medanta

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A Knowledge Sharing Initiative by Medanta

# Clip-Based Breakthrough in a 75-Year-Old with Severe MR, TR, and PAH

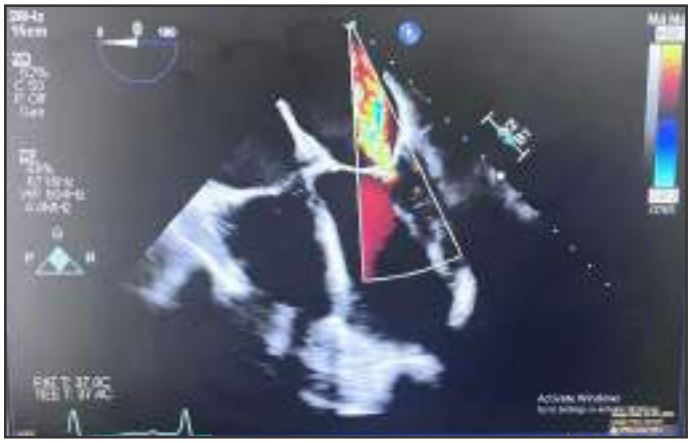
**Scan to watch Dr. Rajneesh Kapoor explain the case in detail.**

Mitral and tricuspid regurgitation (MR and TR) are common forms of valvular heart disease in elderly patients and often co-exist with other cardiac conditions such as pulmonary arterial hypertension (PAH) and reduced left ventricular ejection fraction (LVEF). When severe, this combination can result in recurrent heart failure, poor functional status, and hospitalisations. In patients at high surgical risk, clip-based percutaneous valve repair therapies, such as MitraClip and TriClip, have emerged as valuable alternatives, offering meaningful improvement in symptoms, quality of life, and clinical outcomes.

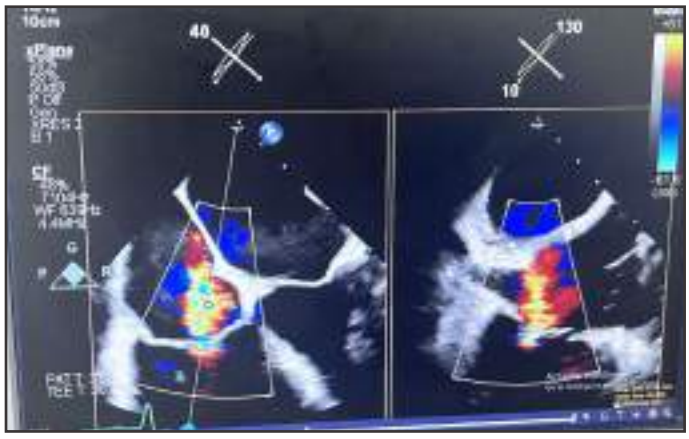
## Case Study

A 75-year-old frail female with a known history of anterior wall myocardial infarction (AWMI) and percutaneous coronary intervention (PCI) with stenting five years ago, presented to Medanta - Gurugram with worsening symptoms of heart failure. Though she had maintained a clinically stable condition for several years despite a reduced LVEF of approximately 25%, her condition had recently deteriorated. Over the last three months, she experienced four hospital admissions for decompensated heart failure, raising concerns of progressive structural heart disease.

At presentation, the patient exhibited clear signs of advanced heart failure, including fatigue, dyspnea, and fluid overload, despite adherence to optimal medical therapy. Given her deteriorating condition, a thorough cardiovascular examination and imaging were promptly undertaken. Echocardiography revealed a severely reduced left ventricular ejection fraction (LVEF) of less than 25%, along with significant mitral and tricuspid regurgitation. Pulmonary artery pressures were markedly elevated, consistent with secondary pulmonary arterial hypertension (PAH). These findings confirmed progressive valvular dysfunction and declining cardiac performance, despite prior revascularisation and medical management.



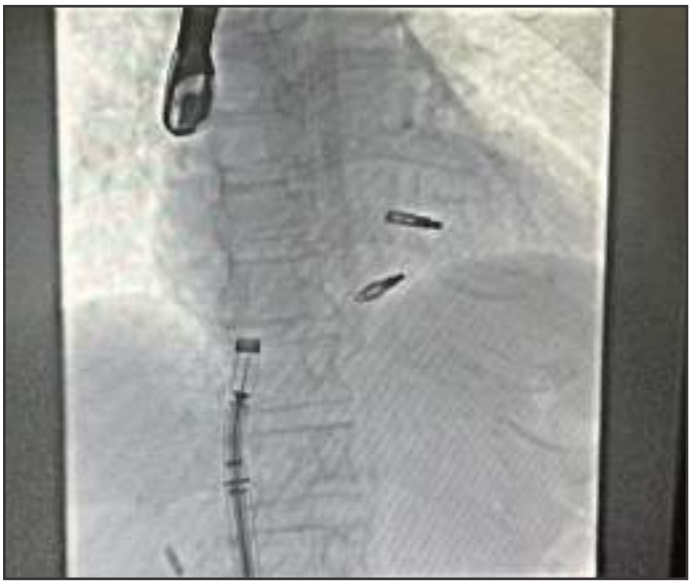
Pre-clip image showing severe MR



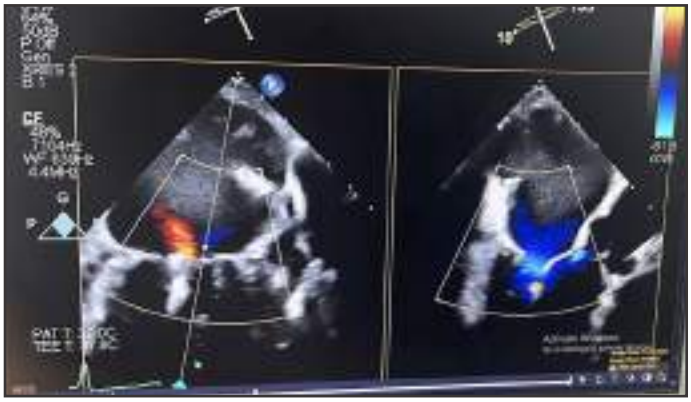
Pre-clip image showing severe TR

These findings, combined with the patient's frail body habitus and multiple recent admissions for heart failure, further underscored the urgency of definitive intervention.

Owing to her advanced age, significant comorbidities, and severely impaired ventricular function, she was considered a high-risk candidate for surgical valve repair or replacement. As a result, a transcatheter approach was chosen. A dual-valve clip procedure was planned with MitraClip for the mitral valve and TriClip for the tricuspid valve, both performed in a single sitting. The strategy was finalised following evaluation by a multidisciplinary heart team. The percutaneous procedure was completed successfully. Both the mitral and tricuspid regurgitations showed excellent reduction post-clip deployment. Notably, pulmonary artery pressures also demonstrated a significant intra-procedural improvement, reflecting favourable haemodynamic response.

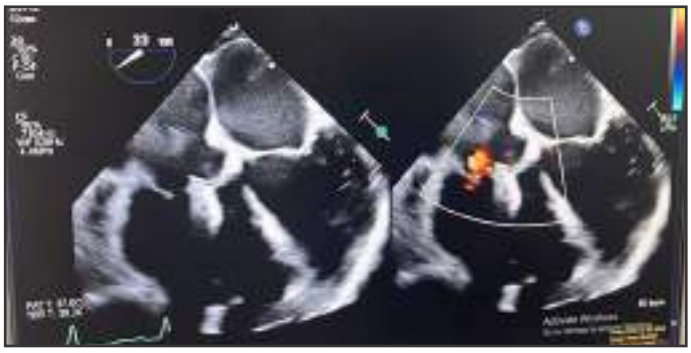


Fluoroscopy image of clip



Post-clip image showing mild MR

Post-procedure, the patient tolerated the intervention exceptionally well. There were no complications during the immediate post-operative period. She experienced symptomatic relief within the first 48 hours, and her clinical parameters improved steadily. The absence of arrhythmias, bleeding, or access site complications facilitated early mobilisation and recovery.



Post-clip image showing mild TR

The patient was discharged on post-procedure day 4 after an uneventful recovery. She was stable at the time of discharge, with improved respiratory function and physical capacity, and was advised regular follow-up with cardiology and heart failure teams.

## Conclusion

This case highlights the clinical value of clip-based valve repair in elderly patients with complex, high-risk structural heart disease. The patient presented with a challenging profile:severe MR and TR, PAH, severely reduced LVEF, and advanced age with frailty, all of which significantly increased surgical risk. Traditional surgical options would have posed substantial morbidity and mortality risk.

The successful outcome of the combined MitraClip and TriClip procedure underscores the importance of a multidisciplinary heart team approach in evaluating and managing such patients. The timely application of minimally invasive structural interventions led to early discharge, reduced risk of further decompensation, and improved quality of life.

With growing clinical evidence, clip-based therapies are increasingly being recognised as definitive solutions-not just alternatives-for patients with advanced valvular heart disease who are not ideal surgical candidates. This case is a testament to how targeted intervention, patient selection, and precision-based therapy can together deliver life-altering outcomes, even in the most vulnerable population.

**Dr. Rajneesh Kapoor**

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## Medanta@Work

# Primary Intrarenal Teratoma in an Infant Masquerading as Multicystic Dysplastic Kidney

Primary intrarenal teratomas are incredibly rare tumours, with only about 20 cases reported globally. The sacrococcygeal region and the gonads are the most common sites of origin. Teratomas contain identifiable mature and immature cells or tissues derived from one or more of the three primordial germ layers.

In infancy, common flank masses include hydronephrosis, Wilms' tumour, cystic kidney diseases, and retroperitoneal malignancies such as neuroblastomas. Diagnosing a renal teratoma is challenging due to its rarity, the subtlety of its early symptoms, and its ability to mimic other tumours by containing tissues from multiple cell lines.

## Case Study

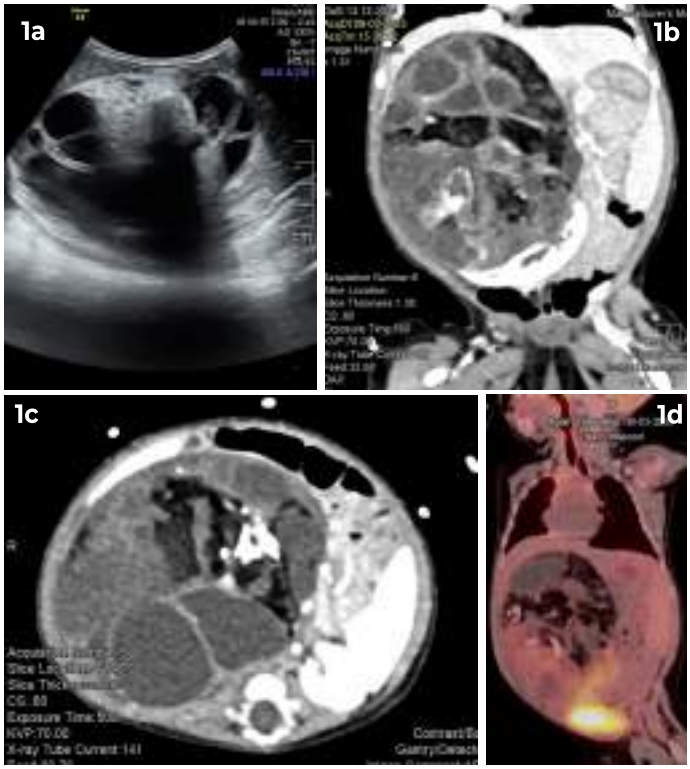
A 2-month-old female infant, with no anomalies detected on antenatal scans, presented with sudden-onset, rapidly progressing swelling in the right flank, poor feeding, and vomiting. She was referred to Medanta - Lucknow as a suspected case of multicystic dysplastic kidney (MCDK) based on ultrasonography at a local facility.

At presentation to our OPD, the mass had grown significantly, occasionally causing respiratory difficulty due to its size, along with reduced appetite. Despite this, the infant was alert and playful. On examination, a solid mass was palpable, extending from the inferior liver margin to the pelvic brim, crossing the midline medially.

Although initially presumed benign, the mass appeared more concerning on clinical evaluation. Infantile malignancies like neuroblastoma can present similarly and progress rapidly, necessitating urgent and accurate diagnosis.

A series of investigations followed: abdominal ultrasonography, contrast-enhanced CT (CECT KUB), 18F-FDG PET CT, and USG-guided biopsy with immunohistochemistry (IHC). Tumour markers (AFP, beta-HCG, LDH) and 24-hour urinary catecholamines were also assessed.

Imaging revealed a markedly enlarged right kidney measuring 11.8 × 7.3 cm, compressing the right lobe of the liver, extending medially to the midline and inferiorly to the iliac fossa. USG suggested MCDK with multiple non-communicating cortical cysts and loss of renal architecture.




1a: USG imaging of mass showing multiple non communicating cysts. 1b,1c: CECT KUB showing large encapsulated right renal mass with multiple cystic spaces and nodular calcification. Functioning renal parenchyma pushed down. 1d: PET CT imaging ruling out metastasis

CECT showed a well-encapsulated, oval, heterogeneous right renal mass (9.0 × 8.5 × 11 cm), with cystic areas, coarse calcifications, and macroscopic fat. Residual kidney tissue was displaced to the right iliac fossa. There was notable mass effect with displacement of bowel loops, scalloping of the liver, and compression or involvement of the aorta and IVC.

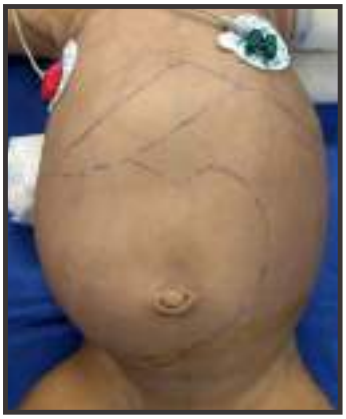
USG-guided biopsy of the solid areas revealed small undifferentiated blastemal cells in cords and nests, without significant anaplasia or atypical mitoses. WT1 and vimentin were patchily positive, suggesting a possible triphasic Wilms' tumour (favourable histology).

PET-CT showed faint metabolic activity in the mass, with no other areas of uptake. AFP was elevated at 1,755 ng/ml, while beta-HCG and LDH were within normal limits.

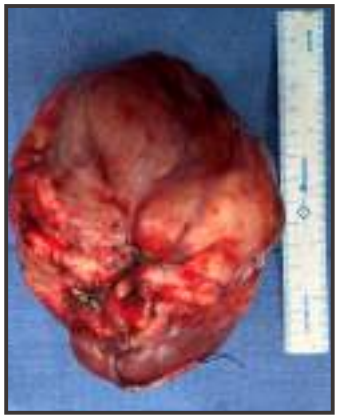
Following preoperative optimisation and with the cardiothoracic and vascular surgery team on standby, a high-risk radical right nephroureterectomy with lymph

node sampling was performed via a right transverse supraumbilical incision. A large, encapsulated mass was identified, displacing the bowel and adherent to the liver. Three major feeding vessels arose from the renal pedicle. The residual kidney was displaced to the iliac fossa.

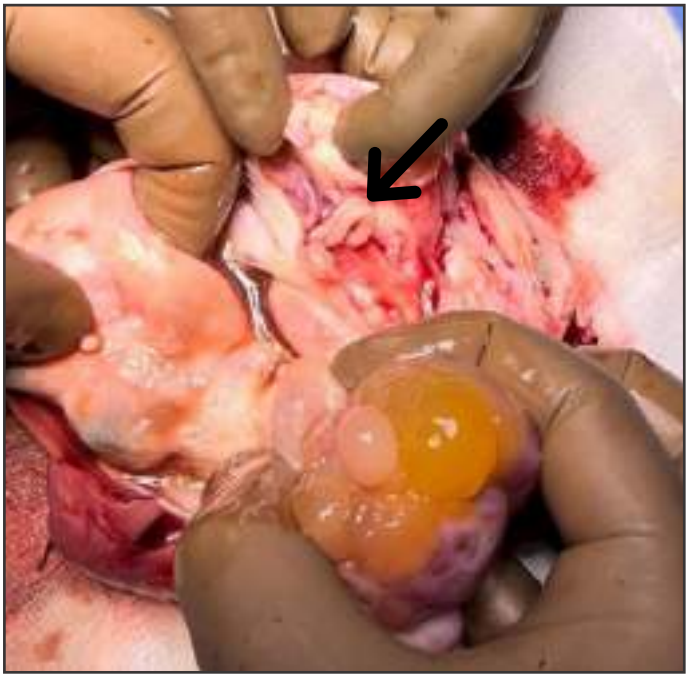
No lymphadenopathy or tumour thrombus was noted, and the IVC was freed from compression. The tumour was excised without spillage.



Preoperative surface marking of mass

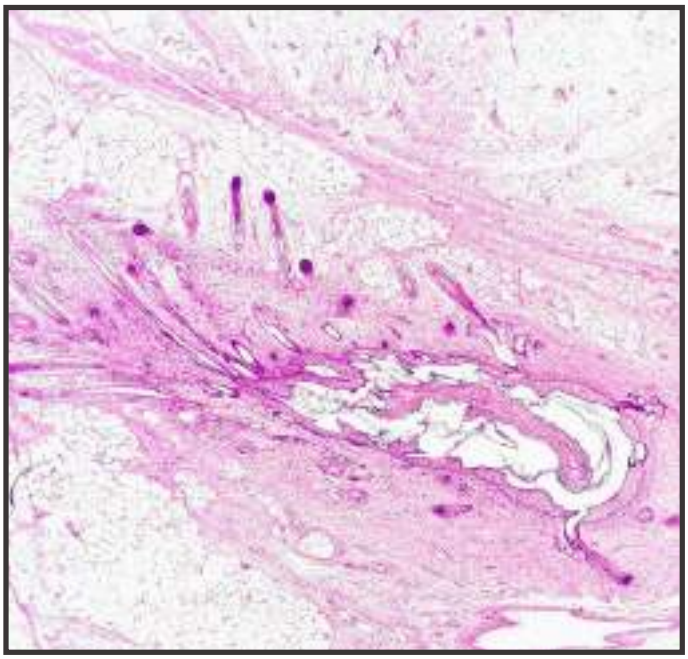


Gross specimen

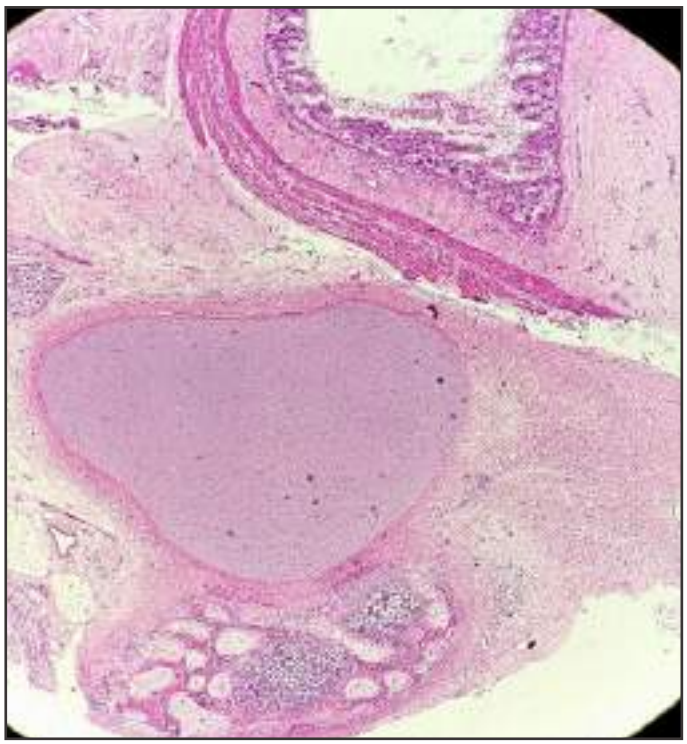


Specimen cut open revealing lanugo hair (left inferior), bowel with mesentery (arrow) and cystic areas

Blood loss was approximately 250 ml. The mass weighed 490 grams. Grossly, the specimen revealed structures from all germ layers, including lanugo hair, intestine with lumen, cartilage, bone, and Wharton's jelly. Postoperatively, the infant developed a chyle leak, managed conservatively with a low-fat diet, medium-chain triglycerides, and octreotide. The abdominal drain was removed on day 5, and the child was discharged on day 7.



Cyst with squamous lining and hair follicles. Surrounding adipose tissue seen, H&E x40



Intestinal wall, cartilage and bone , H&E x40

Histopathology confirmed a teratoma with mature tissues (skin with hair follicles, bowel, respiratory epithelium, glial tissue, bone, cartilage, adrenal tissue, and more) along with immature neuroepithelial elements. Immature renal tissue composed of blastemal cells and tubules was also noted.

IHC showed WT1 positivity in blastemal and tubular cells, and negativity for synaptophysin. Focal yolk sac elements were confirmed by AFP immunostaining. The final diagnosis was intrarenal immature fetiform teratoma, Grade III, with focal yolk sac and nephroblastoma-like elements. No anaplasia, necrosis, rhabdoid or sarcomatoid features were seen. Margins, sampled lymph nodes, and peritoneal fluid were tumour-free.

The child has now been under follow-up for four months. AFP levels normalised by two months post-surgery, and USG abdomen remains normal. Chemotherapy has been kept as a backup, to be initiated only in case of recurrence.

## Discussion

Teratomas can imitate a wide range of conditions due to the presence of tissues from all germ layers. In this case, the fluid-filled spaces mimicked multicystic dysplastic kidney. With only around 20 reported renal teratomas globally, diagnosis requires high clinical suspicion.

To classify a lesion as a primary renal teratoma, two criteria must be met:

1. The tumour must originate entirely within the kidney.

2. It must show evidence of heterotopic organ formation.

Grading of immature teratomas is based on the number of low-power fields showing neuroepithelium. Grade III is defined as more than three fields with immature elements.

In this case, the clinical challenge lay in determining whether the mass was benign or malignant, and whether it was best treated surgically or with chemotherapy. Biopsy results can vary depending on site of sampling, and the decision must be based on a combination of histology, imaging, and clinical behaviour.

In infants, large masses can displace major vessels, making dissection and blood loss difficult to manage. Paediatric anaesthesia, intraoperative support (including CTVS backup), and meticulous dissection were key to the successful outcome.

As treatment guidelines for such rare tumours are not well defined, a conservative approach is often followed when histology does not show aggressive features. Regular monitoring with tumour markers and imaging is essential.

## Conclusion

Although rare, renal teratomas should be considered in the differential diagnosis of cystic renal lesions. Differentiating them from Wilms' tumour is essential to avoid unnecessary chemotherapy. Complete surgical excision remains the mainstay of treatment, with close follow-up and chemotherapy reserved for recurrence.

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# A Massive Uterine Angioleiomyoma Masquerading as an Ovarian Malignancy

## A Diagnostic Dilemma

Scan to watch Dr. Shweta Rai and Dr. Mala Sinha explain the case in detail.

### Introduction

Leiomyoma of the uterus is the most common tumour of the female pelvis, affecting 50–60% of women and increasing to 70% by the age of 50.

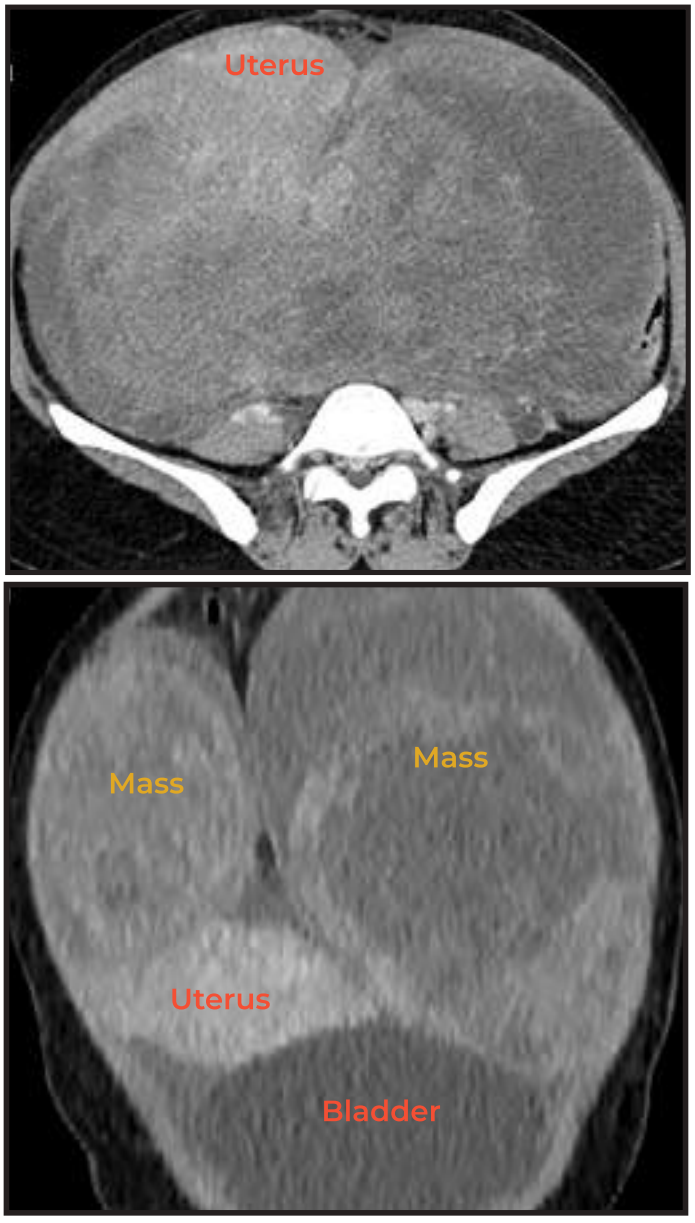
Angioleiomyoma (AL), also known as vascular leiomyoma, is a rare variant of leiomyoma originating from smooth muscle cells and containing thick-walled vessels. It usually occurs in the subcutaneous tissue, most commonly in the lower extremities. The uterus is an extremely rare site for angioleiomyoma. Literature reveals that only 15 cases have been described in the uterine corpus. It typically presents in middle-aged women with menorrhagia, abdominal pain, or an abdominal mass. Because of its vascular nature, it may undergo spontaneous rupture and pose a life-threatening emergency.

Typical appearances of leiomyoma are easily recognised on imaging; however, atypical features due to degenerative changes can lead to a diagnostic dilemma. Here, we report an unusual case of a large, cystic, degenerated uterine angioleiomyoma mimicking a malignant ovarian tumour.

### Case Study

A 38-year-old P2L2 woman presented to the OPD of Medanta - Patna with complaints of an abdominal mass for 1 year and difficulty voiding for the past 1 month. She had a normal menstrual cycle without dysmenorrhea, no medical comorbidities, and no family history of malignancy. She was of average build, with moderate pallor and no lymphadenopathy. All blood investigations, including tumour markers, were within normal limits, except for haemoglobin, which was slightly low (8.9 gm%).

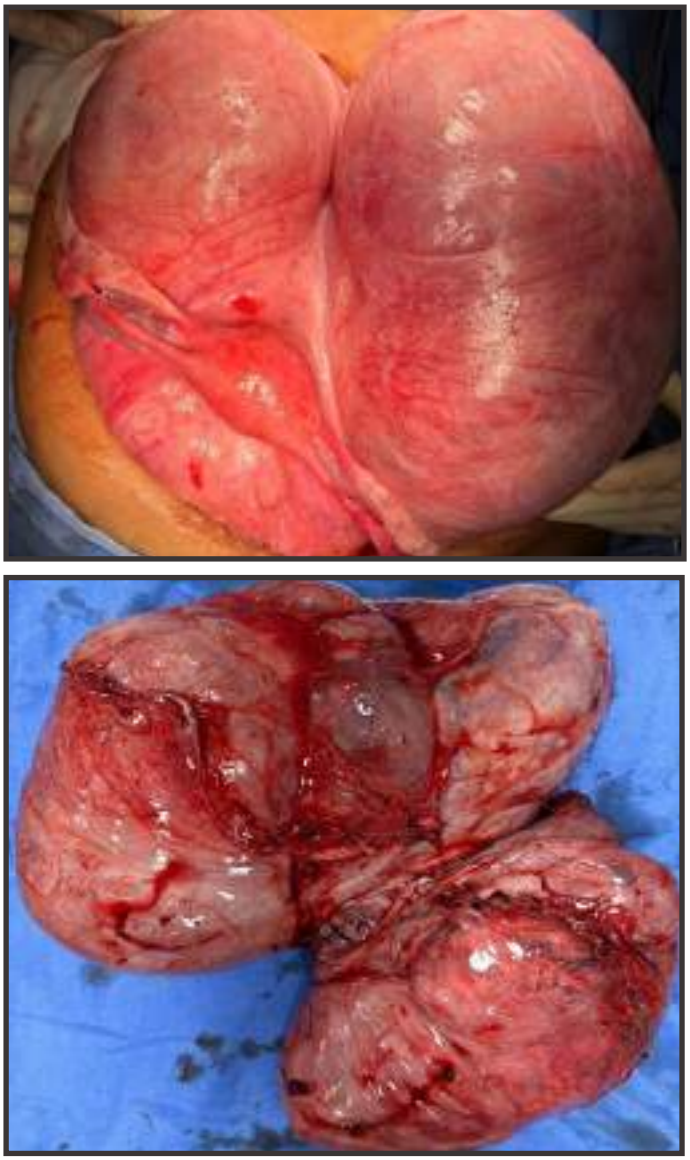
On clinical examination, an abdominopelvic mass equivalent to 32–34 weeks of gestation was noted. The mass was predominantly cystic, non-tender, and had restricted mobility. Transabdominal sonography (TAS) revealed a normal-sized uterus with an endometrial thickness of ~6 mm and a large ~14 cm abdominopelvic mass, predominantly solid with internal cystic areas and mild vascularity on colour Doppler. Bilateral ovaries were not visualised separately from the lesion. Subsequent contrast-enhanced CT (CECT) showed a large solid-cystic, well-defined lobulated heterogeneous mass ~32.8 × 28.5 × 17.4 cm with marked internal vascularity. No calcification or fat component was seen. Bilateral ovaries could not be delineated separately. There was no ascites or loco-regional lymphadenopathy. Findings suggested an ovarian neoplasm.




CT images showing large abdominopelvic mass displacing uterus and bladder, mimicking ovarian malignancy

## Intraoperative Findings

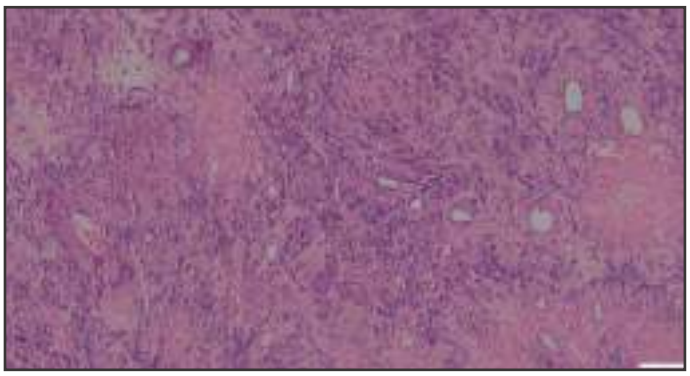
Following preoperative workup, the patient underwent exploratory laparotomy with excision of the mass and hysterectomy, based on a preoperative diagnosis of ovarian tumour. Intraoperatively, a large bilobed cystic mass (~30 × 30 cm and 25 × 30 cm) was noted arising from the posterior uterine wall. The sigmoid colon was draped over the mass with peritoneal adhesions, and the right ureter was densely adherent to the mass, with upstream hydronephrosis. Bilateral fallopian tubes and ovaries were normal.



Intraoperative view and excised specimen of a massive uterine fibroid

Excision of the abdominopelvic mass along with hysterectomy and bilateral salpingectomy was performed. The specimen was sent for frozen section, which reported a spindle cell neoplasm of myomatous origin. The mass weighed 7.8 kg. On gross examination, the cut surface showed a predominantly solid tumour with scattered cysts containing mucinous to myxoid material.

Final histopathology confirmed vascular leiomyoma with 1–2 mitoses per high-power field (HPF), and no nuclear atypia or necrosis.



Microscopic image showing interlacing fascicles of spindle cells with numerous interspersed vascular channels

The postoperative course was uneventful, and the patient was discharged in a stable condition. Six months post-surgery, she continues to do well.

## Discussion

Uterine angioleiomyoma, a rare benign tumour, originates from mesenchymal tissue and is composed of smooth muscle cells and thick-walled vessels. It accounts for only 0.34% –0.40% of all uterine leiomyomas.

Patients typically present with severe dysmenorrhea, abdominal pain or discomfort, menorrhagia, abdominal mass, and anaemia. Additional findings reported include consumptive coagulopathy, spontaneous rupture with intra-abdominal bleeding, pseudo-Meigs syndrome, and raised CA-125 levels. These tumours usually range from 4 to 30 cm, although only a few reach sizes greater than 20 cm.

Ultrasound (transabdominal or transvaginal) is the primary and most effective modality for diagnosing leiomyomas. However, degenerative changes may result in a heterogeneous appearance, leading to diagnostic challenges.

Typically, leiomyomas on CT appear as intermediate signal intensity on T1 and low signal intensity on T2-weighted images. Myxoid degeneration or necrosis can present as high signal intensity on T2-weighted images. Leiomyomas with cystic degeneration and oedema may form cystic spaces. The “bridging vessel sign,” where vessels bridge the mass and myometrial tissue, helps identify the uterine origin.

CT is not the primary modality for diagnosing leiomyoma, but incidental findings may be noted. A key diagnostic challenge with large leiomyomas is identifying the origin and visualising the adnexa. The "interface vessel sign" on colour Doppler or MRI can help differentiate subserosal fibroids from adnexal masses, uterine origin is indicated by tortuous vessels at the interface with the uterus.

Large leiomyomas with cystic degeneration can mimic primary ovarian malignancies. Similar cases have been reported by Low et al. and Akkour et al., where degenerated leiomyomas appeared radiologically as aggressive ovarian tumours.

## Conclusion

While leiomyomas typically have characteristic ultrasound appearances, degenerative changes can lead to variable and atypical imaging findings, posing diagnostic challenges. A strong clinical and radiologic correlation, along with awareness of variant imaging features, can help differentiate degenerating fibroids from more aggressive lesions. Thorough clinicopathological evaluation is crucial for accurate diagnosis and appropriate management, avoiding overtreatment of benign lesions.

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**TechByte**

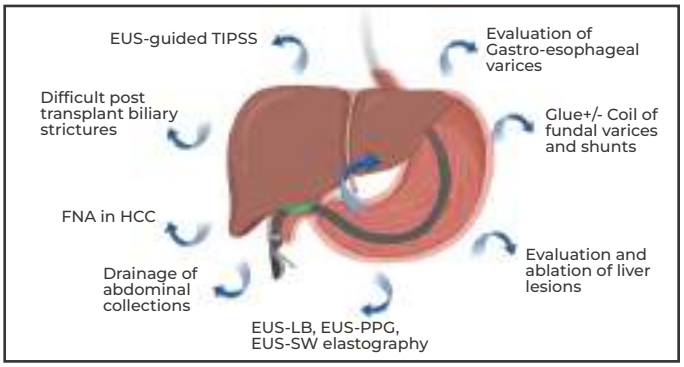
# Endo-hepatology

## A Branch in Evolution

**Scan to watch Dr. Narendra Singh Choudhary explain the case in detail.**

Endo-hepatology has gained increasing attention in recent years within the field of liver disease management. It harnesses the power of endoscopic ultrasound (EUS), a technology that combines endoscopy (for visualising the gut lumen) with ultrasound (via a probe attached to the endoscope). This enables high-resolution imaging of organs located close to the gastrointestinal tract, including the liver, pancreas, common bile duct, and gallbladder.

Below given image reviews the evolving scope of Endo-hepatology.




Scope of Endo-hepatology

What sets EUS apart is its ability to offer multiple diagnostic and therapeutic interventions within a single session, making it an efficient, minimally invasive tool in hepatology. The table ahead outlines the wide range of procedures that can be performed through EUS in liver disease care.

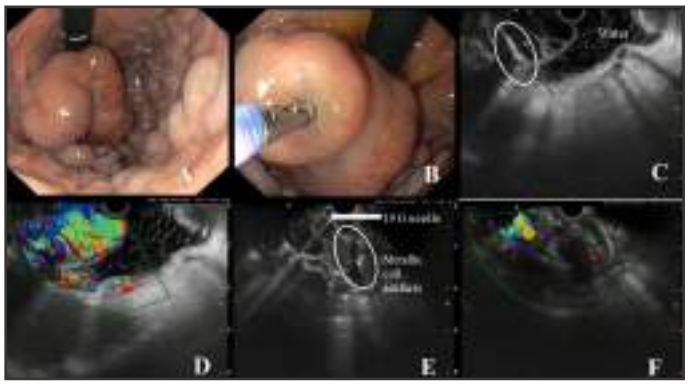
Among the most widely studied techniques are **EUS-guided coil and glue therapy** for gastric varices and **EUS-guided liver biopsy**.

Traditional endoscopic glue therapy carries the risk of embolisation. In contrast, the EUS-guided method begins with placement of slightly oversized coils into the varix, followed by glue injection. The coils trap the glue within

the varix, significantly reducing the risk of embolisation and improving variceal obliteration.

| EUS-guided Procedures in Endo-hepatology | |
|---|---|
| **Category** | **Procedures** |
| Diagnostic | Liver parenchyma evaluation with shear wave elastography (EUS-SWE); Detection of small metastases not visible on conventional imaging |
| Tissue Diagnosis | EUS-guided liver biopsy (EUS-LB); Fine needle aspiration (FNA) from lymph nodes, liver lesions, or portal vein thrombus in doubtful cases; Aspiration of post-transplant collections |
| Variceal Bleeding | EUS-guided obliteration of gastric or ectopic varices using glue, coils, or a combination of both |
| Recurrent Encephalopathy | Transgastric shunt obliteration (ETSO) |
| Emerging and Future Applications | Portal pressure measurement (EUS-PPG), tumour ablation, portal venous sampling, TIPS creation (in porcine models) |

Below given image illustrates a cirrhotic patient who experienced bleeding despite previous endoscopic glue therapy. EUS-guided treatment was successful even in the presence of clots in the stomach which typically hinder visibility for standard endoscopy. EUS can also be used for ectopic varices (e.g. duodenal, rectal), which are difficult to treat via conventional approaches.

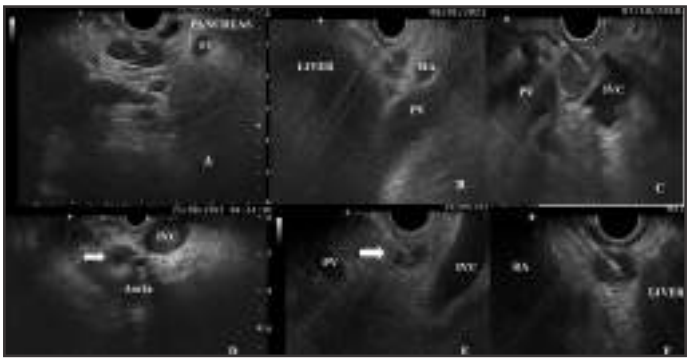



UGIE view showing a large fundal varix (A), which is soft to touch (B), EUS image showing artifacts of previous glue (in circle) and a large patent gastric varix (left upper quadrant), flow Doppler shows patent varix (D), coil being placed (sharp metallic artifacts) (E), post procedure Doppler showing absence of blood flow (F)

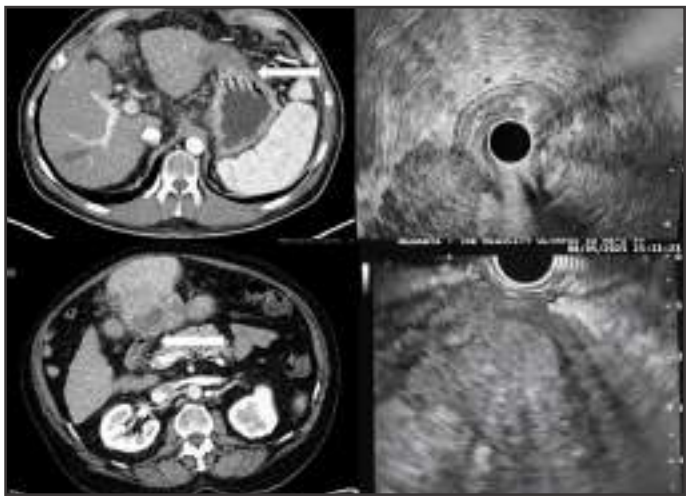
In patients with recurrent hepatic encephalopathy and relatively preserved liver function (Child-Pugh Class A or B), transgastric shunt obliteration via EUS provides a cost-effective, single-session alternative to interventional radiology (IR)-guided techniques such as BRTO.

While EUS-guided liver biopsy is slightly more expensive than the percutaneous approach, it is less painful, carries a comparable risk of complications, and can be conveniently done during a planned EUS for another indication - for instance, cholestasis work-up without clear biliary obstruction, or when lymph node aspiration or variceal therapy is planned.

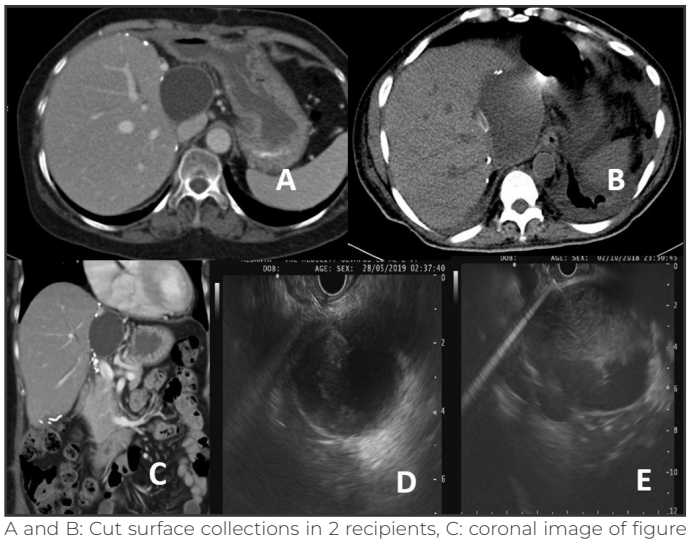
EUS also plays a key role in liver transplant assessments. FNA of lymph nodes helps rule out metastatic disease, which is a contraindication for transplant. These nodes are often small and located near vessels making them difficult to access with traditional methods but easily approachable with real-time EUS guidance from the stomach or duodenum.



A: EUS-guided FNA from peripancreatic lymph node; B: porta lymph node; C: portocaval lymph node; D: aortocaval node; E: portocaval node; E: lymph node between right atrium and liver (paraesophageal). Other than B, all nodes were malignant. HA (hepatic artery), IVC (inferior vena cava), PV (portal vein), RA (right atrium), SV (splenic vein)



Upper 2 images: CT raises the possibility of gastric wall infiltration, radial EUS confirms loss of planes between the gastric wall and HCC (left lower quadrant of the right upper corner image), lower images of another patient show loss of planes (linear EUS image, right lower corner)




A and B: Cut surface collections in 2 recipients, C: coronal image of figure A, collection is higher up just below the heart with a difficult percutaneous approach due to visceral organs in the path, D and E: EUS-guided drainage of collections shown in images A and B

In patients where imaging raises suspicion of gastric wall infiltration by hepatocellular carcinoma (HCC), EUS is the most accurate tool to assess the extent of invasion.

Similarly, post-transplant collections (e.g. seromas or bilomas) located behind the stomach can be hard to access percutaneously. EUS allows for a one-time aspiration that can both diagnose and help guide further management.

## Conclusion

Endo-hepatology is a rapidly advancing subspecialty that is transforming the way liver diseases are diagnosed and treated. With its growing range of indications, from diagnostic imaging and biopsy to pressure measurements, and variceal therapy, it holds immense potential to redefine clinical practice in hepatology accurate diagnosis and appropriate management, avoiding overtreatment of benign lesions.

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**Dr. Swapnil Dhampalwar**
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## Welcome Onboard

**Dr. Bharat Gopal**
Senior Director - Interventional Pulmonology
Medanta - Gurugram

Dr. Gopal is a senior pulmonologist with over 25 years of experience in respiratory medicine, critical care, and interventional pulmonology. A pioneer in advanced airway procedures like EBUS and cryobiopsy, he is highly regarded for his expertise in managing complex airway diseases, sleep disorders, and respiratory failure. He has contributed significantly to national guidelines on asthma, COPD, bronchoscopy, and pneumonia.

**Dr. Pawan Rawal**
Senior Director - Gastroenterology
Medanta - Gurugram

Dr. Rawal is a senior gastroenterologist and hepatologist with over 18 years of experience in managing complex pancreaticobiliary disorders, chronic liver diseases, GI and liver cancers, and paediatric gastroenterology. He specialises in advanced therapeutic endoscopy, including ERCP, EUS, and third-space endoscopy.

**Dr. Shaheen Ahmad**
Director - Cath Lab
Medanta - Patna

Dr. Ahmad is an interventional cardiologist with over 12 years of experience. His expertise includes complex coronary interventions (CHIP, bifurcation, left main), structural heart procedures (TAVI, device closures), and cardiac device therapy (pacemaker, ICD, CRT). He is also skilled in intracoronary imaging (IVUS, OCT, FFR), mechanical circulatory support, and peripheral vascular interventions.

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**Dr. Vinit Pandey**
Director - Cardiac Surgery
Medanta - Indore

Dr. Pandey is a seasoned cardiothoracic and vascular surgeon with expertise in CABG, valve repair and replacement, congenital and paediatric heart surgery, vascular procedures, and minimally invasive cardiac surgery.

**Dr. Ananya Deori**
Associate Consultant - Surgical Breast Oncology
Medanta - Gurugram

Dr. Deori specialises in breast cancer surgery, oncoplastic breast surgery, and breast reconstruction using both implant-based and autologous techniques.

**Dr. Akanksha Prasad**
Senior Consultant - Ophthalmology
Medanta - Patna

Dr. Prasad is an ophthalmologist specialising in cataract surgery, corneal disorders, ocular surface disease, dry eye and glaucoma care, medical retina, and low vision rehabilitation.

**Dr. Kumar Shubham**
Associate Consultant - Interventional Cardiology
Medanta - Gurugram

Dr. Shubham specialises in clinical and interventional cardiology, with expertise in coronary angioplasty, cardiac catheterisation, Echo, arrhythmia management, and pacemaker therapy.

**Dr. Dhananjay Kumar**
Consultant - ENT and Head & Neck Surgery
Medanta - Gurugram

Dr. Kumar specialises in cochlear implants, endoscopic sinus and skull base surgery, scarless ear surgery, rhinoplasty, and robotic ENT procedures, along with the management of sleep apnoea, vertigo, and head–neck tumours.

**Dr. Abhishek Kumar Tiwari**
Associate Consultant - Interventional Cardiology
Medanta - Gurugram

Dr. Tiwari specialises in coronary and peripheral arterial interventions, intravascular imaging, echocardiography, ECG, and critical cardiac care.

**Dr. (Major) Simha Vikram**
Consultant - Internal Medicine
Medanta Mediclinic - Ranchi

Dr. Vikram is an internal medicine specialist with expertise in managing hypertension, diabetes, coronary artery disease, and thyroid disorders.

**Dr. Sanjiv Kumar**
Associate Consultant - Neurosurgery
Medanta - Patna

Dr. Kumar specialises in brain tumours, spinal disorders, neurotrauma, and advanced neurosurgical procedures.

**Dr. Nahid Anjum**
Consultant - Lab and Pathology
Medanta - Patna

Dr. Anjum specialises in molecular diagnostics (PCR), ELISA, infection control, bacterial and viral testing, including COVID-19, hepatitis B/C, and HIV.

**Dr. Abhishek Vashisth**
Associate Consultant - Nephrology
Medanta - Gurugram

Dr. Vashisth is a nephrologist with expertise in renal transplantation, glomerular diseases like lupus nephritis, and chronic kidney disorders.

# THE EXCHANGE

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**Dr. Ghanashyam Timilsina**
Associate Consultant - Emergency
Medanta - Patna

Dr. Timilsina is an emergency medicine and trauma specialist with expertise in trauma response, cardiac emergencies, advanced resuscitation, and high-acuity critical care management.

**Dr. Siddharth Chand**
Associate Consultant - Neurology
Medanta - Gurugram

Dr. Chand is a neurologist with clinical expertise in stroke, neuroimmunology, neuroinfections, and headache management.

**Dr. Abhishek Singh Chauhan**
Associate Consultant - Respiratory and Sleep Medicine
Medanta - Gurugram

Dr. Chauhan is a pulmonologist with expertise in interstitial lung disease, sleep-related breathing disorders, obstructive airway diseases, and critical care ventilation.

IN CASE OF **EMERGENCY** DIAL **1068**

## Medanta Network

### Hospitals

**Medanta - Gurugram**
Sector - 38, Gurugram, Haryana | Tel: 0124 4141 414 | info@medanta.org

**Medanta - Lucknow**
Sector - A, Pocket - 1, Sushant Golf City,
Amar Shaheed Path, Lucknow I Tel: 0522 4505 050

**Medanta - Patna**
Jay Prabha Medanta Super-Speciality Hospital,
Kankarbagh Main Road, Kankarbagh Colony, Patna
Tel: 0612 350 5050

**Medanta Abdur Razzaque Ansari Memorial Weavers' Hospital, Ranchi**
P.O. Irba, P.S. Ormanjhi, Ranchi | Tel: 1800 891 3100

**Medanta - Ranchi**
NH 33, P.O. Irba, P.S. Ormanjhi, Ranchi |
Tel: 1800 891 3100

**Medanta - Indore**
Plot No. 8, PU4, Scheme No. 54, Vijaynagar Square,
AB Road, Indore I Tel: 0731 4747 000

### Mediclinics

**Defence Colony**
E - 18, Defence Colony, New Delhi | Tel: 011 4411 4411

**Cybercity**
UG 15/16, DLF Building 10 C, DLF Cyber City,
Phase II, Gurugram I Tel: 0124 4141 472

**Subhash Chowk**
Plot No. 743P, Sector - 38, Subhash Chowk,
Gurugram I Tel: 0124 4834 547

**Cyber Park**
Shop No. 16 and 17, Tower B, Ground Floor,
DLF Cyber Park, Plot No. 405B, Sector-20 Udyog Vihar, Gurugram I Tel: 93541 41472

**Golf Course Road**
562 SP, Sector 27, Golf Course Road
Gurugram I Tel: 0124 6930 099

**Mediclinic - Ranchi**
Shah Corporate, Kutchary Road, Opp. Atal Smriti Vendor Market, Ranchi I Tel: 1800 891 3100

**Medanta Helpline: 88-0000-1068**

medanta.org  Upcoming Hospital: Noida