medanta

THE EXCHANGE

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A Knowledge Sharing Initiative by Medanta

Robot-Assisted Management of Mid-Ureteric Stenosis in a Two-Year-Old

Congenital ureteric narrowing due to a valve or stenosis is an extremely rare cause of ureteric obstruction and hydronephrosis in children, with only around 65 cases reported in the medical literature worldwide. Depending on the level, ureteric valves may mimic pelviureteric junction (PUJ) or vesicoureteric junction (VUJ) obstruction. Mid-ureteric obstruction is less common, accounting for approximately 17% of cases, compared to 50% in the proximal and 33% in the distal ureter.

Ureteric anomalies can be challenging to diagnose using routine imaging, especially in the presence of a megaureter, and most cases are misdiagnosed preoperatively. Accurate diagnosis often requires close interdepartmental collaboration, particularly with Radiology and Nuclear Medicine teams.

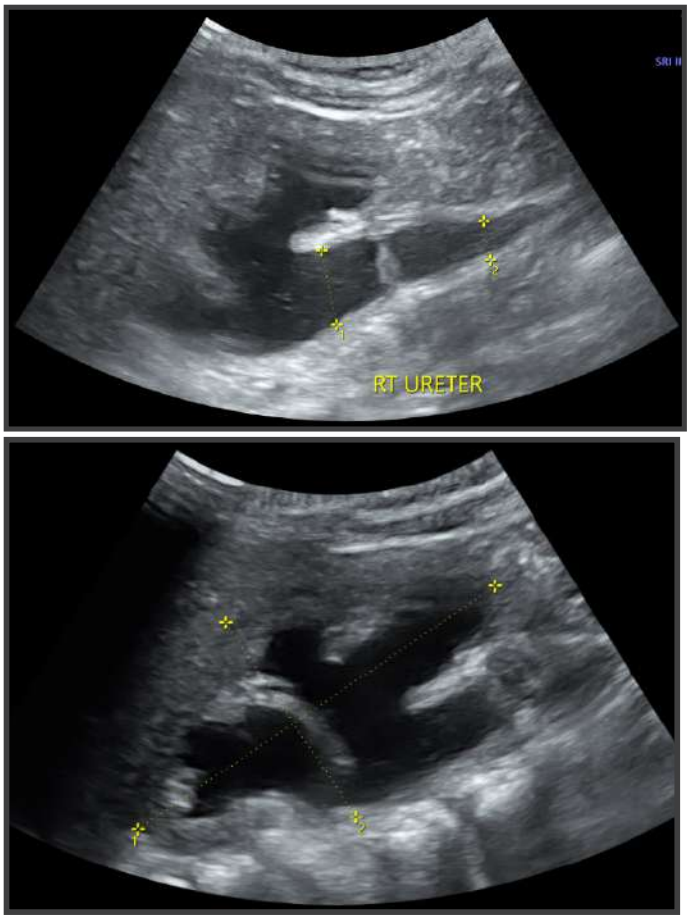
We report a case of mid-ureteric stenosis in a young boy, successfully managed surgically using the Da Vinci Xi robotic system.

Case Study

A 2-year-old boy presented with a 20-day history of generalised abdominal pain, persistent low-grade fever, and reduced appetite. He had previously been evaluated by a local paediatrician, who identified right-sided hydronephrosis with a dilated upper ureter on ultrasonography (USG) of the kidneys, ureters, and bladder (KUB). Subsequently, his parents brought him to Medanta - Lucknow for further evaluation with the above report.

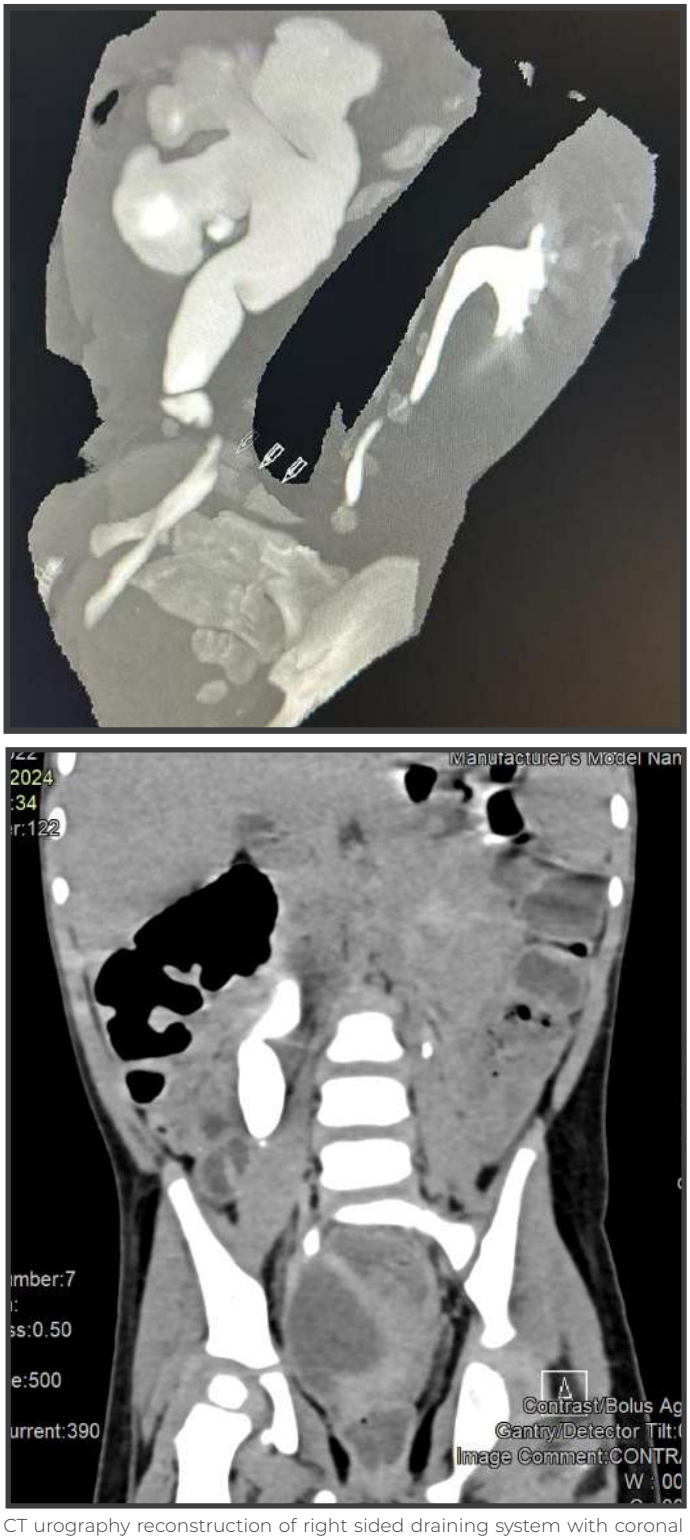
All antenatal scans had been normal, and there was no prior history of hospitalisation. On detailed history and clinical examination, the child was noted to have associated features suggestive of constipation, bladder-bowel dysfunction, and phimosis, all of which could have contributed to his presenting symptoms. He was not yet toilet trained, although his urinary stream was reportedly good.

Routine blood investigations were within normal limits at the time of presentation. Initial basic workup included an X-ray KUB to assess for significant constipation, and urine routine examination, microscopy, and culture to rule out a urinary tract infection (UTI). In order to establish the surgical significance of the observed hydroureteronephrosis, USG KUB was repeated, along with a renal nuclear scan and CT urography.



USG KUB images delineating dilated upper ureter and PCS dilatation in right kidney hydronephrosis

Repeat USG revealed a hydronephrotic right kidney measuring 8 × 4.3 cm, with a dilated renal pelvis measuring 18 mm and proximal ureter dilated up to 14 mm, raising the suspicion of a mid-ureteric kink or septum. The left kidney and bilateral retrovesical ureters appeared normal.



CT urography reconstruction of right sided draining system with coronal section demonstrating possible level of stenosis

An EC diuretic renal scan revealed a right hydronephrotic kidney with preserved parenchymal tracer uptake and a rising drainage curve, indicating outflow obstruction, with a preserved split renal function of 52%. There was delayed tracer retention beyond two hours. CT urography demonstrated an abrupt narrowing in the calibre of the ureter at the L4–L5 level, resulting in a tortuous upper ureter and mild dilatation of the terminal segment as well. Voiding cystourethrogram (VCUG) ruled out vesicoureteric reflux in both the filling and voiding phases.

At initial presentation, the child appeared to have significant constipation, bladder-bowel dysfunction, phimosis, and recurrent episodes of UTI, which could have contributed to his discomfort. After a detailed discussion with the parents regarding the benefits of surgical management versus watchful waiting, a decision was made to initially manage him conservatively, address the contributing factors, and closely follow up the underlying surgical issue.

He was advised dietary modifications, laxatives, early toilet training, timed voiding, and a regimen of regular preputial stretching. On three-monthly USG KUB follow-up, the parameters assessing hydronephrosis remained static, as did the biannual EC scan. Meanwhile, the child became asymptomatic and achieved toilet training.

At approximately 10 months of follow-up, no improvement in drainage was observed. He continued to experience occasional abdominal pain despite resolution of the other factors contributing to pain and poor appetite. Hence, a decision was made to proceed with surgical intervention.

One month prior to surgery, cystoscopy with right-sided retrograde pyelogram (RGP) was performed to evaluate the level of the septum and to place a 3/16 DJ stent across it, in order to facilitate later anastomosis. The 0.018" guidewire was negotiated into the renal pelvis without difficulty, although post-procedure contrast hold-up was noted. The RGP showed grossly ballooned calyces, a dilated, tortuous upper one-third of the ureter, and a mid-ureteric kink or valve at the level of L4 vertebra.

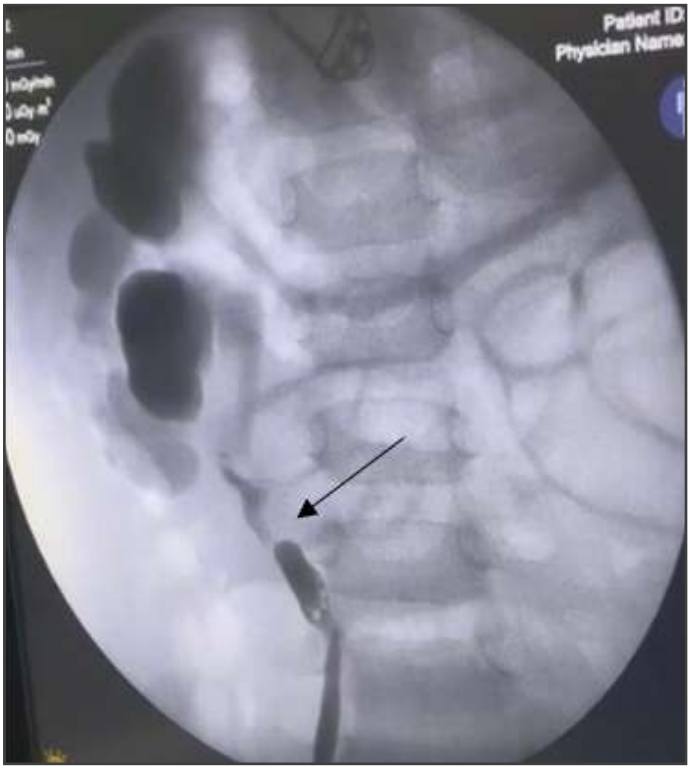
Subsequently, a robot-assisted laparoscopic repair of the narrowed ureteric segment was performed. Port placement followed the standard approach for right-sided pyeloplasty in children, utilising three robotic ports placed along the midline, along with one laparoscopic assistant port.

Intraoperatively, the entire ureter was carefully delineated until the narrowing identified on the preoperative RGP was located. The ureter was opened longitudinally at the site of narrowing, which measured approximately 5 mm in length.

Considering the delicate vascularity of the paediatric ureter, a transverse Heineke–Mikulicz type repair was performed over a 3.5/16 double-J stent, using 5-0 Vicryl sutures in a single-layer interrupted fashion. A Lasix challenge was administered post-anastomosis to assess for any ureteral ballooning.

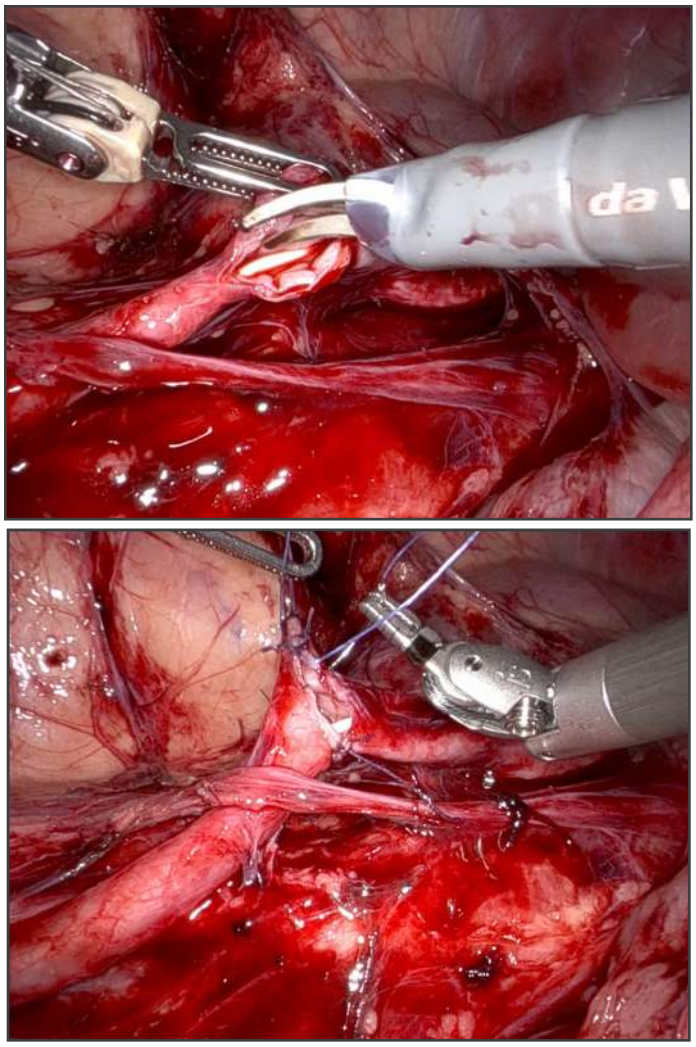
The operative time was 54 minutes, and no drain was required. The child remained pain-free and was discharged uneventfully within 48 hours.

This case highlights the significant benefits of using an advanced surgical robotic system such as the Da Vinci Xi for managing rare and complex anomalies like ureteric stenosis or narrowing, particularly when the precise location of the intraluminal pathology is uncertain and intraoperative confirmation is required in the limited surgical space of an infant's abdomen.



RGP image of right sided tortuous kinked ureter demonstrating possible stenosis at L4 level

As with all minimally invasive procedures, paediatric anaesthesia support is indispensable, requiring limited bag-mask ventilation to ensure minimal bowel distension. Until recently, such cases were managed via open surgery, necessitating large incisions for accurate identification of pathology. With the advent of robotic surgery in paediatric urology, we can now offer precise surgical intervention with minimal blood loss, smaller scars, improved patient comfort, and earlier discharge.



3DHD display images demonstrating spatulation of ureter across narrowed segment and repair in transverse fashion

Discussion

Congenital mid-ureteric valve (MUV) stenosis is a rare but important cause of hydronephrosis. Preoperative diagnosis remains clinically challenging and requires careful attention. Whenever dilation is noted only in the proximal ureter, this diagnosis should be considered, and imaging should be reviewed thoroughly in collaboration with an experienced radiologist.

Ureteric valves have been associated with complete and incomplete renal duplications, ectopic ureters, vesicoureteral reflux, and horseshoe kidney. They have also been linked to conditions such as renal lithiasis (17%) and arterial hypertension (14%).

Differential diagnoses to consider include non-obstructive foetal folds, low pelviureteric junction obstruction, distal ureteral stenosis, vesicoureteral reflux, and primary megaureter. Ureteric valves are typically composed of transverse folds of muscle fibres covered by urothelial

mucosa, whereas congenital stenosis involve narrowing of the lumen without structural mucosal changes.

Management usually involves surgical excision of the affected segment containing the valve, followed by end-to-end anastomosis. Endoscopic treatment with laser excision or ablation of the ureteric valve is challenging in younger patients due to the lack of appropriately sized scopes and the risk of restenosis. We have reserved this approach for possible future recurrence.

The main surgical challenge lies in identifying the segment with intraluminal pathology, particularly when there is no abrupt narrowing or when multiple segments are involved, as observed in our retrograde pyelography images. In such cases, observing ureteric peristalsis under direct vision can help pinpoint the exact site of stenosis before ureterotomy.

Conclusion

This case exemplifies the critical importance of interdepartmental coordination and a multidisciplinary approach in establishing the diagnosis of rare anomalies and in managing such nuanced cases in young patients. With the use of the Da Vinci Xi robotic system, we were able to deliver a precise and minimally painful surgical experience for our young patient.

Although robotic surgery is still considered avant-garde in the paediatric age group by many, the advantages offered by advanced systems from Intuitive, particularly improved dexterity through wristed instruments, the ability to 'burp' the system to reduce intra-abdominal pressure, and enhanced visual clarity, are considerable when compared to conventional laparoscopy, especially in complex reconstructive urological procedures in children.

For neonatal surgeries, the Senhance robot by Asensus Surgical (recently acquired by Karl Storz) is developing 3 mm and 5 mm reusable instruments, which are expected to result in less morbidity compared to the current 8 mm ports. With increasing availability of robotic platforms and growing surgeon expertise, robotic paediatric urology is likely to become the gold standard in the near future.

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Consultant - Paediatric Surgery and Paediatric Urology

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Honey Bee Sting-Induced Acute Ischemic Stroke

A Rare Neurological Complication

Bee stings, typically resulting in mild local reactions or, at times, systemic allergic responses, can, in rare instances, lead to severe neurological complications such as ischemic strokes. The underlying mechanisms are multifaceted, involving direct neurotoxic effects of venom components, immune-mediated responses, and haemodynamic alterations due to anaphylactic shock or catecholamine surges. Although uncommon, documented cases highlight the potential severity of such events.

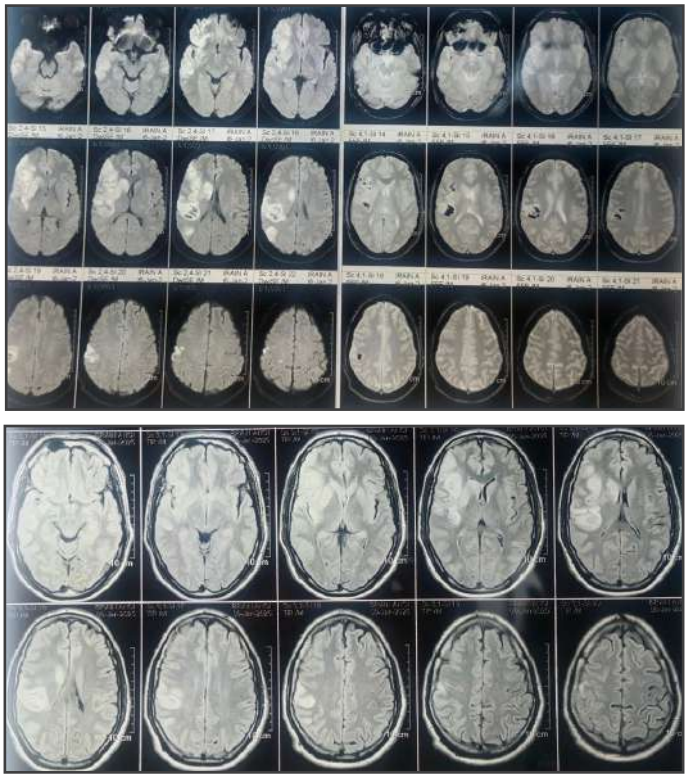
We present a case of a 49-year-old male who developed an acute ischemic stroke with haemorrhagic transformation within 48 hours following a honey bee sting, underscoring the importance of recognising the potential for severe neurological sequelae post-envenomation, even in the absence of immediate systemic allergic reactions.

Case Study

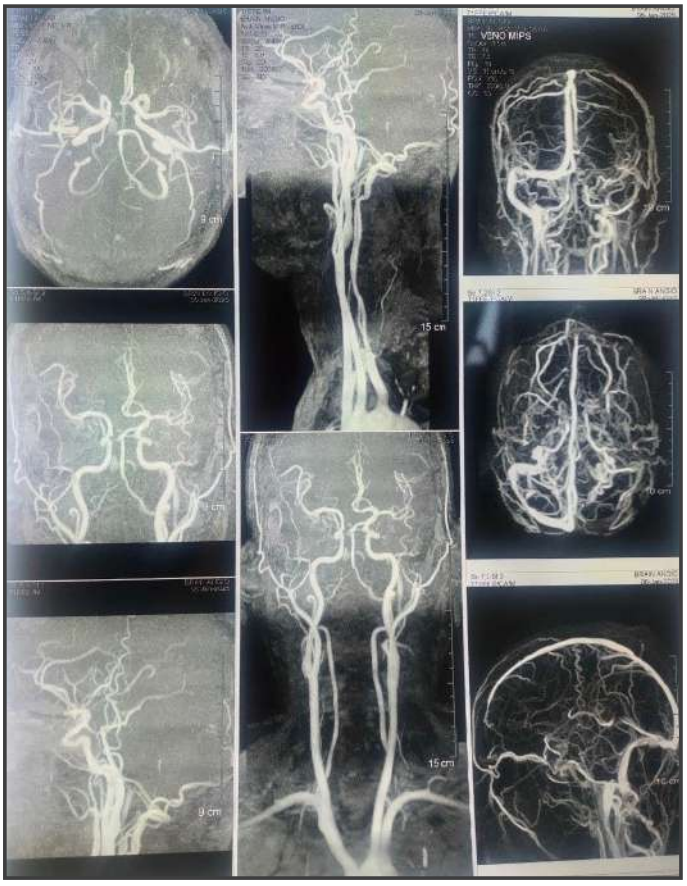
A 49-year-old previously healthy male sustained multiple honey bee stings while working in his field. He was initially treated at a local hospital with intravenous antihistamines and corticosteroids. Approximately 24 hours post-envenomation, he developed gait disturbances, speech difficulties, irritability, and restlessness, and was referred to Medanta - Indore for evaluation and management.

On arrival, the patient was conscious but confused, exhibiting motor aphasia. Vital signs were stable (pulse: 90 bpm; BP: 130/80 mmHg), fundus on examination was normal. The pupils were bilaterally equal and reactive to light. Neurological examination revealed left-sided hypokinesia and an extensor plantar response; cranial nerve function and fundoscopic findings were normal. There was no history of fever, dyspnea, vomiting, or prior medical conditions.

A provisional diagnosis of acute ischemic stroke with left hemiparesis and aphasia, potentially secondary to bee sting, was made. Initial non-contrast CT of the brain was unremarkable. Subsequent MRI with MR angiography revealed a moderate to large T2/FLAIR hyperintense area with diffusion restriction and low ADC values in the right ganglionic frontal, parietal, temporal, and perisylvian insular regions. There was partial effacement of regional cortical sulci, the right sylvian fissure, and the right lateral ventricle, along with patchy haemorrhagic gradient blooming foci within the infarcts.



Moderate to large infarcts in right ganglionic frontal, parietal, temporal, and perisylvian insular regions with diffusion restriction, low ADC, partial sulcal and ventricular effacement, and patchy haemorrhagic foci



MR angiogram suggestive of atherosclerotic plaque

MR angiography showed approximately 20% luminal stenosis at the origins of both internal carotid arteries, suggestive of atherosclerotic plaques, and a similar degree of narrowing in the proximal right middle cerebral artery.

Laboratory investigations revealed a haemoglobin level of 15.3 g/dL, total leukocyte count of 11,800/mm³, and platelet count of 230,000/mm³. Liver function tests showed elevated aspartate aminotransferase (AST) at 215 U/L, while alanine aminotransferase (ALT) and other parameters were within normal limits. Renal function tests were normal. Electrocardiogram and 2D echocardiography showed no abnormalities. Honey bee-specific IgE antibodies tested on day 3 were negative.

Investigation	Observed Value	Unit	Biological Reference Interval
Insect Allergen - Honey Bee VenomMadhu Makhhi (Apis Mellifera) (Serum)	Negative,0.08	kUA/L	Negative: < 0.1 Positive: >= 0.1

RESULT INTERPRETATION:

RESULT	IGE LEVEL	SYMPTOM
<0.1	Undetectable	Unlikely
0.1 - 0.5	Very low	Uncommon
0.5 - 2.0	Low	Low
2.0 - 15.0	Moderate	Common
15 - 50	High	High
>50	Very high	Very high

Method: ImmunoCAP (Fluoroenzymeimmunoassay)
(Specific IgE Test)

Allergy test report for insect allergen - honey bee venom

The patient was managed conservatively with intravenous antibiotics, corticosteroids, antihistamines, antiseizure medications, and single antiplatelet therapy. Supportive care included physiotherapy and speech therapy. The patient exhibited significant clinical improvement and was discharged in a stable condition.

Discussion

Bee stings, though commonly resulting in mild local reactions, can, in rare instances, precipitate severe neurological complications such as ischemic strokes. The pathophysiology involves a complex interplay of inflammatory, vascular, and neurotoxic mechanisms.

Following envenomation, there is an upregulation of pro-inflammatory cytokines, including interleukins (IL-1, IL-6, IL-8) and tumour necrosis factor-alpha (TNF-α), which can adversely affect multiple organ systems, including the central nervous system. These cytokines contribute to vascular inflammation and endothelial dysfunction, potentially leading to ischemic events.

Vasoactive substances in bee venom, such as histamine, leukotrienes, thromboxane, and serotonin, can induce vasoconstriction and promote platelet aggregation, further exacerbating the risk of cerebral infarction.

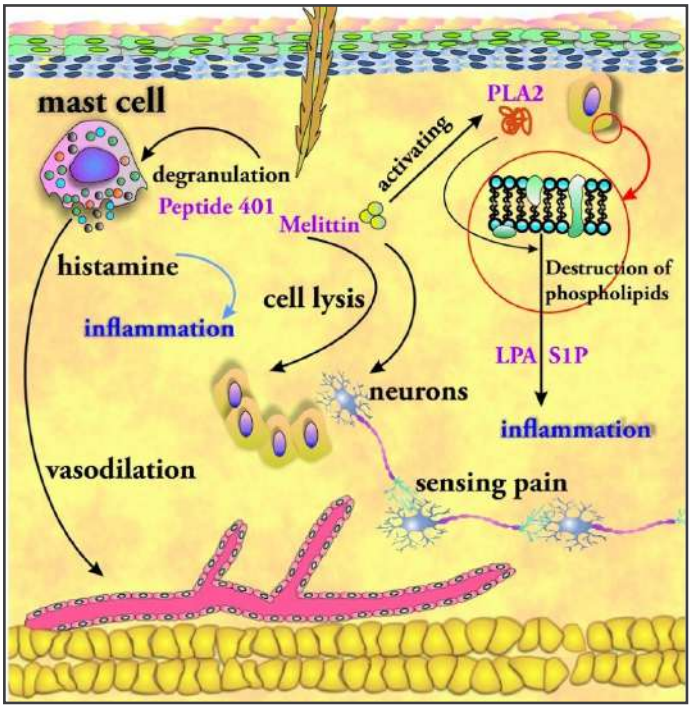
Melittin, a principal component of bee venom, impedes bradykinin release and complement cleavage, inhibiting

thrombin and platelet activation. It also stimulates nitric oxide production in endothelial cells, reducing thrombocyte adhesion and potentially leading to haemorrhagic events.

Phospholipase A2 (PLA2), another significant venom constituent, has been associated with coagulation abnormalities, including prolonged prothrombin time (PT), activated partial thromboplastin time (APTT), and reduced antithrombin III activity.

Neurological manifestations following bee stings can range from cranial nerve palsies to strokes, with reported onset times varying from 15 minutes to several days post-envenomation.

In the presented case, the patient developed an acute ischemic stroke with haemorrhagic transformation 48 hours after multiple honey bee stings. This underscores the importance of recognising the potential for delayed and severe neurological sequelae following bee envenomation, even in the absence of immediate systemic allergic reactions.



Main pathophysiological effects of bee venom biochemicals on a variety of cells following a sting

Conclusion

Neurological complications resulting from bee stings, such as ischemic stroke, haemorrhagic stroke, or subarachnoid haemorrhage, are exceedingly rare but can be life-threatening. In cases where severe symptoms manifest post-envenomation, immediate medical evaluation and intervention are crucial to mitigate potential neurological sequelae.

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GI Mucormycosis Masquerading as an Abdominal Mass in an Immunocompetent Child

Mucormycosis (MM) is an invasive fungal infection caused by fungi of the subphylum Mucormycotina, order Mucorales, with the most frequently isolated species being Mucor, Rhizopus or Rhizomucor. It is an angioinvasive, opportunistic fungal infection that can affect any organ system. The most common forms of MM are rhino-orbito-cerebral and pulmonary infections.

Gastrointestinal (GI) involvement is relatively rare, accounting for 4–7% of all cases, and most commonly affects the stomach, colon, and ileum. GI mucormycosis in children is usually associated with a very high mortality rate. It typically affects premature and low birth weight neonates, as well as other high-risk individuals such as children undergoing abdominal or corrective cardiac surgeries, and those admitted to intensive care units where the outcomes are often fatal. Very rarely, GI mucormycosis occurs in immunocompetent children and may mimic an abdominal mass.

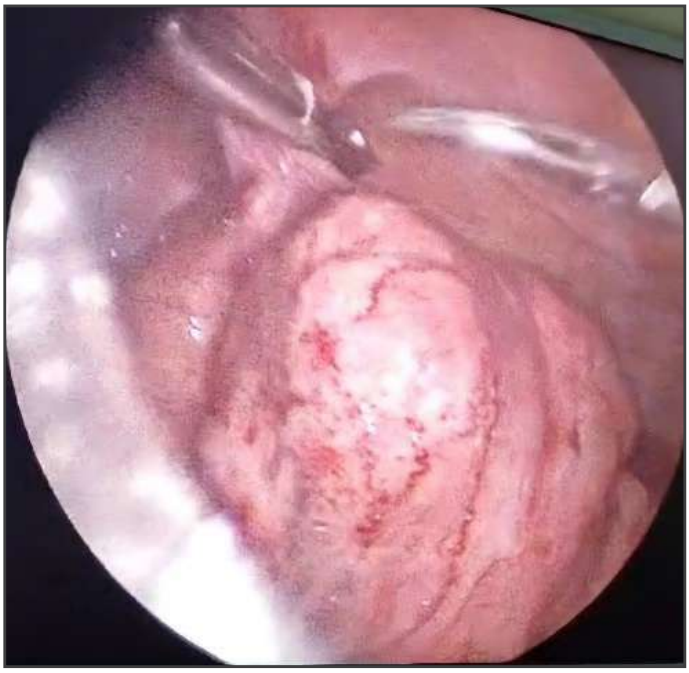
We present the case of a 5-year-old boy who was initially misdiagnosed with an inflammatory myofibroblastic tumour due to the presence of an abdominal mass. However, histopathological examination of the resected mass subsequently revealed a diagnosis of gastrointestinal mucormycosis.

This case highlights the atypical presentation of this potentially fatal but treatable condition. We will also discuss certain genetic analysis results which confounded our diagnosis and may have future implications for similar paediatric cases.

Case Study

A 5-year-old boy from Iraq presented to the Paediatric Surgery department at Medanta - Gurugram with complaints of a palpable mass in the right lower quadrant of the abdomen. He also had intermittent colicky abdominal pain, which was generalised at the time of presentation.

Previously, the child had been diagnosed with acute appendicitis in his home country and was taken up for laparoscopic appendicectomy. However, on laparoscopy, a large ileocaecal mass with a few enlarged mesenteric lymph nodes in the ileocaecal region was found. A laparoscopy-guided biopsy was performed, which was reported as an inflammatory myofibroblastic tumour. As the symptoms persisted, the child was referred to our hospital.



Laparoscopic view of large ileocaecal mass

At presentation, the child was haemodynamically stable but had severe episodic abdominal pain. On examination, there was a palpable, firm, multilobulated mass in the right iliac fossa. His laboratory results were as follows: Hb -10.4 g/dL, TLC - 19.4 $\times 10^9$/L (60% neutrophils), Platelets - 5 lakh/µL. Liver and kidney function tests were within normal limits.

A contrast-enhanced CT scan of the abdomen revealed diffuse circumferential mural thickening of the caecum with an ectatic lumen. The appendix was contained within the inflamed caecum and terminal ileum. Multiple mesenteric lymph nodes were noted in the right iliac fossa. In view of these findings, the child was taken up for surgery.

On laparotomy, a large multilobulated mass lesion involving the caecum and terminal ileum was observed, with apparent extension into the mesentery. A few large mesenteric lymph nodes were noted in the right iliac fossa. Frozen section suggested an inflammatory mass and was inconclusive for malignancy. A right hemicolectomy with ileocolic anastomosis was performed. The mass was densely adherent to Gerota's fascia and the retroperitoneum. Tissue planes were inflamed, and the mass was excised, leaving mesenteric lymph nodes at the origin of the right colic and ileocolic vessels. The specimen was sent for histopathological examination (HPE).

The post-operative period was uneventful, and the child recovered well.

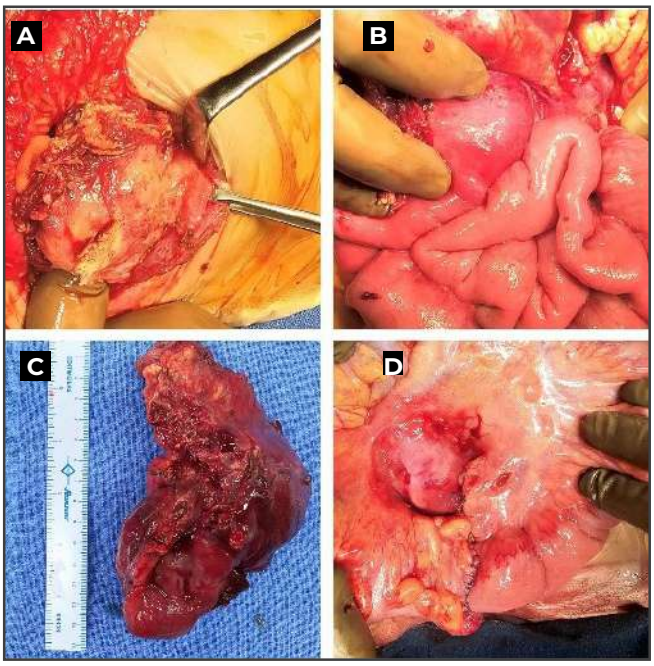


Image showing (a,b) mass with inflammatory adhesions, (c) excised mass, (d) ileocolic anastomosis

Histopathological examination was suggestive of mucormycosis, with the ileocaecal wall lined by focally ulcerated epithelium, extensive neutrophilic and eosinophilic inflammatory infiltrate, and granulomas containing giant cells. The vessels were destroyed by dense inflammation, and areas of necrosis were noted. In view of the HPE report, the child was started on a six-month course of posaconazole.

An immunodeficiency panel, including immunoglobulin levels, $CD3^+/CD4^+/CD8^+/CD16^+/CD56^+/CD19^+$ markers, flow cytometry for the dihydrorhodamine (DHR) assay, and a leukocyte adhesion deficiency type 1 (LAD-1) test, was performed and found to be normal.

This was followed by whole exome sequencing to detect primary immunodeficiency, which revealed a few unexpected findings. A heterozygous mutation in coding exon 15 of the DNAH11 gene was identified, which has been reported in individuals with primary ciliary dyskinesia (PCD).

However, as PCD is inherited in an autosomal recessive manner, the patient was not affected by the disease. Another heterozygous mutation was found in the SEC23B gene, which is associated with Cowden syndrome, an autosomal dominant disorder with variable presentations. At the time of presentation, the child had no hamartomatous growths on the skin or mucous membranes (a surveillance CT of the paranasal sinuses was also performed). The pathology team reviewed the specimen for hamartomatous changes, but none were observed. Consequently, genetic counselling was provided to the patient's family regarding future surveillance for Cowden syndrome.

The child returned to his home country and, on telephonic follow-up, is doing well with no recurrence of symptoms.

Discussion

Mucormycosis is a rare and often fatal fungal infection, most commonly seen in patients with immunodeficiency syndromes such as malignancies, solid organ transplants, prolonged steroid use or poorly controlled diabetes. Gastrointestinal involvement is seen in 4 to 7 percent of all cases and is associated with a high mortality rate of up to 85 percent. While immunocompromised status is the most common risk factor, about 19 percent of cases occur without any identifiable underlying cause. Among these, 9 percent involve the gastrointestinal tract.

Kaur et al. reviewed 200 cases of gastrointestinal mucormycosis reported between 1948 and 2017 in apparently immunocompetent individuals. Their review showed a significant rise in cases after the year 2000, particularly from Asian countries, including India. Before 1990, most cases were seen in premature neonates. In later years, more adult cases were reported, often associated with immunosuppression, steroid use, gastrointestinal ulcers or malnutrition, which was a common factor in both adults and children.

Mucormycosis can be classified into six clinical types based on the site of involvement: rhino cerebral, pulmonary, cutaneous, gastrointestinal, disseminated and miscellaneous forms that may involve the brain, bones, mediastinum or kidneys. In children with gastrointestinal involvement, half are infants. Boys are affected more often than girls, with a male to female ratio of 1.6 to 1. The colon is the most commonly affected organ, followed by the stomach and ileum. The appendix and other extra intestinal sites are also sometimes involved. Children usually present with abdominal distension, pain and bloody diarrhoea. In rare cases, the disease may present as an abdominal mass causing intestinal obstruction.

Diagnosis is often delayed because the symptoms are non-specific. In high risk children, maintaining a high index of suspicion can help start antifungal treatment and surgical management early. Diagnosis in otherwise healthy children remains challenging. Imaging may show bowel wall thickening, surrounding inflammation and spread to nearby structures such as the peritoneum, but these findings are not specific. Blood cultures are usually negative and there is no reliable antigen test available.

Histopathology remains the most definitive method of diagnosis. On microscopy, the fungi appear as broad, ribbon like aseptate hyphae that branch at right or obtuse angles. Special stains like Gomori methenamine silver or periodic acid Schiff can help identify the organism. In some cases, immunohistochemistry using zygomycete antibodies may be helpful. Fungal culture of the tissue specimen is considered the gold standard for diagnosis and identification of the fungal species. Molecular methods like PCR are also being used. When clinical suspicion is high, frozen section analysis of endoscopic biopsies using potassium hydroxide or calcofluor white can aid in rapid diagnosis.

Treatment relies on antifungal therapy along with surgical debridement. However, medical treatment alone is often not enough. Factors such as poor drug penetration due to blood vessel blockage or tissue necrosis reduce the effectiveness of antifungal agents. Surgical removal of infected and dead tissue is usually required. Amphotericin B, including its lipid formulations,

is the first choice for treatment. Posaconazole is generally used when other options fail. Other treatments like iron chelators, hyperbaric oxygen and cytokine therapies such as interferon gamma or colony stimulating factors are being explored, although their role remains unclear and unproven compared to standard therapy.

Conclusion

Gastrointestinal involvement by mucormycosis is not uncommon in children. It is most frequent in immunodeficient children but is increasingly being detected in immunocompetent children as well. Presentations can be variable; besides the typical abdominal pain, bloody diarrhoea, and distension, a palpable abdominal mass may rarely be the presenting feature. Early diagnosis and treatment can significantly reduce the high mortality associated with this disease.

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In Focus

Medanta Lucknow Launches Geriatric Clinic under Elder Care Programme

Medanta Hospital, Lucknow has launched a dedicated Geriatric Clinic to address the growing healthcare needs of Uttar Pradesh's ageing population. With over 30 lakh elderly residents in Lucknow alone, the clinic offers specialised, multidisciplinary care tailored for senior citizens.

Key Highlights:

- Comprehensive Geriatric Assessment (CGA)
- Multispecialty collaboration: Cardiology, Neurology, Endocrinology, Orthopaedics, Psychiatry, Nutrition
- 24x7 helpline for elderly patients
- Home visits, medication management, and follow-ups via trained "health buddies"
- Virtual consultations, caregiver training, and mental wellness support

Medanta's new clinic aims to bridge existing gaps in elderly care through a full-time, holistic approach that prioritises preventive, physical, mental, and social wellbeing.

The clinic is led by Senior Consultants Dr. Ruchita Sharma, Dr. Sakshi Manchanda, and Dr. Ila Pandey, along with Associate Consultants Dr. Harsh Kaushal, Dr. Shivangi Singh, and Dr. Shipra Shukla, who bring extensive expertise in managing the complex health needs of older adults.

By focusing on early detection, chronic disease management, infection screening, caregiver support, and the reduction of avoidable emergency visits, the clinic ensures cost-effective, high-quality care and an improved quality of life for seniors in Uttar Pradesh.

Now open at Medanta Hospital, Lucknow, the clinic offers accessible, expert-led elderly care under one roof.

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Welcome Onboard

Dr. Amit Bhargava

Director - Medical Onco and Haemato Oncology

Medanta Mediclinic - Defence Colony

Dr. Bhargava is a seasoned precision oncologist with over 25 years of experience in oncology and clinical research, specialising in cancer genomics, personalised cancer treatment, haemato-oncology, and bone marrow transplantation.

Dr. Supreet Ballur

Senior Consultant - Paediatric Cardiac Surgery

Medanta - Patna

Dr. Ballur is a paediatric cardiac surgeon specialising in congenital heart surgery, minimally invasive cardiac surgery, and thoracic surgery, with experience treating patients from neonates to adults.

Dr. Abhishek Kumar Singh

Director - Medical Onco and Haemato Oncology

Medanta - Lucknow

Dr. Singh is an experienced medical oncologist with expertise in the management of both solid tumours and blood cancers. He specialises in chemotherapy, immunotherapy, targeted and hormonal therapies, as well as cancer pain management and palliative care.

Dr. Pragati Agarwal

Senior Consultant - Obstetrics and Gynaecology

Medanta - Patna

Dr. Agarwal is a skilled gynaecologist with expertise in menopausal and adolescent health, urogynaecological disorders, and high-risk pregnancies. She is proficient in both open and laparoscopic surgeries, with advanced training in ultrasound, laparoscopy, and urogynaecology.

Dr. Ratish Juyal

Director - Neurology

Medanta - Lucknow

Dr. Juyal is a neurologist with over 16 years of experience in treating neurological disorders such as migraine, epilepsy, stroke, and movement disorders. He is also skilled in neurodiagnostic techniques including EEG, NCV/EMG, and evoked potentials.

Dr. Vipin Kumar Sharma

Consultant - GI Surgery, GI Oncology and Bariatric Surgery

Medanta - Lucknow

Dr. Sharma is a gastrointestinal surgeon specialising in minimally invasive laparoscopic and robotic GI surgeries, with a focus on gastrointestinal and hepatobiliary cancers.

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Dr. Rajit Rattan
Consultant - Medical Onco and Haemato Oncology
Medanta - Gurugram

Dr. Rattan is a medical oncologist with expertise in treating solid organ cancers, including lung, breast, gynaecological, gastrointestinal, and urological malignancies, as well as haematological malignancies. He is proficient in chemotherapy, immunotherapy and targeted therapy.

Dr. Abhinav Yadav
Consultant - Orthopaedics
Medanta - Gurugram

Dr. Yadav is an orthopaedician with expertise in performing knee and shoulder arthroscopy surgeries, joint replacement surgeries, and fracture surgeries.

Dr. Suman Saurabh
Consultant - Orthopaedic Surgery
Medanta - Lucknow

Dr. Saurabh is an orthopaedic surgeon specialising in complex trauma, foot and ankle disorders, sports injuries, deformity correction, and ankle ligament reconstruction.

Dr. Joydeep Singh Vasant
Associate Conusltant - Medical Onco and Haemato Oncology
Medanta - Gurugram

Dr. Vasant is a medical oncologist specialising in the treatment of solid tumours and blood cancers, with expertise in chemotherapy, immunotherapy, targeted therapy, and stem cell transplantation.

Dr. Ankit Singh
Consultant - Neurology
Medanta - Lucknow

Dr. Singh is a neurologist specialising in the treatment of stroke, epilepsy, migraine, Parkinson's disease, Alzheimer's disease, neuroinfections, and demyelinating disorders. He is also skilled in botulinum toxin therapy for movement disorders and spasticity, as well as thrombolytic therapy for acute stroke.

Dr. Kalavadia Kevalkumar Kamlesh
Associate Consultant - Medical Onco and Haemato Oncology
Medanta - Gurugram

Dr. Kamlesh is a medical oncologist specialising in the treatment of solid tumours including lung, breast, head and neck, genitourinary, and gynaecological cancers, as well as haematological malignancies such as lymphomas and leukaemias. He also has expertise in autologous and allogeneic stem cell transplants.

THE EXCHANGE

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Dr. Ajit Kumar
Associate Consultant - Clinical and Preventive Cardiology
Medanta - Ranchi

Dr. Kumar specialises in non-invasive cardiac diagnostics, including echocardiography, treadmill test, Holter monitoring, and stress echo, with a focus on early detection and prevention of heart disease.

Dr. Hitesh Panchal
Associate Consultant - Gastroenterology
Medanta - Gurugram

Dr. Panchal is a gastroenterologist specialising in advanced endoscopy and the management of liver, pancreatico-biliary, and intestinal disorders. His expertise includes ERCP, EUS, and minimally invasive procedures for a wide range of digestive conditions.

Dr. Sheikh Mudassir Khurshid
Associate Consultant - Cardiac Surgery
Medanta - Gurugram

Dr. Sheikh is a cardiothoracic surgeon with expertise in complex heart and aortic surgeries, including blocked arteries, valve repair, congenital defects, and aortic reconstruction.

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

Medanta Network

Hospitals

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

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

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

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

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

Mediclinics

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

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

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

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

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

Medanta Helpline: 88 0000 1068
medanta.org Upcoming Hospital: Noida