HOPE FOR THE PREMATURE

The curious case of the NICU team saving a 23 week preemie

A SECOND SHOT AT LIFE

A classic case of Living Donor Liver Transplant after Cirrhosis
Dear Readers,

We began the month by celebrating one of the most significant days for any hospital – Doctor’s Day. The day was celebrated in both the group hospitals i.e. New Delhi and Mumbai. We observed the day by honouring the doctors and showing appreciation to them through various activities and programs. On this occasion, we expressed our gratitude for their hard work, dedication and commitment towards their patients and acknowledged their contribution to the society.

The cover story for this month is an informative and moving piece on premature deliveries. It is one of the very few cases in India where a 23-week gestation baby was nursed to normalcy by a team of doctors at Nanavati Super Speciality Hospital, Mumbai. The team left no stone unturned for three critical months in the Neonatal ICU and ensured smooth transition of extremely small pre-term baby from the womb to the outside world.

Another equally inspirational story is covered about a Living Donor Liver Transplant at BLK Super Speciality Hospital of an international patient who was suffering with cirrhosis. There are other equally interesting stories about the successful treatment of Middle Cerebral Artery Aneurism, Total Knee Replacement in obese patients and another case that will remind us of the importance of routine health check-up.

We would like to express our gratitude to all the contributors for their stories that we bring to you month on month. The editorial team looks forward to receiving your opinions and feedback besides your contributed articles at editorial@blkhospital.com.

Stay healthy, stay happy!
A Second Shot at Life
A classic case of Living Donor Liver Transplant
after Cirrhosis

THE CASE
A 34-year-old man from Nauru was struggling with Cirrhosis since 2014, owing to a case of Hepatitis B related chronic liver disease with a significant history of alcohol intake. To begin with, he had multiple incidences of bloody vomitings where he had lost around a litre of blood. The patient had to undergo multiple episodes of endoscopy guided banding for oesophageal varices to control this life-threatening complications. The facility for Liver Transplant was not available in his country. Beginning early 2016, the patient started to develop abdominal swelling due to accumulation of fluid in his abdomen, despite being on diuretics for control of ascites, along with other dreaded and complicated symptoms of Cirrhosis. The only real curative option for his end stage liver disease was Liver Transplant.

THE PROCEDURE
In September of 2016, the patient came in contact with Dr. Sanjay Singh Negi, Director and Sr. Consultant, BLK Centre for HPB Surgery & Liver Transplant. The patient was made aware of the requirement of Liver Transplant and all his fears and concerns regarding the same were addressed. His cousin brother was found to be a suitable blood group compatible donor. However, the potential donor was overweight with a high body-mass index and was put on a strict weight loss regime. Post his weight-loss, complete donor evaluation was done and eventually, in October 2016, the patient underwent a Living Donor Liver Transplant.

THE RESULT
The surgery was smooth and uneventful. The donor recovered well and was discharged on post operative day 7. The recipient himself showed remarkable recovery and was shifted out of the ICU on day 5. The patient was gradually started on oral diet and then moved onto normal diet. He was discharged on post operative day 20. The patient spent few weeks in India under doctors’ supervision on outpatient basis until his immunosuppression was regularised. Within 2 months of landing in India, he was raring to fly back to Nauru looking forward to a new life, a second innings.

A Big Headache Taken Care of
Successful management of tricky Aneurysm with Endovascular Coiling

THE CASE
A 59-year-old man, non-hypertensive and non-diabetic, visited Nanavati Super Speciality Hospital with history of severe headache and vomiting accompanied by spells of unconsciousness. The patient was stabilised and was then sent for a brain CT scan. The CT scan revealed acute subarachnoid haemorrhage in the right sylvian fissure. A cerebral Digital Subtraction Angiography (DSA) was then performed, revealing a Middle Cerebral Artery (MCA) trifurcation aneurysm (swelling of the wall of an artery) with a proximal M1 stenosis. The patient was counselled for an emergent management of aneurysm with Endovascular Coiling.

The major challenges that had to be overcome during this procedure included:
1. Exclusion of the aneurysm, by Endovascular Coiling, and keeping the 3 major distal cortical branches arising from the M2-3 trifurcation patent. Any coil prolapse into these branches would have led to a major MCA stroke
2. A stent placement would be mandatory to achieve desired treatment, but it was not possible to load the patient with antiplatelets prior to the procedure as he had already suffered a Subarachnoid Haemorrhage (SAH) due to the rupture of aneurysm

The state-of-the-art Three Dimensional Rotational Angiography (3DRA) facility available in Nanavati Super Speciality Hospital reported exact anatomy of the lesion, and the exact relationship of the MCA branches with each other, and, with the neck of the aneurysm. It also helped in choosing the correct size of stent by estimating the length and diameter.

THE PROCEDURE
The patient was taken for Endovascular Coiling under general anaesthesia, via right femoral arterial approach. A balloon catheter was placed across the neck, and the first successful exclusion of the aneurysm was achieved with coils.

The patient was then loaded on to the table with dual antiplatelets (Ecosprin / Brillinta) via ryles tube, which was followed by a placement of the stent across the desired segment of the MCA branch so as to cover the neck and keep the branches patent. The final step was the balloon dilatation of the M1-M2 junction stenosis. The patient developed vasospasm on day 4 (post SAH sequelae). This was achieved with an intra-arterial nimodipine infusion.

THE RESULT
The patient recovered well and was discharged with modified Rankin Scale (mRS) 0. At 6 months follow-up, the patient was symptom free and a check-up of the cerebral angiogram revealed successful exclusion of aneurysm and normal patency of the M1 segment of MCA.
Hope for the Premature
The curious case of the NICU Team saving a 23 week preemie

Globally, approximately 10% of all pregnancies result in premature delivery even after the best of efforts taken by Obstetricians. The survival of extremely premature babies (those weighing less than 1 kg or born after less than 28 weeks of pregnancy) is even more challenging due to the incomplete development of body organs and functions.

Babies delivered at the gestational age of 23-24 weeks are considered to have borderline survival potential as their organs are extremely immature. Recently, the Neonatal team at Nanavati Super Speciality Hospital was presented with a challenging case of a neonate who was born prematurely after 23 weeks of pregnancy (i.e. less than 6 months of pregnancy). A team of highly dedicated Neonatal specialists and state-of-the-art technology are essential for the nurturing of such delicate lives. The NICU team at Nanavati is used to such challenges, having managed to discharge babies as small as 550 gms (26 weeks of gestation).

It is a herculean measure to manage babies as small as the palm of our hand. There are only a few case reports in our country where babies born before 24 weeks have survived. This unique case of 23-week old gestation baby who was discharged successfully signifies a new milestone and sets the bar even higher for the future.

THE CASE

Mrs. & Mr. Kujur are residents of Tarapur, Palghar in Maharashtra. The mother, Sunita, a 35-year-old woman with premature onset of labour after 23 weeks of pregnancy was referred to Nanavati. This was her second pregnancy with the previous child being 10 years old. She had received a single dose of IV steroid for maturity of the foetal lungs. The baby boy weighing 650 gms was delivered spontaneously in the emergency department. The baby cried after birth, but the breathing was laboured. He was intubated and put on a mechanical ventilator for breathing support wherein he received two doses of surfactant for lung maturity.

THE PROCEDURE

The baby boy responded to an initial management of surfactant therapy, ventilation and intravenous fluids. Total parenteral nutrition was administered through a central catheter. Maintaining metabolic milieu and preventing infections are the biggest challenges in micro-preemies. Early enteral nutrition with exclusive breast milk was administered through a feeding catheter which was gradually increased over the next few weeks. The parenteral nutrition was well tolerated.

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At the time of discharge, the baby weighed 2.7 kg and was on breastfeed. He maintained adequate oxygen saturation by breathing normal room air.

Discussion:
The challenging transition of extremely small preterm babies from the womb to the outside world can be conducted successfully with the combination of expertise and patience.

The care of such extremely young and delicate lives does not end at the time of discharge from NICU. They need to be regularly followed up by Neonatologists for their optimal growth and development.

There is always a very fine balance to be maintained in these babies, because of the high risk of Necrotising Enterocolitis (NEC) that can be precipitated because of enteral feeds. Over the next 30 days, feeds were gradually increased and breastfeeding was started by 35 weeks of gestational age. In addition to two doses of surfactant, the baby boy required a mechanical ventilator for 30 days due to premature lungs. Post ventilator, he required non-invasive CPAP for around 60 days. At the end of 3 months, the baby was breathing on his own with minimal intermittent oxygen requirement administered intra-nasally.

Regular ultrasonographic scans were performed satisfactorily on the baby. A presence of Retinopathy of Prematurity (ROP) was found during regular evaluation of eyes by Paediatric Retina specialist. The infant underwent regular investigations for sepsis and electrolyte levels. He received transfusions of packed red blood cells, iron supplements and erythropoietin for anaemia. For the prevention of Metabolic Bone Disease (MBD) of prematurity, calcium and vitamin D supplements were given to the baby. Inspite of multiple catheters, central lines, prolonged ventilation, the baby did not acquire any major hospital-acquired infection (HAI). This is an important measure of the success of infection prevention protocols, especially when dealing with a micro preemie.

THE RESULT

At the time of discharge, the baby weighed 2.7 kg and was on breastfeed. He maintained adequate oxygen saturation by breathing normal room air.

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Waiting For The Right Time
Not every abnormal heart needs to go under the knife

THE CASE
A 7-month-old boy from Zimbabwe was brought to BLK Super Speciality Hospital for Patent Ductus Arteriosus (PDA) closure. The patient’s history showed increased respiratory rate since birth. The child used to sleep day and night most of the times and was diagnosed with Down’s Syndrome. On clinical assessment, the child showed respiratory distress with subcostal and intercostal retractions. Saturation in upper limb was 78% and 55% in lower limb. First heart sound was normal and second heart sound was normally split with loud P2.

Echoangiography showed 2.8 mm PDA, shunting purely right to left with dilated RA and RV with severe RV dysfunction. As the patient had severe respiratory distress along with severe PAH and increased PA pressures, he was admitted in PICU for evaluation and management of high PA pressure.

THE PROCEDURE
Basic lab investigations for Pulmonary Hypertension were normal with mild increase in reticulocyte count. Peripheral blood smear was not showing evidence of haemolysis. Sickle cell test was negative. Initial VBG was showing high pCO2 (>70). He was kept on 2 litres of oxygen via nasal cannula. Within 1 hour of oxygen, his RV function improved significantly along with normal size of RV and PDA was shunting mainly left to right.

CT scan of chest showed consolidation of left lower lobe, lower 1/3rd of the right lung. As the child had basal consolidation and slept most of the times, Paediatric Pulmonology opinion was sought and sleep study was advised. Sleep study showed severe apnea even during awake phase, the frequency of which increased during sleep. Hence, diagnosis of severe obstructive apnea was made. Paediatric Neurology opinion was sought for assessment of neuromuscular status as the boy was a known case of Down’s Syndrome. CPK level was normal. MRI brain was advised but could not be possible as the patient was desaturating as soon as sedation was given.

THE RESULT
As the boy had severe OSA, BiPAP support with 3 litres of oxygen both during day and night was advised. PDA closure was not done due to high PA pressures. Patient was advised for a follow up visit after 6 months for assessing PA pressures and possible PDA closure at that time.

Back to Enjoying Life
A man with movement disorder effectively cured with Deep Brain Stimulation technology

Deep Brain Stimulation (DBS) is widely acknowledged as one of the most technically advanced and sophisticated procedures in Neurosurgery that has now come of age, and is effective for several neurological disorders. It involves stereotactic implantation of battery powered electrodes in different nuclei of the brain that controls human movement, Epilepsy and behaviour. It is globally used for advanced Parkinsons Disease, Essential or Familial Tremor, Dystonia and sometimes, for Epilepsy and Psychiatric diseases like Resistant Obsessive Compulsive Disorder and Depression.

THE CASE
A 35-year-old civil contractor visited Nanavati Super Speciality Hospital with complaints of abnormal movements in all limbs, progressive in nature for 9 months. The complaints kept increasing progressively and by the end of 9 months, the patient was wheelchair bound, unable to move around or conduct his daily routine. His social and interpersonal relationships saw a gradual decline, and he started suffering from Depression. The patient did not respond to Levodopa, Tetrabenazine & Trihexiphenidyl, or other antidepressants including Escitalopram. An MRI of the brain was normal and so were other investigations. Neurologists ruled out other secondary causes of Dystonia.

THE PROCEDURE
The procedure included Deep Brain Stimulation [DBS] with the help of a CRW–FN Stereotactic frame. A Pre-operative 3T MRI was done wherein fusion images which merge MRI and CT scan, were obtained with the help of a workstation, planning software [Framelink 5.0] and an intra-operative Micro Electrode recording [Lead point 4], so as to get signals from the Globus Pallidus Internus. Macro stimulation was then carried out to check for benefit and adverse effects. Once a satisfactory result was obtained, the location was then confirmed. DBS electrodes were placed one after the other on both sides repeating the same recording and macro stimulation process. An Implantable Pulse Generator [IPG battery] was then placed in the subcutaneous pouch and the electrode wires were tunnelled subcutaneously from cranium to chest and connected to the IPG. The patient showed a remarkable ‘Microlesion’ or stun effect due to the placement of the electrodes even without starting the battery. He experienced immediate post-operative relief in his painful distorting movements and posturing.

THE RESULT
A week later the patient was discharged and the programming was commenced on OPD basis. He showed results with programming which included parameters such as pulse width, frequency, voltage, current and impedance and was clinically well maintained on his adjusted programming parameters. He is now completely free from his Dystonia and has resumed his normal life. He has recommenced his prior occupation as a civil contractor. The patient can now drive on his own and even takes time out for his favourite sport – Cricket.

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Director & Senior Consultant
Dept. of Neurosurgery
Nanavati Super Speciality Hospital

Implanted electrodes, connecting wire and IPG Battery

CT scan coronal view - electrodes positioned in GPi nucleus

Dr. Gaurav Agrawal
Associate Consultant
Paediatric Cardiology
BLK Heart Centre
BLK Super Speciality Hospital, New Delhi

Pre-medical management:
1. Dilated RV with signs of severe PAH
2. PDA shunting right to left

After medical management: normal size of RV

THE RESULT
Waiting For The Right Time
Not every abnormal heart needs to go under the knife

Dr. Gaurav Agrawal
Associate Consultant
Paediatric Cardiology
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Feeling Light Again
Life transforming TKR surgeries for obese patients

The results of Knee Arthroplasty in grossly obese patients have varying degrees of success. Occasionally, patients with BMI of more than 40 are seen in Orthopaedics clinics with severe Osteoarthritis demanding early knee surgery. Their demand is often compelling and they would not heed to weight loss management prior to surgery.

Obese patients have to deal with high stress level activity and their knees fail early under heavy loading conditions. Such knees are more prone to develop complications as compared to that of a patient with BMI of 30 or less. Obese patients usually have to face gross deformities over the years. Relatively Hypoplastic, Osteoporotic bones are generally accompanied with many co-morbid conditions like Hypertension, Diabetes, Hypothyroidism, etc. Their pain scores are high and walking abilities are seriously affected. Many would shun the idea of getting Bariatric surgery done prior to knee surgery. The knee pain is so agonising that they want instant relief from the pain, hoping for improved quality of life.

Under such circumstances it becomes extremely challenging to perform a successful TKR on an obese patient owing to many disadvantages like increased incidences of prosthetic loosening, deep knee sepsis, non-healing wounds & discharges due to fat emulsification. There is also an increased technical complications in obese knee, like ligamentous laxity, inaccurate bone cuts, soft tissue damage, poor positioning of implant, etc. Due to such complexities TKR is seven times less successful in obese patients than normal ones with low BMI.

However, the relief of pain, renewed energy to walk and improved quality of life after Total Knee Replacement lures many patient to accept the procedure despite the odds. The concerted efforts of the team at BLK and advanced technology has enhanced the success rate of TKR even in obese patients, resulting in an active life for them with improved mobility and overall well-being.

Soft-tissue Sarcomas are Malignant Tumours and are usually named for the type of tissue in which they begin. The main types of Sarcoma that occur in the retroperitoneum are Liposarcoma (Cancer of the fatty tissues) and Leiomyosarcoma (Cancer of the involuntary muscle).

THE CASE
A 60 year old known diabetic and normotensive gentleman was brought to BLK Super Speciality Hospital with incidentally detected mass in abdomen (on ultrasound)during routine health check-up. He was asymptomatic and there was no associated history of pain in abdomen, distention, any urinary or abnormal bowel issues. There was no past history of loss of weight or appetite. Abdomen ultrasound showed increased perinephric fat, fat stranding with mild right hydronephrosis.

On examination, a vague mass of about 6 x 5 cm in size was visible with irregular borders palpable in the right loin and both kidneys, palpable with bi-manual palpation. No other palpable organomegaly or ascites was visible.

Further Investigations
A series of further investigations were conducted. CECT of the abdomen showed diffuse hypertrophy of bilateral perirenal fat entirely surrounding and embedding both kidneys, infiltrating soft tissue seen within the fat with septations and nodularity. A large mildly enhancing soft tissue lesion in pre and right paracaval region was seen with areas of necrosis within. MRI of the whole abdomen showed well circumscribed space occupying lesions in perinephric spaces. Another well-defined space occupying lesion was seen at the level of right renal hilum in paracaval location, measuring 6.1 x 8.8 x 9.8 cm. PET CT showed a large heterogeneously enhancing soft tissue mass of size 9.6 x 6.7 x 9.7 cm with SUV max 6.04 located in the right paravertebral region extending from level of right renal hilum to the L4 vertebra. The mass was causing anterior displacement and compression of right ureter.

DTPA scan showed small non obstructed kidneys with moderate to severely impaired cortical functions. After all relevant investigations and PAC, the patient underwent Exploratory Laparotomy and excision of two right perirenal mass.

Intra-op Findings
A well circumscribed, hard lesion of about 8 x 8 cm in right side retroperitoneum, medial to ureter, displacing the same laterally was observed. Another mass of 12 x 8 cm in size was located in the left perirenal fat. Final HPE report showed Benign Tumour consistent with Myxoid Lipoma.

Conclusion
Incidental detection by routine ultrasound leading to diagnosis of extensive Lipoma around patient’s kidney.
EVENTS AND ACTIVITIES

BLK Event Calendar

Continuing Medical Education Program - Acute Care Update was organised by BLK Super Speciality Hospital on 18 May 2017 at India Habitat Centre, New Delhi. It was a multi-speciality event with participation of Cardiac Sciences, Neurosciences, Respiratory Medicine, Interventional Radiology and Gastroenterology centres. The program covered 4 common acute emergencies: Acute Myocardial Infarction, Acute Stroke, Massive Haemoptysis and Massive GI Bleed. Each topic was discussed in an integrated manner, covering the overall approach and recent advances in these specialities. The session also included demonstration of actual cases handled at BLK by the respective speciality. More than 150 delegates from the medical fraternity participated in this event.

Dr. Neeraj Bhalla, Director & Sr. Consultant – Cardiology was the organising secretary of the event supported by other senior faculties of the hospital - Dr. J. C. Vij (Director and Head, BLK Centre for Digestive and Liver Disease), Dr. Chander Mohan (Director, Interventional Radiology), Dr. Sandeep Nayar (HOD, Respiratory Medicine, Allergy and Sleep Disorders), Dr. Vikas Gupta (Director and HOD, Neurosurgery), Dr. Atul Prasad (Director and HOD, Neurology), Dr. Amit Pendharkar (Consultant, Cardiology).

Employee Recognition

Nurse of the Month- Ms. Deepa (Staff Nurse); Employee of the Month- Ms. Moumita Adhikary Sarkar (Executive-Information Technology); Mr. Naresh Kapoor (Executive Director), GDA of the Month- Mr. Charanjeet Singh (Evershine Services); Contractual Worker of the Month- Ms. Shabana (Shine & Standard); Doctor of the Month- Dr. Sunny Kalra (Attending Consultant-Respiratory Medicine, Allergy & Sleep Disorder).

Nanavati & Mumbai Press Club presents Red Ink Awards

Nanavati Super Speciality Hospital partnered with the Mumbai Press Club’s Red Ink Awards for Excellence in Indian Journalism, 2017. Mr. Govind Tupe of ‘Sakal’ newspaper was presented with a special Red Ink award, ‘Mumbai’s Star Reporter’ by Mr. Devendra Fadnavis, Chief Minister of Maharashtra, and Mr. Abhay Soi, CMD, Radiant Life Care. Mr. Tupe was recognised and commemorated for his relentless role as a journalist and a RTI activist. He was instrumental in bringing all offices of cabinet ministers and ministers of state under the RTI umbrella of ‘Public Authorities’.

Nanavati extends medical support for IDBI Federal Life Insurance’s Marathon run

Nanavati Super Speciality Hospital supported the second edition of the IDBI Federal Life Insurance Mumbai 24-hour stadium run as a medical partner. The event was flagged off at the University Grounds, Marine Lines on Saturday, 10th June, 2017 and witnessed participation of more than 700 men and women. The marathon was divided into three categories: 12-hour solo run, 12-hour relay and the gruelling 24-hour run.
BLK & NANAVATI in NEWS

Make a career based on your skills: Counsellors to students

Protect yourself from monsoon maladies

MIRA ROAD WOMAN, A VICTIM OF FAULTY HIP IMPLANT, WALKS AFTER THREE YEARS

DNA

THE TIMES OF INDIA

Business Standard

THE PIONEER

THE HINDU

Mumbai Mirror

Medgate Today