KHETARPAL HOSPITAL

Newsletter

VOL 01 NO. 03 NOVEMBER 2008

Metamorphosing our abilities by leaps and bounds

Prowling into the realm of professional ascendancy

UPCOMING EVENTS

5th Regional Obesity Summit & Support Group Meeting On 28 November 2008

'Management Of Cardiac Emergencies', 3 Day Seminar Cum Workshop For Doctors, Nurses & Paramedical StaffFrom 5 Dec 08 to 7 Dec 08

Subsidized Health Check-Up Camp For Senior Citizens in 2nd Week Of Dec 08

BLS And ACLS Workshop For Doctors, Nurses On 19,20,21 Dec 08

CME On Newer Modifications In Chemotherapy Regimens' On 26 Dec 08

Inaugration Of Dedicated IVF Department in January 2009

Khetarpal Hospital : where care is a culture

Letter From The Director's Desk

ESSENTIAL POWER OF MYRIAD FAITH

Faith is an overwhelming force that can give us the clout to accomplish the seemingly impossible. When we have faith, we have the understanding of entire, inner solace and serenity. We feel much centered in the present because we expect the future is going to be fine, no matter what. With faith we are not attached to a future outcome. With attachment there is always innate fear that we won't be alright unless things work out in a particular, desired way. When we are in fear about the future we can't be very present in the moment and we certainly don't experience inner tranquility.

Faith is also not the same thing as an imposed wish. Faith produces results. Wishing doesn't. Wishing keeps us focused on what we don't have. We feel a sense of deficiency rather than peace. Seek out people who have more faith than you or at least support your faith. Find a friend, a group or a spiritual teacher whose faith will spark your own. Read books about great persons, pilgrims or other stories of holy faith in action. Don't talk about your faith to people who have less than you unless you have enough to share.

If you put your hand in fire, do you believe it would burn? Of course you do, and it probably would. Yet if you were to attend a fire-walking event and spend an evening with a group of people convincing yourselves that the fire wouldn't hurt, it probably wouldn't. Many ordinary people have attended such events and successfully walked over impossibly hot coals with little or no blistering.

Don't worry about dispelling all doubts. We only need faith the size of a seed to move a mountain. Instead of trying to get rid of your doubts, focus instead on paying attention to your miniscule seed of faith. Let your imagination help you with this. Imagine how it would feel if you did have total faith. Imagine what it would feel like to be someone you know of whose faith is greater than yours. As you step out of yourself in this way and see through new eyes, you will experience a bigger faith. Even a moment of faith is a powerful force.

Now the question is, what to have faith in? If you would like to join the experiment in calling forth a quantum leap in the coming week, think of something your heart has been calling for, maybe something that seems a bit out of reach, even a little bit impossible. Be clear about what you want. Be specific. Put it in writing. Visualize it. Pray and ask God for what you want. Know you deserve it and that God wants you to be happy. Then let it go. Next comes the delicate part. Now you have to really let it go. It's important not to go back into doubt by wondering if it worked and when you'll see results. While there is creative power in being clear with God about what we want, there's even more power in placing our request and then having faith that God will deliver it in the best possible way, even if it winds up looking very different than we expected. Imagine that your quantum leap has already occurred, you just don't know where in time it has been placed. You know it's there, you know it's yours and you will receive it simply by going about your life with as much contentment and pleasure as possible.

Essentially, faith means expecting success and declaring everything that happens to be part of your success no matter what. Instead of looking for signs of your success, which is tinged with an attitude of prove-it-to-me doubt, we should be focused in finding signs of success.

Quantum leaps involve a big step into the unfamiliar. They take us out of our comfort zone, requiring us to embrace change quickly. As physicist Fred Alan Wolf, puts it, "Taking the quantum leap means taking a risk, going off into uncharted territory with no guide to follow. Such a venture is an uncertain affair at best. It also means risking something that no one else would dare risk." It's a risk well worth taking. See if you don't move mountains!

Over-the-Phone Weight Loss Counseling Works

Telephone counseling may be as effective as face-to-face counseling in helping people maintain weight loss, researchers report.

The University of Florida study included 234 obese women, ages 50 to 75, in underserved, rural areas of northern Florida.

All the women completed a six-month weight-loss program and lost an average of 22 pounds. They were then divided into three groups. Two groups received telephone or face-to-face weight control counseling, while the third group received printed health education materials.

The women were encouraged to use weight-control strategies and asked to record their food intake on at least two weekdays and one weekend day per week.

The food intake records showed that women in the two counseling groups were much more likely to adhere to the behavioral weight control program. Completion of the written self-monitoring records was the single best behavioral predictor of weight change.

After one year, the women in both counseling groups regained an average of 2.5 pounds, while those in the education control group regained an average of eight pounds, the study found.

"We found that the participants who received extended care were able to maintain their weight loss at higher levels than those participants who only received printed health education materials as a follow-up. The success of telephone counseling gives us a cost-effective alternative to face-to-face visits that is more convenient for rural residents who may need to travel long distances for care," lead researcher Michael G. Perri, a professor and interim dean at the university's College of Public Health and Health Professions, said in a university news release.

Perri and his colleagues also found that telephone counseling was less expensive than in-person counseling (an average of $192 vs. $397) and that telephone counseling offers other benefits to patients in rural communities.

"Because distance represents a major barrier to medical care in rural areas, the availability of a treatment modality that does not require time and costs for travel and attendance at clinic visits represents a potentially important approach to providing ongoing care to rural residents," Perri said.

The researchers said their study, published Monday in the journal *Archives of Internal Medicine*, is the first to demonstrate the effectiveness of telephone counseling for long-term weight management of people in rural areas.

Depression linked with abdominal obesity

The results of a 5-year study suggest that depression predicts an increase in abdominal obesity, which is not related to overall obesity.

The findings suggest that "there may be specific pathophysiological mechanisms that link depression with visceral (abdominal) fat accumulation. These results might also help explain why depression increases the risk of diabetes and cardiovascular disease," Nicole Vogelzangs, from VU University Medical Center, Amsterdam, and co-researchers conclude.

"This is the first large study to demonstrate that older persons with depressive symptoms" accumulate more visceral fat than their counterparts without depression, Vogelzangs told Reuters Health.

The findings, reported in the Archives of General Psychiatry, come from a study of 2,088 well-functioning adults, between 70 and 79 years of age, who were enrolled in the Health, Aging, and Body Composition Study.

Depression was defined as having a score on the Center for Epidemiological Studies Depression test of 16 or higher. At the beginning of the study and 5 years later, overall obesity was assessed in the patients using with body mass index (the ratio of height to weight) and the percentage of body fat.

Abdominal obesity was determined by waist circumference, sagittal diameter (the width of the body from front to back around the abdominal area) and the amount of internal abdominal fat using CT imaging, the report indicates.

After accounting for sociodemographic factors, other illnesses, and overall obesity, patients who had depression at the start of the study were more likely to have increases in both sagittal diameter and visceral fat.

Depression roughly doubled the odds of gaining visceral fat, Vogelzangs said. An association with waist circumference was also observed, but fell short of statistical significance.

As suggested, the increase was specific for visceral fat; no change in overall obesity was noted. This supports a biologic rather than dietary explanation for the findings, the authors note.

"A clinician treating depressed persons should be alert (to) the fact that persons with depressive symptoms are more prone to gain visceral fat, as this increases their risk for heart disease," Vogelzangs emphasized.

Further research, she added, is needed to better understand the relevant mechanisms at play.

SOURCE: Archives of General Psychiatry, December 2008

Men that look no further than their outsides, think health an appurtenance unto life, and quarrel with their constitutions for being sick; but I that have examined the parts of man, and know upon what tender filaments that fabric hangs, do wonder that we are not always so; and considering the thousand doors that lead to death, do thank my God that we can die but once. ~Thomas Browne

Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place. ~Susan Sontag, Illness as Metaphor, 1977

Laparoscopic Sleeve Gastrectomy At Khetarpal Hospital

The incidence of obesity is steadily rising, and it has been estimated that more than 30% of the Indian population will be obese by the year 2025 if the current trends continue. In recent years there has been renewed interest in the surgical treatment of morbid obesity in concomitance with the epidemic of obesity. Bariatric surgery proved effective in providing weight loss of larger magnituse, correction of comorbidities and excellent short-term and long-term outcomes, decreasing overall mortalities and providing a marked survival advantage. The Laparoscopic Sleeve Gastrectomy (LSG) has increased in popularity and in much in use at present amongst laparoscopic surgeons involved in bariatric surgery. As LSG proved to be effective in achieving considerable weight loss in the short-term, it has been proposed by many as a sole bariatric procedure.

Procedure

At Khetarpal Hospital, LSG involves a longitudinal resection of the stomach on the greater curvature from the antrum starting opposite of the nerve of latarjet upto the angle of His. The first step of the procedure is the division of the vascular supply of the greater curvature of the stomach, which is achieved with the section of gastro-colic and gastro-splenic ligaments close to the stomach. The greater curvature completely freed up to the left crus of the diaphragm to completely resect the gastric fundus that harbours the ghrelin secreting cells of the stomach.

The second step of the surgery involves the longitudinal gastrectomy that sleeves the stomach to reduce it to a narrow tube. A naso-gastric tube is used to obtain a precise calibration and to avoid stenosis of the performed gastric plasty. We practice starting the gastrectomy 2-4 cms proximal to the pylorus depending upon the specificity of the case, associated conditions and desired results. The rational for starting closer to the pylorus and using a small caliber bougie oto fashion the gastric tube is to increase the restrictive character of the procedure. Final volume of the gastric tube been adjusted to 60-100 ml usually, after taking in consideration associated factors. The staple line is then re-inforced with sutures to minimize the chances of staple line leak or bleeding.

Results

Till November 2008, we have performed 2 LSG procedures at Khetarpal Hospital. Mean initial BMI ranged from 37.5 kg/m2 to 55 kg/m2. Mean operation time was 50 minutes to 70 minutes. No post operative deaths were reported and a total of 3 complications were noted, all of these were considered as minor complications (2 dehydration, and 1 postoperative vomiting treated conservatively and spontaneously resolved) . No major complications viz. staple line leaks, gastroplasty stricture, pulmonary embolism, gastric ischemia, significant bleeding etc reported.

Promising Potential of LSG

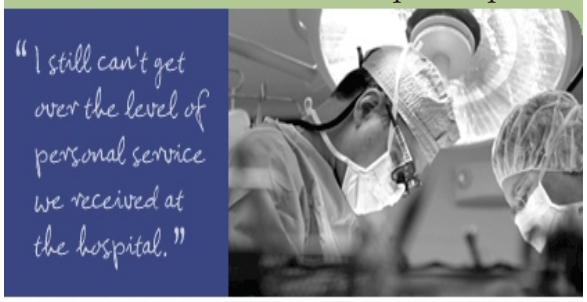
The note-worthy potential of LSG relies in the fact that the procedure is a straightforward operation that can be generally completed laparoscopically, even in the case of an extremely obese patient. It does not involve any digestive anastomosis, no mesenteric defects are created eliminating the risks of internal hernias, no foreign material is used as in the case of gastric banding, the whole digestive tract remains accessible to endosocpy, it is not associated with dumping syndrome, the risk of peptic ulcer is low and the absorption of nutrients, vitamins, minerals and drugs is not altered.

Discussion

When the LSG is done as a sole procedure in the very obese patient, the second procedure is generally required when the weight loss reaches a plateau, in the case of weight regain. The possible mechanisms that account for the limited weight loss or weight regain include a technical problem, such as an incomplete resection of the fundus of the stomach where the ghrelin producing cells are located. This may occur in patients with hiatal hernia, which is often associated with excessive body weight. Gastric dilatation has been evocated as being responsible for poor weight loss after LSG. An excessive large pouch may be the result of an excessively large pouch created at the initial operation due to a too large calibration tube, or because of inappropriate surgical technique such as missed posterior gastric folds. Excessive pressure against the pouch wall by large meals, repeated vomiting or distal obstruction may also account for pouch dilatation. The question whether the LSG may work as a sole bariatric procedure in the long term needs further evidences and evaluations. For this reason, we propose LSG as the first step of a staged approach in patients for whom laparoscopic gastric bypass seems too hazardous because of very high BMI (>50), and/or associated diseases whether related or not to obesity. The decision to do a LSG may also be made during surgery in the case of intraoperative findings, such as liver cirrhosis, adhesions, too thick mesenteria contraindicating a more complex procedure. Then the second step may be deferred until deemed necessary because of insufficient weight loss or weight regain.

It is very unfortunate that we have lost a lot of lives in recent times due to acts of terrorism, which has become the systematic weapon of a war that knows no borders or seldom has a face. Such incidences have increased in recent times and stroking stigmata over the canvas of life and humanity. We offer condolences to the deceased brave men on duty and to all the innocents who laid there lives. As global citizens, we should take the call precisely and toil to create a world free of terrorism and hatred.

Feedback Memoirs At Khetarpal Hospital



Minimal Access General Surgery . Laparoscopic Hernia Repair . Laparoscopic Assisted Vaginal Hysterectomy . Total Laparoscopic Hysterectomy . Laparoscopy For Gall Bladder Stone . Laparoscopic Removal Of Ovarian Cyst . Laparoscopic Bariatric Surgery . Diagnostic Laparoscopy . PCNL . URS . Extra Corporeal Shockwave Lithotripsy . Flexible Ureteroscopy . Laparoscopic Splenectomy . Laparoscopic Appendectomy . Minimally Invasive Procedure For Piles . Endoscopic Spine Surgery . Malignancy Surgeries . Specialities . Anesthesia and Pain Clinic . Andrology . Psychiatry and Deaddiction . Neurology . Gastroenterology . Endocrinology . General Medicine . Cardiology . Opthalmology . Pulmonology . Paediatrics . Maternal and Child Health .Nephrology . Immunology . Rheumatology .Oncology . Geriatrics . Dermatology and Venereal Diseases . Bone and Joint Relacement . Arthroscopy . Cardiothoracic and Vascular Surgery . Neurosurgery . Endocrine Surgery . ENT Surgery . Cosmetic and Aesthetic Surgery . Infertility Clinic .Sports Medicine. Dentistry. Stroke Clinic. Urogynaecology Surgery . Surgery For Incontinence . Metabolic Surgery For Diabetes and Morbid Obesity .

KHETARPAL HOSPITAL

Multi Disciplinary Super Specialty Hospital

Center Of Excellence for all Laparoscopic, Endoscopic and Bariatric surgeries.
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An emblem of excellence, an insignia of innovations, driven by ethical values infused with competency of highest standards ti impact dedicated patient care. Founded in 1992 with a futuristic vision to provide world class treatment and care to everyone, Khetarpal Hospital has embellished its stature continually by leaps and bounds by adapting and innovating newer technologies and adding dimensions to absolute patient care with inimitable outcomes. Here at whatever hour you come, you will see an amalgamated poise of hope, help, holistic care and supreme treatment modalities.

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