DECEMBER 2025 VOLUME 2, ISSUE 2

ZEN ACADEMY BULLETIN

Official newsletter of Zen Multispeciality Hospital, Mumbai

EDITORIAL BOARD

Dr Avinash Supe

Dr Roy Patankar

Dr Prasad Bhukebag

Dr Vishakha Kalikar

CONTACT US

Address :

Plot No 423AB/425, 10th Road,

Chembur East, Near Sandu Garden,

Mumbai - 400071.

For OPD appointment :

+91-22-35205700/+91-22-35205701

Email Id: info@zenhospital.in

Website : www.zenhospital.in

Editorial

Innovation, Community, and the Spirit of Discovery

This edition of the Zen Bulletin highlights what sets our institution apart: the harmony of cutting-edge clinical care, strong community engagement, and the human spirit that shapes our culture. The pages that follow describe transformation in many forms, driven both by innovation and by timeless values of compassion, connection, and care.

The articles by Professor Dr Madhuri Gore on laser treatment of varicose veins and Dr Sitaram Prasad on advances in wound management reflect our commitment to staying at the forefront of medical practice. These developments are not merely technical updates but reaffirm our promise to patients: to continuously invest in tools, techniques, and training that deliver better outcomes and improved quality of life.

The establishment of our **Cardio Rehabilitation Center** by the physiotherapy team reinforces the same philosophy. Acute care is only the beginning. True healthcare supports complete recovery, restoring not only health but confidence and independence. This initiative bridges clinical science with motivation, helping patients transform recovery into resilience.

Our **Walkathon on World Diabetes Day** reflects another vital pillar of our mission: the importance of prevention and community participation. By walking side by side with our community, we demonstrate that healthcare does not happen only within hospital corridors but through visible, meaningful presence in people's lives.

The online **Wednesday evening clinics for Postgraduate students** are another example of practical, patient-centred adaptation. As reported by Dr Priya Gupta, healthcare must evolve with modern lifestyles, offering accessibility in both time and space.

A special element of this issue is **Dr Nilay Chakrabarti's travelogue**, recounting his journey to Peru, Machu Picchu, and the Brazilian rainforest. It reminds us that those who care for others must also nurture their own curiosity, wonder, and sense of discovery. Experiences that enrich the spirit are not separate from our profession; they strengthen the compassion and perspective that make us better caregivers.

This issue of the Zen Bulletin reflects our institutional identity: **clinically advanced, community-focused, accessible, and deeply humane.**

As we progress, we remain dedicated to this integrated vision. We celebrate the clinical breakthroughs in these pages, the community initiatives that strengthen our mission, and the personal journeys that remind us why we do this work.

Warm regards,

Dr Avinash Supe, Dr Roy Patankar

Zen Multi-Specialty Hospital, Chembur

December 2025

Recent advances in the management of Chronic Venous Disease

Dr. Madhuri Gore,General Surgeon and Phlebologist

In the last three decades, better understanding of venous pathophysiology, imaging and anatomy has greatly improved the management of chronic venous disease (CVD) and chronic venous insufficiency (CVI).

Clinical evaluation must include a detailed history[3,5] and systemic examination. Both legs should be examined in the standing position with full exposure, and arterial pulses must always be palpated.

CVD progresses due to vein wall and valve dysfunction causing reflux, along with chronic inflammation and degeneration of elastin and collagen.

The 2020 CEAP update added the suffix r for recurrence and reclassified corona phlebectatica from C1 to C4c due to its higher ulcer risk. Etiology now distinguishes intravenous from extravenous factors.

Table I : The 2020 revision of CEAP Summary of Clinical (C) classification

Class	Description
C0	No visible or palpable signs of venous disease
C1	Telangiectasias or reticular veins
C2	Varicose veins
C2r	Recurrent varicose veins
C3	Edema
C4	Changes in skin and subcutaneous tissue secondary to CVD
C4a	Pigmentation or eczema
C4b	Lipodermatosclerosis or atrophy blanche
C4c	Corona phlebectatica
C5	Healed
C6	Active venous ulcer
C6r	Recurrent active venous ulcer

Each clinical class is subcharacterized by a subscript indicating the presence(symptomatic - s) or absence (asymptomatic - a) of symptoms attributable to venous disease.

Table II : CEAP 2020 - Etiological (E) classification

E Class	Description
Ep	Primary
Es	Secondary
Esi	Secondary - Intravenous
Ese	Secondary - Extravenous
Ec	Congenital
En	No cause identified

Investigations : Doppler ultrasound is the key investigation for confirming CVI, mapping venous anatomy and planning treatment.

Superficial veins (GSV, SSV, ASV, PSV, SFJ, SPJ) are examined standing. Reflux > 0.5 sec is significant.

Perforators can be assessed standing, sitting or supine. Reflux > 0.35 sec is significant.

Deep veins are examined supine for compressibility, flow, reflux, obstruction and residual thrombus. Reflux > 1 sec is significant, and pelvic veins/IVC are evaluated if suspected.

Anatomical variations such as accessory saphenous veins, GSV duplication, SSV cranial extension and intersaphenous veins should be identified. Vein diameter alone does not justify ablation without proven reflux.

A Doppler study within 5–7 days post-ablation is mandatory to confirm closure and detect complications.

Close collaboration between phlebologist and sonologist improves accuracy. Additional tests (CT/MR venogram, descending venography, endovenous ultrasound) are reserved for suspected deep venous obstruction or reflux, recurrent ulceration or post-thrombotic syndrome.

Treatment of CVD:

Patients with C2s–C6 need planned, individualized treatment based on symptoms, reflux pattern, patient factors and available expertise.

Compression therapy is required for all symptomatic patients using stockings, Velcro wraps, multilayer bandages or pneumatic compression (22–60 mmHg; highest pressure for venous ulcers).

Lifestyle measures: daily walking, avoiding prolonged standing/sitting, ankle–calf exercises, leg elevation for edema and weight reduction when indicated.

Venoactive drugs (diosmin, oxyrutins, calcium dobesilate, hesperidin, sulodexide) relieve pain and edema; pentoxifylline may assist ulcer healing.

Ablation of reflux is the current standard of care. Endovenous methods (laser, radiofrequency, glue) are used for truncal veins. UGFS or phlebectomy is preferred for refluxing tributaries.

Deep Venous Obstruction and Reflux

Iliac vein or IVC compression (e.g., May–Thurner syndrome) is best evaluated with IVUS and treated with venoplasty and stenting when patients have persistent edema, recurrent varicosities or venous ulcers. Surgical bypass is now rarely needed.

Deep venous reflux, usually post-DVT, is managed with ablation of superficial reflux, continued compression, and anticoagulation if residual thrombus remains. Deep venous valve reconstruction is reserved for specialised centres.

Venous Leg Ulcer

Treatment includes wound care, ablation of truncal and superficial reflux, perforator ablation, and ongoing compression and exercise. Deep venous intervention is considered only in selected cases.

Treatment by CEAP:

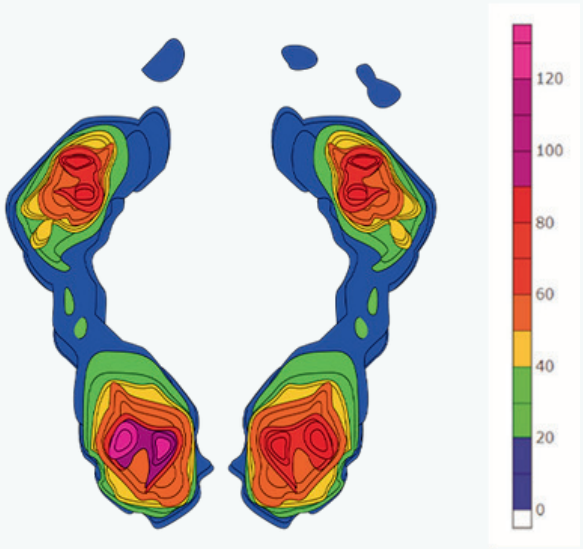
- C1: Cosmetic therapy (sclerotherapy / laser)
- C2s: Compression ± UGFS; EVLA/RFA if truncal reflux
- C3: Compression; UGFS if no truncal reflux; EVLA/RFA if reflux present
- C4–C5: Compression + EVLA/RFA + UGFS/phlebectomy ± perforator ablation

C6 / C6r: Same as C5 plus TIRS; deep venous intervention if indicated

Thermal ablation remains the preferred method due to reliable long-term closure. Glue ablation has higher recanalization risk in veins >8 mm.

References:

1. Lurie F, Kistner RL, Eklof B, et al. The 2020 update of the CEAP classification system and reporting standards. J Vasc Surg Venous Lymphat Disord. 2020;8(3):342-352.
2. Adler C, Dillavou E, Lee D, et al. Varicose veins of the lower extremity: Doppler US evaluation protocols, patterns and pitfalls. RadioGraphics. 2022;42(7):2184-2200.
3. Maeseneer MGD, Lane T, Davies AH, et al. European Society for Vascular Surgery (ESVS) 2022 Clinical Practice Guidelines on the Management of Chronic Venous Disease of the Lower Limbs. Eur J Vasc Endovasc Surg. 2022;63:184-267.



Does the Diabetic foot need focused management?

Dr Sitaram Prasad, Department of Plastic & Reconstructive Surgery

While Diabetes and its complications has caught the attention of the World, in India, the **Diabetes Capital of the world**, there is as yet no focused approach to the systemic and local complications that make the disease fraught with risks both to limb and to life. Among the many complications that uncontrolled diabetes can cause, the problems that affect the foot are the most manifest and the easiest to manage. High sugars can lead to neuropathy, poor circulation, and delayed wound healing—factors that significantly increase the risk of foot ulcers, infections, and amputations. A single window approach to the recognition and the management of these is what might be categorised as the **"The Diabetic foot Clinic"**. It basically provides access to specialised assessment, advanced diagnostic instrumentation and a multidisciplinary approach to the entire problem

Diabetes affects every organ and Nerves, Blood Vessels and Muscles are no exception.

Damage to nerves in diabetes causes sensory and motor neuropathy. Sensory loss reduces the ability to feel touch, pressure, vibration and temperature, making heat or cold injuries go unnoticed. Sensation is assessed using a 10-g monofilament and a tuning fork, while advanced tools can detect early loss more accurately. Regular monitoring of temperature perception helps prevent burns, frostbite and subsequent infections.

Vascular disease is another critical contributor to non-healing ulcers. A **handheld Doppler** provides a more accurate evaluation of blood flow than traditional pulse palpation and also reflects arterial elasticity. When circulation is compromised, further investigations such as Colour Doppler, CT or MR angiography may be necessary. **The Ankle–Brachial Index** remains an essential measure of arterial perfusion and limb risk.

Uncontrolled diabetes leads to glucose deposition within tissues, triggering chronic inflammation that stiffens joints and ligaments. Over time, muscles are gradually replaced by fat. When this loss of flexibility combines with reduced sensation from neuropathy, the architecture of the foot changes and gait becomes altered. These high-pressure areas then develop callosities, which eventually break down and progress to ulcers. Periodic foot scans are extremely valuable in identifying these pressure hotspots early and in tracking improvement during treatment.

Building on this, **pedobarography** helps analyse plantar pressure and gait patterns both in standing and walking positions. This data allows for the creation of customised footwear and orthotic solutions that redistribute plantar pressures effectively. Biofeedback from these assessments often motivates patients to actively slow the progression of the disease.

Diabetic foot clinics go beyond diagnostics and wound dressings. Small interventions such as callus shaving or the application of a total contact cast can be performed immediately in the clinic, preventing further tissue breakdown. These services, combined with strong emphasis on prevention, significantly reduce the risk of foot complications.

The emotional toll of chronic wounds, deformity and mobility restriction can be substantial. Diabetic foot clinics provide psychological support, lifestyle guidance and regular follow-up to help patients remain motivated and compliant with long-term care.

In summary, **a diabetic foot clinic is an essential component of comprehensive diabetes care.** Through early identification of risks, advanced diagnostic tools and coordinated multidisciplinary treatment, **these clinics sharply reduce the likelihood of ulcers, infections and amputations—preserving mobility, independence and overall quality of life.**

Zen Hospital Marks Diabetes Day with Inspiring Walkathon for Diabetic Foot Awareness

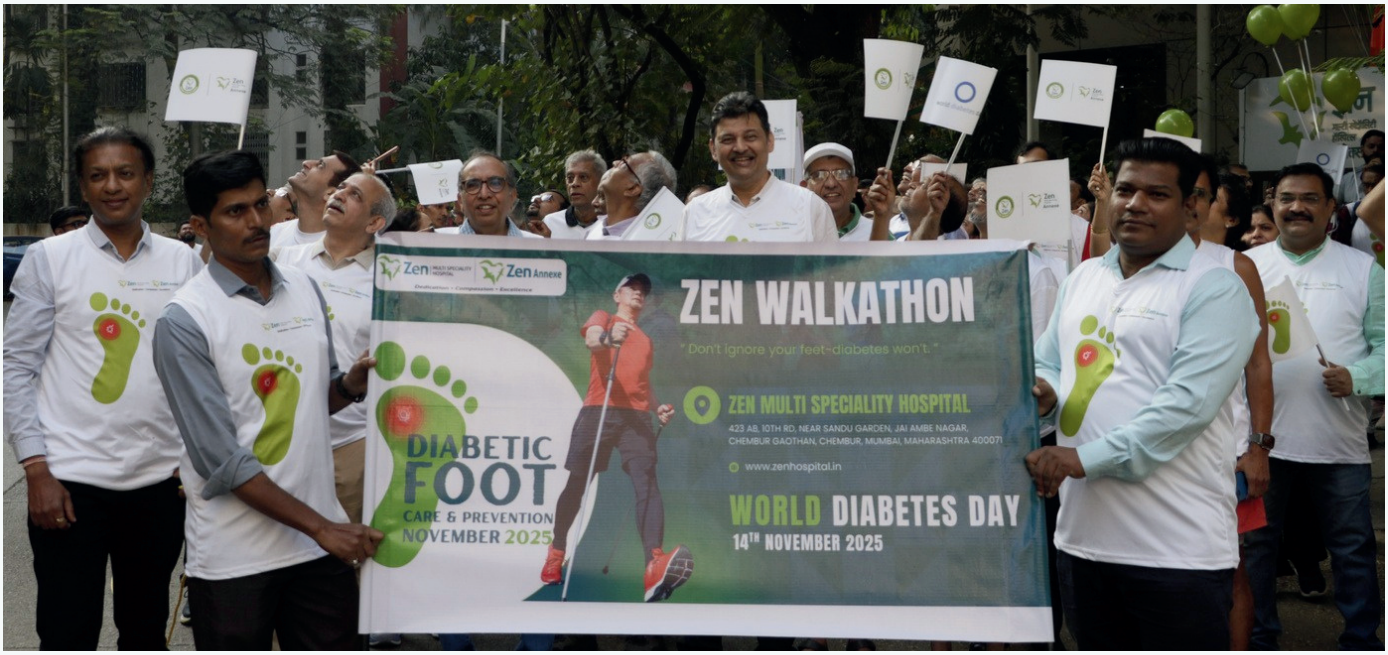
Dr Ramnaryanan Subramaniam, Consultant Surgeon

Zen Multispeciality Hospital celebrated **World Diabetes Day** with a vibrant and impactful **Walkathon dedicated to raising awareness** about diabetic foot care. The event brought together participants from all age groups and backgrounds, united by a shared commitment to preventing diabetes-related complications and promoting healthier lifestyles.

The Walkathon was not just a fitness activity, but a powerful reminder of the importance of **early recognition and care of the diabetic foot**. Through interactive discussions, posters and on-ground engagement, participants learned about the significance of f**oot screening, proper footwear, lifestyle discipline and timely medical attention** in preventing ulcers and amputations.

Zen Hospital extends heartfelt gratitude to all participants, volunteers and team members whose enthusiasm made the event a success. Their participation amplified the message that complications of diabetes — especially those affecting the foot — can be prevented with awareness and timely care.

With initiatives like this Walkathon, Zen Hospital continues its mission to encourage **community participation, support preventive healthcare and build a healthier tomorrow.**



Zen MULTI SPECIALITY HOSPITAL | Zen Annexe

Dedication • Compassion • Excellence

" WOUND UPDATE " 2025

Course Convenors :

Dr. Madhuri Gore

Dr. Sitaram Prasad

Dr. Rajan Modi

Interactive sessions with case discussions.

Event Details:

21st December 2025

At 09:00 am to 05.00 pm

Auditorium, 8 floor
Zen Multispeciality Hospital,
Plot 425, 10th road,
Chembur East, Mumbai 71.

For Registration
Mr. Paresh Shinde
8657703277

Applied for MMC points

REGISTRATION FEES RS 500/-
(Limited Seats)

Digestive Disease

8657703277 zenacademy2015@gmail.com

Zen Hospital Chembur Redefines Physiotherapy With Cutting-Edge Rehabilitation Excellence

Dr Vinith Karanth, Department of Physiotherapy

Zen Multispeciality Hospital, Chembur, is raising the bar in rehabilitation care through its **state-of-the-art Physiotherapy Department** — a centre that combines advanced technology with skilled clinical expertise. Bringing a wide range of rehabilitation services under one roof, the department delivers **specialised care across neuro, cardio-pulmonary, orthopaedic, geriatric, and sports physiotherapy.** Driven by evidence-based practice, the team provides personalised rehabilitation for patients recovering from stroke, orthopaedic surgeries, injuries, respiratory disorders and age-related mobility challenges. Every treatment plan is thoughtfully curated and delivered by **experienced, empathetic physiotherapists** dedicated to restoring mobility, function and confidence. A key strength of the unit is its seamless integration of **high-technology rehabilitation** systems. Modern electrotherapy equipment, advanced strengthening platforms, balance and gait assessment tools and cardio-fitness systems enhance treatment precision and accelerate recovery — positioning the department among the most technologically advanced physiotherapy setups in the region. The spacious and patient-friendly therapy environment ensures safe, comfortable sessions, while a multidisciplinary model of care promotes holistic and sustainable recovery. With **expert clinicians, advanced infrastructure and a commitment to patient-centric outcomes**, Zen Hospital Chembur stands as a leading destination for comprehensive physiotherapy and rehabilitation.

Clinical Skills in the Digital Era: Zen Hospital's PG Masterclass Initiative

Dr Priya Gupta, Consultant Surgeon

In today's rapidly evolving medical landscape, the role of traditional clinical examination is gradually being overshadowed by the accelerating growth of radiological and diagnostic technologies. While these advancements have undoubtedly enhanced precision and efficiency, they have also contributed to a shift in focus—from meticulous bedside evaluation to increased reliance on pathological, biochemical, and radiological investigations. As a result, the art of clinical assessment, once considered the cornerstone of medical practice, is at risk of becoming secondary in contemporary healthcare settings.

Recognizing the importance of preserving and strengthening these fundamental skills, **Zen Multispeciality Hospital has embarked on a proactive initiative to promote clinical excellence among postgraduate medical trainees.**

Understanding the demanding schedules of consultants, who balance clinical responsibilities with academic commitments, as well as the long and often strenuous working hours of postgraduate students, the hospital has designed a **flexible and accessible learning platform** that accommodates these challenges.

The **PG Masterclass Series**, conducted on the Zoom platform during evening hours, was conceptualized to create a space for meaningful academic discussion, case-based learning, and the reinforcement of clinical reasoning. Each session focuses on practical, patient-centered aspects of medical care, encouraging participants to think critically, correlate clinical findings, and refine their diagnostic approach—skills that remain indispensable despite technological progress.

We are proud to share that this initiative has achieved remarkable reach and engagement. What began as an internal academic effort has now grown into a **nationwide learning forum**, with close to 50 postgraduate students from various states regularly participating in the sessions. The consistently high turnout reflects a strong desire among young clinicians to enhance their clinical acumen and engage in collaborative learning.

Zen Multispeciality Hospital remains committed to nurturing **competent, confident, and compassionate medical professionals**. Through initiatives such as the PG Masterclass Series, the institution continues to uphold the value of **clinical excellence in an era of rapid technological transformation.**

Dietary Guidelines for Liver Disease

Dr Priya Palan, Consultant Dietician

Nutrition plays a vital role in managing liver disease and preventing complications. Adequate nourishment strengthens and protects the liver while preventing further deterioration. **Eating Pattern** Follow a grazing pattern—small, frequent meals every 2 to 3 hours. A late-night carbohydrate snack is recommended, such as a banana, thick kheer (made with rice, makhana or sago), or pudding. Unsalted chana and peanuts with puffed rice can be taken as fillers between meals. **Calories and Protein** Because patients with liver disease often eat less, a high-calorie diet is useful unless the patient is overweight. Energy-rich starchy foods like rice, sago, idli, khichdi, sweet potato, potatoes, carrots, banana, sapota and custard apple may be added. Protein is essential for the regeneration of liver cells. Plant and dairy proteins are usually better tolerated than meat. Soy and soy products, sprouts, dried beans, and groundnuts (combined with cereals) are recommended. Low- fat paneer, skimmed milk, egg whites and small portions of lean poultry without skin or fresh fish may also be included. Reduce or avoid animal protein if ammonia levels are high. **Salt and Fluids** Salt must be restricted, so food labels should be checked carefully. Fresh herbs and spices may be used in moderation to improve flavour. Lemon juice, garlic, ginger and nut powders can be added to meals. Fluid intake should be limited if the patient has ascites. **Fats** Fat intake should be limited. Choose healthy fats and avoid trans fats. Coconut oil is preferred because it is digested and absorbed more easily. Full-fat dairy, cream, khoa, cheese, fried foods, margarine and vanaspati should be avoided. **Blood Sugar Control** Patients must monitor blood glucose levels regularly and carefully to prevent hyperglycemia.

Alcohol

Alcohol should be strictly avoided under all circumstances.

Supplements

Vitamins and minerals should be taken only on the advice of a doctor. Supplementation with branched-chain amino acids may help prevent muscle breakdown. Foods naturally rich in BCAAs include chickpeas, lentils, beans, soy products and whey protein.

Foods to Prefer

Whole grains (jowar, bajra, oats, brown rice, makhana, quinoa), plant-based proteins and unsalted nuts, low-fat dairy products, egg whites, steamed fish, and fresh fruits and vegetables such as tomatoes, peas, cauliflower, broccoli, apple, berries, pears and peaches. Coconut oil, fresh herbs and moderate quantities of nuts and seeds (walnuts, almonds, flaxseeds, pumpkin seeds) can be included.

Foods to Avoid

Cream biscuits, cream rolls, khari, ready-to-eat cereals, salted popcorn and crackers; canned beans and processed snacks; full-fat dairy products; processed and red meats such as ham, bacon and organ meats; canned vegetables, packaged juices and ready-to-eat soups; papad, pickles, chutneys, packaged sauces, ketchup, fried foods, gravy mixes and salad dressings.

Salmonella Typhi in an Endometrioma: Double Jeopardy

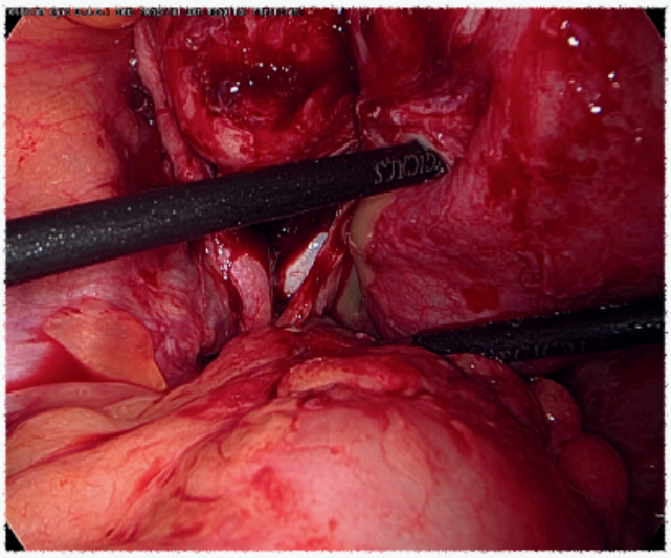
Dr Veena Aurangabadwalla, Department of Obstetrics & Gynaecology

A **38-year-old married woman (P1L1A1)** presented with perineal pain during menses for several months, along with delayed, heavy and painful periods. Twenty days earlier, she had been admitted elsewhere with severe abdominal pain and vomiting. Widal test showed mildly elevated S. typhi titres. CT scan revealed **jejunal wall thickening with suspected obstruction and bilateral adnexal multicystic lesions** (largest 7.6 × 6.5 cm on the right). She was treated medically with IV ceftriaxone for 2 days, followed by oral cefuroxime for 5 days.

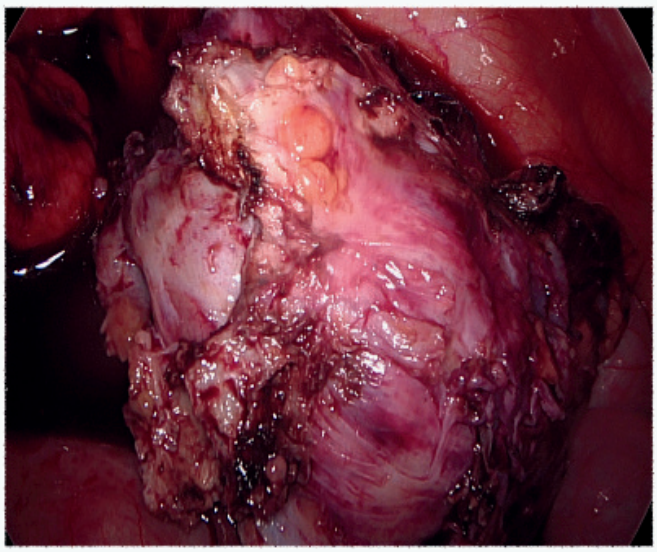
Follow-up ultrasound showed a large right adnexal thick-walled cyst (86 × 65 mm) with internal echoes and calcifications. Labs: CA-125 – 37.17, CRP elevated, Hb 8.3 g/dL. After recovery from acute gastroenteritis and optimisation of Hb, repeat ultrasound showed persistent right adnexal lesion. With a suspicion of endometriosis, she was planned for diagnostic laparoscopy and ovarian surgery.

Laparoscopy revealed a frozen pelvis with both adnexae adherent to the uterus and bowel. Careful adhesiolysis revealed an **8 × 7 cm right tubo-ovarian mass discharging pus;** culture swab was taken. Further dissection exposed **chocolate-coloured fluid within the cyst**. R**ight salpingo-oophorectomy** was completed, preserving the left adnexa.

Histopathology showed an **endometriotic cyst with chronic pyogenic oophoritis and tubo-ovarian abscess**, without atypia/malignancy. **Pus culture grew Salmonella typhi**. She was treated post-operatively with **trimethoprim–sulfamethoxazole** for 10 days based on culture report and recovered uneventfully.



Drainage of pus from the mass



Right ovary with congested tube with cut end showing punctured cyst wall

Discussion: Endometriosis is a chronic inflammatory condition in which endometrial tissue grows outside the uterus, presenting in forms such as superficial lesions, ovarian endometriomas and deep infiltrating disease. Symptoms vary widely, including pelvic pain, dysmenorrhoea, dyschezia and infertility. Salmonella typhi infection is commonly acquired through contaminated food or water. After invading the intestines and Peyer's patches, it can cause abdominal pain, fever and bowel disturbances, and may progress to systemic illness. Rarely, extraintestinal spread can infect ovarian cysts and mimic an ovarian malignancy. Diagnosing tubo-ovarian abscess (TOA) remains difficult because of its low incidence and nonspecific presentation. This case highlights the need for detailed history and combined histopathological and microbiological assessment of tubo-ovarian masses for timely, accurate diagnosis. Diagnostic laparoscopy facilitates early intervention and reduces morbidity, while postoperative follow-up remains essential for complete recovery.

References:

1. Leela Naidu PS, Satyavati S. Salmonella species at aberrant sites: A review. Indian J Med Sci. 1974;28:149–151.
2. Kubota T, Ishi K, Takeuchi H. A study of tubo-ovarian and ovarian abscesses, with a focus on cases with endometrioma. J Obstet Gynaecol Res. 1997;23(5):421–426.
3. Chen MJ, Yang JH, Yang YS, et al. Increased occurrence of tubo-ovarian abscesses in women with stage III and IV endometriosis. Fertil Steril. 2004;82(2):498–499.
4. Cohen JI, Barlett JA, Corey GR. Extra-intestinal manifestations of Salmonella infections. Medicine (Baltimore). 1987;66:349–388.
5. Lalitha MK, John R. Unusual manifestations of salmonellosis – a surgical problem. Q J Med. 1994;87:301–309.
6. Sidahmed H, Hassan A. Salmonella infection of ovarian dermoid cyst. Br Med J. 1975;3(5976):140.
7. Evans-Jones JC, French GL. An ovarian cyst infected with Salmonella typhi — case report. Br J Obstet Gynaecol. 1983;90(7):680–682.

Three Countries, Countless Memories: Peru, Brazil & a Peep into Argentina

Dr. Nilay Chakrabarti, Consultant Surgeon

A trip to South America can feel daunting for an Indian traveller the long flying time, lack of direct flights, language barriers and safety concerns are enough to make anyone hesitate. Yet, armed with Google Translate and great curiosity, my wife and I, along with two close friends from Pune, set off for **Peru and Brazil (with a brief taste of Argentina)** on 5th October.

After a 22-hour journey via London and Miami, we arrived in Lima late at night and checked into our hotel at Miraflores. The following day was dedicated to exploring the city and sampling Peruvian street food — including the iconic **purple drink Chicha Morada** and the famous **raw-fish Ceviche**. Dinner ended with Peru's signature cocktail, **Pisco Sour**.

Next came the much-awaited journey to Machu Picchu. We flew to Cusco to acclimatize at 11,000 feet, toured the Sacred Valley and then boarded the atmospheric Vistadome train from Ollantaytambo. Live music, dance and breathtaking views through the Andes made it a truly "once-in-a-lifetime" experience. An overnight halt at Aguas Calientes was followed by our entry to Machu Picchu — two and a half unforgettable hours walking through the lost city of the Incas, perched dramatically in the mountains.From the mountains we moved into the rainforest — flying to **Puerto Maldonado** and travelling by boat to a lodge deep in the **Amazon jungle.** Wooden cottages with no TV, eerie night walks in torchlight, a **Tarantula sighting, Macaws at dawn**, river safaris, fishing on a jungle lake and excellent food made it an experience we will always cherish.

The next destination offered a complete contrast — the sand dunes of Huacachina. A roller-coaster desert jeep ride, sandboarding at sunset and a wine-and-snacks party in the middle of the desert were memorable. We also took a speedboat into the Pacific to see amazing rock formations and visited one of Peru's oldest Pisco distilleries before flying to Brazil.

Rio de Janeiro dazzled us with its energy — the Maracanã stadium, Sugarloaf Mountain, Selaron Steps, Christ the Redeemer, Copacabana beach and the spectacular **Roxy Dinner Show**. From Rio we flew to **Iguassu Falls**, witnessing the thundering falls from both the Brazilian and Argentine sides — a sight far more powerful than pictures can reveal. Our final stop was **São Paulo**, a bustling financial centre with museums, monuments and European-style urban charm.

We returned to Mumbai on 21st October after a long but deeply fulfilling trip — **one that took us from ancient civilizations to rainforests, deserts, waterfalls and megacities, and left us with memories that will last a lifetime.**

Publications

ScientificScholar®
Knowledge is power
Publisher of Scientific Journals

www.gjhsr.org

Global Journal of Health Science and Research

Guest Editorial

Responsible use of artificial intelligence in content generation

Avinash Supe[1]

[1]Department of Surgical Gastroenterology and Medical Education, Seth G S Medical College, Mumbai, Maharashtra, India.

THE NATIONAL MEDICAL JOURNAL OF INDIA VOL. 38, NO. 4, 2025 237

Speaking for Ourselves

Getting to 'Shows how'

KRISHNA SESHADRI, AVINASH SUPE

How I Do it

Laparoscopic Management of Giant Paraesophageal Hernia

Roy Patankar, Prasad M. Bhukebag
Zen Multispeciality Hospital, Mumbai, Maharashtra, India

Persistent Pathogens Following Minimally Invasive Surgery: Is It Time to Rethink Aldehyde-Based Disinfection?

Kshitija Nalawade [1], Vishakha Kalikar [1], Avinash Supe [2], Roysuneel Patankar [2, 3]

1. Department of Digestive Diseases, Zen Multispeciality Hospital, Mumbai, IND 2. Department of Surgery, Zen Multispeciality Hospital, Mumbai, IND 3. Department of Gastrosurgery, Zen Multispeciality Hospital, Mumbai, IND

Corresponding author: Kshitija Nalawade, dr.kshitijanalawade@gmail.com

Original Article

The use of indocyanine green and near-infrared imaging in laparoscopic completion cholecystectomy for the management of stump cholecystitis: A case series

Sanatan Dattaram Bhandarkar, Vishakha Rajendra Kalikar, Advait Patankar, Roy Patankar
Department of Surgery, Zen Multispeciality Hospital, Chembur, Mumbai, Maharashtra, India

Multi Speciality Hospital
Zen
Dedication • Compassion • Excellence

GI MOTILITY & PHYSIOLOGY LAB

'Accurate diagnosis starts with the right technology'

Zen hospital offers specialized testing to identify and treat gastrointestinal motility disorders with precision.

DEPARTMENTAL SERVICES

- Esophageal Manometry
- pH metry
- Impedance studies
- Anorectal manometry
- Biofeedback

INDICATIONS

- Refractory GERD
- Evaluation before anti-reflux surgery
- Dysphagia
- Chronic constipation, incomplete evacuation, ODS

Contact Us +91-7506238859 www.zenhospital.in

Multi Speciality Hospital
Zen
Dedication • Compassion • Excellence

C13 UREA BREATH TEST NOW AT ZEN HOSPITAL

FAST. ACCURATE. NON-INVASIVE.

A safe and highly accurate way to detect H. pylori infection

INDICATIONS

- For initial diagnosis and post treatment eradication confirmation in patients with persistent dyspepsia
- Testing before long-term NSAID or aspirin therapy to reduce ulcer risk
- Suspected H. pylori infection in patients with known peptic ulcer disease
- Evaluation of chronic gastritis, atrophic gastritis, iron deficiency anemia after other causes have been ruled out

ADVANTAGES

- More comfortable than endoscopy
- No radiation. Safe for children and pregnant women
- More sensitive and specific than stool antigen testing
- High accuracy, minimal sampling error

UREA BREATH TEST ANALYZER

Contact Us +91-7506238859 www.zenhospital.in