

# PULSE

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## ORGAN DONATION SPECIAL



**GODREJ  
MEMORIAL  
HOSPITAL**

COMPASSIONATE CARE FOR ALL  
( NABH & NABL Accredited )

# From the Editor's Desk

## TRANSPLANT..... LIFE

### Statistics:

- 1) More than 150,000 persons are waiting for Kidneys
- 2) More than 30,000 are waiting for Livers
- 3) Average about 3000 - 4000 Renal transplants and about 800 Liver transplants per year
- 4) 10 persons die every day, waiting for an Organ transplant
- 5) One person added to the waiting list every 16 minutes
- 6) 95% transplants are live donors & 5% are 'deceased' donors (it is reverse in western countries)
- 7) 90,000 people die every year in accidents. 70,000 'Brain deaths' every year
- 8) Less than 200 centers do transplants in our country (Godrej Memorial Hospital is now one of them)
- 9) One life (person) can rekindle lives of 8-9 persons.
- 10) Tamil Nadu, Gujarat and Maharashtra are the leading states with a very good number of transplants.



### Organs that can be transplanted:

- 1) Kidneys
- 2) Liver
- 3) Heart
- 4) Lungs
- 5) Pancreas
- 6) Intestines (not yet done in our country)

### Tissue transplants:

- 1) Cornea
- 2) Skin
- 3) Bone
- 4) Bone-marrow
- 5) Tendons & Ligaments, etc.

Before you lose your spark, light up the lives of others & make them sparkle.

By your deeds ye shall be known and by your organs, others & you will remain alive.



### BE A HERO..... PLEDGE YOUR ORGANS

**Dr Kanishka Kapasi**  
MD, DGO

## Message From CEO..

Message from CEO Organ donation programme in Mumbai has had a chequered history. Though there has been a concrete effort to promote organ donation, especially cadaver donation, it has not really taken roots yet. The opinion makers, religious leaders and voluntary organizations have been roped in to propagate the message of organ donation. The success is however, so far eluding. Godrej Memorial Hospital on its part has undertaken several initiatives to increase awareness among its patients and general public. Godrej Memorial Hospital is proud to announce very economical packages for kidney transplant, so that the programme is successful.

**Dr. Suhas Gangurde**  
Chief Executive Officer



## Give thanks. Give life.

**Organ donation** is the donation of biological tissue or an organ of the human body, from a living or dead person to a living recipient in need of a transplantation.

Organ donation can save many lives and thus we must step forward for this noble job. Whether you considered doing charity and other noble deeds in lifetime or not, but death is definitely an opportunity when you can contribute to humanity by the act of organ donation.

**Organ transplantation** is often the only treatment for end stage organ failure, such as kidney liver and heart failure. Although end stage renal disease patients can be treated through other renal replacement therapies, kidney transplantation is generally accepted as the best treatment both for quality of life and cost effectiveness. Kidney transplantation is by far the most frequently carried out transplantation globally.

Organs that can be transplanted are the heart, kidneys, liver, lungs, pancreas, intestine, and thymus. Tissues include bones, tendons (both referred to as musculoskeletal grafts), cornea, skin, heart valves, nerves and veins. Worldwide, the kidneys are the most commonly transplanted organs, followed by the liver and then the heart. Cornea and musculoskeletal grafts are the most commonly transplanted tissues;

Organ donors may be living, brain dead, or dead via circulatory death [cadaver].

### **LIVING DONOR**

In living donors, the donor donates an organ or part of an organ in which the remaining organ can regenerate [ Liver ] or take on the workload of the rest of the organ (primarily single kidney donation, partial donation of liver, lung lobe, and small bowel). Living donor are immediate family members- mother, father, brother, sister, son, Daughter, grandfather, grandmother or spouse i.e. first degree relatives.

### **Benefits of kidney transplantation**

- Greater independence and energy which can help to lead a normal life
- Can have normal diet and fluid intake with fewer restrictions
- No dialysis which gives more freedom

### **Risks of kidney transplantation**

- Bleeding
- Rejection – your body's immune system recognizes the new transplanted kidney as a foreign object and attacks it. To prevent this anti rejection drugs are given known as immunosuppressants.
- Infections – immunosuppressant drugs lowers body's ability to fight infections.
- Others - diabetes, cataract, cancer, high blood pressure

## **THE TRANSPLANT KIDNEY**

The recipient and donor will be operated at the same time in side by side operation rooms. one team of surgeons remove the kidney from the donor while another team places the kidney in recipient. The surgery lasts for 3-4 hours under general anaesthesia.

## **DECEASED KIDNEY DONOR**

Most deceased donors are those who have been pronounced brain dead. Brain dead means the cessation of brain function, typically after receiving an injury (either traumatic or pathological) to the brain, or otherwise cutting off blood circulation to the brain (drowning, suffocation, etc)

**Brain stem death is where a person no longer has any activity in their brain stem, and has permanently lost the potential for consciousness and the capacity to breathe.**

The diagnosis of death reaffirms the preconditions for its consideration i.e.

1. There should be no doubt that the patient's condition is due to irreversible brain damage of known etiology.
2. No evidence that this state is due to depressant drugs.
3. Primary hypothermia as the cause of unconsciousness should be excluded,
4. Potentially reversible circulatory, metabolic and endocrine disturbances should be excluded.
5. Potentially reversible causes of apnoea (dependence on the ventilator), such as muscle relaxants and cervical cord injury, must be excluded.

## **Test**

1. No observed respiratory effort in response to disconnection of the ventilator for long (5min). Adequate oxygenation is ensured by pre-oxygenation and diffusion oxygenation during the disconnection. This test is known as the APNOEA TEST.
2. The diagnosis and tests of brain death has to be made by two senior doctors. (Neurologist /anaesthetist Neither of them can be involved with the hospital's transplant team.

**ZTCC (Zonal Transplant Coordination Center)** is a non-governmental organization started for promoting cadaver organ donation. The main objective of the organization is to implement the deceased donor program as per THOA (Transplantation of Human Organ Act) 1994. To ensure that the available cadaveric organs are distributed fairly and equally. To increase patient access to state of art transplant technology. To create a transplant registry and maintain computerized waiting list of recipients for each organ.

The ZTCC, Mumbai, maintains the computerized waiting list, blood group wise, for each organ like kidney, liver, heart and lung, as per the priority criteria given in the Maharashtra State guidelines. All the registered transplant hospitals send the information of the patients who require organ in the prescribed form for listing. For kidney, each patient is given priority score as per the Govt. guidelines.

## **Donate Organ, Donate life.**

The gap between the numbers of organs available and the number of patients joining the waiting list for a kidney transplant is widening globally. In India, the potential for deceased donation is huge due to the high number of fatal road traffic accidents and this pool is yet to be tapped. So let us all pledge to be a donor if that becomes our fate.

**“ WE ALL MUST PLEDGE TO DONATE OUR ORGANS AFTER DEATH “**



**Dr. Raman Malik**  
MD (Med), DNB (Nephro) AIIMS,  
Sr Consultant in Nephrology &  
Renal Transplant Physician

# LIVER TRANSPLANTATION IN INDIA

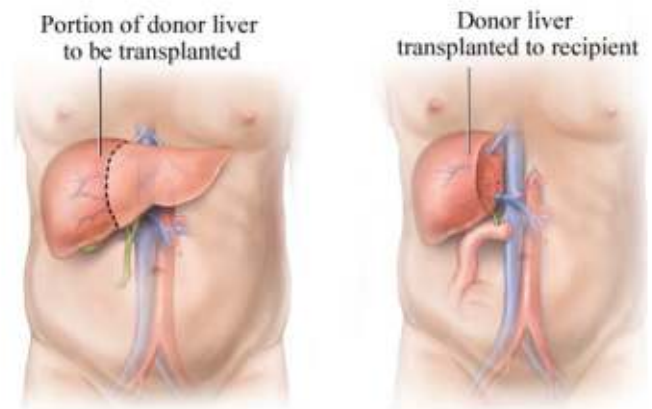
"According to Greek mythology, when the titan Prometheus gave fire to the mortals it made Zeus angry. In return, Zeus chained Prometheus to Mount Caucasus and sent his giant eagle to eat his liver during the day, only to have it regenerate at night."

We are witnessing the a golden phase of organ donation and transplantation in India. Organ donation in combination with advances in immunosuppression therapy has made it possible for many patients with end stage organ disease (kidney, liver, heart, lung, pancreas) to hope for a second chance at life.

The first liver transplantation was performed by Dr Thomas Starzl in 1963 in USA but it became an acceptable standard of treatment for end stage liver disease only in late 1980's. In India, liver transplant surgery had a late start in 1990's, and since then has had a slow growth due to lack of expertise/ well trained teams, hospital support, expense, high mortality and minimal governmental collaboration towards bringing awareness of organ donation/ concept of brain dead through national programmes. In US, liver transplantation has been static at 6200-6500/year for last 5 years whereas in our country a five- fold increase has been reported from 200/year to more than 1100 liver transplants/year. After emergence of private healthcare players (Apollo/ Medanta/ Global/Ambani/ Fortis), super-speciality surgeries like liver transplant have become a reality now in India. The results in Indian set up are comparable with any leading transplant centre across the globe, making this subcontinent a hot spot destination for transplant surgery due to comparable outcomes at a lower cost.

Liver the largest gland in our body weighing about 1500 gms, forms an essential part of our body and serves multiple purposes which are crucial for our existence. Unlike routine renal dialysis in end stage renal disease or ventilator support in respiratory failure patients, we are still to achieve routine liver dialysis for liver failure patients and till then transplant is the only viable option for these patients.

Organ for transplantation is obtained from the deceased donor after declaration of brain death or from a living related



donor whereby a part of the liver is removed from a healthy living donor. Cadaveric liver transplant is routinely done in US but not so frequently in India due to lack of organ donation awareness, lack of clear legislation/ laws across various states and lack of expertise and institution to run these high end surgical procedures. However of late there has been an apparent shift in this aspect, with resultant significant increase in deceased organ donations. Majority of liver transplants done in India are living donor transplants where the patient identifies the donor and also pays for the entire hospital costs. Also living donor liver transplantation is reported to have higher complication rates but lower mortality as compared to cadaveric type. The higher complications rate is due to much more intricate surgical dissection in donor and anastomosis in the recipient vessels and biliary tree that lead to longer hospitalisation and cost.

The timing of transplant is important; a patient needs to be sick enough to derive benefit from transplantation, but at the same time should be well enough to survive this complex surgical procedure. The severity of liver disease and the need for liver transplantation is assessed on the basis of Child Turcotte Pugh (CTP) score which takes into account ascites, encephalopathy, serum bilirubin, serum albumin and prothrombin time. Another score which is used to assess the severity of chronic liver disease is the model for end-stage liver disease (MELD). A MELD score of >15 represents survival benefit of transplantation to a patient with end-stage liver disease. Liver transplantation has well-described indications in the form of chronic liver failure as well as acute liver failure. In the western countries, paracetamol poisoning is a leading cause of acute liver failure whereas this is rarely seen in Indian population.

The cost of a liver transplant surgery averages about 25 lakhs (in US, liver transplant would cost the equivalent of Rs 1.5 crore), plus additional commitment cost of lifelong immunosuppressants which cost Rs 15,000 per month which means it is out of reach of the common man. But it's still comparatively cheaper in India because cost of personnel and hospital charges are lower than western/ European health care. Our government needs to take proactive steps to subsidize the expensive immunosuppressant drugs, create transplant teams at public tertiary care hospitals in each state and create robust awareness through national health programmes on organ donation and concept of 'brain - dead'. Only then we can bridge this gap of providing liver transplant as a viable option even to the common man in India. Presently in India at least 25,000 liver transplants per year are needed,

but at present only about 1100 patients per year are receiving it due to their own affordability status.

In India, we are at an exciting stage in liver transplant field and it is now recognised as a viable modality to treat end-stage liver disease with 1-year survival post transplant of over 90%. The way forward to make liver transplant a viable option even for the common man will need the Government to step in and build public-private partnerships, create national programmes on organ donation, authorise states to encourage hospitals to identify 'brain - dead' patients early to harvest organs and build a transparent system for organ allocation.

**Dr. Biswanath Gouda**  
MPH (USA), DNB (Surgery),  
General Surgeon

## PLEDGE

### Eye Essentials

Our Eyes can always remain alive even after our death

Pledge for Eye Donation

The eyes you donate can give sight to two corneal blind people

Eyes can be donated ONLY after death

Eyes remain fit for retrieval up to 6-8 hours after death

All religions endorse the practice of Eye Donation

Spread the information about eye donation and motivate others to help for this noble cause

Contact the nearest Eye Bank/ Eye Donation Counselor/Hospital for Eye Donation

Call 1919 (Central Eye Bank) for Eye Donation



### 1. What is Eye Donation?

Eye donation is an act of donating one's eyes after his/her death. Only corneal blinds can be benefitted through this process not other types of blindness. It is an act of charity, purely for the benefit of the society and is totally voluntary. It is done after death. The eye donation of the deceased can be authorized by the next of kin even if the deceased did not pledge to donate his / her eyes before death.

### 2. What is the use of eyes received?

The eyes, which are received through such magnanimous gestures, are of great benefit to the society. The front, clear and transparent tissue of the eye called as cornea can be used to restore vision to corneal blind person. The other portions of the eye are also used for research and training purposes to develop cures for some of the common eye diseases.

### 3. What is Corneal Blindness?

The Cornea is the clear tissue covering the front of the eye. It is a focusing element of the eye. The Vision is dramatically reduced or lost if the cornea becomes cloudy. This loss of the vision is referred as corneal blindness.

### 4. What causes corneal blindness?

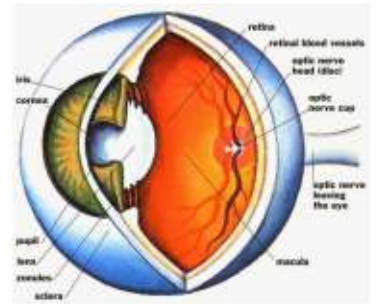
The cornea can get damaged through accidents. Children, while playing with sharp objects (e.g. bows and arrows, pen, pencil, etc.) can accidentally damage their cornea. Corneal blindness can also happen to elders. Some of the industrial causes are chemical burns, flying debris or road accidents. The cornea can get damaged due to infections and malnutrition as well.

## 5. Is there a cure for corneal blindness?

Yes. Removing the damaged cornea and replacing it with a healthy cornea by surgery can cure corneal blindness. Till date the treatment of corneal blind people is corneal grafting. Artificial corneas have not yet been developed and hence the only source for cornea is from our fellow human beings. The first corneal transplant took place in 1905.

## 6. What is the source for the cornea?

Fortunately, cornea can be removed from a deceased person within six hours of death and can be used for surgery. The eyes, which would ultimately be consigned to flames or buried along with the body, can restore sight to two needy people.



## 7. What is the magnitude of corneal blindness?

There are about 4.9 million people suffering from corneal blindness. Majority of the 4.9 million are young adults who have to spend long blind years even though they have a cure. The present collection from all over our country is only 41883 (Year-2011) (source EBAI).

## 8. How can one donate eyes?

Eyes are removed only after death. A person wishing to donate eyes should make close family members aware of their intentions. After the death of the person, it is the family who can inform the nearest eye bank to fulfill the wishes of the deceased or authorize the removal of the eyes if somebody from an eye bank approaches the family.

## 9. What is an Eye Bank?

An Eye Bank is a charitable organization and is not for profit. They are purely functioning for the benefit of the society. The eye banks facilitate removal of eyes (Enucleation), processing of eyes, evaluation and storage of the eyes and distribute them to the needy. The first Eye Bank was set up in United States in 1945 at Newark City.

## 10. How do I ensure that the eyes so donated would not be misused?

Eye Banks are covered under "Transplantation of Human Organs Act" since 1994. It is a criminal offence to buy or sell organs. The Government issues a certificate of registration to eye banks and has a provision to inspect them regularly. In case a complaint is filed against any eye bank, the Government can take legal action.

## 11. How do I contact an eye bank?

A special Toll free number 1919 (BSNL) Nationwide has been allotted for eye banks. Most of the eye banks all over the country have this number, once information for eye donation is communicated to eye banks; the eye bank sends its team to collect the eyes. By calling this number, details about eye donation can also be obtained. Also, all local news paper carries the eye banks number in their Emergency Number list. Lastly, you can contact any hospital and ask them for the local eye bank number.

## 12. What is the procedure for eye donation?

The local telephone directory usually lists the phone number of eye banks under essential services. The eye bank personnel would give directions and precautions to be taken. The process of removing eyes take about 15 to 20 minutes. The eye bank team can come either to the house or to the hospital where death has taken place to remove the eyes there. It would not delay the funeral arrangements.

## 13. What precautions are to be taken?

Switch off fans and switch on Air conditioner (if available). Raise the head of the deceased slightly by placing a pillow underneath. Place wet clean cloth over the closed eye lids. Please ensure that the eyelids are properly closed. Keep a copy of the death certificate ready. Contact the nearest eye bank as quickly as possible. Give the correct address with specific landmarks of your area and contact numbers to enable the team of eye bank for locating the house easily. The eye bank team, which would have a trained technician and/or a registered medical practitioner, would remove the eyes after taking consent on a printed form in the presence of two witnesses. Also small amount of blood sample will be drawn from the deceased to rule out communicable diseases.

#### **14. After the removal of eyes, would there be any complications or disfigurement?**

There are two methods adopted for removal of eyes. Some eye banks would remove the whole eyeball. In such a case there may be temporary bleeding. The team is well trained to take care of such eventualities. There would be no disfigurement. The eye bank team, after the removal of eyes would properly close the eyes so that there is no disfigurement. The second method is the removal of only the clear transparent tissue. Here also a plastic shield is placed in place of the tissue and no difference can be noticed.

#### **15. Is eye donation against religious principles or traditions?**

All religions endorse eye donation. There are numerous examples in our traditions and scriptures, which endorse eye and organ donation. A part of the body would be consumed by flames and reduced to ashes or which is buried and allowed to decay and disintegrate & cannot be put to a better use than restoring vision to the needy!!!

#### **16. Who can donate eyes? Is there any age limit?**

Any person of any age can donate eyes. Even if the deceased has medical history of hypertension, diabetes, asthma, tuberculosis etc., and even spectacle wearers and people who have undergone cataract operation can donate eyes.

#### **17. Who cannot donate their eyes?**

Patients suffering from Rabies, Tetanus, Aids, Hepatitis, Gangrene, Food Poisoning, Septicemia & a person who has died due to drowning etc. cannot donate their eyes.

**Dr. Kalpesh Shah**

**MS, DOMS, FCPS (Gold), ICO (UK), FRCS (Glasgow),  
Consultant Ophthalmologist**

## **RATIONAL USE OF ANTIMICROBIALS**

There can be no two opinions on the fact that antibiotics save lives; but poor prescribing practices are putting patients at risk. We are all aware of the grave threat, posed by the spectre of multi-drug resistant and pan-drug resistant organisms, which is looming large ahead of us. Multi drug resistant organisms are a very serious concern, increasing morbidity and mortality of the patient, duration of hospital stay and the cost of health care to the individual and the organisation. Resistance to the treatment of last resort for life-threatening infections caused by common intestinal bacteria – carbapenem antibiotics – has spread to all regions of the world. Resistance is rampant in every category of microorganisms, be it bacteria, mycobacteria, fungi, viruses or parasites. In order to curb this very real threat, we must use the existing antibiotics and antimicrobial agents in a very controlled and rational manner. We must take immediate steps, in our day to day practice to ensure that antimicrobial agents are used appropriately, for the maximum benefit of the patients and the community.

With this view in mind, as part of the 10th year celebrations, Godrej Memorial Hospital hosted a CME on Rational Antimicrobial Use, on 27-07-2015.

There were three talks, two case presentations and a very interesting discussion among the audience and the speakers.

The first talk was by Dr. Roopa V Iyer, Director, Qualilife Diagnostics, Mulund, and Infection Control Consultant, Prince Aly Khan Hospital, on "Steps Towards Antibiotic Policy". The salient points of her talk were:

#### **Reasons for spread of antimicrobial resistance:**

- Unrestricted sale over the counter of antibiotics
- Uncontrolled misuse of antibiotics
- Within hospitals, the unnecessary use or overuse of antibiotics, leading to the selection and proliferation of resistant and multiple resistant strains of bacteria.
- Resistant strains spread by cross-infection.
- Where resistance is encoded on transmissible plasmids, resistance can also spread between bacterial species.





### Importance of Antibiotic policy:

- To improve patient care by promoting the best practice in antibiotic prophylaxis and therapy
- To make better use of resources by using cheaper drugs where possible.
- To retard the emergence and spread of multiple antibiotic resistant bacteria.
- To improve education of junior doctors by providing guidelines for appropriate therapy
- To eliminate the use of unnecessary or ineffective antibiotics and restrict the use of expensive or unnecessarily powerful ones

### Steps to be taken to form a good antibiotic policy

- An antibiotic committee must be formed in the hospital.
- Antibiotic guidelines must be laid down after discussion between the doctors and the infection control committee.
- Good prescribing practices must be encouraged, and persistently promoted.
- The Microbiologist and laboratory must provide information on the antibiogram, and alert the clinicians about any increasing resistance.
- Education of the prescribing doctors, the junior doctors, nursing staff and the pharmacy staff is very essential, so that all are aware of the hospital policy, and any deviation can be immediately brought to the notice of the committee.

The second talk was by Dr. Tanu Singhal, Consultant-Paediatrics and Infection Control, Kokilaben Dhirubai Ambani Hospital, on "Appropriate Use of Antifungals". The salient points were:

- The incidence of fungal infections in critical care units (Candida, Aspergillus) are rising. Possible reasons may be invasive lines, antibiotics and severe illness among others
- Candida is now the 4th common cause of blood stream infection worldwide and even in India
- Non albicans Candida is now more common in India especially in ICU settings.
- It is very common to isolate Candida from non-sterile sites in the ICU (urine, tracheal secretions, drain fluid etc.)
- Not all of these merit antifungal therapy as many times the Candida is just a colonizer
- However some patients with features of sepsis do have invasive candidiasis and here prompt antifungal therapy is indicated. These need to be identified and treated.
- Risk factors for invasive candidiasis include prolonged ICU stay, broad spectrum antibiotics, central line, immuno suppression, neutropenia, gut surgery, use of TPN,

neonates, diabetes, major transfusions, patients on haemodialysis, high APACHE score, colonization with candida.

- Pre-emptive treatment is recommended in patients with colonisation with candida at multiple sites (2 or more sites).
- Empiric antifungal treatment is recommended in patients showing signs of sepsis, with any of the risk factors mentioned above. In patients who have received azoles previously, and in very sick patients, treatment with echinocandins is advised, otherwise fluconazole is the first antifungal to be given when suspecting candida.
- Both undertreatment and overtreatment with antifungals is common, so doctors need to be very vigilant and cautious while prescribing antifungals.

The third talk was by Dr. Mukesh Pednekar, Consultant Physician, Godrej Memorial Hospital, on "Rational Use of Antibiotics- A Clinician's Perspective". The salient points were:

- An appropriate antibiotic should be, narrow spectrum, easy to administer, cheap, least toxic, with a low selection pressure.
- Before starting the treatment, a prescribing doctor should try and identify the pathogen, using laboratory tests, clinical features, and local organism prevalence. They should also consider the host factors, such as pregnancy, any organ failure, allergy etc., and physiological factors like tissue concentration.
- Antibiotics should be started only if there are clinical signs of a bacterial infection, or a risk of infection (surgical prophylaxis), and a laboratory confirmation should be obtained as early as possible.
- Combination of two or more antibiotics must be used when broad-spectrum coverage is required (in polymicrobial infections), if synergistic action is required (aminoglycosides and cell wall active agents in Enterococcus), or to prevent acquisition of resistance.
- Disadvantages of combination therapy include increase risk of toxicity, increase in multi drug resistant pathogens, increased cost, and antagonism if a bacteriostatic and bactericidal drug are given together.
- A switch from parenteral to oral antibiotic should be made as early as possible, and antibiotics should be stopped immediately if it is not necessary to be continued.
- If there is no improvement after 48 hours of antibiotic, cultures should be repeated, diagnosis re-evaluated, and antibiotics should be either changed or given in a higher dosage, if indicated. There may be a secondary infection, or the antibiotic may not be reaching the site of infection. Surgical drainage may be required, and change to a more narrow-spectrum antibiotic which can concentrate in that particular tissue.

- Antibiotic guidelines should be based on local evidence, and must be prepared as a consensus between all concerned parties. They must be updated from time to time.

This was followed by two case presentations, presented by the ICU Intensivist, GMH. There was a panel discussion following each of these cases, where the important points discussed were

- It is important to treat infection and not colonisation. Every organism isolated from a non-sterile site is not a pathogen.
- Antifungals must be considered in seriously ill patients who are at risk, and do not improve with antibiotics.
- The antibiotic policy of the hospital must be followed when starting antibiotics, but each patient should be evaluated day to day, and based on clinical and laboratory findings, the antibiotic must be escalated or de-escalated.

The take home message given by Dr. Kanishka Kapasi, Coordinator, Dept. of Gynaecology and Obstetrics, GMH, was that we must use our knowledge and skills rationally and without fear, if

we are to overcome the resistant bugs. Microbiology reports, especially cultures and antibiograms must be requested and acted upon. Education, of healthcare personnel and the community is an effective tool to increase compliance. Hand washing is an indispensable, and probably most important weapon to prevent spread of resistant organisms.

Let us all take a step towards more appropriate use of antimicrobials, and together we can make a difference in the shape of things to come.



**Dr. Anuradha Sriram**  
**MD (Microbiology),**  
**Consultant Microbiologist**

## TESTIMONIALS

My father, Sri C K Upase aged 84, bedridden since last 2 years. During this period he is unable to walk single step. Hence we have decided to take consultation of Dr. Sarang Deshpande. After consulting, Dr. Deshpande advised for TKR (Total Knee Replacement) of both the knees.

Surgery of both the knees successfully done on Sat 17th July 2015. Within five days of surgery my father able to stand with the help of walker which was a great moment for our family.

I also appreciate the young, energetic Dr. Sarang Deshpande who used to communicate regularly with patient as well as relatives.

I am sure that my father will walk without any support very soon.

**N C Upase**  
 Son of Patient



## Events of May & June

### Various Camps

DATE	EVENT	VENUE	SERVICES OFFERED	REGISTRATIONS
17th May 2015	Free Cardiac Diagnostic Camp	Balmitra Mandal, Dadar	BP, Blood Sugar, ECG, Medical Consultation & Medicines	60
17 & 24 May & 7, 14, 21, 28 June 2015	Free Cataract Detection Camp	Godrej Memorial Hospital	Ophthalmologist Consultation & Concessional Cataract Surgery	28
14th June 2015	Free Cardiac Diagnostic Camp	Citizens for Social Foundation NGO, Bandra	BP, Blood Sugar, ECG, Medical Consultation & Medicines	65

### CME / Workshops & Conferences

DATE	EVENT	VENUE	SPEAKER	REGISTRATIONS
17th May 2015	a) Hypertension b) Endocrine Disorder with Stress on Thyroid Disorder	Godrej Memorial Hospital	Dr Chetan Shah Dr Anurag Lila	69
18th May 2015	Tiksna Inaguration	Godrej Memorial Hospital		90
19th May 2015	Preconception Counseling	Godrej Memorial Hospital	Dr Kanishka Kapasi	45
17th May 2015	a) What's new in Hematology b) Recent Management in Metastatic Breast Cancer	Godrej Memorial Hospital	Dr Shyam Rathi Dr Vashishta Maniyar	58

### Health Talks

DATE	EVENT	VENUE	SPEAKER	REGISTRATIONS
20,21,27,28 May & 4,5,17,18 June 2015	Tobacco Cessation Training Programme by 'Life First' NGO	Godrej Memorial Hospital	Dr Rohan Bartake & Mrs Ratandeep Chawla	163
9th May 2015	Options for end stage Renal Diseases	Godrej Memorial Hospital	Dr Hareesh Dodeja	70
27th June 2015	Rational Use of Antimicrobials	Godrej Memorial Hospital	Renowned Faculties	58

### Celebrations, Events & Competitions

DATE	EVENT	VENUE
12th May 2015	Nurses Day	Plant 13 Godrej & Boyce
27th June 2015	Debate Competition	Godrej Memorial Hospital

## Events of JULY & AUGUST

### Various Camps

DATE	EVENT	VENUE	SERVICES OFFERED
26th July 2015	Free Cardiac Diagnostic Camp	Lokseva Pratishthan, Park Site, Vikhroli	BP, Blood Sugar, ECG, Medical Consultation & Medicines

# Events of JULY & AUGUST

## CME / Workshops & Conferences

DATE	EVENT	VENUE	SPEAKER
19th July 2015	A) Pre conception care B) Surrogacy - Is it the easy way out..?	Godrej Memorial Hospital	Dr. Kanishka Kapasi Dr. Jay Mehta
26th July 2015	A) Laparoscopic treatment of different Hernias & advance laparoscopic procedures B) Recent trend in management of heart failure	Godrej Memorial Hospital	Dr. Sanjay Sonar Dr. Chetan Shah
5th August 2015	Scientific Debate on Angioplasty vs CABG	Godrej Memorial Hospital	Dr. Deepak Mishra Dr. Shantesh Kaushik Dr. Amit Sanghvi

## Health Talk

DATE	EVENT	VENUE	SPEAKER
31st July 2015	Occupational Stress Management	Capgemini	Ms Tejaswi Kambale

## Celebration, Events & Competitions

DATE	EVENT	VENUE
1st July 2015	Elocution	Godrej Memorial Hospital
1st July 2015	Dr's Day Celebration	Godrej Memorial Hospital
29th July 2015	Antakshari	Godrej Memorial Hospital
30th July 2015	Ramp Walk	Godrej Memorial Hospital
6th & 7th August 2015	Blood Donation Drive	Godrej Memorial Hospital
25th August 2015	Skit Competition	Godrej Memorial Hospital
29th August 2015	Singing Competition	Godrej Memorial Hospital

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