular lesions composed of dilated, thin-walled blood vessels. While common in adults, paediatric cases are rare, and giant CCMS are even more uncommon. These lesions may present with seizures, headaches, or neurological deficits, necessitating careful evaluation and individualized management. The management of giant CCMS in children poses unique challenges due to their size, location, and potential for significant morbidity.

Case report:Age:2 and 3 years. Presentation: seizures in both. MRI confirmed the diagnosis of giant CCMS. Both underwent surgical resection at our institute. Postoperative outcomes were assessed clinically and radiologically over a follow-up period of 3 months and 2 years. Complete resection was achieved in both cases with no significant complications. HPE confirmed the diagnosis. Both of them had improvement significantly and had no seizures. Follow-up imaging confirmed no recurrence or residual lesion. No new postoperative deficits were noted. The management of giant CCMS in paediatric patients requires a multidisciplinary approach and meticulous surgical planning. Complete microsurgical removal remains the mainstay of treatment. Though transient neurological deficits may be encountered, gross total resection leads to a favourable outcome for reduction of mass effect, as well as other effect, as well as other preventing further re-bleeds and achieving long-term seizure control. Early treatment may be preferred for most of them.

TRIVIA CORNER !

10 yr old boy. H/O road traffic accident (RTA). Chest X-ray and limb X-rays were done to look for fractures.
Below is the chest X-ray. What is the abnormality? What is the next investigation you would advise?



Dr.Kanimozhi.S, HOD, Dept of Radiology, KKCTH

Answer on Pg 4

PEDIATRIC DERMATOLOGY

" Pediatric Dermatology for the Discerning Clinician"
Organized by Pediatric Dermatology Foundation In collaboration with Pediatric Dermatology Unit, led by Dr.R.Ramkumar, Senior Consultant Dermatologist, Kanchi Kamakoti CHILD's Trust Hospital, Chennai Held on 5th January 2025 was well attended and with a lot of take home messages.

Clinical Pearls From the CME

• Counselling of patients or parents of atopic dermatitis is the key for successful management. Long sleeved cotton clothes, without metal embellishments is preferred.• Moisturizer to be applied on damp skin, soon after bath, bath time should be ideally less than 5 minutes.• Before starting Azathioprine, TPMT (PHENOTYPE) assay is to be specifically asked, as only genotype assay is available in most of the laboratories and TPMT is an inducible enzyme

• In AD, if lichenification is present, methotrexate should be preferred Cyclosporine can be given in acute erythroderma.• Though high IgE levels may not correlate with severity of atopic dermatitis, it could be a marker for association of external triggers like food allergens.• In AD patients, if folliculitis lesions are present in seborrheic areas like chest/back, it's prudent to initiate antifungal treatment for 10 days, prior initiating systemic steroids/immunosuppressive agents.• In patients of AD, urea based moisturiser less than 5% concentration can be used, not in higher concentrations.

• In AD with features of photoaggravation, azathioprine is a better drug.• Cleaning retroauricular areas daily during shower should be advised in all patients of AD.• Good response is noted in patients with morphea with endothelin receptor blocker agent, bosenton.• In case of using potent topical steroid under occlusion on the nails, always check for obliteration of angle between DIP and pulp of digits. Obliteration of angle may mimic steroid dactylitis.

• In Granulomatous rosacea presenting as periorificial dermatitis , combination of oral roxithromycin and topical metronidazole for 10 days gives good results. Maintenance can be done with topical tacrolimus for next 6 weeks.• While starting systemic steroids in children with a chronic course, it's important to plot their anthropometry on growth chart as stunting is very common and one of their reversible impactful adverse effect.• Alternate day oral prednisolone is better compared to OMP using betamethasone considering cumulative steroid equivalent dosage.

• In cases of childhood psoriasis, BMI is mandatory, in obese kids, BP should be monitored.• In Infantile psoriasis involvement of napkin area and scalp is more common.• Diaper dermatoses is an umbrella term including all the pathology involving the diaper area, whereas diaper dermatitis indicates the primary irritant contact dermatitis due to moisture, urine and feces and inflammatory response thereof.

• During first two weeks of life, if pustules are noted below the umbilical area, staphylococcal pyoderma should be considered in the diagnosis.• Distinguishing features of infantile seborrheic dermatitis is early onset and retroauricular involvement, whereas infantile psoriasis starts after few months of age (latte onset infancy) and umbilical region involvement is more commonly seen. Periumbilical lesions are suggestive of psoriasis in children.

OUT REACH ACTIVITIES

SCREENING CAMP AT SANKARA SCHOOL THIRUVANMAYUR

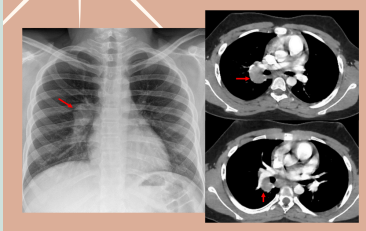
ANNUAL KKCTH CME - PERINATOLOGY
February 15th & 16th 2025

We conducted our annual CME on 15/02/25 and 16/02/25. This year's theme was in line with commencement of OBGYN and women's health services at KKCTH and chosen to be "Perinatology :bridging the gap between mother and new born". It was a much awaited collaboration between the OBGYN and NICU team to provide enlightenment on the updates in antenatal and new born care concerning common and rare conditions.

An interative CTG workshop was conducted by the Department of OBGYN on 15/02/25 where close to15 PG's and faculties from across the city attended. The workshop was received well by the delegates and the department was encouraged to conduct more such academic events in the future.

The main Annual CME was conducted on 16/02/25. True to its cadre, this annual CME was attended by close to 60 faculties from across the country. The topics for the program were handpicked by The OBGYN and NICU team and eminent faculties who were worthy of delivering a talk on these topics were chosen. We were honoured to have the legendary ***Dr. R. Shanmugasundaram, Senior Neonatologist*** presided as the Chief Guest for the event.The best outgoing students from each speciality in paediatrics from the previous years were bestowed and honoured with Gold medal from the Institution.Overall the academic feast was well appreciated and we received commending feedbacks from the delegates of the CME.

RADIOLOGY TRIVIA !ANSWER!



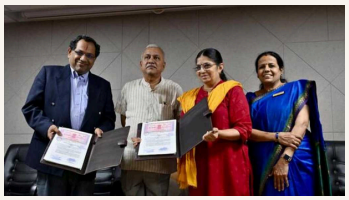
Findings-CXR: There is no bony injury.The abnormality seen on this radiograph (unrelated to the RTA) is an enlarged right hilum (arrow). There is no focal lung lesion.
Impression: Enlarged right hilum is suggestive of adenopathy. TB to be ruled out.
Next radiological investigation of choice is CT chest with contrast.The CT images show right hilar adenopathy (arrows), with low attenuation of nodes indicating necrosis.
Diagnosis: TB

Dr.Kanimozhi.S, HOD, Dept of Radiology, KKCTH

RECENT UPGRADATIONS

KKCTH UPGRADES INFRASTRUCTURE

REC Foundation, CSR arm of REC Limited signs agreement with hospital for equipment procurement
The REC Foundation, the CSR arm of Rural Electrification Corporation Limited (REC), has signed a memorandum of agreement with the Kanchi Kamakoti CHILDS Trust Hospital (KKCTH) to upgrade its facilities. Thara Ramesh, chief programme manager of REC, and S. Rengarajan, CEO of KKCTH signed the MoU.



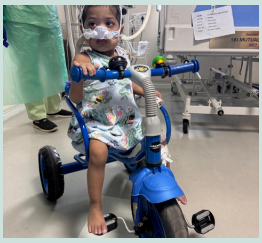
RECENT INNOVATIONS

PET THERAPY AND EARLY MOBILISATION IN PICU

DR.BALA RAMACHANDRAN, DR.K.RAVIKUMAR, DR.K.SUDEEP KUMAR

Kanchi Kamakoti CHILDS Trust Hospital introduces pet therapy in paediatric ICU A Shih Tzu dog named 'Dobby' helps children cope with prolonged hospitalisation through pet therapy.

The Paediatric Intensive Care Unit (PICU) at Kanchi Kamakoti CHILDS Trust Hospital has introduced pet therapy as an additional supportive measure for critically ill children. The initiative, **led by Dr.Bala Ramachandran, Head of Intensive Care & Emergency Medicine,** aims to help young patients cope with the psychological challenges of prolonged hospitalisation.



Imagine lying in an unfamiliar environment with physical restraints and unknown persons coming and poking you every now and then with unpleasant music being played all the time. This is what ICU does to the patients. Delirium and PTSD are now being more and more recognised in children. Early mobilisation is is a holistic approach involving bedside nurse, the patient (the child here), clinician and the family members. Passive mobilisation of all joints is also a part of early mobilisation programme. First, based on the clinical stability of the patient the clinician decides whether mobilisation can be done and how far to mobilise. We categorise into no mobilisation, mobilisation only in the bed, out of the bed and out of the room. There are very few clinical diseases like uncontrolled raised ICP, uncontrolled pulmonary hypertension, unstable hemodynamics, impending cardiac/ respiratory failure, unstable fracture/spine, etc which are contraindications for mobilisation. Then the mobility is done to the level decided having safety and monitoring things in place. Early mobilisation has been shown to decrease the incidence of delirium, improve family involvement and make them happy, and wasting can be reduced if accompanied with good nutrition. Physiotherapist is desirable but not mandatory for this.

Pediatric Rehabilitation unit at KKCTH

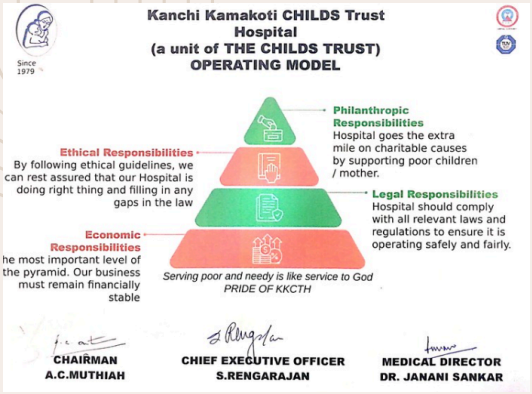
Pediatric rehabilitation unit at KKCTH in collaboration with NICE team has begun its services from APRIL 2024.**You can always reach out to us at +91 75388 42737 nicerehabilitationservice@gmail.com**

DIVYAAMRIT– NO MORE QUEUE FOR MEDICINES

in the current setting, having a relative member admitted in the hospital and running to pharmacy to get medicines is really not a pleasant experience. In addition to this, queue is an additional stress. Thanks to the efforts of the Medical Director and the CEO in improving the patient experience at KKCTH. We have started the process to deliver medicines at bedside through **Divyamrit Pharmacy** for in-patients at KKCTH. We are doing it in phases and we have implemented this in PICU and NICU. This is will go a long way in improving the experience of the patients admitted to KKCTH.

KKCTH BEST IN CLASS AWARD- IRR NGO -1!

Fitch, through its subsidiary IRR Advisory Services, provides an NGO grading system (IRR) that assesses an NGO's scalability, sustainability, and reliability. This grading is distinct from a credit rating, focusing on operational performance and governance rather than debt repayment. The IRR grading scale ranges from IRR1 (highest performance) to IRR7 (poorest performance).



TEAM KKCTH

Our Motto- To serve and grow!

You can always reach us out for obstetric and gynaecology emergencies on +9940408163 or 42001800