GMC NEWS LETTER

VOL-1, ISSUE-3

TOPICS INSIDE

GMCNEWSLETTER

Volume1Issue3

May-June,2023

SUPERIENDENT MESSAGE

Dr. Kiran Kumar , Superintendent GGH, Guntur.

GGH Guntur, since many years has been a centerfor many patient services and Treatment modalities. GGH , had been providing utmost care to the patients in both medical and surgical ways for a better and Healthy society. I can proudly say that GGH, Guntur has grown in a such away to compete with many other private hospitals in providing similar services to the patients at free of charge.

I definitely think that all this great hard work do by whole of GGH, Guntur should get a lot more recognition than that is being currently given. I strongly believe that this GMC News Letter, brings into light all t achievements and progression in medical care and spreads it to the entire fraternity.

I congratulate all the students and faculty who are a part of this News Letter and I assure them all the support I can provide as the Superintendent of GGH, Guntur.

MESSAGE FROM VICE PRINCIPAL'S DESK

WELCOMING OUR NEW VICE PRINCIPALS:

We the team of GMC NEWS LETTER would like take the privilege of inviting **Dr.Sridhar** and **Dr. Prabhakar Rao** as the Vice- Principals of Guntur Medical College. We also thank them for their acceptance of writing messages for this edition of Newsletter.

Dr.SRIDHAR

(Vice-principalAcademic):

It gives me immense pleasure to write a message for the newsletter of Guntur Medical College; Guntur. Our main interest is to publish rare cases that have diagnostic difficulties and thus have difficulty in Management. It will be a great academic feast for our esteemed faculty and students. At the same time our newsletter highlights enormous work done by various departments.

Dr.K.PRABHAKARA RAO

(Vice-principal Admin.):

I am very glad to write this message for GMC newsletter edition 1 ; Issue 3. Since long time Guntur Medical College has been famous for teaching, diagnosis of rare diseases, good treatment, and research activities.

Now, we have a newsletter platform and with this we can make everyone know about the research activities we do News Letter is really encouraging to the staff, UG and PG students of GMC involved in research activities.

Editorial

Dr.D.MADHAVI.,MD.
Professor
Dept. of ANATOMY

GreetingtoAll…….

"Team Work definitely brings you glory" this is what our team believed while going forward and bringing out this News Letter and we are elated with the immense positive response from the medical fraternity regarding the News Letter. Being my first issue I am definitely very happy about the response and this gave me the encouragement to continue as the Editor for this GMC News Letter. Now we are happy in bringing out this issue 3 with more news more fun and more talent. I believe that this issue will definitely reach more people and get more applause than the previous ones. Wish you all a very happy reading…

HAPPY RETIREMENT

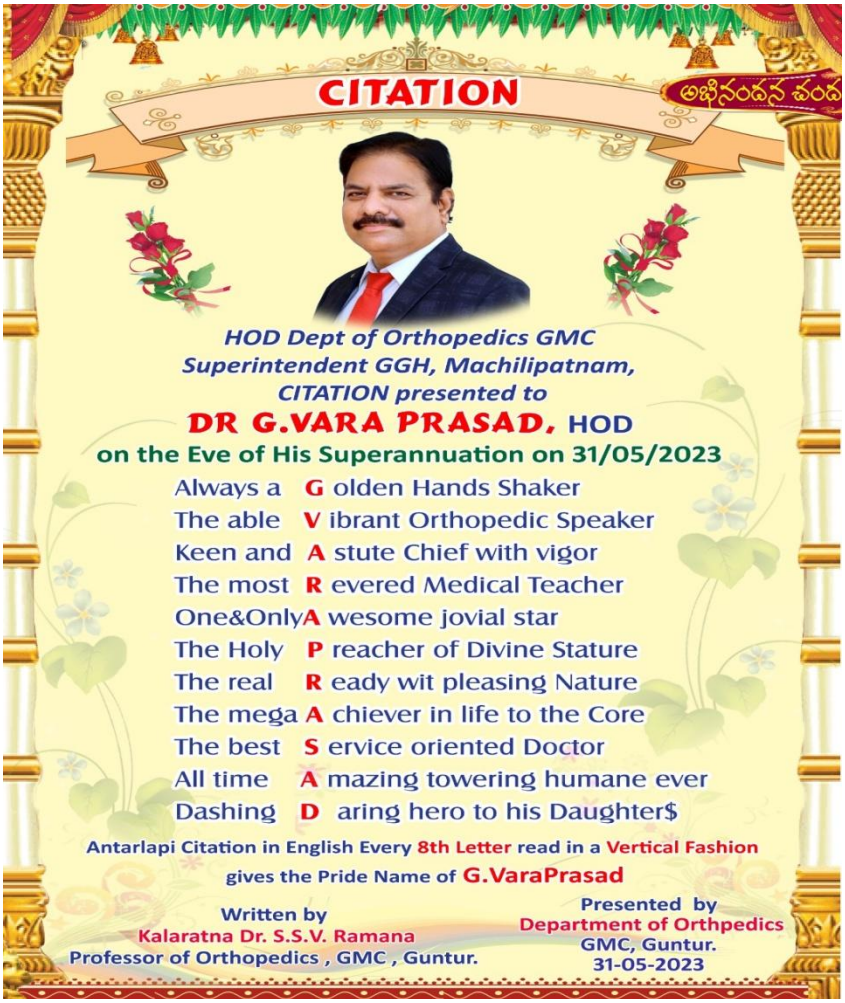
DR.N PRABHAVATHI MD,DGO

Firstly, on behalf of team GMC News Letter we congratulate Dr.Prabhavathi for such a great tenure as the Superintendent of GGH , Guntur. Everybody who knew you definitely know the hard work you have put in to enhance the Facilities and health care at GGH,Guntur. We also thank you for your great support for News Letter Initiation and release. Finally we wish you All The Best for your future endeavors.

DR.G.VARA PRASAD MS
PROF& HOD DET.OF ORTHOPEDICS

Dr.G.Vara Prasad, has been a stalwart in the field of orthopedics with his great abilities not only as a clinician but also as a teacher. Your pleasing and humble nature is what we get to our mind while thinking about you and your great tenure as the Professor and HOD of dept. Of orthopedics.

As your students we feel very lucky to learn atleast a bit from your vast sea of knowledge. We promise you that we keep up all the values that you taught us and become good doctors working for the society. We wish you All the Best for you future endeavors…




పదవీ విరమణ శుభాకాంక్షలు
Sri Dr. G. Varaprasad MS (Ortho)
Prof & Hod of Ortho, GMC
Supdt. GGH Machilipatnam
You are a good LEADER
because more than instructions,
you gave us direction and inspiration.
HAPPY RETIREMENT
సన్మాన సభ


HAPPY
RETIREMENT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CASE REPORTS:

JUNE 30,2023 [VOLUME1ISSUE 3]

Escitalopram induced Galactorrhea – A case report

DEPARTMENT OF PSYCHIATRY

Authors : Dr Chitti Anusha (1st year postgraduate),Dr .Nimeesha (Assisstant professor)

Dr. Venkata Kiran (Associate Professor**) Dr.Uma Jyothi (Professor and HOD)**

Institution: Guntur Medical College, Guntur

Abstract:

Background: Galactorrhea is defined as unusual colorless or milky nipple discharge which is unrelated to the normal milk production of breastfeeding. All conventional antipsychotic drugs block dopamine (D2) receptors on lactotroph cells removing the main inhibitory influence on prolactin secretion and thus causing increase in the secretion. However, it occurs rarely with monoamine oxidase inhibitors, tricyclic antidepressants, and selective serotonin re-uptake inhibitors (SSRIs).). Escitalopram, the S-enantiomer of citalopram is commonly used drug for the treatment of depression in day to day practice. The most common side effects of escitalopram include nausea, vomiting, constipation, diarrhea, headache, sexual dysfunction, agitation, and restlessness. We present a case of young female who developed galactorrhea induced by **Escitalopram (SSRIs).**

Case report: A 30-year-old female suffered from low mood from 7 weeks anhedonia from 6 and half weeks, reduced sleep and appetite for 6 weeks and was diagnosed with depression using the International Classification of Diseases-10 criteria, 6 months ago. She was prescribed escitalopram 5 mg for 4 weeks and later the dose was increased to 10 mg as there was inadequate response. She was maintained on escitalopram 10 mg for 6 months. Then the patient presented to the Psychiatric Outpatient Department, Government General Hospital Guntur with the complaints of abnormal fluid-like discharge from both nipples for last 1 month. She was referred to a gynecologist and ultrasonography of the breasts and few laboratory investigations such as serum prolactin levels and thyroid function tests were done. All blood investigations were within normal limits except serum prolactin levels which were more than 120ng/ml (normal value for nonpregnant female 10-25ng/ml). A Magnetic resonance imaging (MRI) of the brain hypothalamic/pituitary area didn't reveal any mass lesion and in ultrasonography breast also didn't reveal any abnormality. As her galactorrhea developed after initiations of her medication with escitalopram, we stopped her medication. After cessation of the medication, the discharge abated. Her serum prolactin level decreased to normal levels five days after discontinuing escitalopram.

DEPARTMENT OF OPHTHALMOLOGY

A RARE CASE REPORT ON SHAWAF –TRABOULSISYNDROME WITH SPHEROPHAKIA AND MEGALOCORNEA

R.Vineela[1], B.MainaSupraja[1], M.Harika[2], A.V.Pitchireddy[2], Y.Srinivas[3], L.J.Sandhyavali[4]
Junior Resident[1] Assistant Professor[2] Associate professor[3] Professor4

Introduction:

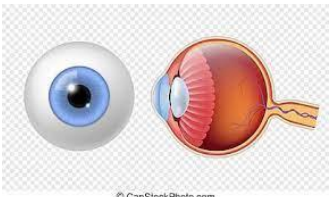
Shawaf - Traboulsi syndrome is an extremely rare autosomal recessive disorder caused by ASPHgene variants characterized by facial dysmorphia,lens dislocation, anterior segment abnormalities, spontaneous filtering bleb and occasional systemic manifestations.

Case:

A 7-year-old male child was admitted in hospital with cough and cold and was referred to Ophthalmology OPD from department of pediatrics. The child was born to a 3rd degree consanguineous marriage where pedigree shows both parents normal (skip generation) and presented with short stature, delayed speech, delayed dentition and language development and moderate intellectual disability with micrognathia and triangular face with short metacarpals seen on X ray and with a history of bilateral inguinal hernia for which surgery was done 1 year ago. On examination, Best corrected visual acuity for right eye is -5.00/-9.00 ×90°and for left eye it is -4.25/-3.50 ×60°. Extraocular movements are free, full and painless in all gazes. Corneal diameter of 14mm in both vertical and horizontal in both eyes.K_V and K_H values of right eye being 42.05D and 43.75D at 59 degrees axis and in the left eye 40.30D and 42.6D at 149degrees axis respectively. Anterior segment shows iridodonesis, phacodonesis and spherophakia. Applanation in RE 12mm of Hg and LE 10 mm of Hg. Fundus examination reveals clear media with medium sized disc and distinct margins with cup disc ratio of 0.6:1 with healthy neuroretinal rim, normal vessels and foveal reflex is present and there are no signs of posterior pole myopic degeneration. Gene testing is positive for ASPHNM_004318.4 of variant c.2181_2183dupATGp.val727_Trp728insTer which is homogenous on Exon 25 of Autosomal recessive inheritance which as per ACMG classification is likely pathogenic PM2, PVS1_strong and PPS which is suggestive of Trabulosi syndrome.

Anthropometry: Weight –15kg *<3rd percentile* *Height –104cm* *<3rdpercentile*

Head circumference–52cm *Chest circumference–50cm,* *arm span-107cm*



Pathophysiology:

Traboulsi syndrome associated variants impair AspHoxygenase domain on the AspH protein ,thereby impairing asparagine and aspartate hydroxylation on the EGF domains of various proteins such as Fibrillin 1 and Latent transforming factor beta binding protein 2 which plays critical role information of microfibrilsandciliaryzonules which hold lens in place.

Diagnosis:

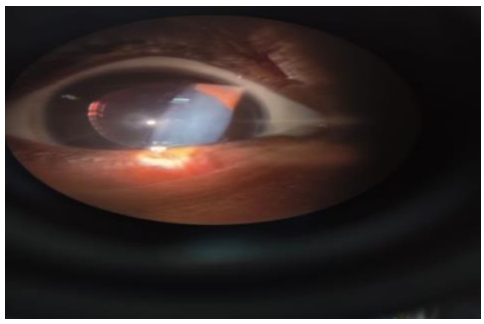
Shawaf – Traboulsi syndrome** commonly called as**Traboulsi syndrome.

Primarily a clinical diagnosis but considered as a syndrome due to overlapping of signs. Hence , Gene testing is done.

Follow-up:*Regular medical follow-up is advised to rule out glaucoma , spontaneous lens dislocation and worsening corneal manifestations and also to rule out cardiac abnormalities. Our patient was also advised for low visual aids for correction of high degree of compound myopic astigmatism.*

Prognosis: Visual prognosis is variable based on the time of diagnosis and management of ocular conditions though typically visual acuity is poor.

Triangular face, Beaked nose megalocornea



Slit lamp examination of right eye

Showing megalocornea and Spherophakia

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A CASE REPORT OF COLOBOMA OF IRIS AND CHOROID INVOLVING OPTIC DISC [IDA MANN TYPE 1] WITH POSTERIOR STAPHYLOMA OF BOTH EYES

PRESENTING AUTHOR:

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JUNIOR RESIDENT IN OPHTHALMOLOGY,

GUNTUR MEDICAL COLLEGE, GUNTUR

CO-AUTHORS:

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- **DR. SERINA SAMUEL M.S.[OPHTHAL],** PROFESSOR, DEPARTMENT OF OPHTHALMOLOGY, GUNTUR MEDICAL COLLEGE, GUNTUR.
- **DR. M.NIRMALA M.S.,[OPHTHAL],** ASSISTANT PROFESSOR, DEPARTMENT OF OPHTHALMOLOGY, GUNTUR MEDICAL COLLEGE, GUNTUR.

CASE

A 30-years old female patient came to ophthalmology OPD for visually challenged certificate with chief complaint of defective vision in both eyes since childhood.

H/O similar complaints in the family is present.

H/O second degree consanguineous marriage

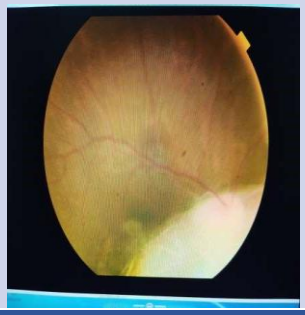
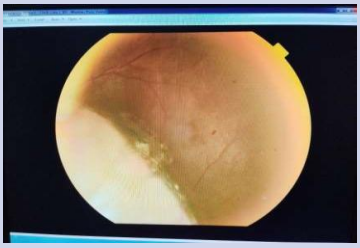
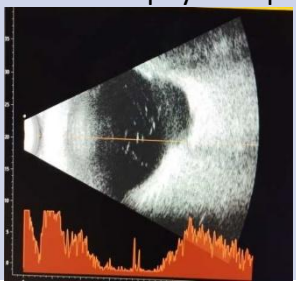
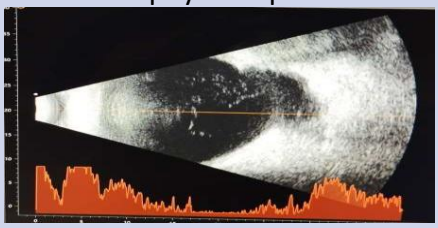
ON EXAMINATION :

	OD	OS
BCVA FOR DISTANT VISION [SNELLEN'S CHART]	**6/18** with pinhole not improving further	**6/24** with pinhole not improving further
ON SUBJECTIVE VERIFICATION	**6/18** with glasses not improving further.	**6/24** with glasses not improving further.

CLINICAL PICTURE	OD	OS
		

SLIT LAMP EXAMINATION	OD	OS
ANTERIOR SEGMENT	• Micro cornea. • Iris colobomainfero-nasal @ 5 'O clock position. 	• Micro cornea. • Iris colobomainfero-nasal @ 5 'O clock position. 
PUPIL	• Defect present infero-nasal @ 5'O clock postion. • Reacting to light.	• Defect present infero- nasal @ 5 'O clock position. • Reacting to light.
LENS	Clear.	Clear.

FUNDUS EXAMINATION [DIRECT OPHTHALMASCOPE]	OD	OS
	Media – clear Oval / comma shape defect present infero-nasal involving optic disc [Ida Mann type 1].	Media – clear Oval / comma shape defect present infero-nasal involving optic disc [Ida Mann type 1]. .

FUNDUS PICTURE [CANON FUNDUS CAMERA]	OD	OS
		
B – SCAN	**OD**	
	Posterior staphyloma present. 	Posterior staphyloma present. 

- **MRI BRAIN** is within normal limits.

  Management :

- Patient was advice for regular follow up with dilated fundus examination due to the **risk of retinal detachment** in future.
- Guarded visual prognosis regarding poor prognosis is explained.

- Coloboma is derived from the Greek *koloboma*, meaning mutilated, curtailed, or with defect. The term is used to describe ocular defects of the eyelids, iris, lens, ciliary body, zonules, choroid, retina or optic nerve.

- It can affect one eye (unilateral) or both eyes (bilateral).

- Coloboma of the iris, ciliary body, choroid, retina and/or optic nerve derive from failed or incomplete closure of the embryonic fissure (also known as choroidal or optic fissure) during development.

- Anteriorly located coloboma often appears as a defect in the iris tissue, in the shape of a keyhole. They are classified as **"typical" if found in the inferonasal quadrant** of the affected structure and "atypical" if found elsewhere. Cornea, ciliary body and zonules may also be involved.

- Posteriorly located coloboma can involve the optic nerve, retina, and choroid. If the **retina is involved, it is reduced to glial tissue with no underlying RPE or choroid**. This appears as an area of whitening often with pigment deposition at the junction of the coloboma and normal retina. If the **optic nerve is involved, it can have a range of appearance from physiologic cupping to extensive retinal involvement**

- **Retinal detachment and cataract** are the most common complications associated with retino-choroidal coloboma. Coloboma of the posterior pole is associated with an **increased risk for retinal detachment with occurs in 23-42% of patients**

Differential diagnosis

- Aniridia.
- Iris trauma.
- Iris atrophy.
- Morning glory disc.
- Congenital optic pits.
- Optic nerve staphylomata.

- Interval **monitoring for retinal detachment** should be done with a dilated fundus examination approximately every 6-12 months or sooner if indicated for patients with posterior coloboma.
- A risk of retinal detachment is there which may be **upto 40%.** Prophylactic laser of such eyes may reduce the occurrence of retinal detachment, though randomized trial for this is not yet available

CONCLUSION

In the above discussed case, on excluding other conditions like aniridia, iris atrophy, iris trauma, morning glory disc, congenital optic pits, optic nerve staphylomata, I came to a diagnosis of **COLOBOMA OF IRIS AND CHOROID INVOLVING OPTIC DISC [IDA MANN TYPE 1] WITH POSTERIOR STAPHYLOMA OF BOTH EYES.**

ANGIOMATOSIS OF BREAST – A DIAGNOSTIC CHALLENGE

Department of Pathology and General Surgery FS1

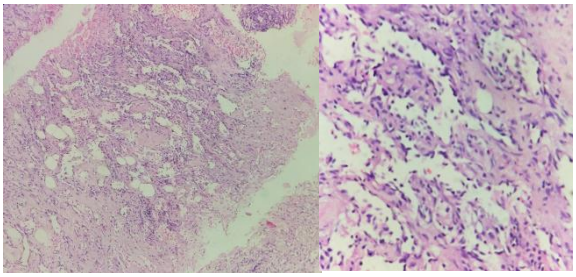
Angiomatosis of the breast is an extremely rare benign vascular lesion. This is a diagnostic challenge given the limited number of cases reported in the literature. Due to similar features of more common malignant vascular tumor, angiosarcoma, familiarity with Angiomatosis in the differential diagnosis is important.

We present a case of Angiomatosis of breast in a 37 years old female presented to surgical OP with chief complaint of left breast lump since 3 months with gradually increasing in size associated with pain. On examination 10x6cm ill-defined firm, fixed lump in upper outer quadrant of left breast with a clinical diagnosis of Phyllodes.

Ultrasound showed a well defined hypoechoic lesion with anechoic foci at 10'o clock to 1'o clock position of left breast with no internal vascularity. Surrounding parenchyma appears hyperechoic. Impression -to rule out infective etiology. Ultrasound was followed by FANC which showed mastitis features.

Trucut biopsy revealed the histological picture of a

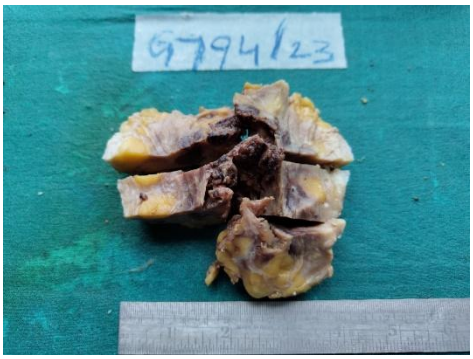
ANGIOMATOSIS/HEMANGIOMA



Low power view showing inter-
High power view showing vascular channels
communicating vascular channels
lined by flat endothelial cells

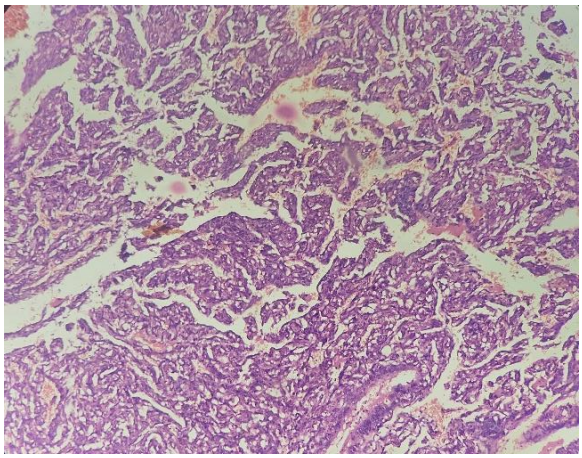
In the follow up we received excision biopsy specimen

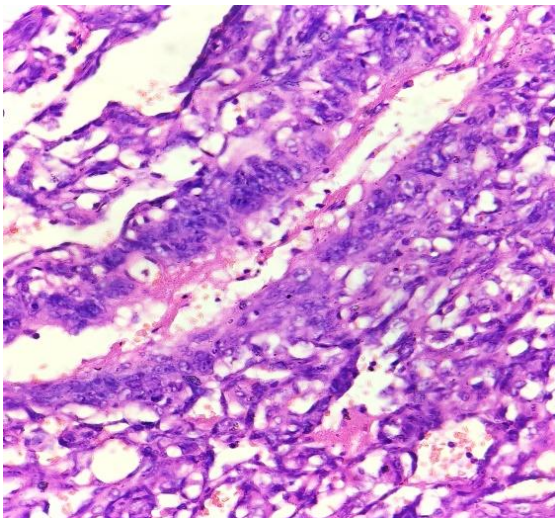
GROSS EXAMINATION: multiple grey white to greyish yellow tissue masses altogether measuring 10x6x4cm. Cut section spongy, cystic with dark brown areas.



We have done ancillary investigations like IHC with CD34

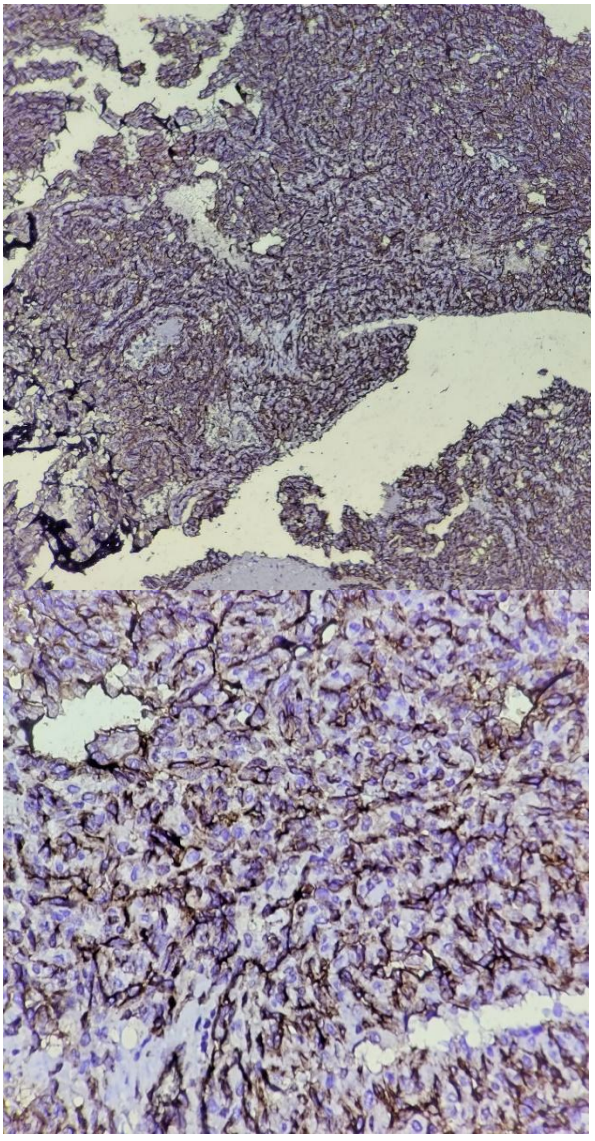
MICROSCOPIC EXAMINATION: Multiple section studied show intercommunicating vascular channels lined by flattened endothelial cells and diffusely grow throughout the breast parenchyma. Suggestive of **Angiomatosis of Breast**





Low power view showing vascular Channels diffusely involving breast parenchyma

High power view showing inter-communicating vascular channels



Low power view10x
High power view 40x

IHC with CD34 showing strong positivity

Angiomatosis is locally aggressive and may recur if not adequately excised.

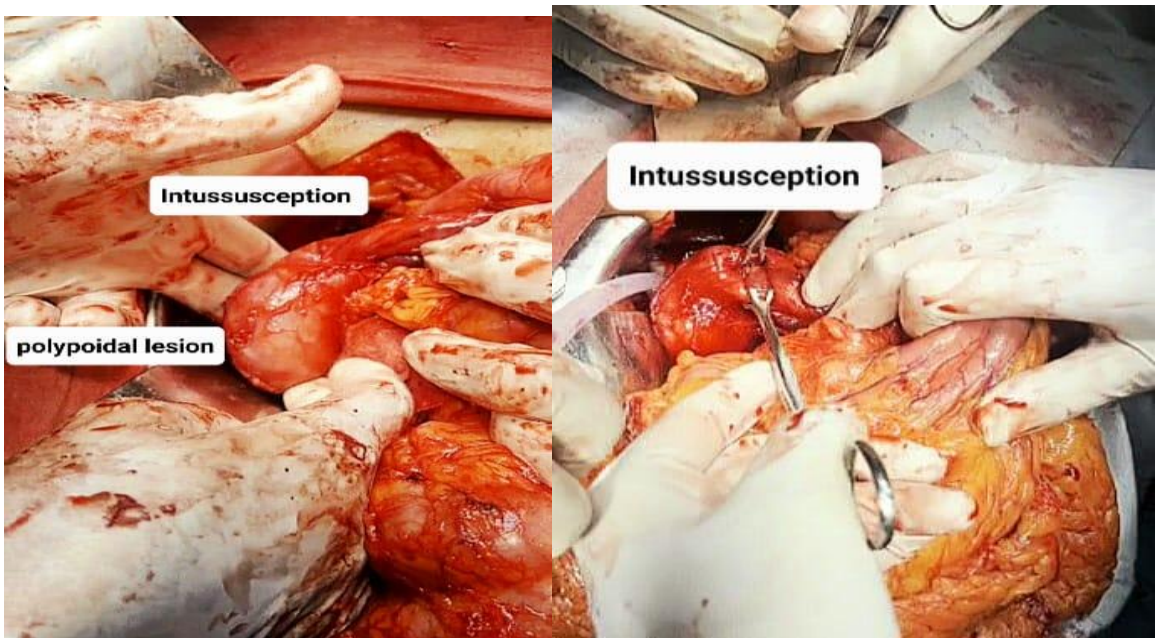
CASE REPORT: A RARE CASE OF DUODENAL POLYP WITH GASTRODUODENAL INTUSSUSCEPTION

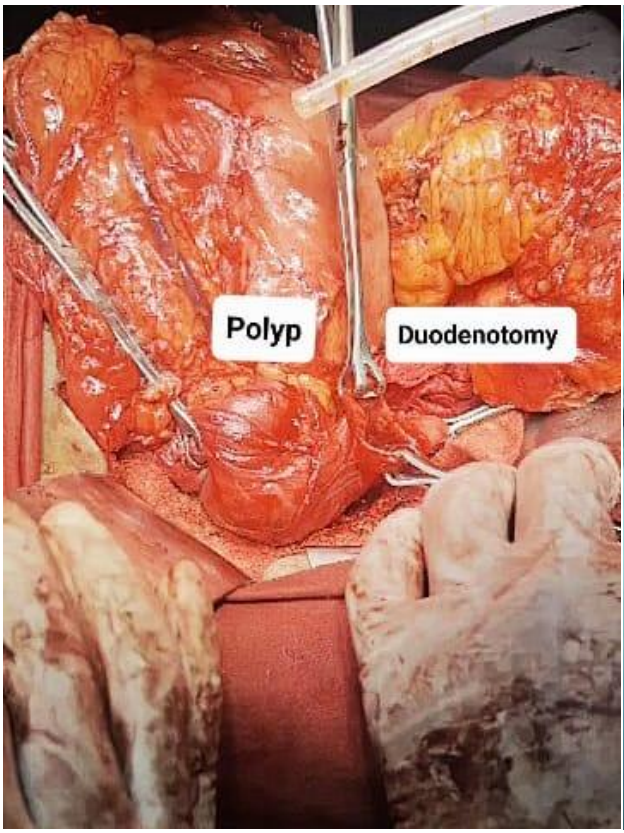
LAPAROTOMY WITH DUODENOTOMY, EXCISION OF POLYP (FROZEN SECTION) AND CLOSURE OF DUODENUM

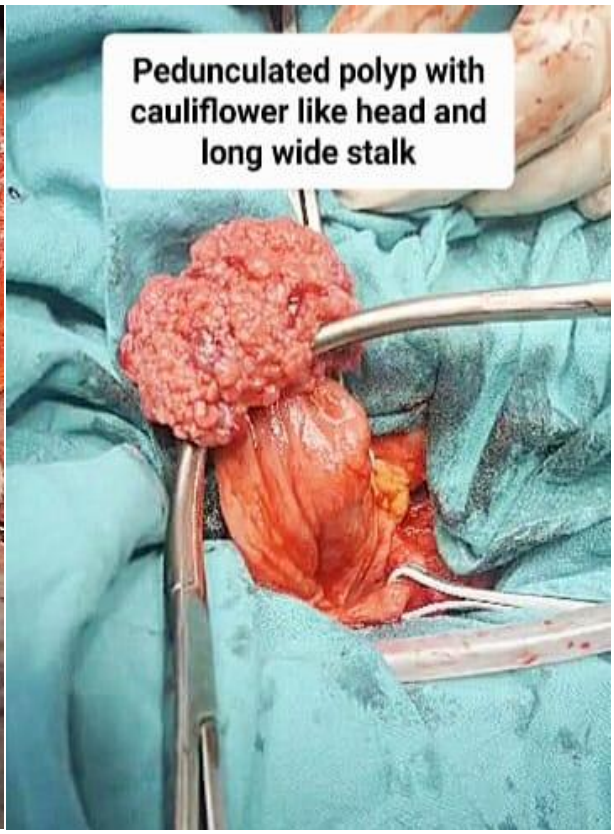
Dr. Y Kiran Kumar, chief surgeon &Professor,superintendent
Dr.Ch.R.Chalam, Dr.L Vamsidhar, Dr.K.Nagasanthosh, Dr.Anusha
***Post-graduates*: Dr.Nikhil, Dr Siva Kishore,**
Dr.Sai Likitha, Dr.Venugopal, Dr.Koteswararao
Department Of General Surgery, Unit-II

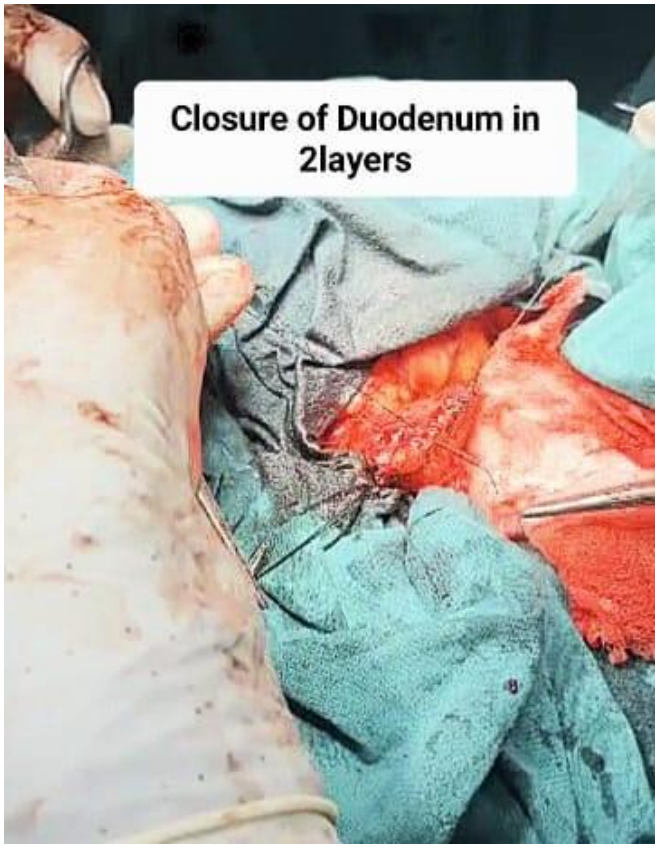
65yrs elderly male patient presented with complaints of Dyspepsia, Epigastric discomfort, Heart Burn, Belching, mobile mass per abdomen, gross anemia, anorexia not responding to symptomatic medication, patient was admitted in surgery 2nd unit. UGIE shows D2 Duodenal polyp with thick stalk in D1, with biopsy ruling out malignancy. MRI Abdomen shows Gastro Duodenal Intussusception with D2 Polyp. Following multiple blood transfusions and relevant investigations patient is planned for surgery. Under GA, Midline Laparotomy incision of length 20cm is given and abdomen is opened in layers to enter peritoneal cavity. Duodenum is mobilized by Kocher's maneoveur. Mobile Polypoidal lesion is palpable in D2 part of duodenum with Gastro Duodenal Intussusception.Manual reduction of intussusception is done by pushing the lesion proximally. Duodenotomy is done by giving transverse incision in D2 . Single Cauliflower like pedunculated polyp of size 5*3cm is noted with a stalk of diameter 1cm is noted arising from proximal part of D1. Excision of polyp along with its stalk is done and specimen is sent for frozen section. Frozen section reports it as a benign adenomatous polyp. Duodenum is closed in 2 layers. Abdomen is closed in layers.

Postoperative period is uneventful and patient is discharged on POD 10 after complete suture removal.



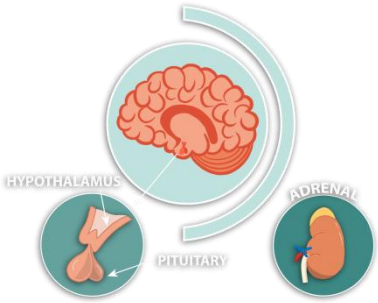

Polyp
Duodenotomy


Pedunculated polyp with cauliflower like head and long wide stalk


Closure of Duodenum in 2layers


EVENTS

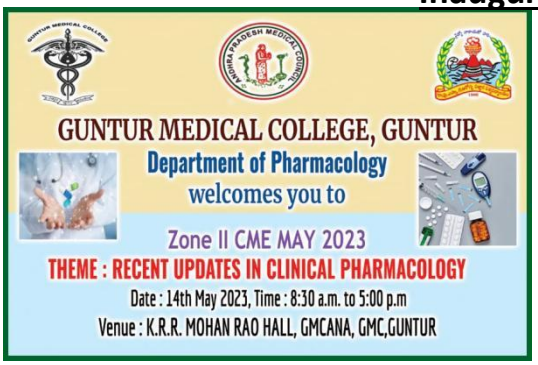

CME
High Quality
Low Cost


HYPOTHALAMUS
PITUITARY
ADRENAL

ZONE II CME MAY 2023 – DEPARTMENT OF PHARMACOLOGY
THEME: RECENT UPDATES IN CLINICAL PHARMACOLOGY

- On 14 May, 2023 Zone II CME, Department of Pharmacology was conducted at K.R.R. Mohan Rao hall, GMCANA, which focused on the "Recent updates in Clinical Pharmacology".
- It was inaugurated by the chief guests, our beloved principal mam, Dr. N. Uma Jyothi mam & Dr. N. Prabhavathi mam, Medical superintendent.

Inauguration



Speakers and topics

1. Protocol for Evaluating Newer AntiDiabetic Drugs by Dr. P. Usha Kiran, Prof & HOD, Rangaraya Medical College.
2. 'Off Label Use of Drugs' in Medical Practice- Risks, Benefits and Regulations by Dr. Sushil Sharma, Prof & HOD, Dept of Pharmacology, AIIMS, Mangalgiri.
3. Role of Pharmacologists in Drug and Therapeutics Committee in Tertiary Hospital Care by Dr. K. Umamaheshwar Rao, Prof & HOD, Vice Principal (Admin), SVIMS-SPMC (W), Tirupathi.
4. Recent Advances in Anti Diabetic Drugs by Dr. K. Chandrakala, Professor, Vice Principal (Academic), GMC, Guntur.
5. Lifestyle Disorders - Role of Low Carbohydrate and High Fat Diet & Intermittent Fasting by Dr. K. Sankar, Prof & HOD, Dept of Pharmacology, GMC, Guntur.

- Approximately 100 people were attended. During the CME, attendees shared opinions, thoughts, suggestions about the recent advances in Pharmacology.





Quiz

- Quiz program has been conducted for all the Postgraduates who have attended the CME.
- It was conducted in 5 rounds with 5 questions in each round
- The winners were given prizes at the end of the program.









A special thanks to our Principal mam, Dr. N. Uma Jyothi mam & superintendent Dr. N. Prabhavathi mam, for their diligent inputs, encouragement & guidance.

ORGANISING COMMITTEE:

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- Dr. M. Triveni , Assoc. prof., Dept of Pharmacology, Guntur.

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- Dr. G. Gowthami

POSTER...

Dr.A.EDWIN RICHARD

2nd PG,,DEPT.OFORTHOPEADICS

RECURRENT DISLOCATION OF SHOULDER WITH BONY BANKART -a case report

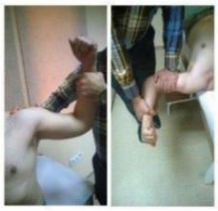
DR.A.EDWIN RICHARD
DEPARTMENT OF ORTHOPAEDICS
GUNTUR MEDICAL COLLEGE

INTRODUCTION:

The shoulder joint has the largest range of motion of all joints with little inherent bony stability . Joint stability is maintained by static and dynamic elements. Translation of humeral head can cause an associated avulsion of the glenoid labrum known as bankarts lesion with posterolateral defect of humerus known as Hillsachs lesion. Bony bankart – a piece of Glenoid along with ligamento labrocapsular complex called impression fracture. To prevent recurrent dislocation with bony bankarts , latarjet is considered as promising intervention.

CASE PRESENTATION:

A 37 year old male plumber by occupation came to ortho OPD with complaints of recurrent instability of shoulder since 5 years. Patient had history of trauma 5 years back .He had event of anterior dislocation of right shoulder where dislocation corrected by closed technique under sedation followed by he had events of recurrent shoulder dislocation which get corrected on its own.

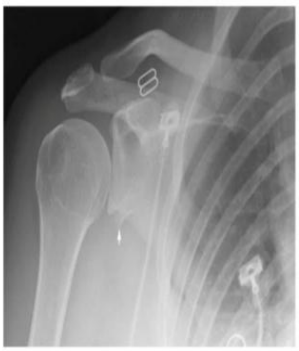


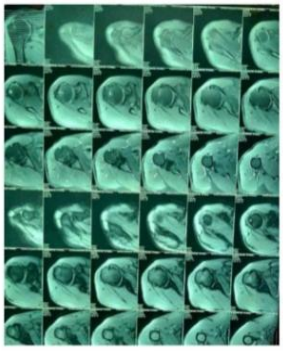
GENERAL EXAMINATION: Moderately built and nourished personality with pallor, no icterus, cyanosis and regional lymphadenopathy. Vitals were normal.

SYSTEMIC EXAMINATION : No abnormality detected.

LOCAL EXAMINATION OF RIGHT SHOULDER: Patient was examine in supine, sitting and standing position compared with opposite side shoulder showing muscular wasting on right side . ANTERIOR APPREHENSION AND RELOCATION TEST- Provocative tests showed positive

RADIOGRAPHY : X RAYS and MRI was taken

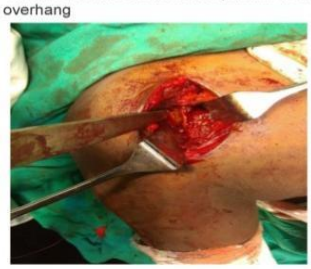


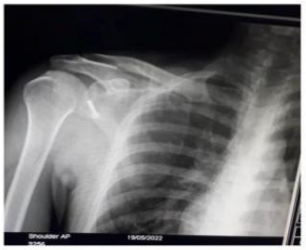


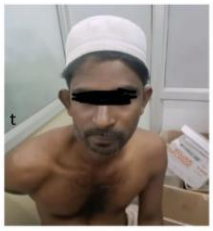
IMPRESSION: A well defined osteochondral defect is noted in posterosuperior of humeral head -Hill sachs lesion, anteroinferior glenoid labrum is seen stripped off from glenoid bone from 2-5 o clock position-Bony Bankart lesion, mild glenohumeral joint effusion with fluid along long head of biceps.

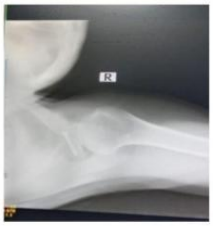
SURGERY:LATARJET PREOCEDURE THROUGH DELTO PECTORAL APPROACH

skin incision from the tip of the coracoid extending 4to5 cm toward the axillary crease
Dissect down to the deltopectoral interval
Perform deltopectoral interval dissection
Soft tissue dissection around the coracoid
Perform the osteotomy, Release the coracoid
Decorticate the coracoid
•drill two holes using a 3.2 mm drill
•externally rotate the arm keep the elbow by the side
Expose the subscapularis, Expose the glenoid
•expose the glenoid 2 cm medially from 5 o'clock to 2 o'clock in a right shoulder (a vertical distance of 2 to 3 cm)
•place a 4.5-mm partially threaded malleolar screw into the inferior hole (tendinous end).
•ensure that the coracoid lies parallel to the anterior border of the glenoid with no overhang









DISCUSSION:

Many different procedures have been described for anterior shoulder instability, most of these procedures have been successful in restoring glenohumeral stability, some have been associated with loss of shoulder external rotation and development of glenohumeral osteoarthritis. Loss of external rotation may bring an early end to a throwing athlete's career. A procedure that restores glenohumeral stability while preserving external rotation is, therefore desirable. Additionally, as many as 85% of shoulders With recurrent dislocation The Latarjet coracoid transfer procedure provides a "triple blocking" effect in the treatment of anterior shoulder instability. First, the coracoid bone blocking, making it more difficult for the humeral head to subluxate or dislocate. Second, the conjoined tendon acts as a sling reinforcing the inferior capsular ligamentous complex Finally, repair of the inferior capsular ligamentous complex to the stump of the coracoacromial ligament reconstructs the capsule labral anatomy

CONCLUSION:

Latarjet is considered as one of the most promising procedure for recurrent shoulder dislocation with bony bankarts results showing less chance of recurrence and less restriction of range of movements .

REFERENCES:

1.Allain J, Goutallier D, Glorion C: Long-term results of the Lataljet procedure for the treatment of anterior instability of the shoulder. J Bone Joint Surg
2.Rockwood and green – glenohumeral instability chapter 40-pg no1517

THANKS TO GOD FAMILY TEACHERS AND FRIENDS

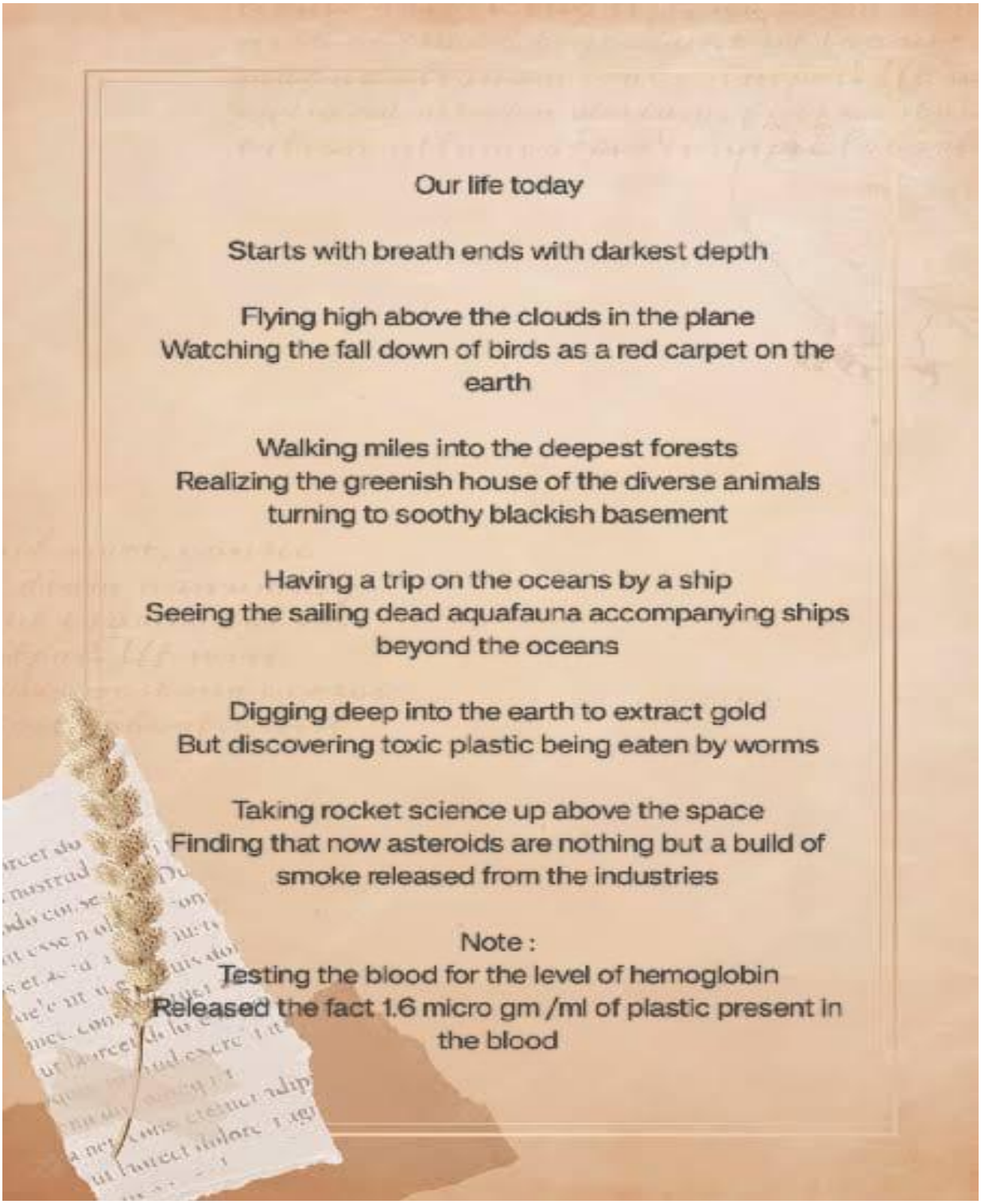
GGH ON LOCAL NEWSPAPERS

Inauguration of new medical dispensary in PODILIPRASAD block ,GGH under the supervision and efforts of **DR.Y.KIRAN KUMAR**,superiendent& Professor of Surgery ,Govt.General Hospital along with Deputy Superiendent DR. DSS SRINIVAS PRASAD and ,DR.K.SANKAR,MD,DTCD,PROFFESSOR & HOD DEPT. OF PHARMACOLOGY to help the patients as the present available dispensary is in OP building .This is just an example to showcase about the developments taking place in GGH under our beloved superiendent *Dr.Y.KIRAN KUMAR.*

జీజీహెచ్‌కి పూర్వ వైభవం

గుంటూరు వైద్యం, న్యూస్‌టుడే: సర్వజనాసుపత్రికి పూర్వ వైభవం తెచ్చే
సూపరింటెండెంట్ కిరణ్‌కుమార్ చేస్తున్న ప్రయత్నాలకు అందరూ సహకరి
గుంటూరు వైద్య కళాశాల ఔషధశాస్త్ర విభాగం అధిపతి, ఆరోగ్య విశ్వవిద్యా
పూర్వ రిజిస్ట్రార్ ఆచార్య శంకర్ సూచించారు. అత్యవసర వైద్య విభాగ
పంలో గతంలో తొలగించిన ఔషధాల పంపిణీ కేంద్రాన్ని కిరణ్‌కుమార్,
లతో కలిసి సోమవారం తిరిగి ప్రారంభించారు. ఈసందర్భంగా శంకర్
డుతూ పాదిల ప్రసాద్ భవనం నుంచి మందుల కోసం సుదూరంగా ఉన్న
ఆసుపత్రి వరకు రోగులు వెళ్లడం చాలా ఇబ్బందికరంగా ఉంటుంద
ప్రస్తుతం ఏర్పాటు చేసిన కౌంటర్‌తో తక్షణమే మందులు తీసుకునే సదు
కలిగిందన్నారు. అదేవిధంగా దేశ, విదేశాల్లో సర్వజనాసుపత్రికి గతంలో
పేరు, ప్రఖ్యాతులు ఉన్నాయన్నారు. వాటిని తిరిగి పునరుద్ధరించేందుకు
మార్ ఎంతో శ్రమిస్తున్నారని, ఇందుకు అన్ని తరగతుల ఉద్యోగుల తోడ్పా
సరమన్నారు. కార్యక్రమంలో సూపరింటెండెంట్ కిరణ్‌కుమార్, డిప్యూటీ
టెండెంట్ డీఎస్ఎస్ శ్రీనివాసప్రసాద్, వైద్యాధికారి సుధీర్ పాల్గొన్నారు.

STUDENTSCORNER



Our life today

Starts with breath ends with darkest depth

Flying high above the clouds in the plane
Watching the fall down of birds as a red carpet on the earth

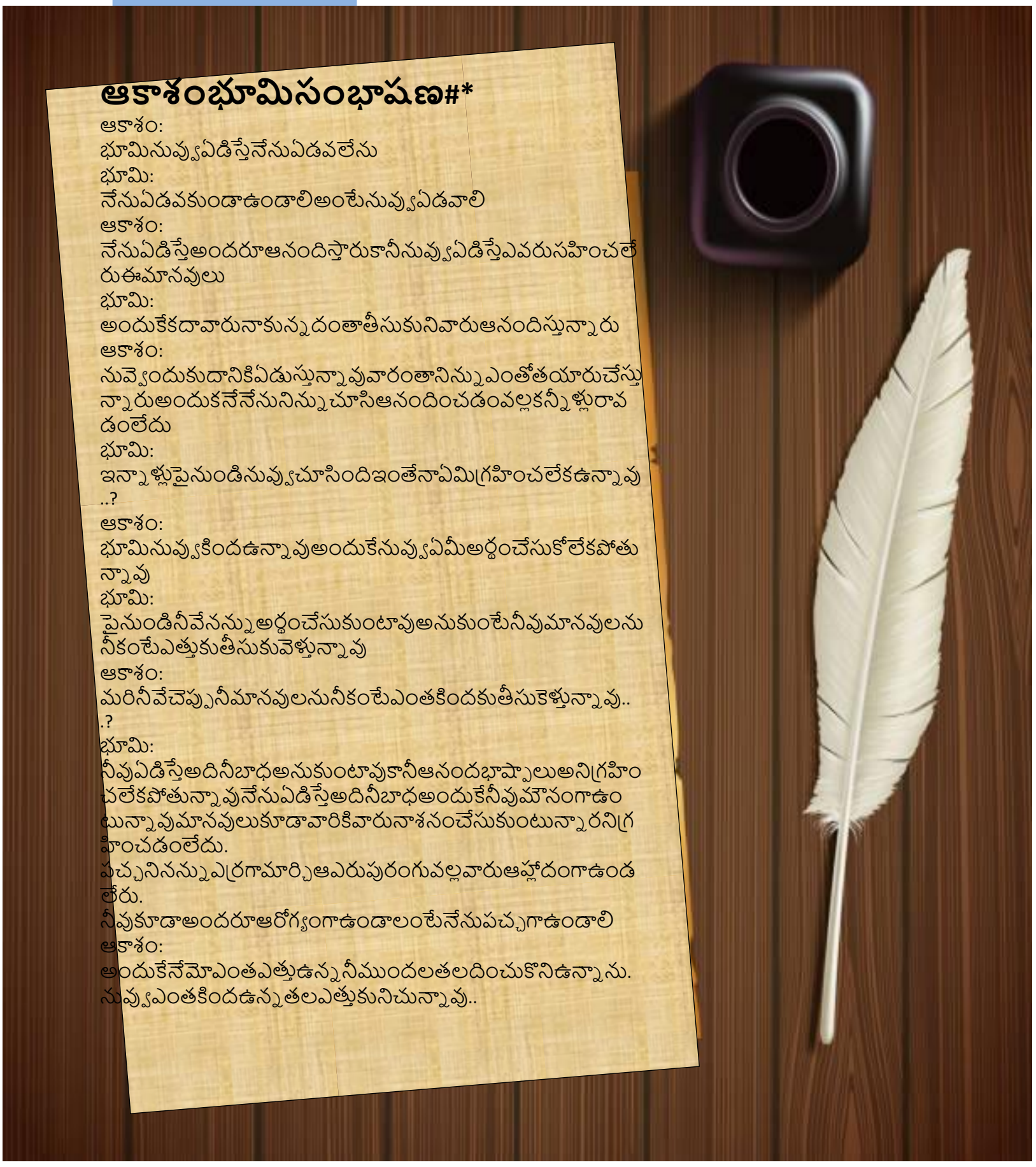
Walking miles into the deepest forests
Realizing the greenish house of the diverse animals turning to soothy blackish basement

Having a trip on the oceans by a ship
Seeing the sailing dead aquafauna accompanying ships beyond the oceans

Digging deep into the earth to extract gold
But discovering toxic plastic being eaten by worms

Taking rocket science up above the space
Finding that now asteroids are nothing but a build of smoke released from the industries

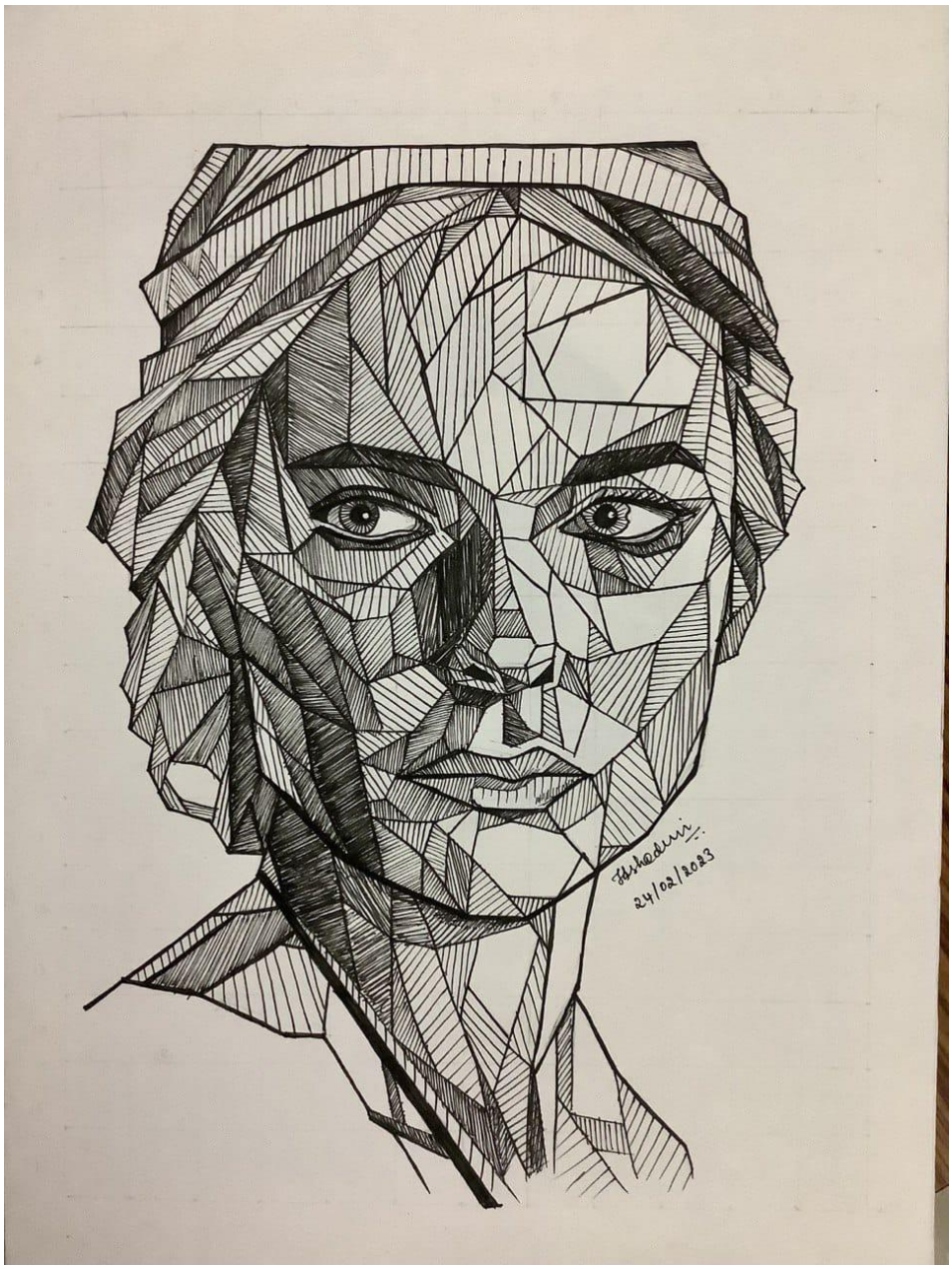
Note :
Testing the blood for the level of hemoglobin
Released the fact 1.6 micro gm /ml of plastic present in the blood



ఆకాశంభూమిసంభాషణ#*

ఆకాశం:
భూమినువ్వుఏడిస్తేనేనుఏడవలేను
భూమి:
నేనుఏడవకుండాఉండాలిఅంటేనువ్వుఏడవాలి
ఆకాశం:
నేనుఏడిస్తేఅందరూఆనందిస్తారుకానీనువ్వుఏడిస్తేఎవరుసహించలేరుఈమానవులు
భూమి:
అందుకేకదావారునాకున్నదంతాతీసుకునివారుఆనందిస్తున్నారు
ఆకాశం:
నువ్వెందుకుదానికిఏడుస్తున్నావువారంతానిన్నుఎంతోతయారుచేస్తున్నారుఅందుకనేనేనునిన్నుచూసిఆనందించడంవల్లకన్నీళ్లురావడంలేదు
భూమి:
ఇన్నాళ్లుపైనుండినువ్వుచూసిందిఇంతేనాఏమిగ్రహించలేకఉన్నావు..?
ఆకాశం:
భూమినువ్వుకిందఉన్నావుఅందుకేనువ్వుఏమీఅర్థంచేసుకోలేకపోతున్నావు
భూమి:
పైనుండినీవేనన్నుఅర్థంచేసుకుంటావుఅనుకుంటేనీవుమానవులనునీకంటేఎత్తుకుతీసుకువెళ్తున్నావు
ఆకాశం:
మరినీవేచెప్పునీమానవులనునీకంటేఎంతకిందకుతీసుకెళ్తున్నావు..?
భూమి:
నీవుఏడిస్తేఅదినీబాధఅనుకుంటావుకానీఆనందభాష్పాలుఅనిగ్రహించలేకపోతున్నావునేనుఏడిస్తేఅదినీబాధఅందుకేనీవుమౌనంగాఉంటున్నావుమానవులుకూడావారికివారునాశనంచేసుకుంటున్నారనిగ్రహించడంలేదు.
పచ్చనిననున్నెర్రగామార్చిఆఎరుపురంగువల్లవారుఆహ్లాదంగాఉండలేరు.
నీవుకూడాఅందరూఆరోగ్యంగాఉండాలంటేనేనుపచ్చగాఉండాలి
ఆకాశం:
అందుకేనేమోఎంతఎత్తుఉన్ననీముందలతలదించుకొనిఉన్నాను.
నువ్వుఎంతకిందఉన్నతలఎత్తుకునిచున్నావు..

ARTSYCRAFTSY



rukmini-2021

Sravan2K21

GREYMATTER!!!!!!.....

CROSSWORDS

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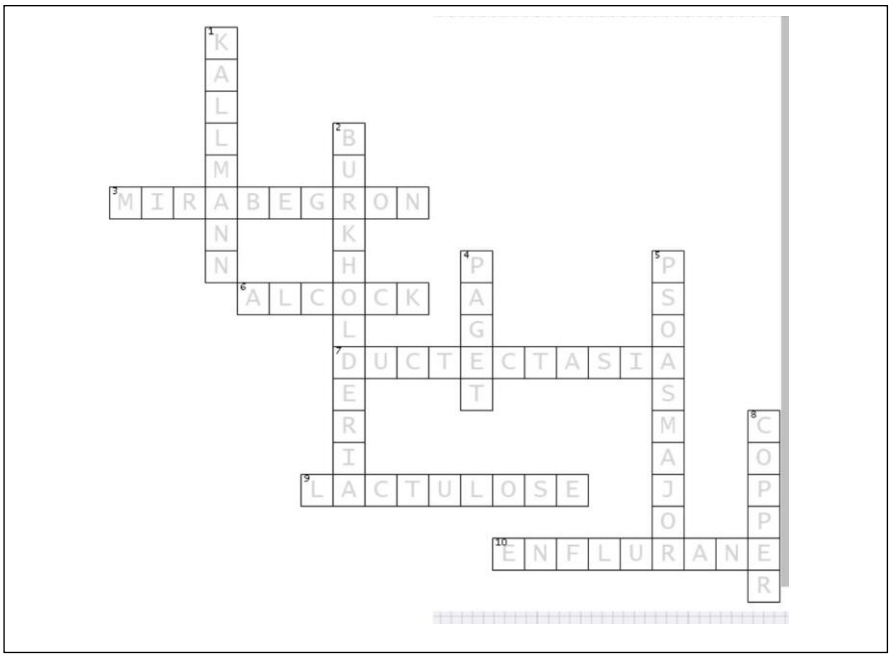
-S.SREESWATHI2K20



HELLOMEDICOS!!!

TWIST YOUR GREY MATTER

ANSWERS FOR CROSS WORDS

DOWN

1. Syndromeassociatedwithproblemsofolfaction and puberty in females-

2. Causeofchestinfectioninachildwithcystic fibrosis

4.Bonedisorderassociatedwithleonine facies

5.Musclewith14fleshyslips

8.Cofactorforenzymethatconvertstyrosineinto Dihydroxy phenylalanine

CROSS

3.Newdrugapprovedforoveractivebladder

6.nervewhichisblockedduringepisiotomypasses through this canal

7.BreastPathologywhichpresentsasPerialveolar mass with green brown nipple discharge

9.Drugofchoiceforhepaticencephalopathy

10.Anaestheticthatiscontraindicatedinepilepsyas it can raise intracranial tension and producetonic clonic seizures

FORANSWERSREFERNEXTEDITIONISSUE3

EDITORIAL NOTE

New team, added talent, additional creativity, great team work…this has been the story after the second issue of GMC NEWS LETTER Volume 1 Issue 2. We feel so happy to expand the wings of the editorial team by adding a few members with a Great zeal to take this News Letter to greater heights. Firstly we thank all the readers for making the 2nd issue of our NEWS LETTER a great success. Without all your appreciation we would have not been able to bring this 3rd issue. Many new sections have been added without any compromise to bring forward to you every news in and around Guntur Medical College. We expect that this 3rd issue also reaches to its maximum extent and becomes a part of Guntur Medical College forever and ever.

.

We want to convey the message, "If you are failing to plan, you are planning to fail". So, be wise and do your best in the upcoming exams. Lastly preparation is the key to success. Try to be Healthy and Energetic in every situation. Hope you enjoyed this edition of our newsletter and will see you geniuses soon with our next edition.

-UG EDITORIAL TEAM
GMC NEWS LETTER,

INSTRUCTIONS:

Articlesincluded inthe newsletter:

- *Casescenariosand reportsaboutrare diseasesandprocedures performed.*
- *AcademicachievementsofdepartmentssuchasCMEs,awardsreceived,any initiatives undertaken, any days celebrated with public health importance etc,.*
- *Personalcontributionsintheformofpoems,originalwrite-ups,artwork,andanything relevant.*

E-mailaddress tosend:*gmcnewsletter01@gmail.com*

- *Sendyourarticles,photographs,art,jokes,writeups,queriesorsuggestionstothis mailaddressbytheend ofeverymonthwhichwillgetpublishedinthenextissueto be released after two months.*

Note:

- *The articles submitted will be scrutinized by the advisory and editorial board and the decision of the Editor will be final while publishing.*
- *Duetospaceconstraintabridgedandmodifiedversionsofthearticles,case scenarios and case reports strictly restricted to not more than 2 pages is requested.*
- *ItisalsorequestedtosendthearticlesinwordformatandnottosendasPPTor PDF.*
- *It was noticed that academic papers published in different journals are being sent asa whole document which may lead to removal of certain important points necessary for the readers. Keeping in view of this it is requested to send them as a synopsis with the most important findings.*
- *Articles received and not published in the current edition will be included in the next edition.*

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