

Editor's Note

*Reflection touching 5th year showcasing varied interesting articles & cases from different clinical specialties, strengthen our role as a solution provider not only to common diseases but also to those which can only be diagnosed and managed by a multispecialty centre of excellence of our stature. In this quarter our doctors participated in national & international seminar & symposia contributing to medical fraternity vis-à-vis our community engagement effort continued in the form of stakeholder discussion on cancer awareness on World Cancer Day and also with a free medical camp at Munshiganj on Shadhinata Dibosh treating approx 2000 outdoor patients. Role of Customer Relation Department in providing value-added services to patients is highlighted in this edition which we hope will give our readers a closer insight; we wish a Shuvo Nobo Borsho to all on **Bangla New Year 1424**.*

Community Discussion on World Cancer Day 2017



This year on World Cancer Day to raise awareness of cancer and to encourage its prevention, detection and treatment, a discussion was organized on February 4, 2017 at United Hospital Seminar Hall where key opinion leaders from government health sector, education sector, community organizations, corporate houses, anti-cancer drug manufacturers, female entrepreneurs, psychologists, cancer survivors, media representatives from TV & Newspaper and health reporters participated and shared their views to tackle the increasing burden of cancer in Bangladesh in a holistic manner. Renowned journalist Mr Iqbal Sobhan Chowdhury, Media Adviser to PM, lauded United Hospital for its flag-bearer role in cancer awareness and

pledged for better cancer awareness coverage on behalf of media fraternity. Professor Dr M Iqbal Arslan, Dean of Faculty of Basic Sciences of BSMMU focused on the role of lifestyle modification in prevention & early detection of cancer. Mr Faridur Rahman Khan, Managing Director

of United Hospital highlighted the role of United Hospital Cancer Care Centre for community awareness against cancer and sought a combined public-private effort to handle the severity of this deadly disease. Amongst others, former secretary of Bangladesh Govt Dr A T M Shamsul Huda (President Gulshan Society) and Mr Abdul Mueyed Chowdhury, Member of Parliament & Cancer Survivor Poet Ms Kazi Rozi, eminent film director Mr Syed Salahuddin Zaki, female entrepreneur Mrs Nasreen Fatema Awal, renowned psychologist Prof Dr Mehtab Khanam, educationist Prof Dr Mesbahuddin Ahmed, oncologist Prof Dr Golam Mohiuddin Faruk and Journalist Mr Shishir Moral & Mr Toufiq Maruf were present in the discussion.

Free Medical Camp on Shadhinata Dibosh

On 26 March 2017 United Hospital conducted a free medical camp to observe Shadhinata Dibosh (Independence Day) in a befitting manner. The medical camp was inaugurated by Mr Faridur Rahman Khan, Managing Director of United Hospital Limited. Doctors, nurses, paramedics and technicians of United Hospital from Cardiology, Oncology, Nephrology, Neonatology, Medicine, Eye,

ENT & Head Neck Surgery, Obstetrics & Gynaecology and Paediatrics department attended the free medical camp at Yunus Khan - Mahmuda Khanam Memorial Health Complex at Louhajong of Munshiganj.

In addition free investigations like pathology tests, X-ray, Ultrasound,



Echocardiography and free medicines were also provided to more than thousand patients of Louhajong and adjacent areas who availed the services of the camp.

United Group celebrates Father of the Nation's 98th Birth Anniversary

United Group played a leading role on 17th March 2017, in the day-long celebration of the 98th birthday of the greatest leader Father of the Nation Bangabandhu Sheikh Mujibur Rahman at his mazaar at Tungipara, Gopalganj.

The day is celebrated as the National Children's Day that especially marked a photo exhibition on Father of the Nation titled "From Khoka to Bangabandhu" which was sponsored by United Group,

witnessed by President Abdul Hamid, Prime Minister Sheikh Hasina, Ministers, Members of Parliament as well as the people of all strata on the mazaar premises. Vice-Chairman of the United Group Mr Abul Kalam Azad and Director Mr Fahad Khan attended the program. In the same spirit, United Group further sponsored another photo exhibition on 23rd March 2017 at Old Central Jail named "Bangabandhu Manei

Shadhinata", where Mr Obaidul Quader MP, Minister for Ministry of Road Transport and Bridges, handed over a crest to Mr Fahad Khan, Director of United Hospital.



Befitting Commemoration of World Kidney Day 2017

Kidney Disease & Obesity was the theme of this year's World Kidney Day which was celebrated in a befitting manner by morning inauguration of Health Booth at hospital lobby; followed by a Scientific Seminar at hospital seminar hall. Consultant Nephrologists Prof M Mujibul Haque Mollah and Dr

Tanveer Bin Latif spoke on the occasion. Dialysis patients were greeted with a special get-well card thanking them for relying on United Hospital as their healthcare provider. As a part of community engagement, health awareness talk at corporate houses and TV Talk show were also organized.



Elderly patients at risk of Mitral Regurgitation

Dr Shabnam Azim

Mitral Regurgitation is a condition in which heart's mitral valve doesn't close tightly, allowing blood to flow backward in heart and blood can't move forward to the rest of the body efficiently, making one feel tired or out of breath.

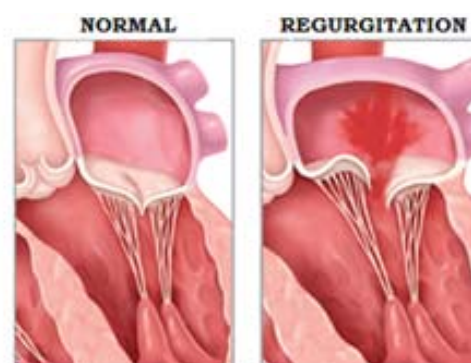
Common causes of mitral valve regurgitation include mitral valve prolapse, when a portion of the valve balloons upwards toward the left atrium; a history of rheumatic fever which scars the heart valve, infection of the heart valves and degeneration of the mitral valve leaflets. This common heart condition affects up to 20% of middle aged and older adults. Initially most patients with mitral valve regurgitation have normal heart function as long as the heart can compensate for the excess blood. Initial symptoms of mitral valve regurgitation can include chest pain, palpitation and shortness of breath. As the left atrium dilates, the mitral valve continues to leak more blood backwards, eventually causing the left atrium and ventricle to lose the ability to properly move out blood towards the body. At this point when the heart functions poorly, patients become more short of breath with exertion, having increasing palpitation and abnormal heart rhythm such as atrial fibrillation.

Age is the most obvious risk factor for mitral regurgitation and the elderly

patients are at highest risk. Normal cardiovascular risk factors e.g. high blood pressure and cholesterol may also be important as they can lead to coronary artery disease and heart failure which in turn is associated with heart enlargement and can lead to mitral regurgitation. Intravenous drug use increases the risk of endocarditis and can lead to regurgitation. Congenital heart disease of a baby can lead to an increased risk of significant mitral regurgitation in later life.

The heart's function and the regurgitation of the valves are monitored by echocardiography to have an image of the heart, its valves, and the flow of blood. Once the heart dilates to a certain extent, surgery is performed to replace or fix the affected heart valve, to prevent further damage of the heart chambers and improve heart function.

A 52 year non-diabetic and hypertensive male came to cardiology outpatient department with dyspnea on exertion. He had a progressive decrease in his exercise capacity with shortness of breath after climbing less than two flights of stairs. On examination his blood pressure was 110/60mm Hg, pulse was 78b/min and on auscultation 1st and 2nd heart sounds were regular with holosystolic blowing murmur at the apex, chest was clear.



There was bilateral ankle oedema and ECG showed left ventricular hypertrophy. Transthoracic echocardiography showed type II dysfunction with posterior leaflet prolapse causing mitral valve regurgitation. Doppler echocardiography showed an anteriorly directed jet mitral regurgitation which was graded severe. Both mitral valve leaflets were thickened and the anterior leaflet motion was normal. Left ventricular size was increased and the ejection fraction was 61%. There was also significant pulmonary hypertension and grade II+ Tricuspid regurgitation.

Preoperative cardiac catheterization showed normal coronary arteries.

The patient was discharged and referred for reconstructive mitral and tricuspid valve surgery.

3rd Advanced Skill Technique in Echocardiography

The 3rd advanced skill technique in Echocardiography arranged by International society of Cardiovascular Ultrasound, Bangladesh Chapter & JROP Institute of Echo, Ultrasound & Vascular Doppler, Delhi, India was held at United Hospital from 23 to 26 February 2017. There were 32 cardiologists participating in this program from all over the country. The international faculty who took part in the



Echocardiography course were Dr S K Parashar, the father of Indian Echocardiography, Dr Sameer

Shrivastava, Director of Non-invasive Cardiology, Fortis Escorts Heart Institute and Dr Rakesh Gupta, Director, JROP Institute of Echocardiography, India. The scientific program included not only lectures but also practical workshops. The major aim of this training course was to improve the skill, knowledge and experience our Cardiologists in the field of advanced Echocardiography.

Congenital Constriction Band Syndrome: A Rare Case Report

Dr Umme Iffat Siddiqua, Prof Dr Shahidul Islam, Dr Jan Mohammad, Dr Qamrul Hasan

A 29 year old South African female primi gravida with 21+ weeks of pregnancy came to United Hospital for anomaly scan. This was a planned pregnancy and till this time it was uneventful. She also had no history of teratogenic drug intake or positive family history of any congenital anomaly. During USG scanning all the parameters were found to be corresponding to her LMP and amniotic fluid was also normal. But during search for anomaly it was found that the left leg of fetus just few inches below the knee was completely amputated. The remaining portion of tibia and fibula of fetus was normal in thickness though tapered down to end at amputated site.

Congenital constriction band (also known as ABS or amniotic band syndrome, amniotic band sequence, pseudoainhum, ADAM complex, amniotic band constriction, Streeter dysplasia, annular defects) is a congenital disorder caused by entrapment of fetal parts (usually a limb or digit) in fibrous amniotic bands while in utero. It may present as constriction rings around the digits, arms and legs, swelling of the

extremities distal to the point of constriction (congenital lymphedema), amputation of digits, arms and legs (congenital amputation). Etiology of this syndrome is unknown; however there are two main theories. The amniotic band theory is that ABS occurs due to partial rupture of the amniotic sac. This rupture involves only the amnion; the chorion remains intact. Fibrous bands of the ruptured amnion float in the amniotic fluid and can encircle and trap some parts of the fetus. Later the fetus grows but the bands do not, rather become constricting. This constriction reduces blood circulation, hence causes congenital abnormalities and in some cases a complete natural amputation may occur. The vascular disruption theory says because the constricting mechanism does not explain the high incidence of cleft palate and other forms of cleft defects occurring together with ABS, this co-occurrence suggests an intrinsic defect of the blood circulation. Diagnosis can be made by 3D ultrasound and MRI. ABS is not genetic i.e. not inherited; so it is extremely unlikely to affect a future pregnancy.



Amputation of left leg of fetus seen on USG scan

The incidence is 1 in 1200 live births. Upto 50% of cases have other congenital anomalies including club foot deformity, cleft lip and cleft palate. Hand and finger anomalies occur in upto 80% of cases. After birth of the baby, plastic and reconstructive surgery can be considered; prosthetics also may help some to live a more functional life with long term physical and occupational therapy. In rare cases, fetal surgery might be considered provided neither vital organs nor the umbilical cord of fetus were affected.

Gross Tumor Volume Estimation Using Computed Tomography for Stereotactic Body Radiotherapy

Kh Anamul Haque, Md Faruk Hossain, Md Anisuzzaman Bhuiyan, Ramma Lingaiah, Md Abbas Ali, Ummay Kulsum & Karthick Raj Mani

The objective of this study was to estimate the Gross Tumor Volume (GTV) using different mode (Axial, Helical, Slow, KV-CBCT & 4D-CT) of computed tomography (CT) and its implication in delineation and treatment delivery.

Few cases of primary lung carcinoma or metastatic lung carcinoma precisely treated with Stereotactic Body Radiotherapy were included in this study. All the patients underwent 4 modes of CT scan i.e. Axial, Helical, Slow & 4D-CT using 16 Slice PET-CT scanner and daily KV-CBCT for the daily treatment verification. For standardization all the patients underwent different modes of scan using 2.5mm slice thickness, 16 detectors rows and field of view of 400mm. Slow CT were performed using axial mode scan by increasing the CT tube rotation time as per the breathing period: 4D-CT scans were performed and the entire respiratory cycle was divided into 10 phases. Maximum Intensity Pixel (MIP), Minimum Intensity Pixel (MinIP) & Average Intensity Pixel (AvIP) were derived from the 10 Phases. GTVs were delineated for all the patients in all the scan modes (GTVAX - Axial, GTVSP - Spiral, GTVSI - Slow, GTVMIP - 4DCT & GTVCB - KVCBCT) in the Eclipse treatment planning system version 11.0 (M/S Varian Medical System, USA). The GTVs were measured, documented and compared

with the different modes of the CT scan. Find table on:

“Volume comparison of different CT modes on patient data”

| CT Mode | Mean \pm SD (cc) | Range (cc) | Ratio (MIP) |
|---------|--------------------|--------------|-------------|
| MIP | 36.50 \pm 40.47 | 2.29 - 87.0 | 1 |
| Slow | 35.38 \pm 39.52 | 2.1 - 82.0 | 0.97 |
| Axial | 31.95 \pm 37.29 | 1.32 - 77.87 | 0.87 |
| Helical | 28.98 \pm 33.36 | 1.01 - 65.9 | 0.79 |
| CBCT | 37.16 \pm 42.23 | 2.29 - 92.0 | 1.02 |
| CT 50 | 30.18 \pm 34.22 | 1.32 - 68.53 | — |
| AVG | 28.76 \pm 33.45 | 1.18 - 69.53 | — |

Overall estimate of helical scan and axial scan compared to MIP is 21% and 12.5% respectively; CBCT and slow CT volume has a good correlation with MIP volume.

It can be concluded that in Stereotactic Body Radiotherapy (SBRT) of lung tumors, it is better to avoid axial and helical scan for target delineation. MIP is still a golden standard for the Internal target Volume (ITV) delineation, but in the absence of 4DCT scanner, Slow CT and KV-CBCT data can also be used for ITV delineation.

Collaboration of Cardiac Surgery & Urology treating A Patient of Renal Cell Carcinoma with Inferior Vena Cava Infiltration

Dr Rezaul Hassan, Dr M Zahid Hasan

A 48 year old hypertensive female presented with a 2 month history of generalized weakness, loss of appetite, weight loss and abdominal discomfort. On physical examination the patient was anaemic, icteric with mild tachycardia. Her laboratory examination revealed anemia, elevated level of serum bilirubin and liver enzymes (ALT, AST, Alkaline Phosphatase), raised serum LDH, features of coagulopathy (raised APTT, INR, FDP, D-dimer). Abdominal ultrasonography (USG) showed right renal mass, dilated inferior vena cava (IVC) with echogenic thrombus in right renal vein and IVC extending up to the heart. Contrast CT scan of the whole abdomen and chest showed right kidney was replaced by a heterogeneous density soft tissue mass with extension into the right renal vein, IVC, proximal part of left renal vein, confluence of hepatic vein and up to the right atrium (RA) (Fig-1). There were no hepatic lesion and no paraaortic lymphadenopathy. There were no lesion found in intrathoracic great vessels and lungs.

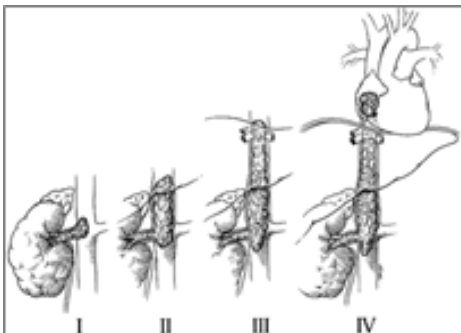
The patient's condition was deteriorating rapidly due to hepatic encephalopathy. She was shifted to ICU for necessary support and close monitoring. On the following day a medical board was arranged involving all allied Consultants; decision was taken for Radical Nephrectomy with Thombectomy from all extension with hypothermic cardiopulmonary bypass with cardiac arrest.

Surgical procedure was planned in collaboration with a urological team aiming complete resection of primary tumor, paraaortic lymphadenectomy (if

present) and removal of IVC thrombus extending to RA with the help of cardiopulmonary bypass. The right kidney was mobilized by sharp and blunt dissection through a rooftop incision. IVC felt firm with tumor thrombus within. Right nephrectomy was performed. IVC was mobilized gently and taped. Cardiopulmonary bypass (CPB) was established by aortic cannula (24 Fr), venous cannulas were placed in the superior vena cava directly (24 Fr) and right femoral vein (22 Fr). Under moderate hypothermia and low flow, the ascending aorta was cross-clamped and cold blood cardioplegic solution was administered for myocardial protection antegradely. After arresting heart, RA was opened and the mass was seen just reaching the IVC-RA junction. The tumor thrombus was removed through RA from IVC and hepatic vein level (Fig-2). Abdominal IVC was opened and the entire residual mass was removed from below, small amount of thrombus was also removed from left renal vein. After IVC and RA were closed, the patient was gradually weaned from bypass and cannulas were removed. Total bypass time was 155 minutes and total cross clamp time was 85 minutes. After 7 hour long operation patient was shifted to CICU where she was drowsy for two days

requiring ventilator support. On 5th POD onward she was completely awake and alert, taking food orally. On 9th POD LFT, RFT, CBC electrolyte, CXR, coagulation profile and abdominal USG, all showed normal findings.

Postoperative Venous Doppler showed no residual thrombus in venous system. The specimen (Fig-3) showed involvement of the perinephric fat as well as ureteric lumen. Patient did not have any complications such as pneumonia, wound infection, deep venous thrombosis rather improvement of hepatic dysfunction in the immediate post operative period. The patient was discharged from hospital on the 12th post-operative day. Her histopathology report showed Papillary renal cell carcinoma TNM stage T3b Nx Mx involving kidney, renal capsule, perinephric fat, renal pelvis and proximal ureter, paraaortic Lymph node and Tumor thrombus. FDG based PET scan done 9 week after surgery showed hyper metabolic spot only in sixth segment of Liver, IVC and Left Renal Vein. She further was planned for Targeted Therapy Pazopanib as follow up treatment.



Renal Cell Carcinoma in Rt. Kidney with extension (stage 1 – IV) in IVC and RA



Fig-1: IVC and RA, opposite RV & HVs



Fig-2: Tumor thrombus extracted from RA, IVC, HVs, RV



Fig-3 : Right Kidney with Tumour inside

Placenta Accreta----A Growing Concern in Recent Obstetric Practice

Dr Nusrat Zaman, Dr Afsari Ahmad

Placenta accreta is a severe complication and is currently the most common indication for peripartum hysterectomy. Placenta accreta occurs when the chorionic villi invade the myometrium abnormally. It is divided into three grades based on histopathology; placenta accreta where the chorionic villi are in contact with the myometrium, placenta increta where the chorionic villi invade the myometrium, and placenta percreta where the chorionic villi penetrate the uterine serosa. It is becoming an increasingly common complication mainly due to the increasing rate of caesarean delivery, as placenta tends to implant in the lower uterine segment specially over the previous caesarean scar; it gets more severe particularly when accompanied with a coexisting placenta praevia.

Antenatal diagnosis can be achieved by ultrasound in the majority of cases. MRI also assists to know the extent of placental invasion to urinary bladder or adjacent lateral pelvic wall. Women with placenta accreta are usually delivered by elective caesarean section. In order to avoid an emergency caesarean section and to minimize complication of prematurity it is acceptable to schedule caesarean at 34 to 35 weeks. In third world countries like ours, it is acceptable to deliver at 36 completed weeks if patient is stable or earlier if alarming bleeding appears. Since, placenta accreta is most likely to affect the urinary bladder and general anaesthesia may be the most appropriate choice in majority of the cases, hence multidisciplinary team approach with senior obstetrician, senior anesthesiologist and urologist and delivery at a center with adequate resources, including those for massive transfusion are essential to reduce neonatal and maternal morbidity and mortality. ICU facility may also be required for post-operative management of mother and NICU facility for preterm neonate. Caesarean

hysterectomy is probably the preferable and acceptable treatment. In carefully selected cases, when fertility is desired, conservative management may be considered with caution. Post-operative Methotrexate is used in some cases of placenta accreta where uterus is preserved.

A 35 year old lady in her third pregnancy (gravida 3) was admitted in United Hospital at 36+ weeks of pregnancy with central placenta praevia with placenta accreta with history of two previous caesarian

sections. Patient gave consent for hysterectomy if required. The baby was delivered by caesarian section with upper segment incision and placenta

to base of bladder were seen. Urinary bladder showed no rent. Both ureters were checked. Continuous catheter and a drain tube were kept. Postoperative recovery was uneventful. Patient got total 5 units of whole blood. Catheter was kept for 7 days and patient was ready to be discharged from hospital.

On 7th post-operative day she developed paralytic ileus and her abdomen was distended. Ultrasound showed mild collection in pelvis. Patient was evaluated by Urologist and General Surgeon. Decision was taken to remove pelvic collection. Ultrasonography guided peritoneal fluid aspiration was done and a pigtail drain was kept in situ as fresh uriniferous collection was detected in pelvis. Cystoscopic evaluation was done, later which revealed no injury. D-J stenting was done. Bladder

wall showed sloughing out of placental necrotic tissue in small areas of bladder mucosa within bladder lumen. There was retained placental tissue in the dome of urinary bladder.

Decision of relaparotomy was immediately taken to remove all placental dead tissue. Stump in vault showed no abnormalities. All dead necrotic tissue were removed from the dome of the bladder. Then dome of the bladder was repaired in 2 layers. A drain tube was kept in pelvis. Continuous trichannel catheter was given for irrigation and drainage.

Meanwhile all possible supportive treatments such as albumin infusion, blood transfusion and high protein diet were being given to patient; with review by Urologist and Medicine Consultant. After 10 days of relaparotomy, pelvic drain tube was removed. Patient was advised to keep catheter for another 2 weeks; patient was discharged on 16th day post relaparotomy.



Mild accreta

Edge of placenta grows into the uterine wall.



was kept in situ. Placenta accreta was found completely encroaching the anterior uterine wall, bladder and right broad ligament. Profuse haemorrhage extending up to right broad ligament was observed which was controlled by clamping all vessels. During this procedure clamp was given in right infundibulopelvic ligament and total abdominal hysterectomy was done. Some placental tissue encroaching up

United Hospital Customer Relation Department

It is becoming evident more and more every day that in a hospital, good service not just good outcomes, relates to patient satisfaction. At United Hospital, we have adopted customer service as priority policy as we believe in increasing the value of patient's experience through the relationship they have with each of us, which eventually leads to rise in loyalty. Hence at United Hospital, the name Customer Relation is given to this department, not just Customer Care or Customer Service as we believe each member of Customer Relation Department work as a Caregiver showing compassion to the patients and their family members, providing a safe

out-patient consultation clinic desks, investigation and admission desks. They are also responsible for the administration and clerical functions associated with the flow of all general type of information within the hospital, to ensure it is well coordinated, efficient, accurate ensuring timely availability when and where required.

The basic activities of CROs can be listed as below:

- To provide administrative support to the clinical services provided at the hospital, focusing on their area of work e.g. OPD, ED etc.
- To ensure that the administrative

- To ensure patients receive a seamless efficient and effective administrative support service in all section under their purview.

Other than these, some specific job as per demand of certain specific desks define job nature at specific CRO desks.

Main Reception Area at Main Lobby; this is the point at which first official contact takes place between the hospital visitor/patient and hospital and hospital staff, and a positive image must be portrayed from the start.

Information Desk/Reception; CRO working here must be fully familiar with their required roles and ensure that they



environment in the hospital for them, building trust, respecting the patient's time and engaging the patient & family in the treatment process discussion and thereby providing value-added service.

United Hospital Customer Relation Department comprises of Customer Relation Officers, who have Deputy Supervisors and Supervisors monitoring, guiding & supervising them; who again report to Deputy In-charges above whom there is a Customer Relation In-charge with overall control and command responsibility. Customer Relation Department at present has sixty-five members, who are deployed at different customer touch-points of the hospital and based on nature of urgency and patient need of the specified area, they are trained and sensitized to perceive, understand and act upon the situation. Generally Customer Relation Officers are responsible for dissemination of information, right communication for patients and visitors at the hospital lobby, service desks, ED,

tasks are directly involved in the patient flow work efficiently and to ensure that delays in service delivery to patients are quickly dealt with.

- To ensure that the information collected and processed through the computerized patient management system is accurate.
- To ensure that the patient receives an efficient and effective administrative support service in all section under the given responsibility.
- To ensure all information flow to be well coordinated, efficient, accurate and available in timely fashion when and where required.
- To ensure delays to patients are quickly dealt with.
- To ensure information collected and processed through the computerized patient management system is accurate.

treat patients with courtesy and provide a helpful service. The preliminary function of this area is to provide information to patients and visitors and direct them to the relevant service they require.

The Information Desk normally operates from 08.00 am to 09:00 pm after 09:00 pm patients will be directed to A & E department if required.

The lobby reception operates 24 hours. At least one CRO is available at all times, for initial guidance and direction to patients to the relevant area of services required.



Registration Counter; here for all new patients, a registration form is given to fill up their personal particulars. All patients in this hospital get registered on the computer system and are issued a Patient ID number. CRO here informs, guides and assists patients for the registration process.

Accident & Emergency department is a 24 hour operational station where CRO works to ensure all calls are being addressed with utmost urgency and promptness, to organize and coordinate Ambulance Call after liaising with Duty Manager and EMO on-duty and also to communicate back to patient's attendant as required, to inform higher management of any emergency situation, as necessary, to keep an eye and supervise overall cleanliness and maintenance

service to provide outpatient services through which patients can have access to Consultants for availing Medical Consultation. This access will be for patients with pre-fixed appointments and for those who come as walk-in. CRO also ensures that patient flow is smooth and that patients suffer no undue delay with regard to gaining access to a clinical service.

Admission Counter operates 24 hours. However the admission procedure will be done in the emergency department between 09.00 pm to 08:00 am.

For elective / pre-scheduled admission, patient arrives at the admission counter with the admission advice or is escorted by OPD CRO/Nurse for those outpatients who are being admitted after being seen

Health Check Lounge is mostly for serving pre-scheduled corporate client bookings for different health check packages; walk-in patients also avail health check packages who come to hospital with pre-set intention to buy. This area starts functioning from 8am in the morning on weekdays and serves as a waiting and relaxing lounge for patients who sit here waiting for their call for next investigation on the line or for their call for post-investigation doctor consultation. CROs here are fully knowledgeable about all the health screening packages and also fully aware of the corporate clients agreement offerings. They guide patients to concerned areas or persons, should they want to avail any other services while in the hospital. Any need of the patient while they are waiting in the



issues of A&E area and inform house-keeping, facility maintenance, nursing etc other concerned stakeholders as necessary, to maintain logbook of all calls and ambulance movement, to be aware of all medico-legal and/or sensitive issues pertaining to patient's condition or incidents like brought dead cases or patient transfer outside.

Outpatient Department (Consultant Clinic); here preliminary function of CRO is to help/guide the patients and visitors and direct them to the relevant service they require. CRO must treat patients/visitors with courtesy and provide a helpful

by the Consultant earlier.

CROs at Admission Desk attend to all patients who are being admitted; giving input about the patient details in the computer system after ascertaining information such as mode of payment, type of room preferred, deposit required, validity of guaranty letter, liaising with insurance companies, type of room available and norms to follow while admitted etc. An inpatient admission form will be generated for patient or his/her next of kin; after verification of personal details the form will be duly signed. CRO will ensure hospital admission process is being done smoothly and hassle free, bed/cabin allocation are done as per patient requirement and affordability, give all necessary information about room category and facility and tariff. CRO will ensure patient has been taken to his/her chosen room/ward escorted by an usher.

lounge, should also be served along with proactive promotion of other hospital services while the patient is waiting and conversing with them at the lounge.

Delivering health care through practicing good customer service skills has become quite pivotal these days as patient satisfaction surveys repeatedly show that hospital caregivers' attitudes, manners and amenities encountered in patient's experience weigh with similar importance to treatment processes. We believe, United Hospital, as a brand is a living entity and we enrich it cumulatively over time, with thousand small gestures that we convey to satisfy patients.

The purpose of our Customer Relation department is to blend hospitality with the patient's wellness.

To fine-tune delivering patient satisfaction; we always ask ourselves, what I would want to experience as a patient myself, and we add the answer to that question to our Customer Relation program.



Massive or Giant Vesical Calculus is A Rare Entity: A Case Report

Prof Dr Abdul Awal, Dr Shihab Arefin Chowdhury

Massive or giant vesical calculus is a rare entity in the recent urological practice and these have been found to grow to enormous proportions with minimal or no symptoms. Males are affected more than the females. Vesical calculi are usually secondary to bladder outlet obstruction. These patients present with recurrent urinary tract infection, haematuria or with retention of urine.



Giant vesical calculus extracted from the urinary bladder

Two such stones were removed from the urinary bladder of a 50 year old Bangladeshi male who came to the Accident & Emergency department of United Hospital with profuse

haematuria, penile swelling & tenderness with purulent yellowish discharge. Patient had severe lower abdominal tenderness with a urinary catheter in-situ. The patient was quadriplegic for more than a decade, as a result of post-rabies vaccination complication and also had other co-morbidities like diabetes, hypertension, critical triple vessel disease, with history of recent ventricular tachycardia and non-ST elevation MI (NSTEMI) upon which he was resuscitated from cardiogenic shock.

The patient developed these symptoms in early January 2017 and was in and out of several hospitals with these problems due to lack of adequate facilities to manage surgery related cardiac risks. Before coming to United Hospital, patient visited four other big corporate hospitals of the city, from where he was refused surgery because of his multiple co-morbidities which posed risk for anaesthesia. Finally following admission, after detailed investigations and with sufficient cardiac risk precautions the patient underwent open cystolithotomy under

local anesthesia as giving general & spinal anaesthesia was risky for him, hence the surgery needed to be completed not only with efficiency but also with promptness.

Cystolithotomy is the surgical removal of the bladder stones via a lower abdominal incision usually done under a sub-arachnoid block (spinal anesthesia); but in this case due to patient's cardiac complication risks, open cystolithotomy was done under local anesthesia. During surgery, digital rectal help was needed to remove the stone as it was adherent with bladder mucosa. Post-operative period was uneventful. His urinary output was quite normal and had no defaecatory problems. Patient left the hospital 3 days after operation with penile catheter removed and with a supra-pubic catheter advised to be removed 14 days after the procedure.

There are many causes of stone formation in urinary bladder as minerals like calcium or magnesium salts can deposit there and crystallize. In this patient the cause is assumed to be prolonged lying down since patient was quadriplegic for long time.

Long Term Outcome of Off-Pump Coronary Artery Bypass Grafting in patients with In-Stent Restenosis

Dr Syed Al-Nahian, Dr Saydur Rahman Khan, Dr Sonjoy Biswas, Dr S M Zakir Khaled, Dr Jahangir Kabir

One of the major complications of percutaneous coronary intervention is in-stent restenosis (ISR), even in the modern era of drug-eluting stents (DESs) and advanced antiplatelet agents. Now-a-days, it has become more challenging problem for both the cardiologists and the cardiac surgeons. We reviewed the long-term outcome of patients with ISR who underwent off-pump coronary artery bypass grafting (CABG).

Symptomatic patients (n=130) having Canadian Cardiovascular Society (CCS) score II-IV with ISR and multi-vessel disease were identified using cardiac catheterization laboratory data between January 2010 and November 2015. All patients underwent

off-pump CABG for the management of ISR. Skeletonized left internal thoracic artery (LITA) was used to Left Anterior Descending (LAD) artery in all patients and venous graft were used in other arteries. Endarterectomy was avoided in majority of the patients. The interval from the latest intervention ranged from 4 to 96 months. Clinical outcome events of interest included death, myocardial infarction (MI), target vessel revascularization (TVR) and combined end point of these major adverse cardiovascular events (MACE). Follow-up periods ranged from 6 to 60 months.

There were no operative deaths and neither of the procedures were converted to on-pump CABG nor

Intra-Aortic Balloon Pump (IABP) was required in preoperative or postoperative period. Age distribution ranged from 48 years to 65 years, among them 119 were male while 11 were female. In the long term follow up there were only 2 mortalities, causes of which were non cardiac and there were no reported incidence of MI. All patients in the follow-up were at a Canadian Cardiovascular Society (CCS) class 0 or 1.

In conclusion, it can be deduced that the off-pump bypass surgery for patients with ISR and multi-vessel disease can be safely performed and provides a favorable long-term clinical outcome.

Limb Salvage – A Beneficial Alternative to Amputation

Brig Gen Prof Dr M A Mannan, Dr Masum Billah

The limb salvage has advanced since the time of the Civil War, when nearly all severely traumatized limbs were amputated. The primary goal of limb salvage is to restore and maintain stability & ambulation. The decision to salvage the critically injured limb is multifactorial and should be individualized along with definitive indications. Limb salvage is more cost-effective than amputations in the long run, so early detection and management is beneficial for the patients.

A 39 year old Chinese male patient was admitted in United Hospital through Accident & Emergency department with history of blast injury (Air Conditioner blast at work place) severe lacerated injury in his left thigh and leg with burn injury of both hand and face with multiple

abrasion in the right leg with pain and active bleeding. X-ray of left lower limb revealed open segmental fracture of upper 3rd and severely comminuted fracture of lower 3rd of left tibia with bone loss from middle 3rd of left tibia and comminuted fracture of middle 3rd of left fibula. He had no other medical co-morbidity. His clinical presentation indicated:

- Open contaminated and lacerated wound from postero-medial aspect of left thigh to lower leg, with exposed bone (Tibia). Lower 1/3rd of the left lower limb was swollen and painful with active bleeding. Loss of skin and sub-cutaneous tissues, also medial head of gastrocnemius, Tibialis Posterior, Extensor Hallucis Longus and Soleus muscles were lost. Movement of left lower limb was restricted. No neurological deficit of left foot was present. Left Arteria Dorsalis Pedis (ADP) was palpable and he could move all toes actively.
- Left heel was swollen, bruised and had blisters.
- Multiple abrasions in the medial aspect of right thigh and leg with tenderness. Movement of right lower limb was painful and restricted. No neurovascular deficit of right lower limb was present. Right ADP was palpable. Could move all toes actively.
- Severe burn injury (Superficial burn) of both hands including all fingers, wrist joint with dorsal and volar aspect of both hands. The range of movement (ROM) of both wrist joints were painful and restricted. Radial pulse was palpable with no neurological deficit.
- Superficial burn was present on whole face, both ears, scalp, eyebrow and eye lashes. No injury was found in eyes though inhalation burn was present.

Surgical toileting, wound debridement and immobilization were done by



uni-axial external-fixator on first day. Then series of operations were performed to save the limbs, these being:

- a) Local flap mobilization to cover bony area
- b) Muscle flap mobilization of lateral head of gastrocnemius muscle and lower end of medial gastrocnemius muscle to cover anterior aspect of tibia
- c) Split thickness skin graft with flap mobilization done by Plastic Surgeon
- d) After controlling the infection and proper healing of the wound, uni-axial external fixator was removed and application of ILIZAROV external fixator done
- e) Burn dressing done by Plastic Surgeon in between the series of surgical procedures routinely

Post-operative rehabilitation was done under supervision of physiotherapist to improve movement of all joints, restore stability and ambulation.

The patient has gone back to China, in follow up communication he has informed that doctors in China have assessed and appreciated the treatment given here and also agreed with our next plan of treatment which is transportation of tibia to fill the gap by ILIZAROV.

Participation in ASPIRE 2017

United Hospital ObGyn Consultant Dr Naseem Mahmud attended The 7th Congress of the Asia Pacific Initiative on Reproduction, ASPIRE 2017, which was held from 30th March to 2nd April 2017 at Kualalampur, Malaysia. Asia Pacific Initiative on Reproduction, ASPIRE, initiates new projects & events to raise awareness of infertility related services in the Asia Pacific region. Almost 1200 participants from over 37 countries participated in this congress.

Corporate Agreement Signing and Facility Tour

United Hospital Limited signed Corporate Medical Services Agreement with the following companies in this quarter:



- Overseas Chinese Association in Bangladesh
- Bangladesh Association of Software and Information Services (BASIS)
- Southeast Bank Limited
- Trust Bank Limited
- Australian High Commission, Dhaka
- Baridhara Society



The officials from following companies / organizations visited United Hospital in this quarter.

- U.S. Embassy, Dhaka
- Embassy of Denmark, Dhaka



Health Awareness Talk as CSR Activity

As a part of CSR activities, United Hospital Limited organized following Health Awareness Sessions in different Corporate Companies.



- Awareness on Cancer at the corporate office of Banglalink on 02 February 2017 which was conducted by Dr. Md. Rashid Un Nabi, Consultant, Radiation Oncology Department.
- Awareness on Cervical Cancer at the corporate office of LM Ericsson & Grameenphone Limited on 08 & 09 February 2017 respectively. Both the sessions was conducted by Dr Humaira Alam, Consultant, Obstetrics & Gynaecology Department.
- Awareness on Kidney Disease at the corporate office of SGS Bangladesh Limited on 16 March 2017. The session was conducted by Dr. Tanveer Bin Latif, Consultant, Nephrology Department.
- Awareness on Tuberculosis at Canadian International School & Scholastica, Gulshan Campus, Dhaka on 19 & 30 March 2017 respectively. Both the sessions was conducted by Dr. Rawshan Arra Khanam, Specialist, Respiratory Medicine Department.



Antenatal Class for the Expectant Mothers

As a part of patient education and consequent value addition to the treatment, "12th & 13th Antenatal Class" under the supervision of Obstetrics & Gynaecology Department was organized on Saturday 21 January & 25 February 2017. Participants were the pregnant mothers with a companion who are availing United Hospital Obstetric prenatal care. Dr Afsari Ahmed, Junior Consultant, Obstetrics & Gynaecology Department, Ms Tasneem Hasin, In-Charge, Dietetics & Nutrition Department, Ms Umme Kulsum Lizu, Clinical Physiotherapist and Ms Suraiya Parvin, Senior Staff Nurse of United Hospital gave presentation on various topics.

Participation in U.S. Embassy Health Fair 2017

United Hospital participated in the Health Fair 2017 at U.S. Embassy, Dhaka on 25 January 2017 attended by the American & Bangladeshi employees of U.S. Embassy, Dhaka. Dr Rawshan Arra Khanam, Specialist-Internal Medicine, Ms Chowdhury Tasneem Hasin, In-Charge, Dietetics & Nutrition & Md Kayumuzzman, Officer Marketing Department of United Hospital joined in the health fair. Various flyers, brochures, health/wellness educational materials and other informative papers of United Hospital were displayed; Medicine Specialist & Dietician gave free consultation / counseling to the employees of U.S. Embassy who visited the stall.



Training



Haque, Executive Purchase, Mr Mohammad Jalil, Inventory Officer, Store & Inventory and Mr Md Shah Alam, Store Officer attended the training. In the training, emphasis was given

Training on "Logistics, Inventory and Store Management" was arranged by DCCI Business Institute (DBI) on 24 and 25 March 2017. From United Hospital Mr Md Mizanur Rahman, In-Charge Purchase & Procurement, Mr Mohd Anamul on the rules of storage of goods & the safety level, new method of store LEFO (Last Expiry First Out), managing store of new items, most usage of items and less usage of items. Total twelve participants attended training from various organizations.



National Malaria Control program organized a 5 day long training from 29 January to 2 February 2017 on Malaria Microscopy for the Medical Technologies (Lab) at the conference Room of National Malaria Control Program, DGHS. Ms Shakila Khanam, Medical Lab Technologist from Pathology Department of United Hospital attended the training. In the training details of laboratory diagnosis of malaria parasites were explained. Total 15 Medical Technologists (Lab) from different hospitals were present in the training.



TOT on Baby Friendly Hospital Initiative (BFHI) at Bangladesh Breast Feeding Foundation, Mohakhali was held from 27 to 30 March 2017. Dr Shahnaz Parvin, Junior Consultant Pediatrics, Dr Tania Rahman, SHO, Obs & Gyne, Ms Nasrin Akter, Unit Supervisor and Ms Sabita Ghosh, Staff Nurse attended the training from United Hospital.

Seminars

Scientific Seminars with the following topics were organized in this quarter:



- Recent Updates in Intervention Cardiology & Joint Arthroscopy at United Hospital presented by Dr Kaisar Nasrullah Khan, Consultant, Cardiology & Dr A H M Rezaul Haque Consultant, Orthopaedics Department of United Hospital on 30 January 2017 at Nexus Hospitals Bangladesh, Mymensingh.
- Uniqueness of Cancer care Centre: United Hospital presented by Dr Ferdous Shahriar Sayed, Consultant, Medical Oncology & Dr Md Rashid Un Nabi, Consultant, Radiation Oncology of United Hospital on 05 February 2017.
- Obesity & Kidney Disease presented by Dr Salina Akter, Specialist, Nephrology Department of United Hospital on 09 March 2017.
- Healthy mouth for a Healthy Life presented by Dr Md Nazrul Islam, Specialist, Dentistry Department of United Hospital on 23 March 2017.

Participation in 7th Bangla Interventional Therapeutics



Bangla Interventional Therapeutics (BIT) is an initiative taken by the interventional cardiologists of the region, which arranges international conference every year to increase expertise and improvement of skill on interventional cardiology, since its inception in 2011. The 7th Bangla Interventional Therapeutics International Interventional Cardiology conference was held from 10th to 12th February 2017 at Hotel Radisson Blu, Dhaka. Over 5000 doctors attended the conference from different institutes of Bangladesh, India & other countries. As faculty from Bangladesh, United Hospital Chief Consultant Cardiology Dr N A M Momenuzzaman, Consultant Dr. Fatema Begum and Consultant Dr. Kaisar Nasrullah Khan participated in live demonstration and also as moderator and discussants on different sessions, further presenting cases on different topics. Dr Tunaggina Khan and Dr Samsunnahar Moni, Specialist Cardiology, also attended and participated in poster presentation.

New Consultants



Prof. Dr. Md. Abdul Awal
MBBS, MS (Urology)
Department of Urology & Andrology



Dr. S. M. Hasan Shahriar
MBBS, MRCP (UK)
Department of Neurology



Col. Dr. Anjuman Ara Beauty
MBBS, DCH, FCPS (Paediatrics)
Department of Paediatric Neurology



Dr. Md. Shahidullah Sabuj
MBBS, MD (Neurology), FCPS (Medicine)
Department of Neurology



Prof. Dr. Md. Shamsul Alam
MBBS, MCPS (Surgery)
MS (Cardiothoracic Surgery)
Department of Thoracic Surgery



Lt. Col. Dr. S M Shahidul Haque
MBBS, FCPS (Physical Medicine)
Department of Physical Medicine



Congratulations to the Newly Weds on their Marriage

- Senior Staff Nurse Ms Romana Akther of NICU got married to Brother Md Moniruzzaman of CCU on 16 December 2016.



Congratulations & Best Wishes to the following Staff and their Spouses

- Head of Human Resource Department Mr Khandaker Mohammed Nurullah and Mrs Sayeda Maria Sultana had a baby girl Sabrina Khandaker on 15 January 2017.
- Executive Mr Abdul Aziz of Accounts & Finance Department had a baby boy Mohammad Awsaf Abrar on 15 March 2017.
- Deputy Manager of Financial Reporting Mrs Rumana Amin of Finance & Accounts Department had a baby girl Zayana Binte Zia on 28 March 2017.



Condolence & Prayers

- Head of Internal Audit Mr Mohammad Geasuddin Ahmed lost his elder son Mr Nur Ahmed Humayun on 12 March 2017.

Annual Inter-Departmental Badminton Tournament

The annual Inter-departmental Badminton Tournament 2016 was inaugurated by Mr Najmul Hasan, Chief Executive Officer of United Hospital on Thursday 9 January 2017. The preliminary knockout matches of this year's tournament started with the participation of 66 players in 33 Teams under four groups, representing different categories. The teams were divided according to age i.e (i) under 40 (ii) 40 to 50 (iii) above 50 and the fourth category comprised of female participants. All the games were played with huge enthusiasm up to late evening, cheered by the supporters of each team.

Mr Faridur Rahman Khan, Managing

Director of United Hospital Limited was present as the Chief Guest to watch the final games and distributed trophy with prizes amongst the winners, runners-up & other officials on Thursday 2 February 2017.

The winners of the tournament are:

Group Ka (under 40) - Mr Sohel Mridha & Mr Mushfikul Alam Khandaker
Group Kha (40 and 50) - Mr Syed Shah Wahidullah & Mr Md Abdul Aziz
Group Ga (above 50) - Mr Najmul Hasan & Dr Mahboob Rahman Khan
Female Group - Ms Papia Biswas & Ms Jesia Parvin



In addition to the crests given to the winners and runners-up, medals were also given to referees & commentators, token of appreciation was given to the lines-men and other support staff, whose support made it possible to hold the tournament smoothly.