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डॉ० जयश्री मेहता M.S., F.I.C.S. अध्यक्ष मारतीय आयर्विज्ञान परिषद

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D.O.No.MCI-7(8)/2018-Med./ /38 .

Dated: 24 08/18

Dear Dr. N. P. Narain

I, on behalf of the Management Committee of Dr. B. C. Roy National Award Fund Society and on my own behalf, am pleased to inform you that you have been selected for the prestigious Dr. B. C. Roy National Award for the year 2017 in the category of "Eminent Medical Teacher", which you rightly and richly deserve.

I extend my heartiest congratulations and compliments to you for the same.

In this context, you are requested to submit your brief profile in *letter format* in hard as well as soft copy and also a passport size photograph to Dr. Reena Nayyar, Member Secretary or Mr. Rajiv Kumar, Assistant Secretary, Medical Council of India, Dwarka, New Delhi, as early as possible, for the purposes of Souvenir.

Yours sincerely

(Dr. Jayshree Mehta)

Dr. N. P. Narain, Prof. Of Surgery & Consultant General & Laparoscopic Surgeon, Patna Medical College & Hospital, Patna -800 004 (Bihar)



DR. N. P. NARAIN

M.S., D.Ortho, Ph.D., D.N.B., F.I.C.S.,
F.R.C.S. (England), F.R.C.S. (Edin.)
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Consultant General & laparoscopic surgeon

Professor of Surgery,
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243, PatliputraColony (Near Patliputra Co-operative) Patna-13 CI-0612-2265265 R-0612-2267575 Mob-9835027575, 9470458898 Email- drn.narain@rediffmail.com narainnp53@gmail.com

DR. B. C. ROY NATIONAL AWARD- 2017 EMINENT MEDICAL TEACHER CATEGORY

Name

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CURRICULUM VITAE

Name:

Dr. Prof. N. P. Narain

Present Post:

Professor of Surgery

Patna Medical College.

Patna, Bihar

Father's Name:

Late Dr. Udai Narain

Date of Birth:

01-01-1953

Address:

Dr. N. P. Narain

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Patna -800013, Bihar Mob. 9835027575 9470458898

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Academic Qualifications: M.B.B.S.

1976 (Patna University)

Dip. Orthopaedics 1979 (Patna University)

M.S. Surgery

1982 (Patna University)

DNB (Surgery)

1987 (Govt. of India)

FRCS (Edinburgh) 1992 (Royal College of Surgeons,

Edinburgh)

FRCS (England)

1994 (Royal College of Surgeons,

England)

FRCS (Glasgow)

1995(Royal College of Surgeons,

Glasgow)

Working Experience : Medical Officer, Health Department Govt. of Bihar (16-03-79

to 12-09-1986)

Teaching Experience in Medical College:

Resident Surgical Officer - Patna Medical College (13-09-1986 to 08-01-1990).

- Registrar Surgery Nalanda Medical College (23-09-1990 to 10-02-1995).
- Assistant Professor of Surgery- Nalanda Medical College (09-11-1997 to 17-12-2003).
- Associate Professor of Surgery-Darbhanga Medical College & Patna Medical College (18-12-2003 to 09-03-2016).
- Professor of Surgery Patna Medical College (10-03-2016 continuing w.e.f. 03-12-2003).

Field of Specialization:

Teaching Activities:

General and Laparoscopic Surgeon

- Very popular teacher in the Medical College, highly acclaimed by students and collegues.
- Has been teacher of undergraduates and post graduates for last 27 years.
- Has guided research of M.S. students, about 45 post graduates in last 15 years.
- Teaching and training students and young graduates along with District Hospital level doctors in various CME programmes for last15 years in various common surgical problems associated with the society.
- Examiner for last 20 years of under-graduate and post graduate students in various universities of India.
- DNB theory examiner, question setter and clinical and practical examiner in more than 20 universities of India for last 15 years.
- Only surgeon from Bihar to be examiner for FRCS/MRCS for the Royal College of Surgeons of England and Royal College of Surgeons of Glasgow.
- Worked as consultant surgeon in various Medical colleges and Private Nursing Homes and operating common and difficult surgical cases.

Professional Activities:

- Has operated many difficult and unusual surgical cases with great applause and coverage in newspapers.
- Popular among people as a good and efficient general and laparoscopic surgeon.
- Great aptitude of helping poor people by providing skilled surgical expertise to them in the hospital and outside hospital.
- Abdominal Tuberculosis: conservative and surgical management and its association with other surgical conditions in Bihar.
- Gastric perforation in relation to socioeconomic conditions in Bihar. (ongoing)
- Incidence of Gastric Carcinoma in cases of Gastric perforation in surgical emergency cases. (ongoing)
- Life member Association of Surgeons of India
- Life member Minimal Access Surgeons of India
- Life member Indian Medical Associations
- Life member Association of Surgeons, Bihar Chapter
- Member General Medical Council England (GMC)
- Fellow International College of Surgeons
- Fellow Royal College of Surgeons of England
- Fellow Royal College of Surgeons of Edinburgh
- Fellow Royal College of Surgeons of Glasgow
- Chairman Scientific Committee, Associations of Surgeon of India (Bihar Chapter)
- Teaching Faculty Association of Surgeons of India
- Attended more than 20 conferences of State Chapter (Bihar & Jharkhand), Association of Surgeons of India and presented paper in 17 of them.

Arena of Research:

Membership & fellowship:

Conferences attended
& paper presented:
(photocopy of
Certificates enclosed)

- Attended more than 20 conferences of Association of Surgeons of India and presented paper in 12 of them.
- Attended International conference of Association of Surgeons of India (Bihar Chapter) in Bangkok and Indonesia and presented paper in them.

Paper published:

Has published more than 30 papers in national and state journals (photocopy of publications attached).

| VISIONAL | CERTIFICATE |
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CERTIFICATE

rassed the examination for the Diploma in Oxthopoedic Suxpexy 'eld in the month of December PATNA UNIVERSITY J. 2 JAN 1982 This is to certify that Novemal Rakash Maxing Unib, 世間 , 1980. youngh It frish

National Mourd of Axaminations

Kew Delhi, India

hereby certifies that

Nirmal Prakash Barain

his proficiency at an examination held in Becember, 1993 to the satisfaction of the has pursued the prescribed course of postgraduate training and has demonstrated 海oard.

and Ninety Four, the Board admits him at the Convocation held at New Delhi as a Accordingly, on this Twentieth day of July in the year One Chousand Kine Hundred

Diplomate of the National Board for the practice of

diabing pranago

1) amon as Pregident



Funahim & In abarto printipully

founded in Geneba, 1935; Incorporated in Washington, B.C., 1940

This attests that having complied with all requirements for fellowship

Hr. Virmal Prahash Harain

Has been duly elected a Mellom

International College of Surgeons

General Surgery

In Witness Wherent, me affix our hands and seal this

Unahadenan

o Carpi.

June 22, 1991

India Section

Par Ma

Corporate Secretary, Interpolicies College of Horgeom land-Arungy

Berretury, Bection



We: the Court of Examiners of The Royal College of Surgeons of England have examined Nirmal Prakash Narain

in the Basic Sciences relevant to Surgery and Clinical Surgery-in-General and find himqualified for admission to the Fellowship.

As witness our hands this 25th day of October 1995

| (Senior Examin | ur) 11 | | |
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| | | | |

Know all Men by these Presents, that We

The Royal College of Surgeons of England

do hereby admit the above as a Fellow of the College.

As Wilness our Common Seal this 14th day of December 1995



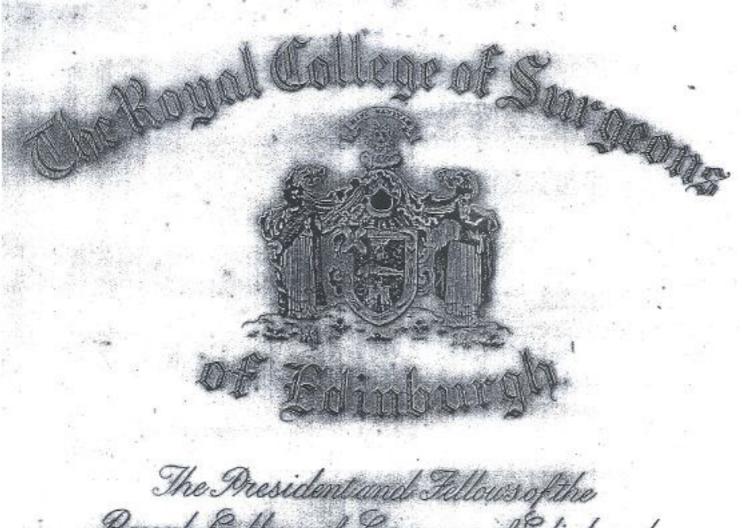
Body Sember

Certhatus

Vice Presidents

Secretary

Johnsonth.



The President and Fellows of the Poyal College of Turgeons of Edinburgh hereby admit to the Fellowship of the College

. Mimal Prakash Narain

who has completed the required form of training

The Succession of the second s

of the said College

Zata (si dhan lon)

Foretry Vallen

f stends 19th to



Royal College of Physicians and Surgeons of Glasgow

DIPLOMA OF FELLOWSHIP

(F.R.C.S. Glasg.)

It is hereby certified that

NIRMAL PRAKASH NARAIN

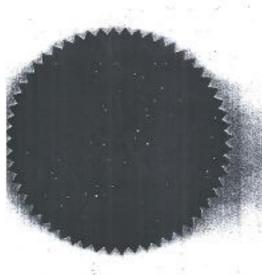
has been examined in the Science and Art of Surgery and, being of good character and professional status, has been duly elected a Surgical Fellow of the Royal College of Physicians and Surgeons of Glasgow.

In Witness whereof we have hereto appended our Signatures, and the Corporate Seal of the Royal College is hereon impressed,

this IHIRD day of JUSE

One Thousand Nine Hundred and NINETY SIX

Kannon Karker President





CERTIFICATE OF REGISTRATIO

BIHAR MEDICAL COLUMN OFFI

| MRMAL ROBERSH-NOSPIN | NAME, WITH FATHER'S NAME. |
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Dr NP Narain FRCS(Glasg) 243 Patliputra Colony PATNA Bihar 800 013 INDIA

03 February 2014

Dear Dr Narain

IMRCS Part B OSCE Examiner Appointment letter

I am delighted to confirm that your application for admission to the Panel of Examiners at the Glasgow College, for the Intercollegiate Membership of the Royal College of Surgeons (IMRCS) Part 8 OSCE, has now been approved by the Intercollegiate Committee for Basic Surgical Examinations (ICBSE). I can confirm that your examiner number is 1303. Examiners will be appointed for a period of 6 years from the date of this letter, the first of which will be a probationary year. The College requests that examiners endeavour to examine at, at least one diet of the examination per year, in order to maintain their examiner status. I enclose an Examiner Code of Conduct Form and I would be grateful if you could sign and return to the College, using the pre-paid envelope provided.

The administrator. Ms Emma Stephens, will be in touch approximately 12 weeks prior to the commencement of each exam to request availability to examine and will advise if you have been selected for a particular exam diet. We do hope you enjoy your time on the IMRCS Part B OSCE Examiner panel and if you have any queries meantime, please do not hesitate to contact Emma on 0141 221 6072 or email her emma.stephens@rcpsz.ac.uk.

Kind regards

Yours sincerely

Mr Andy Malyon

Director of Surgical Examinations

Encs

Your GMC reference number, 4371498

General Medical Council

CARL LISABADS CAMILLIANS

Dr. N P NARAIN 243 Patliputra Colony Patna Bihar 800 013 India Financian Street
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Dear Dr Narain

Confirmation of GMC Online account activation

Thank you for activating your GMC Online account.

You can now, among other things, update your details, make payments and complete surveys online.

If you did not activate your GMC Online account please contact us immediately.

Yours sincerely

Jane Durkin

Head of Registration Enquiries and Support

Registration Directorate

CONFIDENTIAL

NBE/PRAC/EXAM/SEPT-2015/232

6th October 2015

Dr. N.P. NARAIN
PROF. OF GENERAL SURGERY
PATNA MEDICAL COLLEGE
PATNA - 800 004
BIHAR
09835027575
drn.narain@rediffmail.com

Sub: Examinership for Practical Examination of NBE

Sir.

National Board of Examinations conducts high level and uniform standard Postgraduate and Postdoctoral examinations in the field of modern medicine and allied sciences. NBE awards DNB qualification (Diplomate of National Board) in the concerned specialty to the successful candidates.

The practical examination in the specialty of GENERAL SURGERY will be held at Yashoda Hospital SP Road, Secunderabad from/on 29th to 31st October 2015. NBE is pleased to appoint you as an Examiner for the above said examination.

A copy of the guidelines for the "Conduct of the Practical Examinations" is sent herewith for your information.

Please confirm your acceptance/regret for the Practical Examination by return-of post or E-mail/ID _ — <u>anuraq@natboard.edu.in</u> or<u>exam1@natboard.edu.in</u>. For clarification if any, please contact the undersigned at 9990866100/ 011-45593015/ 9990866200. Please send the consent form to the undersigned in confidential cover.

You are requested to contact Dr P.Venu Gopal (coordinator of the practical examination). Phone No.:9848099714.

Air fare by economy class is permitted wherever travel is undertaken by air (at most economical fare available). Flight tickets have to be booked only through NBE. For flight tickets please contact NBE Travel Desk (Mr. Jha) at 09911486644 e-mail id - travel@natboard.edu.in (from 9:30 am to 6:00 pm)

Examination is a sensitive process and in order to maintain the sanctity of the examinations the title "examiner" should not be used in your professional communications.

Please do not accept this assignment in case any vigilance enquiry is pending against you.

Yours sincerely

(Dr. Anurag Agarwal) Additional Director

Encl., as above



राष्ट्रीय परीक्षा बोर्ड NATIONAL BOARD OF EXAMINATIONS

Ref.No:NBE/Thesis/Assess.2014

Dateo 35 December 2014

"SCHEIDENT'AL"

DR N P NARAIN, HOUSE NO. 243, PATALIPUTRA COLONEY, PATANA - 800013 09835027575 drp.narain@rediffmail.com

Subject: Assessment of thesis in the subject of GENERAL SURGERY

Sir.

Please find enclosed thesis with code number as mentioned below for assessment. You are requested to send back the hard bound thesis along with assessment report within 25 days of the receipt of this letter in assessment form enclosed.

Remuneration for assessment will be made @ Rs 1000/- per thesis. Please send, the duly filled remuneration form along with assessment report. Please acknowledge the receipt of thesis at thesis1@natbnace.edu.id.

Yours sincerely

(Dr. ANURAG AGARWAL)
Additional Director

Enclosures:

1) Thesis with code number - 142353

2) Assessment Report forms.

3) Remuneration form.

Splenic Injury: A Study on Conservative and Operative Management

* N. P. Narain

Introduction:

With the increasing incidence of violence and road traffic accidents splenic injury is commonly met with associated with blunt abdominal trauma in our surgical emergency. The common convention of splenectomy in splenic injury is associated with post-operative septicaemia, Pneumonia and cardiac infarction. Moreover in most patients, splenectomy may be followed by immunological impairment and increased succeptibility to infection, particularly in children. It has been pointed out that an injured spleen can either heal spontaneously or be successively conserved by a variety of operative techniques (Strauch, 1979).

Material and Method :

64 cases of splenic injury diagnosed clinically, radiologically or by ultrasonography and confirmed on exploratory laparotomy in the surgical unit of Patna Medical College in three years period (1985-88) have been studied in relation to their site, type of injury and management. The cases of splenic injury were selected on the basis of history of blunt and mixed trauma, general clinical signs of internal haemorrhage like increasing pallor, rising pulse rate, sighing respiration, and restlessness. Local signs of abdominal rigidity more in left upper quadrant, local tenderness and shifting dullness in flanks was taken into account. Associated rib fracture and injury to pleura and lung on left side was also considered for the diagnosis of splenic injury. Plain x-ray abdomen and ultrasonography proved to be of much help in the diagnosis. The cases have been classified in nonoperative, operative and conservative surgery groups.

Result :

Out of 64 cases of splenic injury 48 were male

*M. S., D. Orthop. Ph. D. (Surgery). Department of Surgery, Patna, Medical College & Hospital, Patna, Bihar). and 16 female. The maximum number of cases (56%) were in the age group of 20-40 years of age. (23%) cases were in the age group of 10-20 years. (68%) of the cases were brought within 24 hours of injury. The operative procedure was decided on the nature of splenic injury, improvement or deterioration in clinical signs and by amount of blood transfusion required.

Out of 64 cases of splenic injury, spleen was conserved in 43 (67%) and only 21(33%) cases were subjected to splenectomy. Non-operative treatment were taken up in the cases who were haemodynamically stable, or who required less than 2 units of blood in 48 hours or in cases where injury in other viscera or gut was ruled out clinically or radiologically. However two cases kept on nonoperative treatment had to undergo urgent laparotomy and spleenectomy on 5th and 7th day of injury because of delayed haemorrhage. Out of 43 cases, in which non-operative or conservative operative procedure were taken up, splenic repair was done in 15 cases. Out of these 15 cases suturing of capsulor tear and fragmentation was done in 12 cases by prolene or vicryl with or without jelcosponge, and partial resection was carried out in 2 cases where-as in one case only splenic artery ligation was done.

It was found that more units of blood was needed to resuccitate, cases above 15 years of age than those below 15 years. Out of 42 cases above 15 years of age splenectomy was done in 14(33.3%) cases whereas in cases below 15 years of age it was done only in 2(9.1%) cases.

There were 5 mortality (12%) in this series. Out of this, 3 cases were from splenectomy group and one case each from non-operative and conservative surgery group. Out of 21 cases in which splenectomy was done 2 cases were of from non-operative group in which delayed haemorrhage on 5th and 7th day of injury occured and emergency laparotomy and splenectomy was performed. In one case of conservative surgery group in which there was rupture of spleen and repair was done, there was re-bleeding for which urgent splenectomy was done.

TABLE—I

NATURE OF SPLENIC INJURY IN DIFFERENT TREATMENT GROUP

| Nature of Injury | 9 | No. of | NT | | | | Ope | rate | đ | | | |
|------------------|-------------|--------|------------|-----|------|---------|-----|------|---|-----------------|----|--|
| | | cases | Non-operat | ted | Sple | enecton | ıy | | | nserva urger | | |
| Capsular tear | | 4 | 0 | - | | 1 | | | | 3 | | |
| Contusion | State State | 3 | 3 | | | 0 | | | | 0 | | |
| . Haematoma | | 12 | 10 | | 2 8 | 0 | | | | 2 | 56 | |
| Rupture | | 37 | 15 | | | 13 | | | | 9 | | |
| Fragmentation | | . 7 | 0. | | 7 | 6 | | | | 1 | | |
| Vascular injury | | 1 | 0 | | | 1 | 20 | | | 0 | | |

There were also associated injuries alongwith splenic injury in 27 cases.

TABLE—II

DISTRIBUTION OF 36 ASSOCIATED INJURIES IN 27 CASES.

| | Associated Injury | No. of cases | |
|-------|---------------------------|--------------|------------|
| y Fig | Rib fracture | 12 | |
| | Injury to lung and pleura | - 1 | 1.0 |
| | Renal injury | 10 | 100 |
| | Gut injury | . 2 | 3.5 |
| | Liver injury | 8 | 1. 1. 18.1 |
| | Retroperitoneal haematoma | 4 | 1000 |

BLOOD TRANSFUSION GIVEN TO CASES IN VARIOUS AGE GROUPS

| - A | Age in No. of | | * | | Blood transfusion in units | | | |
|--------|---------------|-------|---|----|----------------------------|-----|-------------|--|
| | | cases | | U. | 1-2 | 3-4 | 5 and above | |
| 3 0 | Below 15 | 22 | 6 | 9 | 7 | 3 | 2 | |
| i cere | Above 15 | 42 | | 7 | . 10 | 20 | 5 \ | |

TABLE—IV

AGE IN RELATION TO DIFFERENT TREATMENT GROUP

| Age in years | No. of cases | Non-operated | Splenenctomy | Conservative surgery |
|--------------|--------------|--------------|--------------|----------------------|
| Below 15 | 22 | 13 (59 %) | 7 (31.9%) | 2 (9.1%) |
| Above 15 | 42 | 15 (35.7%) | 14 (33,3%) | 13 (31.0%) |

Observation on Teen-age Pregnancy

* Rajkumari

Introduction:

Due to various changing social factors the number of teen-age mothers are increasing in the west and therefore, attention is being focussed to the outcome of pregnancy and labour in this age group. The obstetric behaviour is expected to be different because although they may attain reproductive maturity their physical development is incomplete, psychologically they are immature and their various systems specially the endocrinal system does not attain full maturity.

In this country, especially in the eastern part, due to prevalent early marriages, teen-age pregnancy has been a more common feature. It has often been reported that the incidence of complications in pregnancy and poor foetal outcome is more common with these mothers. Though Underhill and Atkins (1978) reported increased incidence of complications in pregnancy and poor foetal outcome, associated with social and psychological difficulties, Dwyer (1974) found none.

Material and Method :

1500 women were studied during the period January 1982 to December 1983. These were further divided into 1) Age group A (teen age below 20 years) and 2) Age group B (between 20 to 25 years) at the time of conception.

The duration of pregnancy was estimated by noting last menstrual period of where the date of the last menstrual period was uncertain, the duration of pregnancy was estimated by clinical assessment.

Antenatal complications like abortion, anaemia, toxaemia, antepartum haemorrhage, urinary tract infection were noted. Duration of labour, more of delivery and complications of third stage of labour were noted. An apgar score of less than five at one minute was taken as evidence of birth asphyxia.

Discussion:

"Pregnancy in young girls is not a cause for anxiety and the young mother shows an excellent capacity for meternity while the infants are of high vitality" (Caso and di-Fonzo, 1950). The apparent immaturity presents no problem in labour on the contrary labour was quick, dilatation of the cervix was faster, perhaps due to absence of fear pschychosis or less time period to be able to observe the apprehension and fear of child birth. As the maturity gros, it is at once replaced by tension, apprehension and fear affecting the labour patterns.

Incidence of anzemia was almost same in the two groups. We found a comparatively low incidence of toxaemia in teen aged mothers, contrast to the findings of Utian (1967), and Lewish and Nosh (1967), but similar to the findings of Osbourne et al (1981).

Average duration of labour was less in teen-aged group than the older group. Biswas and Goswami (1983) has also reported that the duration of labour in the 1st and 2nd stage is lesser in the teen-age. The shorter labour is probably related to a good myometrium and fully developed pelvis. The outcome of labour was favourable in the teen age primigravidae with 67.5 percent spontaneous veginal deliverees. Sinclair (1952) delivered 95% of young primigravidae spontaneously. Caesarean section rate was much lower in younger group (2.5%) as: compared to the 11.7 percent in other group. Forceps rate was almost equal in the two series. Vonder Ake and Bach (1951) delivered 71% were low outlet forceps and Clough (1958) 82% with low forceps. These were routine forceps delivery. There was no decrease in the apgar scores or other perinatal complications to suggest that the interest of the foetus were jeoparadised in an attempt to achieve vaginal delivery. Complications of the third stage was far less in the ten-age group. Babies of teen-aged mothers are slightly premature by weight than the older group.

In our series incidence of pre-mature labour was much higher in teen-aged mothers. Similar to the findings of Utian (1967).

[&]quot;Medical Officer, District Tuberculosis Centre Munger, Bihar,

A Symptomatic Gall Stone – Controversies in the Management

Dr. Basudco Prasad Jaiswall, Dr. N.P. Narain2

INTRODUCTION

With the advent of Abdominal ultrasonography the early diagonisis and management of gallstone has been revolutionized. Although it is difficult to know, which gall stones will remain asymptomatic and for what duration. The fact remains true that longer the stone remains, the more are the chances of complications like acute cholecystitis, cholangitis, pancreatitis and carcinoma of gall bladder.

MATERIALS AND METHODS

In our study fourty seven (47) cases of ultasonographically diagnosed cases of gall stones were followed non operatively for three years as these patients refused surgery or were not found to be medically fit for surgery. These patients are of above 50 years of age group. Patients were examined every six months for signs and symptoms along with repeat ultrasound. It was found that in thirty seven (37) cases no specific problem

came up except flatulence and dyspepsia and occasional epigastric/ right hypochondric pain. Out of Ten (10) remaining cases, seven (7) cases had recurrent attacks of acute cholecystitis & one had acute pancreatitis, two cases had mucocele, empyaema and cholangitis. Two factors were found to be precipitating in above Ten (10) cases; one diabetes and second very large or very small size of stones. None of the cases were found to be malignant.

CONCLUSION

Only Twenty one percent (21%) of cases diagnosed as silent gall stones not operated turned to be symptomatic. Others remained silent even at two to three years duration. Diabetes and unequal size of stone

were found to be precipitating factor in those case, however a close observation is mandatory in all such cases to prevent complications and to decide switching over to operative management. But operative treatment on incidental diagnosis of gall stone is still controversial. The present study indicates close follow up of such cases to prevent complications.

- C. Sendes A, Diaz JC, Burdiles P, et.al. Mirizzi Syndrome and Cholecystobiliary fistula. A unifying classification. Br J surge 1989; 76:1139.
- Grady W.A. Ransom DF; The natural history of silent gall stones. The innocent gall stone is not a myth. N Eng J Med 1982; 307:798.
- M.S. (Surgery). Senior Resident. Deptt. of Surgery, Nalanda Medical College & Hospital, Patna (Bihar).
- MS, FRCS, DNB, Associate. Prof. Deptt. of Surgery, Nalanda Medical College & Hospital, Patna (Bihar).

KEY WORD: mesh repair, Incisional hernia, complication.

INTRODUCTION

About fifteer percent (15%) of Laparotomy done develop incisional Hernia in due course of time, of which 85% Cases are in lower abdomen (infra umbilical). In this condition a part of abdominal content reside permanently (in the hernia sac that is to say in 2rd abdominal cavity), although initially part of the hernia may be reducesible. Reduction of the large incisional hernia may lead to respiratory embarrassment, specially if the content in sac are more than Twenty percent (20%) of abdominal content with significant loss of domain.

MATERIAL & METHODS

In our study lifty six (56) cases of incisional hernia repair done, were studied with two year follow up (from April 2008 to March 2010). All the patients, mostly obsee were repaired with prolene mesh with 4 to 6 cm excess from the margin of hernia aperture in all directions with continuous peripheral suturing and interrupted central situring 1 to 2 cm apart with suction drains.

All patients were post operatively managed by NG tube, IV fluid and antibiotics with gradual switch over to oral diet.

In thirty eight (38) cases mesh was put between sheath and muscles and in nine cases between muscles and fascia transversalis (both sublay). Out of thirty eight (38) cases in thirty (30) cases mesh was fully covered with sheath and in eight (8) cases only partial cover could be done, onlay repair above the sheath was done, in fourteen (14) cases, inlay with the sheath margin, in four (4) cases only.

COMPLICATIONS

Eighteen (18) cases/thirty (30%) had complications like haematoma, would infection, seroma and recurrence either alone or together.

In our observation recurrence occurred in six (6) cases, wound infection in fourteen (14) cases, seroma ten (10) cases and hematoma eight (8) cases. Some of these cases were treated conservatively i.e. with antibiotic and dressing, few required aspiration or incisional drainage:

Obesity and infection were found to be main factor to have recurrence.

A Comparative Study of Different Mesh Repair of Abdominal Incisional Hernia

Dr. Basudeo Prasad Jaiswall, Dr. N.P. Warain2

DISCUSSION

Incisional hernia repair after through investigations by multidisplinery team and good surgical technique include component separation (layer to layer); tissue expansion, local and distant muscles flaps and knowledge of free tissue transfer (for cases of significant loss of domain). Size of prosthesis should cover any residual defect plus and additional 4 to 6 cm in all directions of hernia gap from margin to prevent recurrence form the margin of mesh. Fixation suture should be continuous at margin and interrupted in centre not more than 1-2 cm apart. It should be kept in mind that in place of early incisional hernia repair after tissue maturation has good result.

USUAL CASES OF RECURRENCE

- Large hemia with significant loss of domain.
- Obesity (increase body mass).
- Hernia in elderly patient with loss of normal texture of tissue.
- Patient who suffers from post operative complications i.e. infection, haematoma, seroma etc.
- Inadequate peripheral fixation of mesh leads to recurrence under edge of the mesh.

CONCLUSION

The present study indicates that early incisional hernia repair i.e. after tissue maturation with proper use of prosthetic mesh, without infection, tension and meticulous surgery with good preoperative evaluation and preparation is rewarding.

Preperitoneal sublay fixation of mesh has been found to be better than inlay, and onlay fixation over the rectus sheath. Extra coverage of gap by mesh over the margin greatly reduces risk of recurrence.

- Flum DR, Horvath K, Koepsell T. Have outcomes of incisional hernia repair improved with time? – a population – based analysis Ann Surg 2003; 237: 129-35.
 - Rios A, Rodrigues JM, Munitiz V, Alcarez P, Perez D, Parrilla P. Factors that affect recurrence after incisional hemiomhaphy with prosthetic meterial, Eur. J Surg 200: 167:855-9.
- 3. Tran. NV, Petty PM, Bite U, Cin. Tr.
 Johnson CH, Arnold Pg Tissue expansion

 assisted closure of massive vs. Although the coll surg 2003:196:48

 hernia, J Am cell surg 2003:196:48
- Bendavid R Incisional parapublic heroises Surgery 1990; 108:898-901.
- Anh R Coll Surg. Engl 2004:86; 353-368.
- Santora TA, Roslyn JJ. Incisional house surg clin North Am 1993.73; 557-70.
- Casser k, Munito A. surgical treatment of incisional hemia Br J surg 2002, 88:233-24.
- M.S. (Surgery). Senior Resident, Deptt. of Surgery, Nalanda Medical College in Hospital, Patna (Bihar).
- MS, FRCS, DNB, Associate, Prof. Deptt. of Surgery, Nalanda Medical College. & Hospital, Patna (Bihar).

ORIGINAL & CLINICAL RESEARCH

KEY WORD : aggressive resection, Carcinoma Gall Bladder

INTRODUCTION

The commonest cancer of biliary tract, is Gall Bladder Carcinoma with reported incident of 10.6/1 lac population, in North India, making G.B. cancer the 3rd commonest cancer after breast and cervical carcinoma. Unfortunately majority of carcinoma gall bladder present in late stage silently. This is because of non-specific nature of early carcinoma and tendency of gall bladder cancer towards early dessimination leads to late presentations of the patient. With an overall five (5) year survival not noted above 5-10%.

MATERIAL AND METHOD

During the period of Feb. 2008 to March 2010 out of Ninety Six (96) cases of open cholecystectomy done and in seventeen (17) cases found to be histologically proved carcinoma gall bladder involving serosa of Gall Bladder stage II (T, NoMo) were taken up for the study, After proper conselling resurgery was done between 10-21 days post operatively. Segment IVb/V of liver (G.B. fossa) was resected and nodal clearance from the Porta and along the C.B.D. was done. Haemostasis was secured with haemostatic patch (Surgi-seal patch, cautery & ligation of bleeding vessels along with liver tissue).

Abdomen was closed with drain along with line of incision (Kocher's incision). Out of Seventeen (17) cases, In Twelve, (12) cases uneventful recovery was noticed. In three (3) cases bile leak with line drain for 5 to 10 days. In two (2) cases local haematoma was found, which was managed by ultra sound guided espiration.

All the cases were subjected to routine (protocol) chemotheraphy post operatively. The cases were followed up at 1 month, 3 months, 6 months 1 year and 1 years. Out of seventeen (17) operated cases two (2) cases developed obstructive jaundice and subsequentially

Aggressive Resection in Carcinoma Gall Bladder How Far Justified

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hepato renal failure within 6 months and died. In 1 year disease free survival was noticed in ten (10) cases and one and half year survival was noticed in 5 cases.

DISCUSSION

G.B. cancer is an aggressive malignancy and majority of patients are un suitable for curative resection at the time of diagnosis. A tremendous increase in laproscopic cholecystectomy help in early picking of carcinoma Gall Bladder. A good number of cases have been reported in Japan, U.K. and North America with disease free survival after radical cholecystectomy and maximal possible nodal clearance. In present series also with segmental liver resection and possible nodal clearance giving a disease free survival of one year to one and half year is certainly enthusiastic effort.

CONCLUSION

Carcinoma Gall Bladder though with very high mortality & morbidity, is best treated if diagnosed early. Stage II disease with only serosal involvement is better treated by resurgery with liver segment IVb/V resection and possible nodal clearance. This gives a disease free survival of one to one and half year in 60 to 70% cases.

Even with aggressive resection the diseases free survival is limited to one year in most of the cases and that also in early stage i.e. state II. So it is the stage of the disease which decide the outcome of aggressive surgery in terms of morbidity and motality.

- Shibala K, Uchida H., lymphatic invasion: an important prognostic factor for stage. T₁₅-T₃ Gall Bladder cancer and an indication for additional radical resection of incidental Gall Bladder cancer, World J Surg. 2009. 33/1035-41.
- Misra S, Chaturvedi A, Gall Bladder cencer. Curr treat options Gastroenterol 2006/9/95-106.
- Kondo S, Nimura Y, Extensive surgery for carcinoma of the Gall Bladder, Br. J. Surg 2002/89/179-84.
- Misra MC, Gularia S, Management of Cancer Gall Bladder found as a surprise on resected gall bladder specimen. J Surg oncol 2008, Vo. 93/690-8.
- M.S. (Surgery), Senior Resident, Deptt. of Surgery, Nalanda Medical College & Hospital, Patna (Bihar).
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KEY WORD : Diabetic foot, wound debridement, control of infection, insulin, weight relieving shoes & braces.

INTRODUCTION

It is unfortunate that about twenty percent (20%) cases of diabetes come with diabetic foot problem out of which twenty percent (20%) ultimately land in amputation, Important underlaying causes leading to diabetic foot are motor, sensory and autonomic neuropathy with progressive infection. The badly infected. ulcers dominantly on planter skin keeps progressing due to unequal pressure and poor vascularity. Standard treatment of diabetic foot ulcer include frequent would debridement, wound care, treatment of infection and revascularization of ischaemic limb and adequate off-loading of weight. Managing a patient after amputation costs twice than of successful limb salvage. So all efforts should be made to salvage the affected limb. Functional status of affected limb is important to maintain day to day activity in the affected diabetic person.

MATERIAL AND METHOD

During the period of March 2008 to Feb. 2010, 37 cases of established diabeties with foot ulcer admitted in routine OPD/Emergency surgical ward were studied and managed.

Routine Haemogram with Blood sugar - fasting/2 hrs P.P. Lipid profile, X-ray foot with Doppler study of blood flow, pus culture and sensitivity from the ulcer of all cases were done.

Three (3) cases had medium, size terial block in the affected leg and Two of them had amputation at various sel, even after proper treatment.

In twenty nine (29) cases imperglycaemia was managed by insulin moluble), whereas in eight (8) of them who refused to take insulin, oral hypoglycaemic agents were used. In all these eight (8) cases infection was more virulent with delayed healing than the insulin group. Regular wound debridement and wound care was done

Diabetic Foot Manament, Its Challenges and Out Came

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in all cases. Meticulous debridement, specially in deep spaces of foot was found to be most rewarding in thirty two (32) cases. Pressure off-loading was done in twenty one (21) cases with selective shoes and braces with person to person requirement.

All these cases showed improved healing then in persons without specific braces and shoes. Inspite of all efforts six (6) cases had to undergo amputation at various level. In all these cases poor drug compliance, irregularities in dressing and debridement of wound, no use of insulin and improper or non use of off loading braces and shoes were found to be important deteriorating factors.

Our of Thirty seven (37) cases, Thirty five (35) cases were followed upto 6 months or upto healing. Pus culture and sensitivity of all cases were done and antibiotic instituted accordingly.

CONCLUSION

Regid diabetic control by insulin, meticulous wound debridement and dressing with off-loading of affected limbs was found to be key factor in proper and successful management of diabetic foot. Function of limb & joints along with healing of ulcer should be always in our mind. Systematic antibiotic proved to be less important then meticulous dressing and wound debridement.

- Singh S, Evans L, Datta D, et.al. The cost of Managing lower limb techemia. Eur Jvasc Endovasc Surg 1996; 12:359.
- O'Meera SM, clullum NA, Majid M, et.al. Systematic review of anti-microbiol agents used for chronic would. Br J Surg 2001:884.
- Keratein M.D. Heel ulcerations in the diabetic patients 2002; 14:212.
- Jeffcoate WJ, Harding KG. Diabetic Fool ulder Lancent 2003; 361 (9368): 1545.
- M.S. (Surgery), Senior Resident, Deptt. of Surgery, Nalanda Medical College & Hospital, Patna (Bihar).
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KEY WORD: Ascariasis, Intestinal obstruction, perforation, extra intestitional manifestation and complication.

INTRODUCTION

Ascariasis is a health problem in many countries of the world. Open air sanitation poor hygiene, increasing trend of outside food in urban population are responsible for increasing number of cases, Growing tourism allows people to carry parasite (migration) to other part of the world. Primarily Ascaries lumbricoides is endemic, where poverty over crowding, ooor sanitation and unsafe water supply exist and involve millions of people in under develop and developing countries. Adult worms live in proximal small bowel of human and fertilized egg excreated in the faeces, which may remain donnant for years and regrow, following ingestion. The eggs hatch in small intestine and penetrate intestinal wall to enter the portal circulation or lymphatic through which they migrate through the liver, heart, pulmonary artery, lungs and finally migrating back to pesophegus to return to intestine again, It has also been found in extra intestinal areas and hepato billiary area. It is more common in adolescent age group between five to fifteen years.

COMMON SURGICAL COMPLICATIONS OF ASCARIES INFESTATION

Although mild infestation is usually harmless where as heavy infestation may lead to symptoms and serious disorder and complications like bolous obstruction or intestinal perforation. Other than medical problem common, surgical complications are intestinal or hepatobilliary.

OBSERVATION

A total of One hundred fourteen (114) cases of intestinal and extraintestinal ascariasis seen in SODP/surgical emergency of Nalanda Medical College in the period of March, 2008 to Feb. 2010 were observed. Among these Eighteen (18) cases of extra intestional ascariasis were diagnosed incidentally on ultrasound done for upper abdominal pain. Out of eighteen (18), six (6) presented as obstructive jaundice and one had cholangistis with fever & jaundice. All the nine cases were reated medically with antihelmenthic and antibiotic as and when required. In one case 3CP with removal of worm from CBD was done to relieve obstructive jaundice.

Surgical Complications of Intestinal Ascariasis and Its Management

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Out of ninety six 196) cases of intestinal ascariasis presenting in surgical emergency as pain, voniting abdominal distension or with features of peritonitis, seventy four (74) cases were found to have intestinal obstruction due to worms and twenty two (22) cases had intestinal peforation with our without worm lying in peritoneal cavity. Primary repair of perforation was done in fourteen (14) out of twenty two (22) cases. In six (6) cases resection & anastomosis was done. While in one case ileostomy was done. Out of seventy four (74) cases presenting as intestinal obstruction and diagnosed finally on O.T. table, in sixty two (62) cases simple enterotomy and removal of large number of worms was done. In four (4) cases, distal milking was done where as in six (6) cases resection & anastomosis and in two (2) cases ileostoniv was done. All these eight (8) cases had gangarene in a segment of small bowel.

In the perforation group, four (4)/nineteen percent (19%) patients died. While in obstructive group, there was only two (2) death (2.5%) and that was due to sudden shock during removal of large amount of worms from the gut.

DISCUSSION

Intestinal ascariasis is a common problem in our area. Poor socio-economic status, bad food hygiene and ignorance with or without illiteracy are responsible for infestation and progressive increase in the number of worms in the intestine, leading to intestinal obstruction and perforation. Extra intestinal infestation usually in biliary tree is incidentally diagnosed and usually asymptomatic, except rarely with cholongitis and obstructive jaundice. It is

difficult to pin point diagnosis of intestinal obstruction or perforation due to worms preoperatively. However poor socio-economic status of the patient with poor hygiene or passage of worms in stool or vomitus in the past should give us, high index of suspicious regarding this condition. Fetal anaphylactic shock can take place during handling of worms in operation. Early surgical intervention both in obstruction and perforation will improve morbidity & mortality. Worm in CBD may lead to obstructive jaundice.

CONCLUSION

In endemic areas patients preschting with acute intestinal obstruction or perforation, intestinal ascariasis should be considered as one of the important cause, Pre-operative confirmation of diagnosis is difficult. Majority of cases are diagnosed on O.T. table. Early surgical intervention is rewarding. Extra intestinal ascariasis is usually asymptomatic and incidentally diagnosed, but can lead to hepatobilliary symptom also.

- Beitia AO, Haller JO, Kantor A; (1º Findings in pediatric gastro intestinal ascariasis, Comput Med. Imaging Graph 21: 47, 1997.
- Wasadikar PP, Kulkarni AB; Intestinal obstruction due to ascariasis. Br J Surg 84: 810, 1997.
- Salman AB : Management of Intestinal obstruction caused by accesses. J pediatr surg 32: 585, 1997.
- Gualard M, Herrera I: Acute pancrealitis due to pancoealic duct ascariasis migration after pancrealic sphenoterotomy and pancreatic stent placement. Endoscopy 29:53, 1997.
- M.S. (Surgery), Senior Resident, Deptt. of Surgery, Nalanda Medical College & Hospital, Patna (Bihar).
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MANAGEMENT IN MIRIZZI SYNDROME

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INTRODUCTION :-

Mirizzi in 1948 described the above syndrome as an unusual complication of gall stone disease. Unfortunately inspite of advancement in imaging teachnique, this condition is not diagnosed preoperatively but has got high risk of introperative C.B.D., injury.

MC sherry classified mirizzi syndrome into type I common hepatic duct compression by impacted cystic duct stone and type II. Type III and type IV as cholecystocholedocho fistula of various sizes.

MATERIALS AND METHODS :-

In course of three year from March 2008 to Feb 2011, twelve cases of mirizzi syndrome were diagnosed on operative table and operative procedures were decided, depending on the type of the syndrome. Out of twelve cases, seven cases were of type I, where only cholecystectomy found to be sufficient. Out of seven cholecystectomy done, one case had postoperative billiary stricture, which was later managed by ERCP & stenting. In remaining five cases where type II and type III was found was managed by partial cholecystectomy with choledochoplasty by G.B. cuff. One case of type IV managed by roux-en-y, hepatico jejunostomy.

Out of above four cases of type II & III, where cholecystectomy and choledochoplasty was done, two cases had a leak with bilioma, both cases were managed by ultrasound guided aspiration and intraperitoneal tube inseration. One patient improved with conservative treatment and other

patient died of biliary peritonitis and septiciaemia later on.

CONCLUSION:

Preoperative diagnosis of mirizzi syndrome is difficult. Most cases are diagnosed on operative table. Operative procedure depends on type of sydrome. Even in good hands, morbidity and mortality of about 20% to 25 & is found. Roux en Y hepatico jejunostomy though technically difficult was found to be more safe than choledochoplasty in terms of post operative morbidity & mortality.

REFERENCES :-

- Mirizzi PL syndrome delconductohepatico J int chir 1948, 8:731.
- Baer HU, matthewes JB shweltzer WP, et.al. management of Mirizzi syndrome and the surgical implications of cholecystocholedochal fistula. Br J Surg. 1990, 77:743.
- MC sherry CK, Ferstenderg H, Vishup M, The Mirzzi sydrome, suggested classification and surgical therapy. Surg gastroenteral 1982, 1:219.
- Jhonson IW, Schon JK, lee WC, et al. Mirzzi syndrome. Experience from a multi institutional review. An Surg 2001, 1:11.

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STUDY OF 37 CASES OF ASYMPTOMATIC GALL STONE

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INTRODUCTION:

Abdominal ultrasonography has revolutionized the early diagnosis and management of gallstone. On the other hand it is difficult to know which gall stones will remain asymptomatic and for what duration. It is true, that longer stone remains the more are the chances of complication like cholangitis, acute cholecystitis, pancreatitis and carcinoma of gall bladder.

MATERIALS AND METHODS:

In the present study thirty seven cases of utrasonographically diagnosed case of gall stones were followed non operatively for three years as these patients refused surgery or were not found to be medically fit for surgery. Patients were examined every six months for signs and symptoms along with repeat ultrasound. It was found that in twenty nine cases no specific problem camp up except flatulence and dyspepsia and occasional epigastric, right hypochondric pain. Out of eight remaining cases, five cases had recurrent attacks of acute cholecystitis & one had acute pancreatitis, two cases had mucocele, empyaema and cholangitis. Two factors were

found to be precipitating in above eight cases, one diabeties and second very large or very small size of stones. None of the cases were found to be malignant.

CONCLUSION:

Only 19% of cases diagnosed as silent gall stones not operated turned to be symptomatic. Others remained silent even at two to three years duration. Diabeties and unequal size of stone were found to be precipitating factor in those case, however a close observation in mandatory in all such cases to prevent complications and to decide switching over to operative management.

- Grady W. A. Ransom DF: The natural history of silent gall stones. The innocent gall stone is not a myth. N. Eng J Med 1982; 304:798.
- C Sendes A, Diaz JC, Burdiles P, et.al. Mirizzi Syndrome and Cholecystobiliary fistula. A unifying classification. Br J surge 1989; 76:1139.

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INTRODUCTION

Hernia repair is one of the commonest procedure performed by general surgeons, indeed, it has been stated that "the history of hernia repair is the history of surgery".

Hernia account for 10-15% of all surgical procedures.

The rapid changes that have been witnessed in open approach surgeries, prosthetic materials and laparoscopic surgeries have made hernia surgery, a most interesting field of endeavor that demands renewed discipline and dedication.

Repair of inguinal hernia is one of the commonest surgical procedure performed worldwide. Irrespective of country, race or socioeconomic status hernia constitutes a major health care-drain.

There are three important landmarks in the history of repair of inguinal hernia -

- Tissue repair Eduardo Bassini 1888.
- Onlay Mesh Irving Lichtenstein (1984)
 (Tension Free repair)
- Laparoscopic Ger, Shultz, Hernia repair crobitt etc., 1990.

A newer concept of groin hernia repair is to cover the hernia defect with a prosthetic mesh. This mesh is placed on one of the layer of the abdominal wall either using an open approach or a minimal assess laparoscopic technique.

The advent of laparoscopic has revolutionized abdominal surgery and a large body of evidence has been amassed to compare laparoscopic and open techniques in the repair of inguinal hernia. The two most common types of laparoscopic repair are the transabdominal preperitoneal repair (TAPP) and totally extraperitoneal (TEP).

Though a variety of procedure are performed none can be termed as an ideal procedure as each one is accompanied by varied early late complications, the most significant being recurrence. In 1981, William Bull, one of the most prominent surgeon, wrote of hernia repairs "it is wise to estimate the value of given procedures by the relative proportions of relapses".

Although, many studies have explored the relative merits and potential risks of laparoscopic surgery for the repair of inguinal hernia, but still the debate surrounding the optimal treatment for the surgical repair of

A Comparative Study between Laparoscopic Hernia Repair and Open Lichtenstein Mesh Repair

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inguinal hemia has continued.

In 1996, the International study group for laparoscopic inguinal hernia repair (ISLIR) suggested a 'standard' approach to data collection as a basis for an individual patient data (IPD) meta-analysis to combine the results from all available randomized evidence evaluating laparoscopic repair for inguinal hernia. Over the randomized trials have compared laparoscopic surgery with the Lichtenstein repair. They show that, although the laparoscopic operation takes longer to performed, proven advantages are reduced pain both following surgery and up to five years later, more rapid return to full activity and reduced incidence of the wound complications of infection, bleeding and seroma.

National statistics show that the proportion of cases performed laparoscopically is slowly rising but all agree that there is a slow learning curve associated with these technically demanding operations.

In our institutions, inguinal hernia repair is one of the common surgeries performed daily. This study aims at studying the efficiency, advantages, disadvantages, limitations, post operative complications, post operative pain, duration of hospital stay and the cost effectiveness between the Lichtenstein (Mesh) repair and laparoscopic inguinal hernia mesh repair surgeries and to arrive at a conclusion

as to the best modalit, of treatment after comparison of morbidity and recurrence of the procedures among these and in relation to standard published material.

MATERIAL AND METHODS

The present study is a prospective study of 60 cases of inguinal hemia admitted in Department of General Surgery, Patna Medical College & Hospital, Patna, Bihar,

60 cases for the purpose of the study were selected on the basis of the non probability (purposive) sampling method.

The inclusion criteria

Patients with unilateral or bilateral inguinal hernia with reducible and uncomplicated inconstruction, no strangulation or anymother complication) with primary hernias are included in the study.

The exclusion criteria are

All patients who presented with complete hernia and with complications of inguinal hernia like obstruction or strangulation are excluded from the study. ASA (American Society of Anaesthiologist) Gr>3 are also excluded from the study.

Thorough history

Clinical Examination

- In addition to -

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Table 4: Atypical bone marrow findings observed in leishmaniasis.

| | Number of cases | 22.22 7.40 5.55 | |
|--|-----------------|-----------------------|--|
| Bone marrow aspirate cytology Aggregates of LD bodies Kinetoplast only | 24 03 | | |
| Giant cells Bone marrow biopsy (total 19 cases) | - 56 | 2.32 | |
| Increased fibratic foci | 0.5 | 4.62 | |

Visceral leishmaniasis is considered to be disease of low altitude as climatic and geographical factors play an important role in the distribution of vector, parasite, and reservoir .The centre of our study caters largest area of endemic zone for leishmaniasis i.e. North Bihar, including adjoining neighbour country of Nepal. This may either be related environmental factors, population congestion with rural practices of agriculture. Socioeconomic factors including illiteracy and poverty may be related to the spread of leishmaniasis as 78.7% of cases were present in lower economic group in our study. Fever and hepatosplenomegaly were the common clinical presentation in the present study which is consistent with other studies. The present study observed that pancytopenia and thrombocytopenia were present in 96.29% and 4.62%cases which is in contrast with another study from other studies in endemic region which observed pancytopenia and thrombocytopenia in only 10% and 30% cases, respectively. The probable reason may be delayed diagnosis due to late presentation of cases from remote areas in the study. On bone marrow aspirate cytology, increased histiocytes and hemophagucytosis were an important common phenomenon observed in the present study However another study has also reported hemophagocytosis as common finding which may be attributed to longer duration of symptoms. Other associated features such as plasmacytosis, erythroid hyperplasia, and dysmyelopoiesis may also be helpful indicators of leishmaniasis. Aggregates of LD bodies in from of irregular flower shape, ring shape, and strap shape may also be uncommonly observed in Inishmaniasis, which at times may mimic

fungal spores or platelet aggregates and therefore necessitates a pathologist to have knowledge of such irregular aggregates. The present study also indicates that LD body may also be present inside nonhistiocytic cells like polymorph, metamyelocyte, and therefore vigilant search of the parasite ... nonhistiocytic cells should also be done.. The bone marrow biopsy examination commonly indicates increased cellularity and vascularity which may be due to reparative process and uncommonly shows necrosis or granuloma which may be associated due to thrombosis of capillary lumen by parasites. Although giant cells, necrosis and granulomas are considered to be uncommon and atypical findings in VL in present study, their presence should also prompt close search of LD bodies on hone marrow aspirate cytology. This is especially important in these areas where TB is endemic and may be associated with leishmaniasis.

CONCLUSION

Thus to conclude the knowledge of common, uncommon, and atypical features on bone marrow aspirate cytology is helpful during diagnosis of leishmanlasts in endemic areas where clinical suspicion is high. In contrast to previous study from endemic region, hemophagocytosis and pancytopenia were commonly observed white granular and free cytoplasmic bodies were uncommon morphological findings in the present study. The features will guide the pathologist for vigilant search of LD bodies in the marrow aspirate for definite diagnosis. In addition, it will also be useful in preventing the use of

advanced and costly diagnostic modalities in the diagnosis of visceral leishmaniasis

Conflict of Interests

The authors declare that they have no conflict of interests.

- B. L. Herweldt, "Leishmaniasis," in Harrison's Principles of Internal Medicine, A. S. Fauci, E. Braunwald, D. L. Kasper et al., Eds., pp. 1296–1300, McGraw-Hill, New York, NY, USA, 17th edition, 2008.
- 2 G. S. Bhunia, S. Kesari, A. Jeyaram, V. Kumar, and P. Das, "Influence of topography on the endemicity of Kalazar: a study based on remote sensing and geographical information system," Geospatial Health, vol. 4, no. 2, pp. 155–165, 2010. Y. Daneshbod, S. J. Dehghani, and K. Daneshbod, "Bone marrow aspiration findings in kala-azar," Acta Cytologica, vol. 54, no. 1; pp. 12–24, 2010.
- K. K. Ohingra, P. Gupta, V. Saroha, N. Setia, N. Khurana, and T. Singh, "Morphological findings in bone marrow biopsy and aspirate smears of visceral kala azar:
- K. Park, "Leishmaniasis," in Park's Textbook of Preventive and Social Medicine, K. Park, Ed., pp. 279–282, M/s Banarsidas Bhanot, Jabalpur, India, 22nd edition, 2015
- D.-E. A. Elneiem. J. Schorscher, A. Bendall et al., "Risk mapping of visceral leishmaniasis: the role of local variation in rainfall and attitude on the presence and incidence of kala-azar in eastern Sudan,"American Journal of Tropical Medicine and Hyglene, vol. 68, no. 1, pp. 10–17, 2003
- L. M. Prieto Tato, E. La Orden izquierdo, S. Guillén Martn et al., "Visceral childhood leishmanlasis: diagnosis and treatment," Anales de Pediatria, vol. 72, no. 5, pp. 347–351, 2010.

- · Routine blood (Hb%, BT, CT, TLC, DLC, blood sugar),
- · Urine investigations (R/E, Culture sensitivity of urine if evidence of infections), blood urea and serum creatinine if required.
- · Chest x-ray P/A view (specially for chronic cough, COPD, asthma and elderly patients).
- Radiographic procedures like USG and ECHO are recommended if it is indicated for certain patients.
- · And other investigations are also done if required.

Preoperative treatment included:

- Correction of anemia
- Weight reduction if obese
- Improvement of nutritional status
- Treatment of respiratory infection (URTI & LRTI if any)
- Abstinence from smoking/ alcohol
- Advice regarding breathing exercises
- · Treatment of urinary symptoms if any.
- Constipation (cause should be carefully evaluated and treated).

Anaesthesia used : (Randomly choosen)

- Spinal anesthesia for open cases
- General anesthesia for laparoscopic hernia mesh repair.

Operative procedure

- · For open hernia The Lichtenstein repair
- For laparoscopic hernia TEP, TAPP

A single dose of preoperative broad spectrum antibiotic given followed by the same postoperatively.

 Analgesics- Injection Tramadol i.m. was given postoperatively for 2 days and later SOS.

Post operative care and complications

- After surgery all patients were monitored carefully for pain, bleeding, hematoma, wound infection and urinary retention.
- Pain was assessed using verbal graphic rating scale.
- A wound infection ranged from minimal discharge of pus from a single cutaneous suture to extensive and invasive process requiring lengthy hospitalization and intravenous antibiotics.

- Bleeding was defined as subcutaneous hematoma which can result from careless ties or cautery.
- · Urinary retention was termed as inability to urinate requiring catheterization.

Discharge

The patients were discharged when fit and asked to come for regular follow up after 7 days 1,3,6,9,12 months postoperatively. Different patients were followed up for different periods with many dropouts. The patients were advised to return to pre-hernia lifestyle except lifting heavy weights.

All were followed-up for post operative pain, interference with activities of daily living, use of analgesics, visit to a GP and recurrence.

The age/ sex incidence, mode of presentation, precipitating factors, surgical treatment, post operative complications, cost of the treatment, hospital stay were all evaluated and compared with standard published literature.

STATISTICAL METHODS APPLIED

Descriptive: The Descriptive procedure displays univariate summary statistics for several variables in a single table and calculates standardized values (Z scores). Variables can be ordered by the size of their means (in ascending or descending order), alphabetically or by the order in which you select the variables (the default).

Crosstabs: The crosstabs procedure forms two- way and multiway tables and provides a variety of tests and measures of association for two- way tables. The structure of the table and whether categories are ordered to determine what test or measure to use.

RESULTS

In our study the incidence of hernia was common in the middle age group, greatest in the 45-164 yrs age group (43.3%) and men were affected more than women. The occurrence of hernia is common among the farmers and labourers accounting for 56.7% in comparison to other occupation like teacher or conductor (33.3%). 73.3% patients presented within the first 1 yr of onset of complaints while 26.7% of them presented after 1 yrs. In our study 26.7% were smokers and 73.3% non smokers. The incidence of hernia was more common in people who

8.3% of patients who had two precipating factors (constipation & BPH), 7 of the patients suffered from hypertension while 2 of them had illness like diabetes mellitus. Chronic cough and COPD was seen in 7 patients. Right, indirect hernia was seen in 20 cases being the most frequent type (33.3%). In our study 30 cases each underwent laparoscopic hernia repair (TEP -12 and TAPP- 18 cases) while 30 cases underwent Lichtenstein hernioplasty. They were randomly chosen for the different surgeries. Severe pain was complained in 6 cases (20%) of Lichtenstein hemioplasty and 2 cases (6.7%) of laparoscopic hemia repair while 22 cases of laparoscopic hemia repair had mild pain. Post- operative wound infection developed in 1 case of Lichtenstein hernioplasty and I case in the laparoscopic hernia group. Hematoma at the operated site was found in 1 case (3.3%) of Lichtenstein hernioplasty. Seroma occurred in 3 cases (10%) of Lichtenstein hern-loplasty and 2 cases (6.7%) of laparascopic hernia repair. Mesh infection was developed in 1 case (3.3%) of Lichtenstein hemioplasty. The duration of hospitalization was 10.3 days in case of Lichtenstein hemioplasty whereas 7.6 days in case of laparoscopic hernia repair. Return to normal routine work was 18 days and 14 days respectively. There was a mean difference of about Rs, 2914 between the two groups of surgery. Hence laparoscopic hernia repair was not cost effective. There were 1 case (3.3%) recurrence noted in the laparoscopic hernia group whereas no recurrence in the hemioplasty group was found. Repair of inguinal hemia is one of the commonest operations performed by surgeons around the world. The treatment of this common problem has seen an evolution from the pure tissue repairs to the prosthetic repairs and in conventional open approach to laparoscopic approach. The fact that so many hernia repairs are practiced is a testimony to the fact that probably none is distinctly superior to the other. However, there is still no agreement about which operation is preferable in a given situation and the reported cumulative recurrence rate varies widely from 1% in special centers to more than 30% cited in reviews. Quality assessment of hemia surgery is

undertook strenuous work accounting for

56.7% of cases. It was also a component in

essential. It is necessary for education and for

evaluation of new methods. For surgeons and surgical units, quality assessment is necessary for improving and defending achievements. We have a long way to go in order to make hernia repair a "once-in-a-lifetime experience" for our patients.

CONCLUSION

The present study is comparative study between The Lichtenstein tension free Mesh repair and the Laparoscopic inguinal hernia mesh repair (TEP/TAPP). The study was conducted with an intension to compare the effectiveness of the different surgeries and complications if any.

All patients were intensively monitored in the immediate post operative period and the complications noted. We found that there was a marked reduction in post operative pain in laparoscopic hemia repair compared to the Lichtenstein mesh repair surgery. But we found that the laparoscopic hemia repair is expensive than open repair. The post-operative complications was significantly lower in laparoscopic group than open group (except few vascular complications in laparoscopic group like seroma and hematoma).

The patients were followed up in the postoperative period for variable durations.

Drop outs to follow up were many. Therefore few recurrences were noted during the study period. The recurrence rates were higher in the laparoscopic hernia repair group when compared to the Lichtenstein mesh repair.

There were few limitations to the study, the duration taken for preparation of the patients from the time of admission to the time of surgery was normally around 2-3 days which led to an apparent increase in the duration of hospitalization in both group. The learning curve for the surgeons in laparoscopic hernia repair led to prolonged duration of surgery and also for the few recurrences noted.

There were few dropouts in the follow up period and since the study period was for a short duration, long term outcomes and results cannot be assessed and thus the follow up continues for these patients.

To summarize, there is no universal repair for groin hernia and no two surgeons will disagree to agree on that point.

Although the laparoscopic surgery have shorter duration stay, less postoperative pain, few post-operative complications, early return to normal routine work and high cosmetic value as compared to Lichtenstein mesh repair but it is a costly technique, need expertisation for surgeons (learning curve) and a few recurrence rate also, in our opinion, surgeries which are cost effective, low recurrence rate with few complications (post operative) are better than surgeries which are costly and having recurrence rate too.

Clearly, before we can draw any firm conclusions on the appropriate laparoscopic technique long term results of large randomized studies to compare open and laparoscopic procedures required.

Both procedures are reliable and show high patient satisfaction. In our opinion, a prospective study and intensive questioning in

the long-term follow-up of patients after inguinal hernia repair are needed to check the reported high rate of severe symptoms and to determine the objectively and subjectively optim al procedure for each patient.

- Lal P, Kajla RK, Chander J, et al. R CT of laparoscopic TEP versus open Lichtenstein inguinal hemia repair. Surg. Endosc. 2003; 17:850-856.
- Eklund A, Rudberg C, et al, Short term results of RCT comparing Lichtenstein open repair with TEP laparoscopic inguinal hernia repair. Surg. 2006, 93:1060-1062.
- Neumayer L., Globie-Hurder A, Jonasson O, et al, Veterans Affairs co-operative studies Program 456 investigators, Open Mesh versus laparoscopic mesh repair for inguinal hemia. N Engl J Med. 2004.
- Schwedt CG, Sauerland S, Bittner R. Comparison of endoscopic procedures vs Lichtenstein and other open mesh techniques for inguinal hernia repair; a meta analyses of RCT. Surg Endosc 2005.
- Wara P, Bay-Nielson M, Juul P, et al. Prospective nationwide analysis of laparoscopic versus Lichtenstein repair of inguinal hernia. Br J Surg. 2008.
- Heikkinen T, Bringman S, Ohtonen P, et al. Five year outcome of laparoscopic and Lichtenstein hemioplasties (2004).

After properly anaesthetizing the skin initially a stab incision is made over skin. Then through this incision the spinal needle was introduced. The sty let taken out and pus was aspirated. This was done to confirm the position of abscess cavity. Then with the help of guide wire the tract dilated. For dilatation of tract with serial metal catheter were used and dilation done up to size approaching to the diameter of catheter.

As dilation completed the catheter was introduced into abscess cavity and pus through catheter confirms its position. It is taken fixed to the skin using 1-0 silk suture. Then catheter was attached to a collecting bag. Then catheter was flushed with 20cc of normal saline in case of thickened pus for proper drainage.

RESULTS

The disease is common in 3rd, 4th and 5th decade of life. Male preponderated in the

series. The cases were mostly from poor section of population a few 2 cases belonged to rich class. Addiction to toddy (Fermented palm extract) was present in 76% of patient. Pain abdomen, anorexia and fever were the main complaints and they constitute for 98%, 80% and 78% respectively. Tenderness over liver was a constant features. Liver function test was deranged in about 45% of patient and it forms one of the important prognostic factors. Leucocytosis over 15 thousand per cumm. Of blood was seen in 16% of cases. The highest and lowest count of polymorphs in the present series were found to be 86 and 56%. Plain X+ ray chest and liver area was done in 50 cases and elevated dome of diaphragm was recorded in 36 cases 72% which is a significant radiological finding. In the present series 68% i.e. 34 cases showed positive serological test for antibody against E. histolytica.

CONCLUSION

The percutaneous catheter drainage with antiamoebic drugs is more effective than USG guided aspiration of uncomplicated liver abscess

REFERENCES

- Schwartz's Principles of Surgery : 9th edition.
- Bailey and Love: Short practice of surgery 13th Ed. Lewis & Cq. Ltd. London.
- Farquharson's Text book of Operative general surgery: 9th edition.
- Lee SH, Tomlinson C: AJR Roent quenol 2008 Mar. 190(3), 616-22.
- Enver Zerem, Aamir hadzic : Interventional USG dept. AJR 2007; 189, W138-W142.
- Sukhjeet Singh, Poras Chaudhary : Annals gastroentrol 2013;26(3):1-8.

ORIGINAL & CLINICAL RESEARCH

ABSTRACT

Objective: The aim of the present study was to compare the ability of four clinical prediction rules to predict adverse outcome in perforated peptic ulcer (PPU): the Boey score, the American Society of Anesthesiologists (ASA) score, the Acute Physiology and Chronic Health Evaluation (* PACHE) II score, and the sepsis score.

Material and Methods : Design : an observational multicenter study. Participants and settings; a total of 117 patients surgically treated for PPU in Department of Surgery, P.M.C.H. Patna, Bihar. Pregnant and breastfeeding women, nonsurgically treated patients, patients with malignant ulcers, and patients with perforation of other organs were excluded. Primary outcome measure: 30-day mortality rate. Statistical analysis: the ability of four clinical prediction rules to distinguish survivors from non-survivors (discrimination ability) was evaluated by the area under the receiver operating characteristic curve (AUC), positive predictive values (PPVs), negative predictive values (NPVs), and adjusted relative risks.

Results: Median age (range) was 70 years (25–92 years), 51% of the patients were

Accuracy of Clinical Prediction Rules in Peptic Ulcer Perforation : An Observational Study

Dr. Abhishek Mishral, Dr. N. P. Narain2

females, and 73% of the patients had at least one co-existing disease. The 30-day mortality proportion was 17% (20/117). The AUCs: the Boey score, 0.63; the sepsis score, 0.69; the ASA score, 0.73; and the APACHE II score, 0.76. Overall, the PPVs of all four prediction rules were low and the NPVs high.

Conclusions: The Body score, the ASA score, the APACHE II score, and the sepsis score predict monality poorly in patients with PPU.

INTRODUCTION

Mortality and morbidity following perforated peptic ulcer (PPU) is substantial, and mortality proportions of 25-30% have been reported in populationbased studies.

A large number of prognostic factors for morbidity and monality following PPU have been characterized and a number of clinical prediction rules proposed.

The most well-known prediction rule in PPU is the Boey score which seeks to predict

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mortality based on the presence of major medical illness, preoperative shock, and perforation longer than 24 h. In the original study by Boey et al., the in-hospital mortality proportion increased progressively with the number of prognostic variables, being 0%, 10%, 45.5%, and 100% in patients with none, one, two, or all three variables, respectively.

The most commonly used preoperative clinical prediction rule worldwide is the American Society of Anesthesiologists (ASA) score. In the ASA scoring system, the patient's preoperative health status, independent of the current surgical disease, is graded in five categories: (1) normal health, (2) mild systemic disease, (3) severe systemic disease, (4) severe systemic disease that is a constant threat to life, and (5) the patient is not expected to survive without surgery.

Another commonly used perioperative prediction rule is the Acute Physiology and Chronic Health Evaluation (APACHE) II score, where the predicted mortality risk is based on the sum of points from 12 physiologic measures, age, and health status.

The score has been sought to be validated in abdominal surgery in general, peritonitis in general, and PPU.

In a recently published paper, 30-day mortality in PPU patients was significantly reduced by implementing a perioperative care protocol, based on diagnostics, monitoring, and treatment according to the Surviving Sepsis Campaign. Sepsis score on admission was included in the protocol.

At present, clinical prediction rules are not routinely used in PPU patients in everyday clinical practice.

Accurate and early identification of PPU patients with an increased risk of adverse outcome is needed to plan and target the level of perioperative monitoring and treatment. The aim of the present study was to compare the performance of four clinical prediction rules in PPU: the Boey score, the ASA score, the APACHE II score, and the sepsis score. We hypothesized that existing clinical prediction rules are poor predictors of adverse outcome in PPU.

MATERIAL AND METHODS

A total of 117 consecutive patients surgically treated for PPU at Patna Medical College & Hospital, Patna, Bihar.

Protocol

Risk stratification according to the four scores (the Boey score, the ASA score, the APACHE II score, and the sepsis score) was done when booking for surgery was performed (preoperatively). Followup time was 30 days. The included patients were part of a clinical controlled multicenter intervention trial.

Outcome measures

The primary outcome measure was 30day mortality. Secondary outcome measures were: (1) development of septic shock (according to the 2001 International Sepsis Conference) within 30 days of surgery and (2) postoperative admission to the intensive care unit (ICU) within 30 days of surgery.

Sample size

Receiver operating characteristics curve; we expected a discriminatory ability (area under the receiver operating characteristic curve; AUC) of 0.75. Based on 80% power to detect a significant association (p = 0.05, two-sided) between the clinical prediction rule and the primary outcome, 80 patients were required in the study.

Multiple logistic regression: with a binary response variable, nine covariates, β = 0.80, α = 0.05, and an anticipated medium effect size, 113 patients were required in order to detect an association between the variables and endpoints.

Statistical analysis

Data were analyzed using the statistical software packages SPSS 19.0. The ability of the four clinical prediction rules to distinguish survivors from non-survivors (discrimination ability) was evaluated by the AUC. The optimal AUC is close to 1.

The risk of dying within 30 days of surgery, given a positive test result (a score above a certain threshold), is reported as the positive predictive value (PPV). Correspondingly, the risk of surviving within 30 days of surgery, given a negative test result (a score below a certain threshold), is reported as the negative predictive value (NPV). The optimal PPV and NPV are close to 100%. The optimal cut-off value of the clinical prediction rules was calculated by means of the Youden index (sensitivity + specificity.—.1).

Based on existing literature, and on the Youden indices, the following thresholds were

chosen: Boey score \$2, ASA score ±3, APACHE
II score ±12, and sepsis score ±3. Finally,
adjusted estimates of the four prediction rules'
association to the outcome measures are
presented as relative risks (RRs) with 95%
confidence intervals (95% CIs). Adjustment
for the following confounders was done; age
±65 years, gender, co-morbidity, alcohol abuse,
preoperative delay >24 h, and smoking.
Definitions of the variables are found in Table

Missing data occurred in less than 5%of the patients. The prevalence and pattern of missing values were evaluated; data were not "missing completely at random" (MCAR). Consequently, multiple imputation for the missing values was performed. Five imputations were made, and the five datasets were analyzed using Markov Chain Monte Carlo fully conditional specification, and the estimates were pooled for overall estimation. Furthermore, completecase analysis was performed. The pooled imputed estimates and the corresponding complete-case estimates were compared, and if there were any noticeable differences, both results are presented, Otherwise, only the pooled imputed estimates are presented.

RESULTS

A total of 117 patients were included. Median age (range) was 70 years (25–92 years), 51% of the patients were females, and 73% of the patients had at least one of six co-morbid diseases. Fifty-three percent of the patients were categorized as ASA class ±3.

Table I. Demographic characteristics.

| Characteristic | n = 117 |
|---|--|
| Age, median (range) | 70 (25-92) |
| Men, no (%) | 57 (49) |
| Body mass index, median (range) | 24 (15-65) |
| Co-morbidity ¹ , no (%) | 85 (73) |
| ASA class ² , no (%) I II IV V | 12(10) 43(37) 45(38) 15(13) 2(2) |
| Daily smoking, no (%) | 59 (50) |
| Alcohol abuse ³ , no (%) | 30 (26) |

 One or more of the following diseases: diabetes, chronic abstructive pulmonary disease, heart disease, liver cirrhosis, active cancer disease, AIDS or other chronically treated disease.

- American Society of Anesthesiologists class.
- More than 36 g/day (men) or 24 g/day (women).

Alcohol abuse was present in 26% of the patients, and 50% of the patients smoked daily (Table I).

Perioperative characteristics of the 117 patients are shown in Table II.

The 30-day mortality proportion was 17% (20/117). In all, 26% (30/117) were diagnosed with septic shock, and 49 patients (42%) were admitted to the ICU.

The AUCs of the four clinical prediction rules – with respect to the primary outcome 30-day mortality – were as follows: the Boey score 0.63; the sepsis score 0.69; the ASA score 0.73; and the APACHE II score 0.76. With respect to the secondary endpoint septic shock, the APACHE II score and the sepsis score had the highest AUC, whereas in relation to ICU admission, the ASA score and the APACHE II score had the highest AUC.

Overall, the PPVs of all four prediction rules were low: 30-day mortality (24–41%), septic shock (35–72%), and ICU admission (49–80%) (Table III).

The NPVs with respect to 30-day mortality were on the other hand high: ASA score ±3, 93%; APACHE II score ±12, 97%; Boey score ±2, 87%; and sepsis score ±3, 90%. For septic shock and ICU admission, the NPVs were lower.

For 30-day mortality, the APACHE II score and the ASA score had the highest RRs, 31.6 (1.8–545.2) and 21.5 (3.1–150.0), respectively. The sepsis score had the strongest association with septic shock: RR 14.6 (4.2–50.2). Only ASA score and sepsis score were significantly associated with ICU admission.

DISCUSSION

In this observational multicenter study in patients surgically treated for PPU, we found poor discriminatory abilities of all four evaluated clinical prediction rules: the Boey score, the ASA score, the APACHE II score, and the sepsis score. This was the case for all outcome measures.

During the last decade, fast-track surgery

Table II. Perioperative characteristics.

| Champted the renoperative characteristics. | |
|--|-----------------------------|
| Characteristic | (n = 117) |
| Time to admission, median (range), hours | 10 (1-336) |
| Time from admission to surgery, median (range), hours | 5 (1-72) |
| Duration of surgery, median (range), minutes | 83 (30-240) |
| Surgical procedure, no (%) • Simple open closure ± omental patch • Laparoscopic closure • Resection | 96 (83) 12 (10) 8 (7) |
| Gastric site of perforation, no (%) | 42 (36) |
| Preoperative metabolic acidosis, no (%) | 56 (48) |
| Preoperative hemoglobin <6.0 mmol/L, no (%) | 10 (8) |
| Preoperative creatinine >110/130 mmol/L, no (%) | 33 (28) |
| Preoperative albumin <550 mmol/L, no (%) | 56 (48) |
| Use of NSAIDs at admission, no (%) | 44 (38) |
| Use of aspirin at admission, no (%) | 36 (31) |
| Use of steroids at admission, no (%) | 17 (15) |
| Use of anticoagulants at admission, no (%) | 7 (6) |
| Shock on admission*, no (%) | 28 (24) |
| Mile in admission, no (%) | 28 (24) |

Abbreviation: NSAID = non-steroidal anti-inflammatory drug.

*Blood pressure <90 mmHg and heart rate >100 per min.

and evidence based in-hospital care have been sought to be implemented in various fields of surgery, leading to a reduction in morbidity and mortality. In patients with PPU, mortality has been reduced considerably by the implementation of a standardized evidence based in-hospital care protocol, The limited number of ICU and high dependency unit beds emphasizes the importance of individual risk stratification. Early and accurate identification of patients with increased risk of adverse outcome is needed to plan and target the level of perioperative monitoring and treatment. Thus, & clinical scoring system should be able to predict adverse outcome with a high degree of precision. Furthermore, the score should be easy to calculate, preferably bedside. These characteristics have proven difficult to realize.

In the present study, the Bocy score had the poorest discriminatory ability of survival, with an AUC of 0.63. Furthermore, the PPV and NPV were low, and the RR was statistically insignificant. In the Bocy score, in-hospital mortality increases progressively with the presence of major medical illness, preoperative shock, and perforation longer than 24 h. The Bocy score has been re-evaluated in a number of single center studies, though without being able to fully replicate the convincing results

found by Boey et al. This is both the case for the PPV, the NPV, and the discriminatory function (AUC). When we apply the same cut-off value as used in the present study (Boey score ±2) to the original work of Boey et al. this results in a substantially lower PPV and NPV, comparable to the previously mentioned studies. The Boey score is crude, consisting of only three parameters.

Consequently, it does not include many of the other existing and well-examined prognostic factors for adverse outcome in PPU, e.g. old "age, tachycardia, and acute renal failure. This might explain the inferior performance in the present study. On the other hand, it is simple to calculate and was created specifically for patients with PPU.

 The ASA score has been criticized for its subjectivity and the wide inter-observer variability.

Nevertheless, it predicts postoperative mortality well. In the present study, the AUC of ASA class was 0.73 (mortality), 0.67 (septic shock), and 0.69 (ICU). The only other study examining the discriminatory ability of ASA score in PPU patients found a somewhat higher AUC of 0.91. This discrepancy is most likely caused by differences in demographic characteristics and in the mortality

rate. The PPVs and NPVs of other studies evaluating ASA score are of similar strengths as in our study. The explanation for the inferior performance of the ASA score could be the fact that ASA score is not developed within PPU patients and only accounts for the premorbid status. However, in our experience it is difficult to completely ignore the current clinical condition of the patient when assessing the ASA score. Consequently, the performance of the ASA score could in fact be overestimated.

Of the four clinical prediction rules evaluated, the APACHE II score performed best overall with AUCs of 0.76 (mortality), 0.78 (septic shock), and 0.72 (ICU). An APACHE II score ±12 seems to imply a nearly 32 **mes increased risk of 30-day mortality.

However, only 24% of the patients predicted to die by the APACHE II score died (PPV 24%). On the other hand, all but four patients predicted to survive (APACHE II score <12) survived (NPV 97%). Use of APACHE II score as a clinical prediction rule in PPU patients has been sparsely examined. Overall, PPVs and NPVs are of similar strengths as in the present study. The only other study examining the discriminatory ability of APACHE II score found a somewhat higher AUC of 0.87. This discrepancy is most likely caused by differences in demographic characteristics and in the mortality rate.

The APACHE II score takes into account age, coexisting diseases, the current clinical status, and current biochemical findings: in total, 14 variables.

This is most likely the main reason why the APACHE II score performs best among the four clinical prediction rules evaluated in the present study. One possible explanation for the somewhat inadequate performance of the APACHE II score in general could be the fact that the score is not developed within a PPU cohort. Thus, well-established important prognostic factors for mortality in PPU patients are not included in the APACHE II score: preoperative delay, co-existing use of

medications, and low serum albumin blood

It is well known that sepsis (systemic inflammatory response syndrome and proven or highly suspected infection) is associated with adverse outcome in

PPU patients. To our knowledge, the discriminatory ability of the sepsis score in PPU has not been examined previously. In the present study, the sepsis score had low AUCs: 30-day mortality 0.69, septic shock 0.74, and ICU admission 0.64. Furthermore, we found low PPVs and NPVs. This might be explained by the fact that the sepsis score is not specific for PPU patients, it does not include co-existing diseases, and it only takes into account few of the other known prognostic factors for PPU.

CONCLUSION

In patients surgically treated for PPU, the Boey score, the ASA score, the APACHE II score, and the sepsis score predict mortality, septic shock, and admission to ICU poorly. The AUCs and PPVs were overall low, while the NPVs were 90-95%. Thus, in the clinical setting, the scores can rule out mortality within 30 days of surgery with a high degree of precision in a PPU cohort with a similar case mix.

In order to be able to precisely predict adverse outcome in PPU patients, we suggest that a score developed within PPU patients and including both pre-morbid objective measures and current objective measures is used.

REFERENCES

- Lunevicius R, Morkevicius M. Management strategies, early results, benefits, and risk factors of laparoscopic repair of perforated peptic ulcer. World J Surg 2005;29:1299–310.
- Chandra SS, Kumar SS. Definitive or conservative surgery for perforated gastric ulcer? - An unresolved problem. Int J

Surg 2009;7:136-9.

- Lohsiriwat V, Prapasrivorakul S, Lohsiriwat D. Perforated peptic ulcer: dinical presentation, surgical outcomes, and the accuracy of the Boey scoring system in predicting postoperative morbidity and mortality. World J Surg 2009;33:80-5.
- Makela JT, Kiviniemi H, Ohtonen P, Laitinen SO. Factors that predict morbidity and mortality in patients with gerforated peptic ulcers. Eur J Surg 2002;168:446– 51.
- Mak PH. Campbell RC, Irwin MG, The ASA Physical Status Classification: Interobserver consistency. American Society of Anesthesiologists. Ansesth Intensive Care 2002;30:633–40.
- Wolters U, Wolf T, Stutzer H, Schroder T. ASA classification and perioperative variables as predictors of postoperative outcome. Br J Anaesth 1996;77:217–22.
- Kocer B, Surmeli S, Solak C, Unal B, Bozkurt B, Yildirim O, et al. Factors affecting mortality and morbidity in patients with peptic ulcer perforation. J Gastroenterol Hepatol 2007;22:565-70.
- Larkin JO, Bourke MG, Muhammed A, Waldron R, Barry K, Eustace PW.Mortality in perforated duodenal ulcer depends upon pre-operative risk: a retrospective 10-year study. Ir J Med Sci 2010;179:545–9.
- Forsmo HM, Glomsaker T, Vandvik PO. Perforated peptic ulcer-a 12-year material. Tidsskr Nor Laegeforen 2005;125: 1822-4.
- 10. Bone RC, Balk RA, Cerra FB, Dellinger RP, Fein AM, Knaus WA, et al. Definitions for sepsis and organ failure and guidelines for the use of innovative therapies in sepsis. The ACCP/SCCM Consensus Conference Committee. American College of Chest Physician. J Society of Critical Care Medicine. Chest 1992;101:1644–55.

ABSTRACT

The present study comprises of 100 cases of chronic anal fissure admitted to the surgical in patient department of Anugrah Medical College & Hospital, Gaya. These cases had been divided into two equal groups containing 50 cases in each. The first group had been treated by manual anal dilatation under general anesthesia and second group had been treated by lateral internal sphincterotomy as advocated by Notaras.

Among recent years these two simple procedures have been the choice of surgeons for treating chronic and fissure and this work is restricted to comparative study between them and a assessment of their relative worth in the treatment of chronic anal fissures,

The open posterior internal sphincterotomy is now not recommended because of high incidence of anal incontinence.

INTRODUCTION

An Anal fissure is a linear ulcer of the lower half of the anal canal, usually located in the posterior commissure in the midline, often misnamed as rectal fissures, in fact, these lesions truly involve just the anal tissue and are typically best seen by virtually inspecting the and anal verge with gental separation of the gluteal cleft. Location may vary, and an anterior midline fissure is seen more often in women, although most fissures in women and men reside in the posterior midline. Characteristic associated finding include a sentinel pile or tag externally and an enlarged anal papilla internally. Fissures away from these two locations should raise the possibility of associated diseases, especially Crohn's disease, hidradenitis suppurative or STDs. Because it involves the highly sensitive squamous epithelium, fissure in ano is often a painful condition. With defecation ulcer is stretched causing pain and mild bleeding.

A fully developed chronic anal fissure may have following components:

- Sentinel piles, a swellen skin tag guarding the lower most margin of the fissue.
- A polyp at the proximal end of the fissure which is nothing but a hypertrophied anal papillae.
- Fibrous induration of the lateral edges of the fissure and of course is the most important part.

Sphincterotomy and Manual Anal Dilatation in Case of Fissure in ANO

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 Exposed circular fibers of the internal sphincter forming the base of the fissure.

The exact cause of anal fissure is unknown but many factors appear likely, such as the passage of large, hard stools, which may be the initiating factor, inappropriate diet, previous anal surgery, childbirth and laxative abuse. Now it is believed that anal fissures are the result of anal sphincter hypertonia and subsequent mucosal ischemia.

The diagnosis is secured by the typical history of pain and bleeding with delecation, especially associated with prior constipation and confirmed by inspection after gently parting the posterior anus. Digital as well as proctoscopic examination may trigger severe pain, interfering with the ability to visualize the ulcer. An endoscopic examination should be performed, but it can be delayed 4-6 weeks, until the pain is resolved with medical management or until surgery is performed for those cases refractory to medical therapy.

A number of treatment modalities is available for the management of fissure in ano. The traditional first line therapy for acute fissures is treatment with warm sitz baths and bran or bulking agents, with rates of fissure healing reported as 87%.

Nitroglycerine causing "reversible chemical sphincterotomy" is another important therapy with few limitations. Diltiagesics and Botulinum toxin is another treatment options. In operative procedure manual anal dilatation, Lateral anal sphincterotomy and anal advancement flap technique is important.

Manual anal dilatation is a simple procedure, in which gental dilatation of anal sphincter is performed under general anesthesia. No more than four finger breaths dilatation is performed. Risk of incontinence and less effectiveness of the procedure in chronic fissure with excessive fibrosis are the limitations of the procedure.

Lateral internal sphincterotomy is a specific procedure in which internal sphincter is specifically incised in appropriate length. Hematoma formation, abscess formation and recurrent ulcers are the major limitations of the procedure.

AIMS AND OBJECTIVES

To assess lateral internal sphincterotomy and manual anal dilatation in case of fissure in ano.

MATERIALS & METHODS

The present study compared of 100 cases of chronic anal fissure selected from patients admitted in surgical ward form surgical outdoor and emergency in various units of Patna Medical College and Hospital, Patna, Bihar,

The cases are divided into two equal groups, each containing 50 cases according to mode of treatment given to them. The

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Table 1: Patient characteristics in the studied groups

| | Fentanyi group (n= 45) | Meperidine group (n= 45) | Clonidine group (/= 45) | Analysis of variance OrX 2 | P-value |
|------------------------------------|---------------------------|-----------------------------|----------------------------|----------------------------|---------|
| Age (years) | 48.9± 17.4 | 45.6± 14.9 | 43.5±13.5 | 0.366 | 0.695 |
| Sex (male/female) | 29/16 | 32/13 | 30/15 | 0.472 | 0.799 |
| Height (cm) | 174.5±12.4 | 169.6±13.5 | 171.4± 12.7 | 0.745 | 0.352 |
| Weight (kg) | 93.6±14.6 | 89.7±15.4 | 90.5±12.2 | 0.815 | 0.071 |
| Type of surgery: Ankle fracture | . 19 | 16 | 18 | | * * |
| Tabial fracture Arthroscopy | 15 | 14 | 13 | 0.3813 | 0.983 |
| Duration of surgery (min) | | 15 | 14 | | |
| | 115.7 | 109.5 | 118.7 | 0.76 | 4 |
| | | | | | 0.541 |

hemodynamic deterioration [12]. Meperidine has selective spinal action at the dorsal horn cells change, into. In addition, meperdine has sympathomimetic activity upon systemic absorption producing increase in cardiac output and heart rate.

Previous studies compared the analgesic efficacy of epidural meperdine and fentanyl with nearly similar finding to the present study, Paech, compared the epidural meperdine or fentanyl during caesarean section and concluded that the quality of analgesia and duration of effective analgesia was good in both groups with minimum side effects. Cox et al., compared epidural fentanyl and meperdine with bupivacaine in the management of postoperative pain after major abdominal surgery. Postoperative pain scores using a visual analogue scale were not significantly different between the two groups. Goh et al., compared fentanyl and meperdine for postoperative epidural analgesia in women having elective caesarean deliveries and conclude that meperdine is a suitable drug for patient-controlled epidural analgesia with greater patient satisfaction when compared to fentanyl.

Similar to our experience multiple clinical studies were performed evaluating the value of epidural meperdine and demonstrated comparable effects to this study; Baraka et al., demonstrated that epidural meperidine was associated with stable hemodynamics, satisfactory analgesia and reduced the need for administration of rescue analgesics when administered epidurally for obstetric patients. Cardiac output and mean arterial pressure was increased after epidural injection of meperidine.

In addition; St-Onge et al., in their study demonstrated that bupivacaine decreases epidural meperidine requirements after abdominal surgery producing satisfactory analgesia without increasing the incidence of side effects. Ferrante et al., in their study in patients undergoing total knee replacement concluded that patients received epidural bupivacaine meperidine combination had a significantly slower regression of sensory enesthesia and slower development of postoperative pain in comparison to patients receiving either bupivacaine alone or bupivacaine with fentanyl. Robinson et al., in their study regarding the analysesic effect of epidural meperidine after cardiac surgery confirmed the relatively prolonged analgesia produced by meperedine in comparison to other opioids without affecting the degree of somnolence.

CONCLUSION

The combined administration of epidural clonidine and meperdine provided better intraoperative hemodynamics and prolonged postoperative analgesia than epidural clonidine fentanyl combination in patients undergoing lower limb orthopedic surgery,

REFERENCES

- Reuben SS, Buvanendran A. Preventing the development of chronic pain after orthopaedic surgery with preventive multimodal analgesic techniques. J Bone Joint Surg Am. 2007;89:1343–58.
- Yousef AA, Amr YM. The effect of adding magnesium sulphate to epidural bupivacaine and fentanyl in elective caesarean section using combined spinalepidural anaesthesia: a prospective double blind randomised study. Int J Obstet Anesth. 2010;19(4):401-4.
- Foster D, Upton R, Christrup L, Popper L. Pharmacokinetics and pharmacodynamics of intranasal versus Intravenous fentanyt in patients with pain after oral surgery. Ann Pharmacother. 2008;42:1380–7.
- Lysakowski C, Dumont L, Czarnetzku C, Tramer MR. Magnesium as an adjuvant 70 postoperative analgesia: a systematic review of randomized trials. Anesth Analg. 2007;104:1532–9, 9, 10.
- Eichenberger U, Glani C, Petersen-Felix S, Graven-Nielsen T, Arendt-Nielsen L, Curatolo M. Lumbar epidural fentanyl: segmental spread and effect on temporal summation and muscle pain. Br J Anaesth. 2003;90:467–73.
- Khaw KS, Nagan Kee WD, Critchley LAH. Epidural meperdine does not cause hemodynamic changes in the tern parturant. Can J Aneth. 2000;47(2):155– 9.

treatment given to the first group was manual anal dilatation and the second group was lateral internal sphincterotomy.

On admission following facts of the patients were recorded.

[I] HISTORY -

- (A) Case History
- (i) Name,
- (iii) Age,
- (iii) Sex
- (iv) Religion,
- (v) Occupation.
- (vi) Address.
- (viii) Date of Admission,
- (viii) Registration Number,
- (ix) Socio-economic group,
- (B) Presenting complain with duration.
- (C) History of presenting complain.
- (D) Past history and family history.
- (E) Personal history.
- (F) Treatment history.

[II] PHYSICAL EXAMINATION <

- (A) General survey.
- (B) General Examination
- (i) Pulse
- (ii) Pallor
- (iii) BP
- (iv) Icterus
- (v) Cyanosis
- (vi) Oedema
- (vii) Lymphnodes
- (viii) Chest
- (ix) CVS
- (x) CNS
- (xi) P/R examin-ton
- (xii) Respiration
 - (B) Local exam ration
 - (i) Inspection
- (ii) Digital rec:al examination in chronic painless cases.
- (iii) Proctoscopic rec a examination in chronic painless cases.

[III] INVESTIGATION

- (i) Routine examination
- (ii) Complete haemogram
- (iii) Routine urine

- (iv) Blood sugar : Fasting, Postprandial
- (v) Sigmoidoscopy
- (vi) Blood urea, serum creatinine.
- (vii) Diagnosis.
- (viii) Treatment given The treatment given to each patient whether lateral internal anal sphincterotomy or manual anal dilatation will be mentioned to make comparison between the two procedure.
- (ix) Follow-up Each case will be examined after 15 days of the discharge then after 2 months, 6 months and 1 year.

First group having 50 cases, was treated by simple sphincter stretching by the following technique:-

First of all, patients were immunized against tetanus by giving tetanus toxoid. Atropin 0.6 mg and diazepam 10 mg were given as pre-anesthetic medication before general anaesthesia. General anaesthesia alongwith relaxant was given. The patient was kept in lithotomy position or lateral position. The anus was gradually stretched by introducing first both index fingers and then index and middle fingers of both hands. A firm steady distraction was maintained for 4-5 minutes on lateral directions till ultimately the anal orifice was widely patulous.

In male patients a better stretch is often obtained in the vertical or anteroposterior axis because the more closely placed Ischia tend to impede lateral distraction. The problem does not arise in women owing to their wider pelvis.

Second group having 50 cases, treated by lateral sphincterotomy, were examined and assessed properly. The technique was as following:-

Patients was immunized against tetrus by giving tetrus toxoid. General anaesthesia was preferred in all cases. Atropin 0.6 mg and diazepam 10 mg was given as pre-anaesthetic medication. Prophylactic antibiotics was given. Bowel was not prepared so that urge to defectation after the operation was not delayed. Patient was kept in lithotomy position.

Operative technique: Under general anaesthesia, a bivalved and speculum was inserted into the anal canal and opened sufficiently to place the anus on a slight stretch. The internal sphincter was felt as a tight band around the blades of the speculum. The lower

border of sphincter was palpated.

A radial incision at 3 O'clock position was made just below the inferior border of the internal sphincter. The upper end of the incision was grasped with forceps and dissection with narrow bladed seissor was earried out. Anoderm was separated from white circular fibres of the internal sphincter,

Lower border of internal sphincter was grasped with forceps and was then divided by a narrow scalped blade upto the dentate line, care being exercised not to penetrate the lining of anal canal. To avoid this hazard, a few inner most fibres of the muscle was left undivided and then ruptured by the index finger. Firm lateral pressure was applied with fingers for 2 to 5 minutes to secure haemostasis. Sentinel tag was excised and the wound was left unsutured. A pad of cotton wool was then applied which was maintained by T-bandage.

The patients were relieved after 7 days stay in the hospital. They were given oral analgesics mainly codeine phosphate to control post-operative pain for the first night or two. Apeiant such as Biscodyl (Dulcolax) 2 tablets at the bed time was given for few days for easy motion.

Antibiotics such as Ampicillin & Cloxacillin and Metronidazole alogwith usual diet were prescribed to the patients.

Patients were advised to take daily bath alongwith sitz-bath after each defecation and then to apply dry dressing if any discharge.

Patients were advised to attain O.P.D. for check-up for 1 year.

During follow up period the following questions were asked to the patients :-

- Do you had any pain during defecations?
- Do you had full control of wind?
- Do you had perfect control on motion?
- Any difference from the previous condition?

RESULTS

Present study consists of 100 cases of chronic anal fissure which were divided randomly into two equal groups irrespective of the age, sex and severity of disease.

Each groups consists of 50 cases.

First group had been treated by Manual anal dilatation whereas the second group had been treated by lateral subcutaneous internal sphincterotomy. Both modes of treatment had been compared to evaluate the efficacy of treatment for chronic anal fissure.

Age: Chronic anal fissure in encountered in all the age groups except 0 to 10 years and above sixty years. It is most frequent in the group of 30 to 40 years. 41% of cases fall in this slab.

Sex : In this series it was found that the incidence of chronic anal fissure was predominant in males as compared to females.

FIRST GROUP

The first group of this series consisted of 50 cases, had received Manual anal dilatation as treatment for chronic anal fissure.

Patients were admitted one day prior to the operation and the bowel was not prepared so as to assess the severity of pain and efficacy of treatment. The patients of this group were kept under observation in the hospital till they recovered safely anaesthesia and then discharged.

SECOND GROUP

Second group also comprised of 50 patients and they were also operated next day of the admission. The bowel was not prepared in this group of patients also. Patients were kept under supervision in the surgical ward for an average period of one week.

ANALYSIS OF THE OPERATIVE RESULTS

 Relief of pain: It was noticed that in most of the patients of both the groups had relief of pain at the time of first defecation after operation. Following Manual anal dilatation 92% of patients were satisfied of their treatment from the very same day of the operation, but in 8% cases (4 patients), there was no satisfactory relief of pain. Those patients have been operated again by doing lateral sphincterotomy, after a week and they got satisfactory result.

In the second group, 94% of cases [47 cases] had immediate relief of pain which was confirmed at the time of defecation, but in this group also 6% patients failed to response to the treatment. Those patients were again called after 3 months and were re-operated by the same procedure and surprisingly the symptoms subsided. It was presumed that the reason of failure after first operation in those cases were incomplete division of internal sphincter.

2. Time off-work: Following Manual analdilatation patients were able to return to their work immediately whereas after lateral sphincterotomy most of the patients resumed their work after a stretch of 7 days. This shows that Manual anal dilatation has a great advantage over lateral sphincterotomy as far as time off-work is concerned.

In present life style of busy schedules people prefer to spend less time in the hospital for their treatment. Anal stretching procedure is more suitable in these patients.

- 3. Continence disturbances: Following Manual anal dilatation impaired control for flatus was found in 2% of cases whereas for the faecal was in 14% of cases. Soiling of under garments were in 22% of cases. In lateral sphincterotomy there was marked reduction of result as far as incontinence was concerned. There was 4% incidences of impaired control for flatus and soiling of under garments were found in 6% of cases. None of the patients had faecal incontinence.
- 4. Wound healing (Ulcer healing): The time taken for healing of ulcer in both group were almost the same. The mean time of healing in patients treated by Manual anal

dilatation was 2.30 weeks whereas it was 2.24 weeks following lateral internal sphincterotomy.

 Recurrence: The recurrence rate following Manual anal dilatation operation in this series was 18% whereas it was 6% after lateral internal sphincterotomy. This shows the over all superiority of lateral internal sphincterotomy over Manual anal dilatation.

CONCLUSION

No doubt that the hospital stay, time offwork and cost involvement is more following lateral internal sphincterotomy procedure; still it is considered better choice than the Manual anal dilatation due to less recurrence rate and better results.

REFERENCES

- Ann Surg. 2005 Aug., 242(2): 208-11.
- Bailey and Love's: Short Paractice of Sur., 25th Edition.
- Dis. Of Colon Rectum 2005 Jul; 49(7): 1045-51.
- Dis. Of the rolon Rectum 2004 Vol. 47, No. 1, Page 35-38.
- 5. Int. J. Surg. 2009 Jul; 7(3): 228-31.
- J.Am.Coll.Surg., 1994 Jun.;178 (6):600-4.
- J. Coll Physicians Surg. Pak 2003 Aug; 13(8): 436-9.
- Journal of gast, Intest. Surg. 2007, Vol. 11; No. 11, Page 1541-1548.
- 9. Journal of gast. Intest. 2010, Vol. 14.
- Operative procedure for fissure in and Cochrane database of symptomatic 2010. Issue I, Art No. CD002/99, DOI: 10.1002/ 1465-1858. CD 002/99. Pub. 3.

significant (p<0.001) reduction in urinary albumin creatinine ratio in both hypertensive and normotensive patient.

Future clinical trials are needed to establish the evidence of benefit by blockade of RAS system, to determine the safety profile and to establish the ling term impact of dual blockade, which has been observed in the present study. With a hope for majority of sufferer with the burden of chronic renal disease.

REFERENCES

 King H. Aubert Herman, W. H. Global burden of diabetes, 1995-2005.

- prevalence, numerical estimates and projection. Diabetes care 1998; 21:1414-1431
- Kintscher U, Unger T, Vascular protection in diabetes: A pharmacological view of angiotensin-II type 1 receptor blockers. Acta Diabetel 2005; 42:26-32.
- Mann JF, Cardiovascular risk in patients with mild renal insufficiency: implications for the use of ACE inhibitors. Presse Med. 2005 Oct 22;34(18): 1303-8.
- Ladela AM, Ladela-Frota C, Pinho L, Stefanelli E, Adna L: Endothelial

- dyusfunction is correlated with microalbuminuria in children with shortduration type 1 diabetes. Diabetes Care 28:2048-2050, 2005.
- Fox JC, Leight K, Sutradhar SC, Demopoulos LA, Gleim GW, Lewin AJ, Bakris GL, J Clin Hypertens (Geenwich). 2004 aug; 6(8): 437-42; quiz 443-4.
- Gerstein HC, HOPE & MICROHOPE, Diabetes metab Res. Rev., 2002, 16:82-5.
- Goodman Gillman, The pharmacological Lasis of therapeutics. 10th Edn., 801-814.

ORIGINAL & CLINICAL RESEARCH

INTRODUCTION

Liver abscess is a fairly common clinical condition encountered in day to day practice in tropical and sub-tropical countries primarily. It is associated with higher morbidity and mortality.

Liver abscess of following types:

- Amoebic liver abscess
- Pyogenic liver absčess
- Fungus liver abscess

The two major types are which are frequently encountered is pyogenic and amoebic liver abscess. As name indicates pyogenic caused by bacteria and amoebic caused by entamoebea histolytica. The pyogenic abscess have pre dominated in reports from medicals centers to be common in temperate regions. In comparison amoebic liver abscess have been reported more frequently in semi tropical and tropical region.

Liver abscess both ALA and PLA continues to be an important cause of morbidity and mortality in tropical countries. The primary mode of treatment liver abscess used to be medical however they render relief only in limited number of cases, however a few cases may be refractory to medical therapy. Then second mode of intervention used to be surgical drainage which is associated with increased risk of morbidity. However the recent advance in interventional radiology, intensive care, progress in anti-biotic therapy and liberal

A Study of USG Guided Aspiration of Hepatic Abscess Versus Catheter Drainage

Dr. Abhishek Mishral, Dr. N. P. Narain²

use of ultrasonography and CT scan of abdomen have led to early diagnosis and treatment of patients with liver abscess thus improving the patient outcome.

In the recent year USG guided percutaneous drainage being done with high rate of success, percutaneous drainage of liver abscess has been an important advancement in treatment of liver abscess.

Various studies has been carried out in different part of world to evaluate the percutaneous method of liver abscess and has shown promising result.

AIM OF THE STUDY

The present study is also designed to study the two method in percutaneous management of LA i.e. percutaneous needle aspiration and percutaneous catheter drainage. It evaluate the clinical outcome, morbidity and mortality associated with it.

MATERIAL AND METHODS

The subjects of study have been the diagnosed patients of liver abscess admitted from surgical outdoor and emergency in the indoor wards of Department of General Surgery, Patna Medical College & Hospital course of study.

It is a comparative study comparative study comparing the result of needle aspiration with catheter drainage in diagnosed cases of liver abscess.

DIAGNOSIS

The diagnosis was based on clinical features such as anorexia, malaise, fever pain abdomen, hepatomegaly, leucocytosis, raised

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ESR, raised liver enzymes, culture of pus. Serology for antibodies and USG evidence of LA.

The above patients were divided into two groups –

Group A included 25 patients who had undergone needle aspiration treatment along with supportive treatment, fluid and electrolyte, antibiotics, anti-amoebic drugs.

Group B included another 25 patients who had under gone percutaneous cathether drainage with supportive treatment, fluid and electrolyte. Antibiotics, anti-amoebic drugs.

Main outcome measures were abdominal pain, fever, anorexia, hepatomegaly, resolution of LA on USG, length of hospital stay and any complications,

INCLUSION CRITERIA

- All diagnosed cases of liver abscess (single or multiple) and diagnosis is supported by USG.
- No features of repture into various cavities and viscera.
- Patients did not respond to drug therapy alone within 48-72 hours.

EXCLUSION CRITERIA

- 1. Abscess not amenable to aspiration
- Features of rupture LA into various cavities and viscera.
- Liver abscess with concomitant pathology that require urgent intervention like acute cholecystitis, cholangitis etc.

GENERAL EXAMINATION

After noting the general state of health, particularly, for emaciation, anaemia and jaundice, the other clinical examination were done. A record of pulse, respiration, temperature and blood pressure including the condition of tongue, teeth and gums was maintained in each case.

EXAMINATION OF ABDOMEN

INSPECTION: Any fullness, swelling over the either side of upper abdomen, change in the skin, venous engorgement and movement of abdominal wall during respiration were recorded. It any lump was visible all the features like size, shape, site and movement with respiration were noted.

PALPATION: Any tenderness, swelling, muscle guarding and rigidity were recorded.

Liver enlargement was determined with particular attention to tenderness, overlying oedema and consistency. Any organomegaly like spleenomegaly is also noted if any.

PERCUSSION: Percussion was done to find out the downward enlargement of liver. The fluid thrill and shifting dullness were of value particularly in case of complicated liver abscess into the peritoneal cavity.

AUSCULTATION: The abdomen was auscultated carefully for bowel sounds.

EXAMINATION OF CHEST

INSPECTION: Evidence of asymmetry, restriction of movement, swelling and oedema of the lower thoracic wall were specially looked for.

PALPATION: The position of trachea was ascertained. Presence of any intercostals tenderness and oedema over the liver are was carefully elicited in each case. Diminished vocal fremitus was also noted.

PERCUSSION: Any impairment of the percussion note to suggest the upward enlargement of liver and presence of fluid in the pleural cavity was noted.

AUSCULTATION: Any diminution in intensity of basal breath sounds were noted. Clinical feature of consolidation of lung were recorded. Presence or absence of adventitious sounds were also noted.

EXAMINATION OF C.V.S: The localization of apical impulse was done and any change in its position was noted. The heart sounds were heard and the nature of sounds were recorded.

INVESTIGATIONS :

- Blood: Total and differential count of WBC, Hb% and BT, CT.
 - 2. Urine routine examination
- Routine examination of stool for the presence of cyst of Ent. Histolytica.
- Blood sugar ; Fasting and post prandial to rule out diabetes.
- Renal profile : Blood urea, serum creatinine, serum electrolytes.
- Liver function test: SGOT, SGPT, Serum bilirubin, serum alkaline phosphatase, serum albumin.
 - HIV and HBsAg
- X-ray : Plain Skiagram of chest in P.A. and oblique views were taken for the

evidence of tenting and elevation of the dome of diaphragm on the effected side, pleural effusion and mediastinal shift, if any were noted. Discoid atelectasis of the right basal pulmonary parenchyma may be found.

- Serology: Elisa for the demonstration of anti-amoebic antibody in titres >1:400 is considered strong evidence of ALA.
- Aspiration of pus to confirm the diagnosis was done and culture of pus to confirm diagnosis.

METHOD

Aspiration was done in this series was mainly through right sided 9th and 10th inter costal space between the posterior and midaxillary lines and occasionally over the most prominent part of presentation or area of maximum tenderness after care full percussion to avoid any puncture of the abdominal viscera. Care was taken to avoid any aspiration if liver was still moving with respiration. As anaesthetic agent 2% lignocaine solution was used. A large bore needle was introduced from selected site of aspiration keeping its direction towards the affected dome of diaphragm. The pus was aspirated and its colour and consistency with particular attention to the anchovy sauce pus was noted. This pus was sent for its detailed examination and also for culture and sensitivity.

Percutaneous needle aspiration of liver abscess under coverage of antibiotic (either broad spectrum or according to the C/S report+anti amoebie drugs).

PERCUTANEOUS CATHETHER DRAINAGE OF LIVER ABSCESS UNDER USG GUIDANCE

The percutaneous catheter drainage (PCD) was accomplished by placing soft nubber catheter (i.e. Malecot catheter) or Nelaton catheter in abscess cavity. The placement of catheter is done under USG guidance using seldinger technique.

Again the site of catheter placement was determined by as per criteria of PCA. Positioning of the patient is also done according the site chosen for catheter placement. It may be either semi-recumbent or supine, leaning forward.

Area is draped in a similar way and infiltration of local anaesthetic is also done as in PCA.

76th Annual National Conference of

The Association of Surgeons of India

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This is to certify that Dr_N.P. NARAIN____

bearing registration no 6 Po 402 has participated as Delegate

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6 credit hours by Karnataka Medical Council

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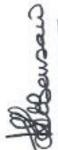


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25th to 27th Nov. 2005 一、日本の一、 日間

This is to certify that Dr. N. P. NARAIN . PATNA

Participated in the conference / Workshop. He took Part in the Scientific Deliberations

He/She presented a paper titled OBSTRUCTIVE JAUNDICE

He/She chaired the session

He/She was awarded

President

Organising Secretary 17. Ast 18.

Hon. Secretary I . . . Inditte

Silver Jubilee Annual Conference of the Association of Surgering III in the NATION OF SOLUTION OF THE SOLU (Biliar Chapter)

25th to 27th Nov. 2005

N. P. Warain. This is to certify that Or. -

Participated in the conference / Workshop. He took Part in the Scientific Deliberations

He/She presented a paper titled.

He/She chaired the session

Upper G. F. Bleed

He/She was awarded_

Dr. Surveydff Present President

Organising Secretary

Hon, Secretary



24th Annual Conference of Indian Society of Gastroenterology (BIHAR & JHARKHAND CHAPTER)

Certificate of Participation

This is to Certify that

Dr. NARAIN.

Indian Society of Gastroenterology (Bihar & Tharkhand Chapter) participated as the esteem Faculty / Delegate / Chairperson in BJ-ISGCON 2016 and workshop in 24th Annual Meet of the (Vide letter.no. 1171 - 42 / 2012 dated 10.05.2016) Bihar State Medical Council with 8 Credit hours. The BJ-ISGCON - 16 has been accredited by the Dated 14h May & 15th May 2016

Dr. Sahjanand Pd. Singh

Bihar Council of Medical Registration Registrar

Bihar Council of Medical Registration Dr. Amar Kant Jha Amar Chairman Academic Committee

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Secretary ISG S. K. Astik

Hanny

1916-27-30 JULY JULY OF C. 1214-127-8 P. Dr. Manish Mandal President ISG

Lidan

Bihar Council of Medical Registration Co-Chairman Academic Committee Dr. Sunil Kumar Singh

JK. 8. 24

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Dr. D. Nageshwar Reddy A.I.G. Hyderabad Workshop director CASH V

Organising Secretary 18. GC N. S. K. Astik

Andrian Society of Gastroenterology

CERTIFICATE OF MEMBERSHIP

This is to certify that

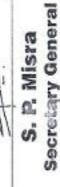
Dr. Nirmal Frakash Narain

has been admitted as

Life member of Indian Society of Gastroenterology Life Membership No: LM001967

BS amo hind

B. S. Ramakrishna









Certificate of Achievement

Nirmal Narain

has successfully passed an assignment which demonstrates satisfactory understanding of the course content having participated in the training course

Introduction to Equality & Diversity (ICBSE)

3 CPD points have been awarded by JSCM for this cause

Shirt de de de de de









ROYAL COLLECT OF PHYSICIANS AND SURGEONS OF GLASGON



Certificate of Achievement

Nirmal Narain

has successfully passed an assignment which demonstrates satisfactory understanding of the course content having participated in the training course

Equality & Diversity in the MRCS (ICBSE)

3 CPD points have been awarded by JSCM for this course

903030303

Modern Association of Gustrointestinal Endusurged, DUN ASSOCIATION OF GASTROWITES



40th Fellowship Course December 4th-6th, 2014 Patna CERTIFICATE OF PARTICIPATION

This is to certify that

Dr. N.P. Narain

participated in the FIAGES Course

as a Faculty.

Convener FIGES Board Dr. Sandeep Dave

Dr. V. Venkatesh President IAGES

En laste

्रिक्टिक्टा स्थानिक

Dr. Sukumar Jha Course President かいろ

bt v.K.Mittal Course Director

13

Dr. Nawneet Kr. Sinha Organising Secretary

SA COMMENS



LIVE OPERATIVE WORKSHOP ON M.I.P.H. & LAP. HERNIA REPAIR

Jointly Organized by Dept. of G.I. Surgery, IGIMS & A.S.I (Bihar Chapter)



Certificate

This is to certify that ... Dr. N. P. NARAIN

has participated as delegate / faculty in a Live Operative Advance Laparoscopic

Workshop on M.I.P. H & Lap. Hernia Repair on 5th December, 15 at Indira

Gandhi Institute of Medical Sciences, Sheikhpura, Patna

Dr. (Prof.) N.R. Biswas Dr. Ashok Kr. Sinha Director, IGIMS, Patna

Dr. C. Khandelwal Org. Chairman

Secretary, ASI (Bihar)

Quemar

DR. SANJAY KR. Joint Org. Secretary

DR. Manish Mandal Organising Secretary

CLINICAL SURGERY UPDATE - 2015

Department of Surgery

Tata Main Hospitai, Jamshedpur 9th July to 12th July 2015

Certificate of Participation

This is to certify that

DR. N. P. MARAJIM......has participated as delegate

in the Clinical Surgery Update 2015, Tata Main Hospital, Jamshedpur.

He / She Presented Paper / Delivered a Guest Lecture / Chaired a Session / Titled

Surviva Parage Dr. Amming Verma Organishing Secretory

Smil King Organising Chairman Dr. Sunil Kerner

All India Institute of Medical Sciences Patna



APSCON-2015

Theme -Minimal invasive surgery



Surgical Disciplines of AIIMS Patna with Association of Surgeons of India (Bihar Chapter)

Organized by:

CERTIFICATE OF PARTICIPATION

Dr. N.P Narain

Patna in collaboration with Association of Surgeons of India (Bihar Chapter), as Chairperson, on 29-30% August, 2015. and Continued Medical Education Programme on Minimal Invasive Surgery", organized by the Surgical Disciplines of AHMS This is to certify thathas attended "Live operative Workshop

(This conference is accredited by Bihar Council of Medical Registration, Patna for 08 credit hours vide letter no. 2331-42/2012 dated 25.08.2015)

Bihar Council of Medical Registration Dr. Sahajanand Pd. Singh

Langh kuma Surl

Dr. Girlsh Kr. Singh

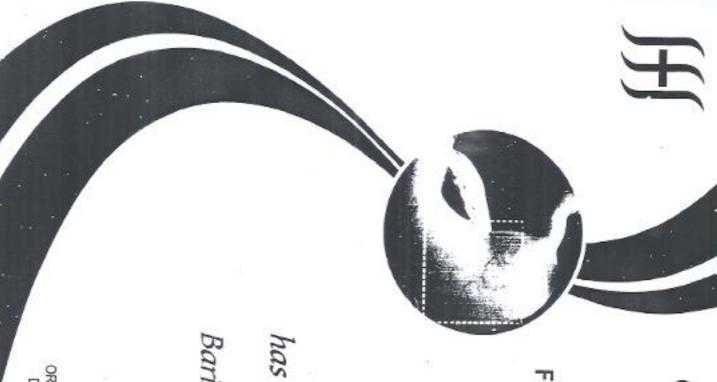
Bihar Council of Medical Registration Dr. Sunil Kr. Singh Co-Chairman

Organising Secretary Dr. Sanjeev Kumar

> Bihar Council of Medical Registration Academic Chairman Dr. Basant Singh

Barres

Organising Chairman Dr. Bindey Kumer



CME CUM WORKSHOP PROGRAMME ON **BARIATRIC SURGERY**

FORD HOSPITAL AND RESEARCH CENTRE (P) LTD. PATNA IN ASSOCIATION WITH A.S.I. BIHAR CHAPTER 27th JULY 2014

This is to certify that

Dr. M. P. Marain.

Bariatric Surgery on 27th July. has attained the CME Cum-Workshop Programme on

ORGANZING SECRETARY

DR PRAVEEN KUMAR

DR SANTOSH KUMAR

HON. SECRETARY A.S.I. BIHAR CHAPTER DR. BINDEY KUMAR



Live Operative Advance Laparoscopic Workshop LAPCON - 2013, Patna

Jointly Organized by Dept. of G.I. Surgery, IGIMS & A.S.I (Bihar Chapter)



This is to certify that..... N. P. NARAIN.

has participated as delegate / faculty in a Live Operative Advance

Laparoscopic Workshop LAPCON - 2013 on 6th April, '13 at Indira

Gandhi Institute of Medical Sciences, Sheikhpura, Patna.

DR. (PROf.) ARUN KUMAR

DR. BINGEY KUMAR Secretary, ASI (Binar)

DR. Wijay Mirral

Course Director

DR. Manish Mandal Organising Secretary

Laura A



tilicate of Attendance



Meebcal Registration

Presented To

J. Narain

We take pleasure in presenting you this certificate of your participation as Faculty/Delegate at

CME on Nephrology, Patna Medical College, Patna, 10th May 2014

Bihar Council of Medical Registration has granted 2 (Two) Credit hours for Faculty & Delegate

(vide BCMR letter number 708-42/2012 dated 07.05.2014)

Principal, Patna Medical College, Patna Chairman, Medical Education Unit and Bihar Council of Medical Registration Chairman Academic Committee Dr. Amar Kant Jha 'Amar'

Bihar Council of Medical Registration

Dr. Sahjanand Prasad Singh

Dr. (Prof.)Rajiv Ranjan Prasad Patna Medical College, Patna Medical Education Unit Co-ordinator

Patna Medical College, Patna Dr. (Prof.) Hemant Kumar Deptt. of Nephrology Organizing Chairman Professor & Head

Co-Chairman Academic Committee Dr. Sunil Kumar Singh

3G Annual Conference of Indian Society of Gastroenterology, 22nd Annual Conference of Indian Schapter) Certificate of Participation

This is to certify that or Marain

Indian Society of Gastroenterology (Bihar & Tharkhand Chapter) BJ-ISGCON 2014 and workshop in 22nd Annual Meet of the participated as the esteem Faculty / Delegate / Chairperson in The BJ-ISGCON. 14 has been accredited by the Bihar State Medical Council with 8 credit hours.

Bihar Council of Medical Registration Dr. Sahjanand Pd. Singh

Secretary, ISG

イルターン

(Vide letter no. 816 dated 27.05.2014)

Dated: 31st May & 1st June 2014

Bihar Council of Medical Registration Chairman Academic Committee Dr. Amar Kant Jha Amar

Bihar Council of Medical Registration Co-Chairman Academic Committee Dr. Sunil Kumar Singh Married Barane

A.I.G., Hyderabad Hours

Dr. D. Nageshwar Reddy

Workshop Director

Dr. Manish Mandal Organizing Secretary (BJ-ISGCON - 14)

Dr. Anant K. Singh (B & J Chapter)

Dr. Shailesh K. Singh

SK. S. 7.

(B & J Chapter) President, ISG

Organizing Chairman (BJ-ISGCON - 14) Dr. Manoj Kumar



In Association with Bihar Chapter









Promising Advances & Practical Approaches in Oncology

CERTIFICATE

This is to certify that

DR. N.P. NARAIN

has attended the 3rd Annual Conference of Society of Oncology from 16th August to 17th August 2014

at Hotel Chanakya, Patna

Bihar Medical Council has granted 8 Credit Points.

(l

Dr. Sahajanand Prasad Singh Registrar Bihar Council of Medical Registration distante

Dr. Amar Kant Jha Amar Chairman Academic Committe Bihar Council of Medical Registration Shrigh

Dr. Sunit Kumar Singh Co-Chairman Academic Committe Bihar Council of Medical Registration

Sull

Dr. Sumantra Sircar Organising Chairman Butanjeli Singh.

Dr. Pritanjali Singh Organising Secretary N. of

Dr. V.P. Singh Founder Secretary Society of Oncology

CERTIFICATE OF PARTICIPATION



4E A.L. 7 14 🔊

N. P. Narain This is to certify that Dr. has attended an orientation session on Standards for Tuberculosis Care in India.

Date: 22 June 2014

Russ Fortier Chief of Party World Health Partners

> Dr. Prashant Kumar District TB officer, Patna- Bihar

& cein Lajus Press

Dr. (Prof) Rajiv Ranjan Prasad President IMA, Bihar



Indian Association of Surgical Gastroenterology 23rd - 24th February 2008 Jamshedpur

Certificate of Participation

Dr. Sunil Kumar Chairman Organising Committee

Dr. Y Perwez

Secretary Organising Committee

National Conference

9

NATIONAL MEDICOS ORGANISATION



20, 21 March 2004

PATNA, BIHAR

This is to certify that

PR N. P. NARAIN.

Participated | Presented a Paper | Chained | Co-Chained a Session/was a Guest Speaker in the National Conference of National Medicos Organisation

Muse

Dr. Narendra Prasad
Chairperson
Organising Committee

C. Khandeli l

Dr. Chiranjiv Khandelwal Chairperson

Scientific Committee

dustin

Dr. Mrityunjoy Kumar President NMO, Bihar



ADVANTAGES & NEWER APPLICATION OF 3T MRI.

1st March, 2014, Hotel Chanakya, Patna

Certificate of Participation

Speaker / Delegate in the CME on Advantages & Newer Application of 3T MRI. Presented to DR. N. P. NARAIN for participating as

1st March, 2014 at Hotel Chanakya, Patna.

This CME is Accredited by Bihar Council of Medical Registration.

Dr. Sahajanand Prasad Singh Registra

Bihar Council of Medical Registration

Bihar Council of Medical Registration Chairman, Academic Committee Dr. Amar Kant Jha Amar

Dr. Sunil Kumar Slngh Skhush

Co-Chairman, Academic Committee Bihar Council of Medical Registration

Hospito India, Patna and white Dr. A. K. Sinha Director

As per Letter No. 293-42/2012 Dated 28.2.2014 of Bihar Council of Medical Registration, this conference is Accredited for 4 hours.



SJAPSICON

Certificate

This is to Certify that

raf (DR) N. P. Narayan

has participated as a Chairperson/Speaker/Delegate/

aculty and attended workshop of annual conference of

association of plastic surgeons of India

Bihar and Jharkhand Chapter) in association with

evantment of Plastic Surgery, Patna Medical College, Patna on and 13th April 2008 at Patna Medical College Hospital,

Patna (Bihar).

Dr. S. K. Jha (Organising Secretary)

Prof. (Dr.) V. P. Choudhary (Organising Chairman)

One Theasaphical Order at Service in India



"A Anion of all who love in the service of all that suffers" Founded by Dr. Annie Besant in 1908

243, PATLIPUTRA CCLONY PATNA-13 Inspired by the feelings for the suffering humanity Shri/ Smt. / Thm. NIRMAL PRAKASA NARAY ON

Joined the Theosaphical Order Of Service In India in the PA-TLIPUT RA J. 10. 8. Unid on

Patran/Tife Member

May he continue to give his best to help the sufferers

Swall Kumar Varma

REGIONAL SECRETARY BINAR REGION

MAL DIRECTOR



College

X

(INDIAN SECTION)



36th ANNUAL CONFERENCE

5th at 7th October, 1990

KING GEORGE'S MEDICAL COLLEGE, LUCKNOW

In appreciation of his active participation in the scientific deliberations, the organising committee is honoured to present this certificate to Dr. N. p. Narain

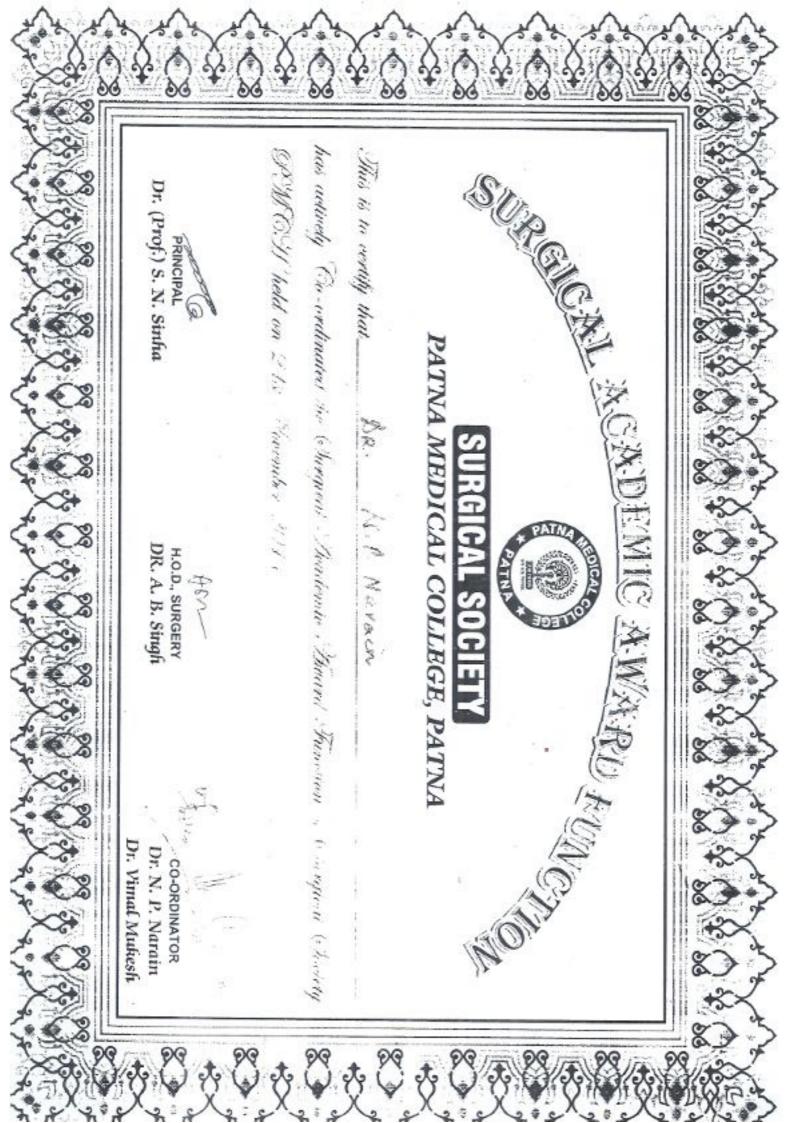
International College of Surgeons DR. A. PARIKH

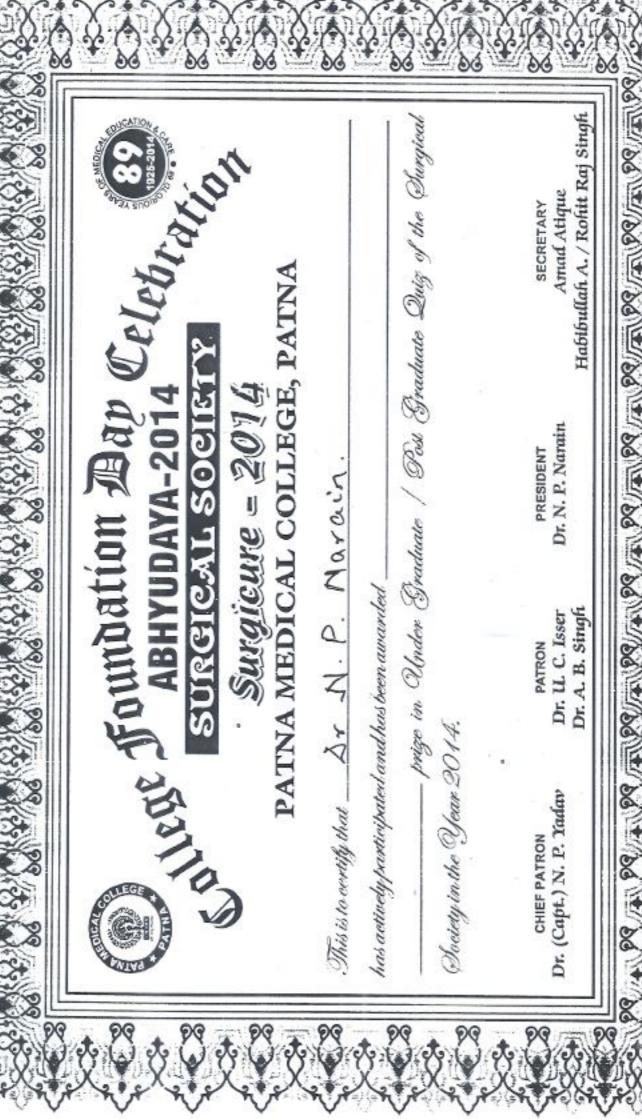
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PROF. N. C. MISRA Organising Committee CHAIRMAN

(74 /2)

DR. O. P SINGH ORGANISING SECRETARY ×





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11/11/19

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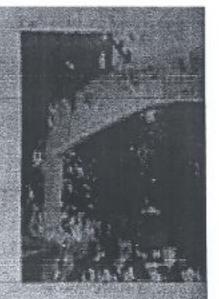
न गर्ना करना

नाम गडडी

य विभाग में

जटिल ऑपरेशन कर निकला 32 किलो ट्यूमर

जागरण संवाददाता, पटना : पीएमसीएव के ऑपरेशन थियेटर नम्बर दो में एक बड़ा ऑपरेशन किया गया। यहां पर डॉ. एनपी नारायण ने ऑपरेशन कर एक मरीज के हाइड्रोसील के पास से 32 किलो का ट्यूमर निकाला। यह ऑपरेशन तीन घटे तक चला। इसके लिए तीन डॉक्टरों की टीम बनाई गई थी। और्धरेशन क रने वाले डॉ.नारायण का कहना है कि इस तरह के टयुमर को **फायलेरियल स्कोटल** ट्यमर कहते हैं। यह ट्यूमर प्राय हाइड्रोसील के पास होता है। डॉक्टरों ने कहा कि पीएमसीएवं के इतिहास में इतना बड़ा ट्यूमर नहीं



जागरण 'संवादलता, उनके नवजात शि बड़ी ख़ुशखबरी है अस्पताल पीएमसी एक विशेष अस्पता जाएगा। अस्पताल कोने से आने वाली सहित भर्ती किया उ के प्राचार्य डॉ. एसए है कि अस्पताल में शिशुओं की देखरेख विशेष अस्पताल बन गया है। यह अस्पतार विभाग के बगल में ब

ताह ओटी रेखल तोड़ यत हो गया बल बेल्डे Or. Jayshree Mehta M.S., F.I.C.S. President Medical Council of India Sector-8, Pocket-14 Dwarka, New Delhi-110 077 Ph: +91-11-25367039 Fax: +91-11-25367031

E-mail: president-mci@nic.in

website: www.mclindia.org



डॉ० जयश्री मेहता M.S., F.I.C.S. अध्यक्ष मारतीय आयर्विज्ञान परिषद

> शेक्टर-८, पानेट-14, ब्राटका, नई विल्ली - 110077 क्षेत्र : +91-11-25367039,

र्कन्तः : +91-11-25367031 ई-मेलः president-mci@nic.in वेस्ताइट : www.mciindia.org

D.O.No.MCI-7(8)/2018-Med./ /38 .

Dated: 24 08/B

Dear Dr. N. P. Narain

I, on behalf of the Management Committee of Dr. B. C. Roy National Award Fund Society and on my own behalf, am pleased to inform you that you have been selected for the prestigious Dr. B. C. Roy National Award for the year 2017 in the category of "Eminent Medical Teacher", which you rightly and richly deserve.

I extend my heartiest congratulations and compliments to you for the same.

In this context, you are requested to submit your brief profile in *letter format* in hard as well as soft copy and also a passport size photograph to Dr. Reena Nayyar, Member Secretary or Mr. Rajiv Kumar, Assistant Secretary, Medical Council of India, Dwarka, New Delhi, as early as possible, for the purposes of Souvenir.

Yours sincerely

(Dr. Jayshree Mehta)

Dr. N. P. Narain, Prof. Of Surgery & Consultant General & Laparoscopic Surgeon, Patna Medical College & Hospital, Patna -800 004 (Bihar)



인동이를 이더라 Jean Francisco Feed No.43/13 얼마를 건매 옷은은

अतराष्ट्राय सम्मान समारह दुमरांव, वक्सर (बिहार)



(प्रशास्त-पत्र)

क्ष/कुर्धा/क्षेचते...डॉ...एन...पी.नारायण...के विकित्सा...के केत वे रान उस्ताद चिरिभल्लाह रतां जी की पुण्यतिथि पर आयोजित कार्यक्रम में 'बिरिभल्लाह कां लीडरणिप अचार्ड-2021' / 'बिरियल्नाह स्वां कोरोना गरिवर्स अवार्ड-2021' से नवाजा जाता है। अपना उत्कृष्ट योगदान दिया है। इसके लिए इन्हें कालीदास रंगालय, पटना में दिनांक 21.08.2021 को मारत

प्रो.नवल किशोर यादव

डॉ. ट्रजबीट नंदन Wandow

かます ख्यं प्रकाश

उपनेता, सत्तारुढ़ दल, बिहार । पूर्व सदस्य बिहार विधान पार्षद । संपादक, जी बिहार-झारखण्ड । अध्यक्ष, ट्रस्ट मुरली मनोहर श्रीवास्तव









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In Association With

The Award For

solution pvc. ltd.

st Prestigious Corporate Award Event

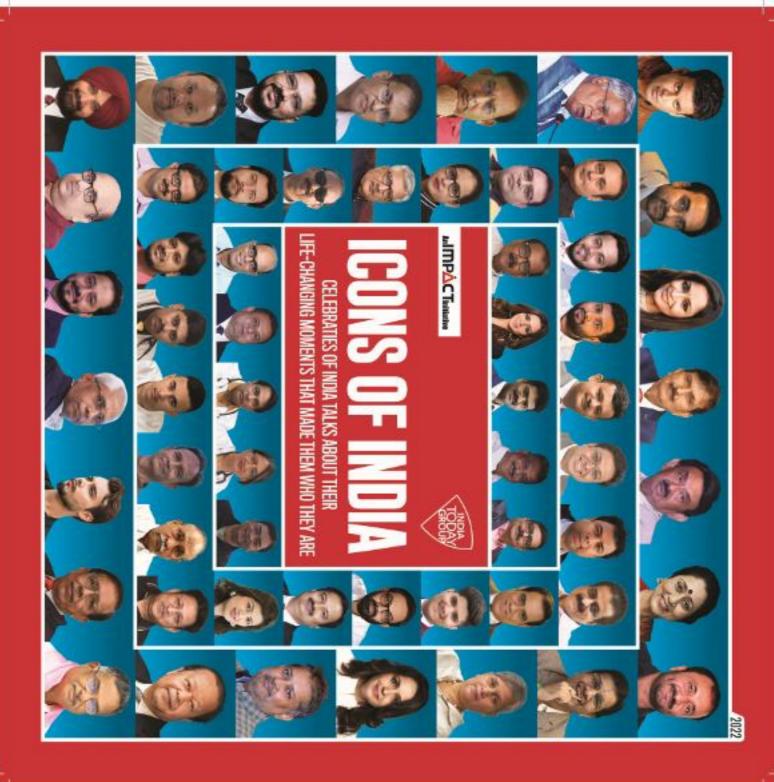
Most Trusted Doctor in Bihar

Goes to

Dr. N.P. Narain

AL EXCELLENCE AWARDS









313dajap

PIONEERS IN HEALTHCARE





सुदर्शन कुमार

सदस्य बिहार विधान सभा 170, बरबीघा (शेखपुरा) ।। सबका मालिक एक।।



मो: 9955333333

पता:- एम0 आई0 जी- 17, हनुमाननगर, कंकड़बाग पटना-800020 (बिहार)

Gria : 05/07/23

чліт ... / 6.9 / 2.3....

ब्रह्मर्षि स्वाभिमान मंच द्वारा बिहार के प्रथम मुख्यमंत्री श्री कृष्ण सिंह जी की 62वीं पुण्य तिथि के अवसर पर दिनांक-19 मार्च, 2023 को विशाल निःशुल्क स्वास्थ्य शिविर का आयोजन मेरे विधान सभा क्षेत्र अन्तर्गत माहुरी मंडल, बरवीघा में किया गया, जिसका लाभ क्षेत्र के सभी तबके के लोगों को निःशुल्क मिला। आमजनों में आपकी कार्यकुशलता एवं आपकी प्रखरता की चर्चा है। मैं चाहूँगा कि इस तरह आप हमारे विधान सभा क्षेत्र बरवीघा में प्रखण्ड स्तरीय निःशुल्क स्वास्थ्य शिविर का आयोजन करने की कृपा करें।

दिनांक-19 मार्च, 2023 को आयोजित विशाल निःशुल्क स्वास्थ्य शिविर के आयोजक एवं उपस्थित सभी सम्मानित विकित्सकों के प्रति इस पुनीत कार्य हेतु में धन्यवाद ज्ञापित करता हूँ। साथ ही साथ सबों के उज्जवल भविष्य की कामना करता हूँ।

सादर।

(सुदर्शन कुमार)

सेवा में,

डॉ० एन०पी० नारायण

M.S., D. Ortho, Ph.D (Surgery), D.N.B., F.IC.S.

F.R.C.S. (England), F.R.C.S. (Edin), F.R.C.S. (Glasgow)

CONSULTANT GENERAL & LAPAROSCOPIC SURGEON

Professor & HOD of Surgery, (Rtd.) P.M.C.H, Patna

Dr. B.C. Roy. National Awardee