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ZEN ACADEMY BULLETIN

Official newsletter of Zen Multispeciality Hospital, Mumbai

Focus: Surgical Innovation | Academic Excellence | Resident Well-being

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Editorial

Beyond Treatment: Building a Culture of Health, Performance, and Prevention

As we proudly enter the **third year of publication of the Zen Academy Bulletin**, it is an opportune moment to reflect on the remarkable journey of learning, innovation, and academic engagement that this platform has undertaken. Over the past two years, every issue has sought to bridge the gap between clinical practice and contemporary medical knowledge while showcasing the expanding spectrum of services and expertise available at Zen Multispeciality Hospital. The continued success of this bulletin reflects not only the enthusiasm of our contributors but also the commitment of our clinicians, allied health professionals, and academic partners who believe that healthcare institutions must serve as centres of learning as much as centres of treatment.

The theme of the current issue marks an important evolution in modern healthcare. Traditionally, medicine has focused on diagnosing and treating disease. Today, however, there is growing recognition that the future of healthcare lies equally in **prevention, performance optimisation, rehabilitation, and long-term wellness.** The articles featured in this issue embody this broader vision.

Sports medicine has emerged as a rapidly developing discipline that extends far beyond the management of elite athletes. Whether it is a young sportsperson recovering from an injury, a middle-aged individual adopting an active lifestyle, or an elderly person striving to maintain mobility and independence, the principles of sports medicine have become increasingly relevant to everyday clinical practice. The specialty combines scientific assessment, injury prevention, evidence-based treatment, and structured rehabilitation to help individuals return safely to their desired level of activity.

Complementing this is the crucial role of **sports physiotherapy,** which has transformed the recovery process from a passive period of rest to an active, goal-directed journey. Modern physiotherapy integrates biomechanics, functional assessment, exercise prescription, and patient education to restore strength, endurance, flexibility, and confidence. It exemplifies the multidisciplinary approach that characterises contemporary healthcare, where outcomes are enhanced through collaboration between physicians, surgeons, physiotherapists, nutritionists, and rehabilitation specialists.

Another important focus of this issue is **diabetes control,** a challenge that continues to assume epidemic proportions in India. While advances in pharmacotherapy have significantly improved outcomes, effective diabetes management extends far beyond medication. Sustainable control requires patient education, lifestyle modification, regular monitoring, nutritional optimisation, physical activity, and long-term engagement with healthcare providers.

The growing burden of diabetes highlights the need to shift from episodic treatment to proactive disease management, emphasising prevention of complications and preservation of quality of life.

A common thread linking all the topics in this issue is the concept of patient empowerment. Whether managing a sports injury, participating in a rehabilitation programme, or controlling diabetes, successful outcomes depend not only on medical expertise but also on informed and active participation by patients themselves. Modern healthcare is increasingly becoming a partnership in which clinicians guide, educate, and support individuals in making healthier choices.

This issue also reflects the broader **philosophy of Zen Hospital—an institution committed to delivering comprehensive care that extends beyond the walls of the operating theatre and outpatient clinic.** Our focus remains on helping individuals not merely survive illness, but achieve optimal health, functional independence, and enhanced quality of life. Through specialized clinical services, rehabilitation programmes, preventive initiatives, and academic activities, we continue to expand our mission of holistic patient care.

As we begin our third year, we reaffirm our commitment to making the **Zen Academy Bulletin a meaningful platform for sharing knowledge, fostering academic dialogue, and highlighting emerging trends in healthcare.** Medicine continues to evolve rapidly, and it is through continuous learning and collaboration that we can best serve our patients and communities.

We express our sincere gratitude to all contributors, reviewers, clinicians, physiotherapists, and healthcare professionals who have enriched this issue with their expertise. We also thank our readers for their continued encouragement and support, which motivate us to pursue excellence in every edition. Special thanks to our Coeditors – **Dr Prasad Bhukebag, Dr Vaishali Patankar and Dr Vishakha Kalikar** for their continued support. We also thank Zen team for their efforts.

As we look ahead, we remain committed to the values that define Zen Hospital—compassion, innovation, academic excellence, and patient-centred care. We hope this issue stimulates thought, encourages discussion, and contributes meaningfully to clinical practice.

"The ultimate goal of medicine is not merely to add years to life, but life to years."

Warm Regards,

Dr Avinash Supe

Dr Roy Patankar



The Hub-and-Spoke Model for Continuous Professional Development in Surgery: Expanding the Reach of Live Surgical Education

Dr Roy Patankar, Dr Avinash Supe - Department of Minimal Access Surgery

Continuing Medical Education (CME) is essential for surgeons to remain current with evolving technology, operative techniques, and clinical guidelines. Traditional surgical workshops, however, are often limited by geography, cost, travel requirements, and participant capacity. To address these challenges, Zen Multispeciality Hospital, Mumbai, has developed an innovative **hub-and-spoke** model that combines live surgical demonstrations, digital technology, and interactive learning to extend the reach of surgical education.

Zen Hospital serves as the central hub, where live operative procedures are conducted in accordance with National Medical Commission recommendations, with **patient safety, ethical standards, and informed consent** as the highest priorities. High-quality audiovisual systems transmit these procedures to an auditorium attended by more than 300 delegates and simultaneously to **over 95 spoke centres** across India, Nepal, Sri Lanka, and several African countries. Each spoke centre is coordinated by experienced local faculty who guide discussions and relate the learning to local clinical practice.

A defining feature of the programme is its **real-time interactivity.** Participants are not passive viewers; they engage through a common communication platform that allows questions from any spoke centre to be answered live by faculty during the procedure. This two-way exchange, supported by local moderation, creates an engaging and collaborative learning environment.

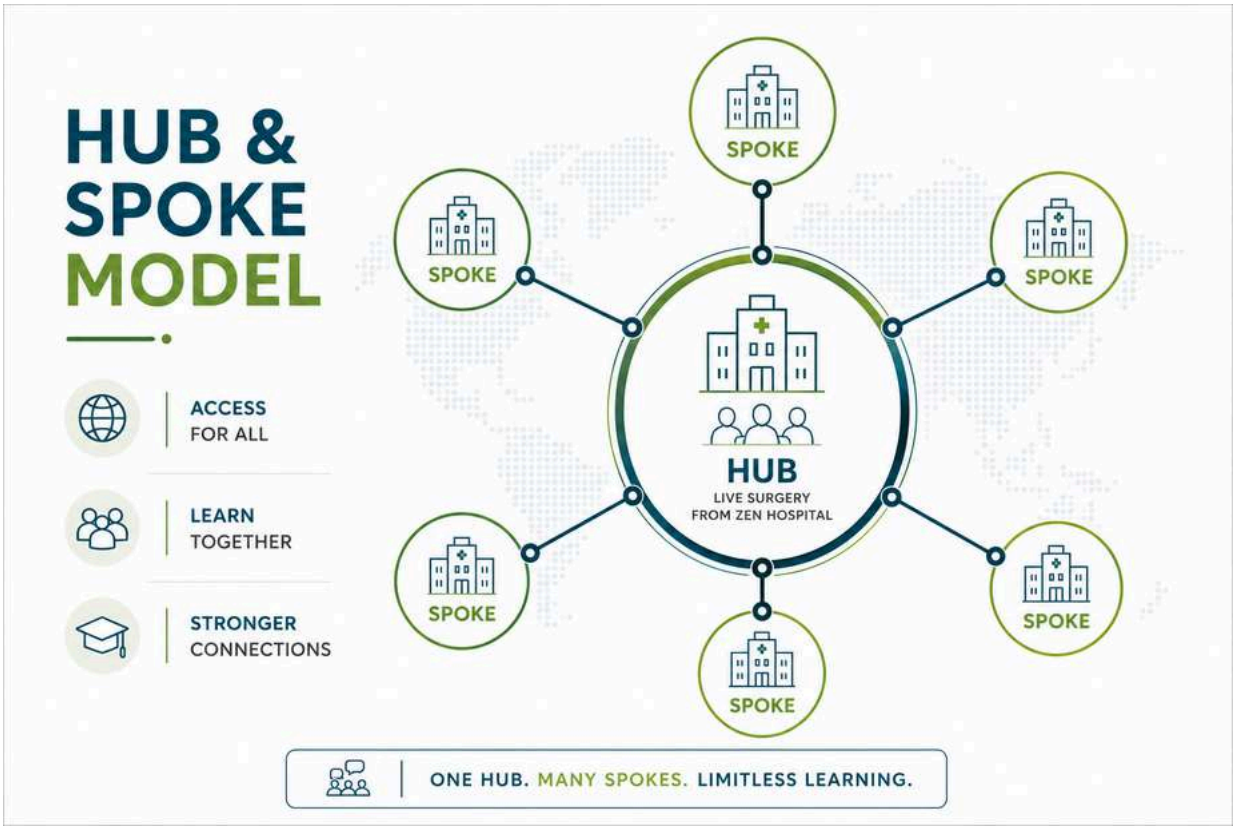
Over the past three years, **more than 4,000 surgeons, physicians, and postgraduate students** have participated in workshops covering laparoscopic surgery, anorectal surgery, management of surgical complications, orthopaedics, and other specialties. Participant feedback has consistently highlighted improved confidence, better operative decision-making, and the adoption of new techniques in routine clinical practice..

The hub-and-spoke model offers several **important educational advantages**. It democratises access to expert surgical education by overcoming geographical barriers and allowing clinicians in smaller cities and remote institutions to participate alongside delegates at the central venue. It reduces the need for travel, lowers costs, supports contextual learning through local faculty, promotes active participation, and strengthens national and international academic collaboration.

The model also reflects the principles of adult learning by delivering clinically relevant, problem-centred education through **live operative demonstrations, expert discussions, and case-based decision-making.** Local moderation further strengthens learning by encouraging practical discussion within individual institutions and adapting key messages to local needs.

Successful implementation depends on **reliable audiovisual infrastructure, robust internet connectivity, trained moderators, and strict ethical oversight.** Future developments such as artificial intelligence-assisted moderation, multilingual captioning, learning analytics, and virtual reality may further improve engagement, accessibility, and personalised learning.

The Zen Hospital hub-and-spoke model demonstrates that high-quality surgical education can extend far beyond the walls of a single institution. By combining technology, collaboration, and real-time interaction, it provides a scalable and sustainable platform for continuing professional development and may help shape the future of surgical training.

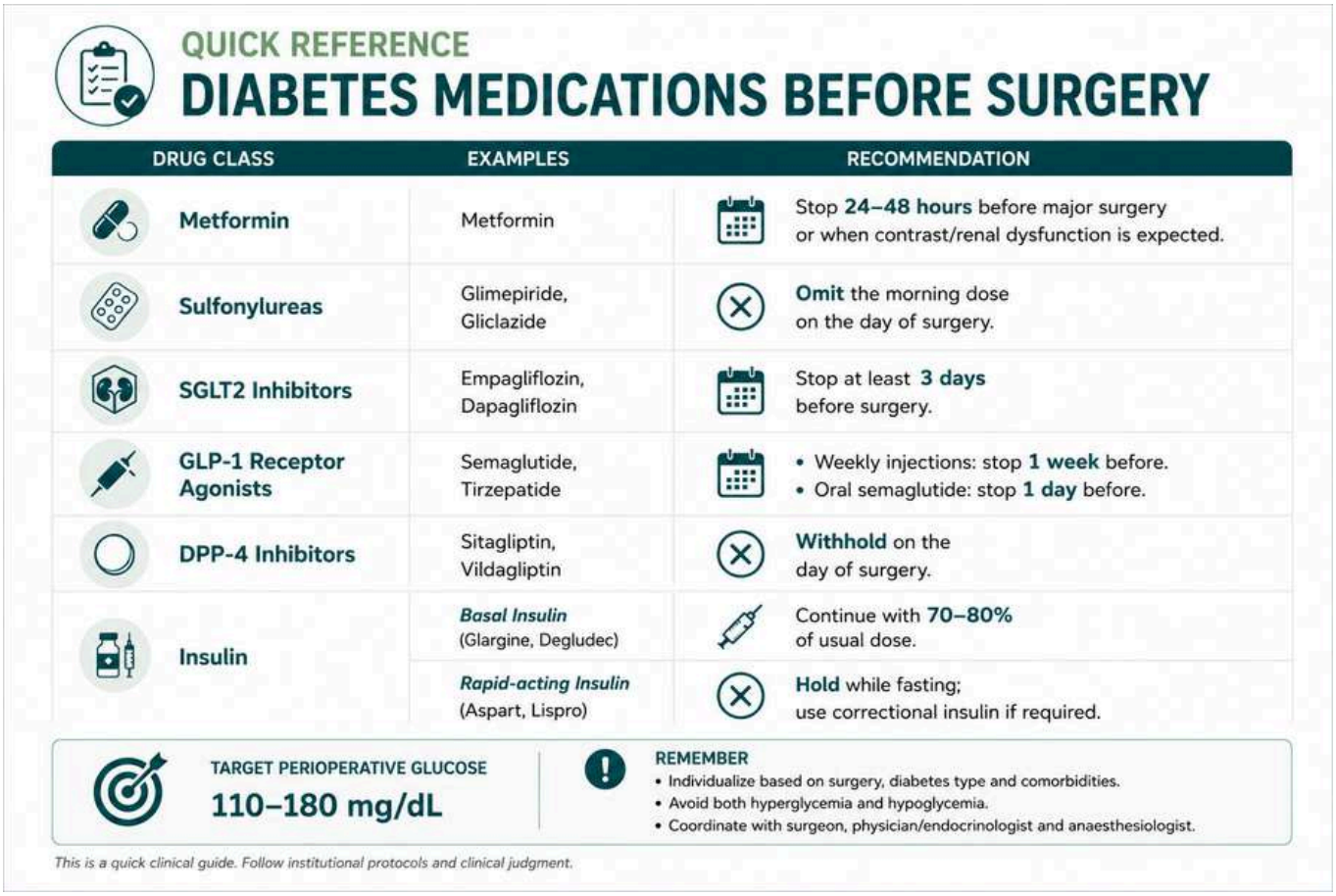


Preoperative Diabetes Management: Optimising Patients for Safe Surgery

Dr Amol Pawar MD - Department of General Medicine

India is home to one of the **world's largest populations of people with diabetes**, making perioperative glycaemic management an increasingly important aspect of surgical care. Poorly controlled diabetes is associated with higher rates of surgical site infection, impaired wound healing, cardiovascular complications, prolonged hospital stay, and increased perioperative morbidity. Careful preoperative optimisation, therefore, plays a pivotal role in improving surgical outcomes.

Current guidelines recommend **maintaining perioperative blood glucose between 110–180 mg/dL,** balancing the risks of both hyperglycaemia and hypoglycaemia. Preoperative assessment should include the type and duration of diabetes, existing microvascular and macrovascular complications, current medications, and glycaemic control. **HbA1c should ideally be below 7%,** although levels below 8% are acceptable for most elective procedures. Renal, cardiovascular, and cerebrovascular comorbidities should also be assessed, while recognising that emergency surgery should never be delayed solely because of hyperglycaemia.



Medication management should be individualised. **Metformin** is withheld before major surgery, **SGLT2 inhibitors** are stopped at least three days preoperatively, and **sulfonylureas and DPP-4 inhibitors** are omitted on the day of surgery. Basal insulin is usually continued at 70–80% of the usual dose, while rapid-acting insulin is withheld during fasting.

On the day of surgery, patients should ideally be scheduled early to minimise fasting. Blood glucose should be monitored regularly, with hyperglycaemia treated using insulin and hypoglycaemia corrected promptly with glucose. Antidiabetic medications can be restarted once the patient is clinically stable, with metformin resumed only after confirming adequate renal function and SGLT2 inhibitors after full oral intake and hydration.

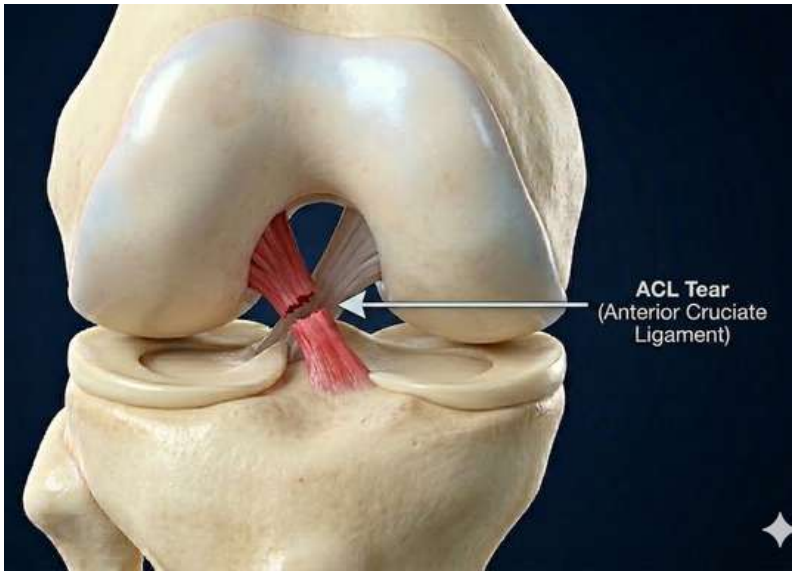
Successful perioperative diabetes management depends on close collaboration between the surgeon, physician or endocrinologist, anaesthetist, and nursing team, ensuring safe surgery and faster recovery. **Good outcomes begin before the first incision,** and careful diabetes optimisation remains a simple, cost-effective way to reduce complications and support faster recovery.

Cholangioscopy Now Available at Zen Endoscopy Centre

Zen Endoscopy Centre has introduced the **Biorad Cholangioscope for advanced diagnosis and treatment of biliary disorders.** This thin, flexible endoscope allows direct visualisation of the bile and pancreatic ducts.



It enables **laser fragmentation of large or impacted bile duct stones** that cannot be removed by standard ERCP and supports targeted tissue sampling from suspicious biliary strictures. This improves diagnostic accuracy, stone clearance, and may reduce the need for surgery.



Arthroscopy and the Evolution of Sports Injury Management

Dr. Nikhil Iyer - Department of Orthopaedics

I've been treating sports injuries long enough to remember when an ACL tear meant a long hospital stay and a large scar. Today, most patients walk out of day-care surgery centres the very same day. That transformation reflects how dramatically **sports medicine has evolved.**

Sports medicine is no longer just about treating injuries. It now encompasses injury prevention, sideline care, minimally invasive surgery, personalised rehabilitation, and safe return to sport through a multidisciplinary team of surgeons, physiotherapists, physicians, athletic trainers, and nutritionists.

As more people participate in recreational sport, sports injuries are becoming increasingly common. While ACL tears were once frequently associated with road traffic accidents, they are now routinely seen after football, badminton, running, gym workouts, and the rapidly growing sport of pickleball. Female athletes continue to sustain ACL injuries more frequently than men, driving significant advances in injury prevention research.

Arthroscopy remains the cornerstone of modern sports surgery. Through small incisions and specialised instruments, surgeons can repair damaged joints with minimal tissue trauma, resulting in less pain, smaller scars, and faster recovery. Procedures such as ACL reconstruction, once requiring prolonged hospitalisation, are now routinely performed as day-care surgeries. Advances in precision instrumentation, biological therapies, and wearable technology have further improved surgical accuracy and rehabilitation.

The injuries most commonly encountered include ACL and meniscal tears, shoulder injuries such as rotator cuff and labral tears, ankle sprains, tennis and golfer's elbow, and stress fractures. Wherever possible, preserving native structures—such as repairing rather than removing the meniscus—offers superior long-term outcomes.

Equally important is prevention. Most sports injuries can be reduced by warming up properly, strengthening the core and lower limbs, increasing training gradually, using correct technique and appropriate equipment, and respecting adequate recovery. Persistent pain, swelling, or instability should never be ignored, as early treatment often prevents more serious injury.

Modern arthroscopy allows patients to return to work, sport, and everyday life faster than ever before. Yet **the most successful operation remains the one that never becomes necessary**. Good preparation, sensible training, and early recognition of injury remain the most effective treatments of all.



Rotator Cuff Tear



Meniscal Tear



Knee arthoscopy

Sports Physiotherapy & Rehabilitation: Returning You to Peak Performance

Dr Vinith Karanth, Department of Physiotherapy

In today's active world, sports injuries affect not only professional athletes but also recreational runners, gym enthusiasts, and fitness-conscious individuals. Whether caused by overuse, trauma, or exercise, these injuries can disrupt daily life and physical performance. At Zen Multispeciality Hospital, Sports Physiotherapy and Rehabilitation services are designed **to restore strength, mobility, and confidence through evidence-based, personalised care.**

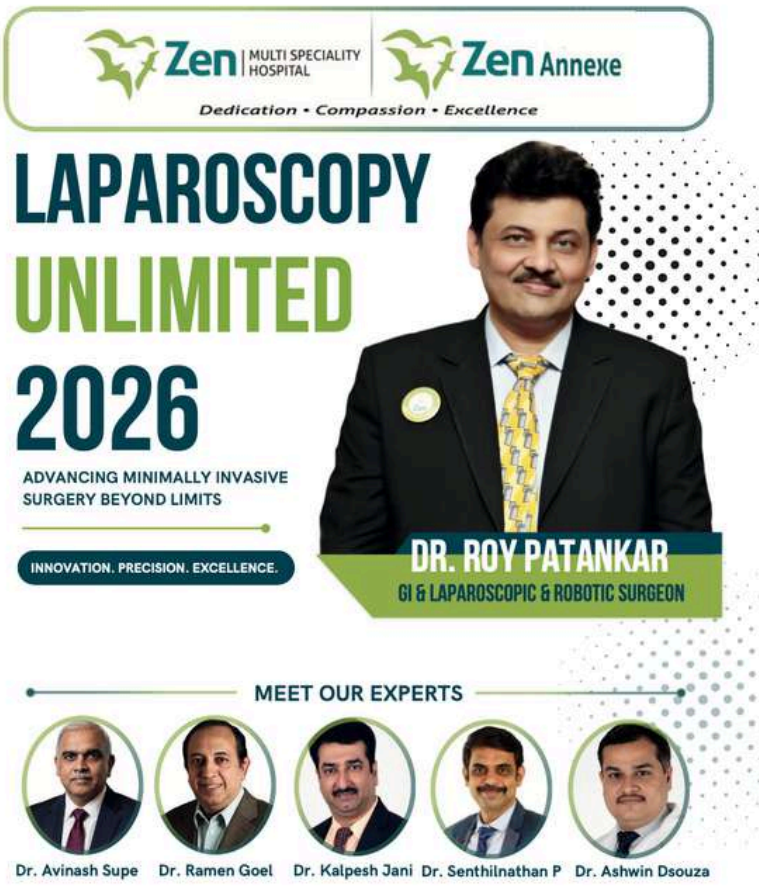
Sports physiotherapy extends beyond pain relief. It focuses on preventing injuries, restoring normal movement, improving muscle strength and flexibility, and enabling a safe return to sport and everyday activities. Every patient undergoes a comprehensive assessment, including postural and biomechanical analysis, muscle strength testing, joint mobility evaluation, and functional movement screening. This allows physiotherapists to identify the underlying cause of injury and develop an individualised rehabilitation programme.



Zen Hospital's Sports Physiotherapy team helps patients recover from common sports and fitness-related injuries such as knee ligament injuries, meniscus tears, shoulder problems, muscle and tendon injuries, ankle sprains, heel pain, stress fractures, and sports-related neck or back pain. Each rehabilitation programme is **planned according to the patient's age, fitness level, activity, and recovery goals.**

Treatment usually **starts with pain relief and healing,** followed by exercises to improve movement, strength, balance, and confidence. The team also supports patients after surgery, including ACL reconstruction, meniscus repair, rotator cuff repair, shoulder stabilisation, fracture fixation, and tendon repair.

With proper assessment, guided exercises, posture and movement correction, and injury-prevention advice, **Zen Hospital helps patients recover safely, avoid repeat injuries, and return to an active lifestyle with confidence.**





Preperitoneal Extended Totally Extraperitoneal (PeTEP): Bridging the Gap in Ventral Hernia Repair

Dr Sanjay Sonar - Department of Minimal Access Surgery

The evolution of minimally invasive abdominal wall surgery has provided surgeons with **multiple planes for mesh placement**, each with its own advantages and limitations. Onlay repair is associated with higher rates of surgical site occurrences and infections, particularly when extensive subcutaneous dissection is required. IPOM Plus avoids large skin flaps but requires expensive composite mesh and fixation devices, with the potential for chronic pain, adhesions, and mesh-related complications. Open repair continues to have higher wound morbidity and recurrence rates.

Current treatment algorithms recommend Ventralex repair for defects measuring 1–2 cm, eTEP-RS for defects larger than 4 cm or those associated with rectus diastasis, and eTEP-RS with TAR or open reconstruction for large complex hernias. However, ventral hernias measuring 2–4 cm represent a therapeutic gap, where open repair may be excessive and eTEP-RS unnecessarily extensive.

Preperitoneal Endoscopic Repair (PeTep), popularised by **Dr Héctor Valenzuela from Mexico**, addresses this gap by utilising the preperitoneal plane for endoscopic mesh placement. The procedure preserves the retrorectus space for future reconstruction while avoiding intraperitoneal mesh placement.

Careful preoperative optimisation remains essential and includes weight reduction, glycaemic control, nutritional assessment, pulmonary optimisation, and CT evaluation of the abdominal wall, preferably with dynamic imaging. Under general anaesthesia, the preperitoneal space can be approached through either a cranial or caudal route. Dissection follows the **"Fatty Trident" described by Miguel et al**., which serves as an anatomical guide to remain within the correct tissue plane. After reduction of the hernia sac, the fascial defect is closed with barbed sutures, rectus diastasis is repaired when required, peritoneal defects are closed, and a medium-weight polypropylene mesh is placed without routine fixation.

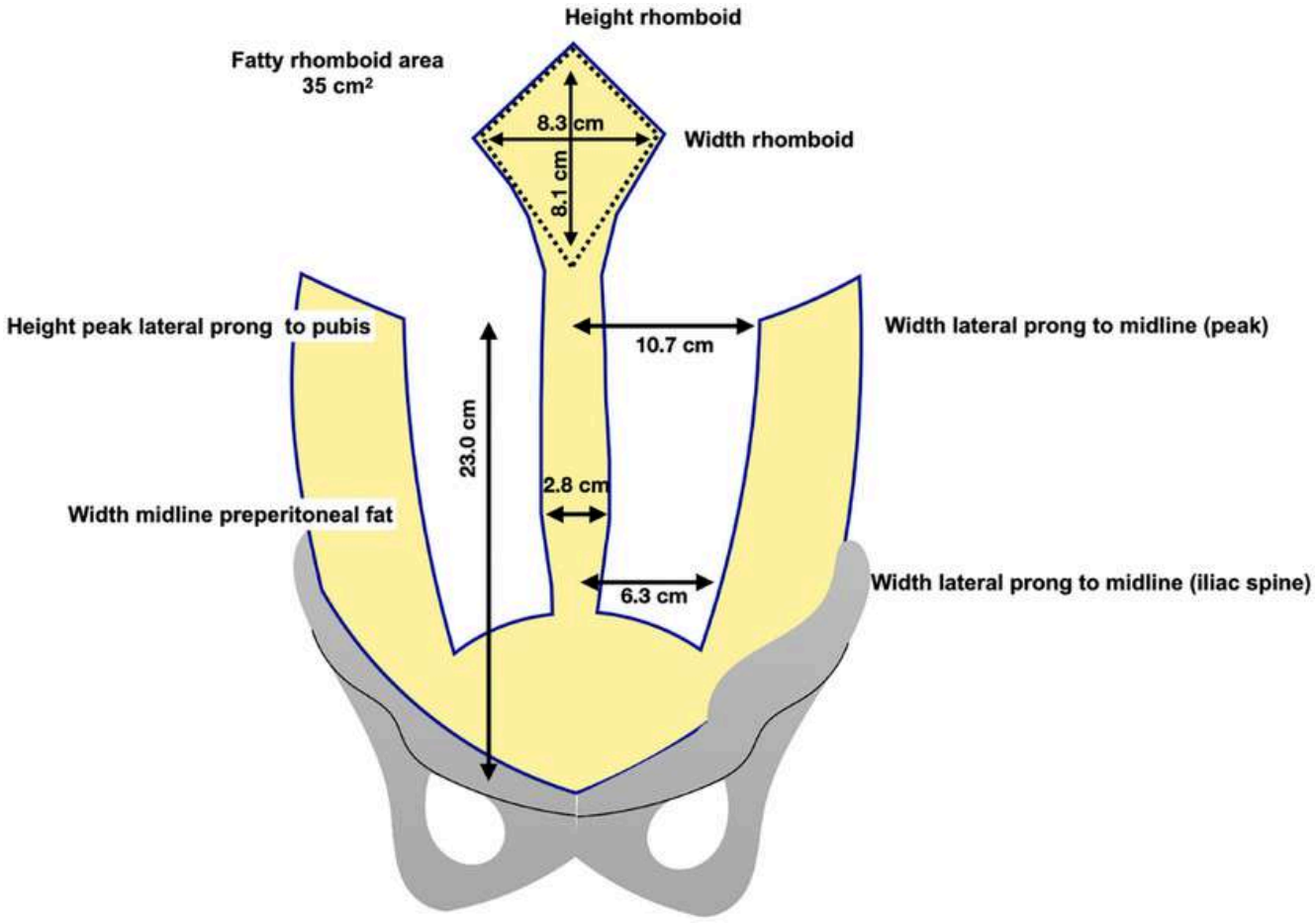


Dr Hector Valenzuela

PeTep offers several advantages. It preserves the retrorectus plane for future surgery, avoids injury to the linea semilunaris and rectus motor nerves, eliminates the need for costly composite mesh and tackers, and usually does not require mesh fixation. These features make it particularly attractive for small to medium-sized ventral hernias.

The technique, however, has a learning curve. Identification of anatomical planes requires a thorough understanding of preperitoneal fat distribution and the so-called **"Fat Desert" zones.** Surgery may be technically demanding in patients with previous abdominal operations, a pendulous abdomen, or a short pubo-umbilical distance. Although uncommon, bleeding, seroma formation, and preperitoneal infection remain recognised complications.

When PeTep cannot be safely completed, conversion to Ventralex repair, IPOM Plus, or eTEP-RS—depending on the defect size and associated rectus diastasis—provides a safe alternative. By filling the therapeutic gap between small open repairs and more extensive retrorectus reconstruction, **PeTep has emerged as an effective and cost-conscious option** for selected ventral hernias.



Fatty Trident

Reading Between the Lines: What Every Physician Should Know About Kaplan–Meier Curves

Dr Avinash Supe, Dr Prasad Bhukebag - Department of Minimal Access Surgery

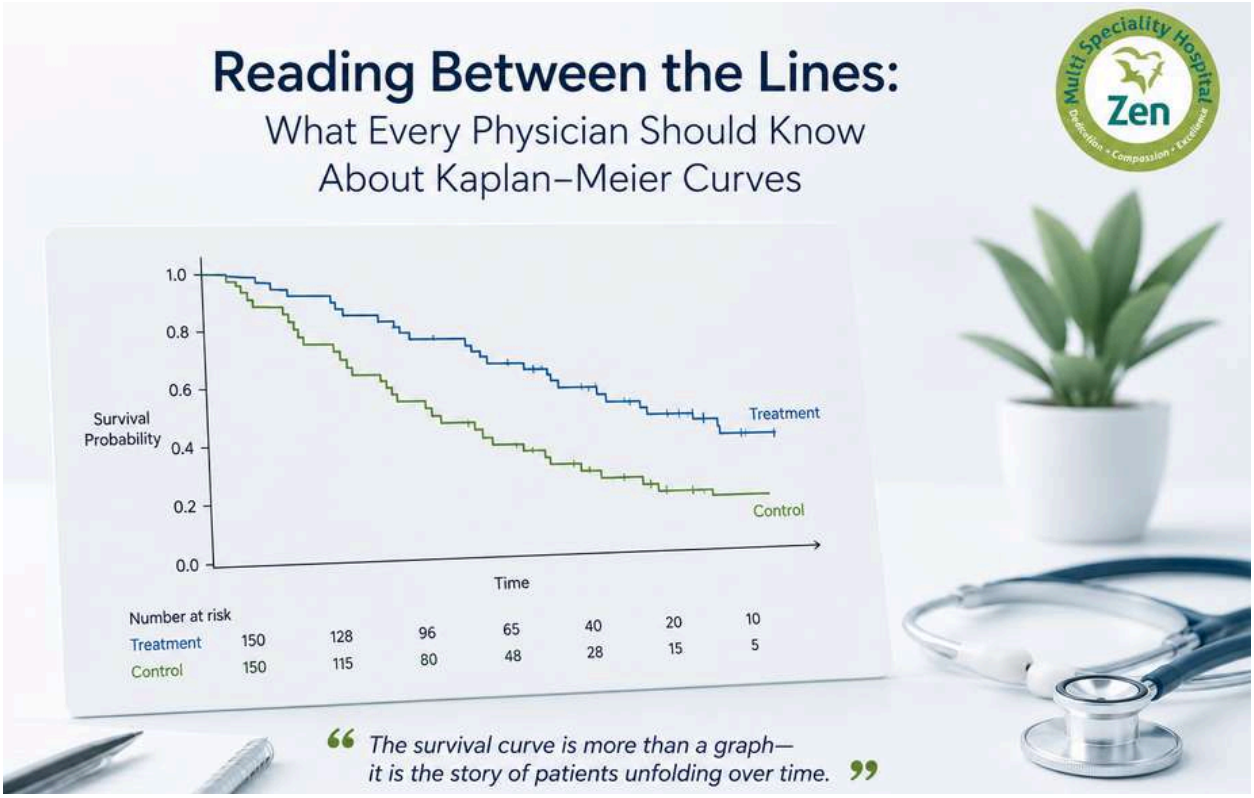
"The survival curve is more than a graph—it is the story of patients unfolding over time."

Kaplan–Meier (KM) survival curves are among the most commonly encountered figures in medical research. Whether evaluating cancer therapies, surgical outcomes, or chronic disease interventions, clinicians regularly rely on these graphs to assess treatment effectiveness. Yet many readers focus only on the p-value or median survival, overlooking the valuable clinical insights contained within the curve itself.

Unlike simple outcome measures, Kaplan–Meier analysis captures not only **whether an event occurs but also when it occurs.** This makes it particularly useful for studying overall survival, disease-free survival, progression-free survival, graft survival, and other time-dependent outcomes.

One of the first features to examine is **when the curves separate.** Early separation suggests an immediate treatment effect, as seen with surgery or antibiotics, whereas delayed separation may indicate therapies that require time to demonstrate benefit, such as immunotherapy. The timing of divergence often provides important biological insights beyond statistical significance.

The distance between the curves reflects the magnitude of clinical benefit. A statistically significant result may still translate into only a small absolute survival advantage, while a visually large separation may represent a meaningful improvement even in studies with limited sample size. Clinicians should therefore interpret both statistical and clinical significance.



Not all survival curves are straightforward. **Crossing curves** suggest that treatment effects vary over time and that a single hazard ratio may be misleading. Similarly, a **plateau at the end of the curve** may indicate durable long-term survival in a subgroup of patients, an increasingly recognised finding with modern immunotherapies.

Clinicians should also look beyond median survival, which represents only the point at which half the participants have experienced the event. Two treatments with similar **median survival** may have very different long-term outcomes, making the entire survival curve more informative than a single number.

Equally important is the often-overlooked **number-at-risk table,** which shows how many patients remain under observation at each time point. As patient numbers decrease, survival estimates become less reliable. Likewise, the small tick marks on the curve represent **censored observations**—patients who were lost to follow-up or completed the study without experiencing the event. Censoring is not a treatment failure but should be considered when interpreting the reliability of late follow-up.

Kaplan–Meier curves are far more than statistical illustrations. They are visual narratives of patient outcomes over time. By examining when curves separate, how far they diverge, whether they cross, the presence of plateaus, the extent of censoring, and the number of patients remaining at risk, clinicians can interpret medical literature more critically and make better evidence-based decisions for their patients.

New Frontiers in Gastroenterology and Endoscopy

Zen Endoscopy Centre continues to expand its advanced diagnostic services with the introduction of the **Carbon-13 Urea Breath Test (C13 UBT) and FibroScan.**

The C13 Urea Breath Test is the **gold standard non-invasive test for detecting Helicobacter pylori** infection and confirming its eradication after treatment. As it does not require endoscopy, it offers a quick, accurate, and patient-friendly alternative for appropriate patients.

With fatty liver disease now the leading cause of chronic liver disease worldwide, **FibroScan provides a rapid, painless, and non-invasive assessment of liver fat and fibrosis**. Using ultrasound-based technology, it accurately stages liver disease without the need for a biopsy, enabling early intervention, appropriate treatment, and long-term monitoring.





Navigating Difficult Encounters: Managing Difficult Relatives, Unexpected Deaths & Political Pressure

Dr Ajeet Mishra, Department of Minimal Access Surgery

Indian hospitals face a communication challenge unlike most Western healthcare settings. A single patient can bring five to ten anxious relatives, often armed with fragmented information from "WhatsApp University" rather than medical training. The problem isn't people — it's a broken system for **communication and escalation**. Fix the system, or suffer the consequences. Left unaddressed, this gap fuels **violence against doctors, media trials, staff burnout, and licensing risk.**

Behaviour that looks like aggression is usually something else in disguise. Shouting at reception often reflects fear and a lack of information. Demands to "call the doctor NOW" signal a loss of control. Recording video reveals mistrust and feeling unheard. Invoking a politician's name is often an attempt to reclaim dignity. Fuss is an unmet need for information, dignity, or control — fix the need, not the person.

The HEAL Framework

For frontline staff, de-escalation can happen in four steps and four minutes: Hear (60 seconds uninterrupted — "Tell me what happened, I'm listening"), Empathise (name the emotion — "I can see you're scared because surgery is delayed"), Align ("We both want your mother safe. Let's work on it"), and Lead (offer one action with a timeline — "I'll get an OT update in 15 minutes and come back to you myself"). Crucially, **never argue clinical facts during an emotional peak.**

A real case illustrates this: an unstable post-PAMI patient left five relatives waiting outside the ICU at 2 a.m. with no update since 9 p.m., leading to shouting and confrontation. The fix wasn't just applying HEAL in the moment — it was building a protocol: updates every four hours, and a firm documentation rule that **"no documentation = no communication."**

Preventing repeat crises means engineering the environment, not just training reactions: a single spokesperson per patient (cutting ten opinions to one), visible whiteboards showing test and report timelines, fixed daily update times with doctors, a visibly named grievance officer on every floor, and hospital-wide staff training in HEAL and escalation protocols.

When a Death Is Unexpected

Before delivering bad news, take two minutes to confirm the facts, choose the right people and place, understand the family, and set your own mindset. Families rarely sue because a patient died — they sue because they felt abandoned, disrespected, or lied to in the first ten minutes.

The SPIKES framework provides a structured approach to breaking bad news through Setting, Perception, Invitation, Knowledge, Emotions, and Summary, ensuring conversations remain compassionate, clear, and well documented. During emotionally charged situations, respond with empathy rather than defensiveness, move key family members to a private area, and involve senior clinicians early to reduce escalation.

Handling Political Pressure

Political requests for admissions, billing concessions, or medico-legal favours cannot be eliminated but should be managed through clear institutional policies. **The TACT model** provides a practical response: Thank, Acknowledge, state the Constraint, and Take Action within policy.

In financial disputes, **meticulous documentation remains the strongest protection.** When explaining higher bills, focus first on the patient's changing clinical condition rather than the cost. Regular family meetings, discussing clinical progress before finances, and requesting political communications in writing can prevent many conflicts.

In the digital era, **silence is often perceived as guilt.** Acknowledge concerns promptly, move discussions offline, investigate complaints thoroughly, and never admit negligence in writing.

Ultimately, institutional dignity outweighs personal ego. As the presentation concludes, ***"We may lose ₹2 lakh today, but we save our licence, reputation, and the trust of the next hundred patients."*** Clinical skill saves lives, but communication and administrative skill protect the hospital, allowing it to continue saving lives.



Why Abdominal Wall Reconstruction is My Passion?

Dr. Vishakha Kalikar DNB Consultant Surgeon,

Every surgeon remembers the operation that changed the way they looked at surgery. For me, that moment came while treating patients with complex abdominal wall defects. What initially appeared to be 'hernia surgery' soon revealed itself as something far deeper. Behind every defect was a story of repeated operations, pain, loss of confidence, physical disability, and emotional distress. I realised that **abdominal wall reconstruction (AWR)** is not merely about closing a defect—**it is about restoring anatomy, function, dignity, and quality of life.** That realisation transformed a surgical interest into a lifelong passion.

The abdominal wall is one of the most underestimated structures in the human body. It protects vital organs, maintains posture, enables movement, supports respiration, and contributes significantly to body image. When this dynamic structure fails because of incisional hernias, trauma, infection, or multiple previous surgeries, the consequences extend far beyond a visible bulge. Patients often experience chronic pain, reduced mobility, inability to work, social embarrassment, and psychological stress. Repairing such defects demands much more than technical expertise; it requires empathy, meticulous planning, and a commitment to achieving durable functional outcomes.

What fascinates me most about AWR is the blend of **science, strategy, and craftsmanship.** Every patient presents a unique challenge. No two abdominal walls are identical. Understanding tissue biology, biomechanics, imaging, previous operative history, patient comorbidities, and lifestyle factors becomes essential before entering the operating theatre. **Careful prehabilitation, nutritional optimisation, smoking cessation, weight management, and multidisciplinary planning** are often as important as the surgery itself. Success begins long before the first incision.

In the operating theatre, AWR represents one of the finest examples of precision surgery. Modern techniques such as component separation, **posterior component separation with transversus abdominis release (TAR),** minimally invasive and robotic approaches, and judicious mesh selection have revolutionised outcomes. These advances have allowed surgeons to reconstruct even the most complex defects while minimising recurrence and improving patient recovery. Every reconstruction is intellectually stimulating because it combines anatomical knowledge with thoughtful intraoperative decision-making.

Yet, the most rewarding part of this specialty is not the operation itself—it is witnessing the transformation in patients. Seeing someone who had lived for years with pain, disability, or fear regain confidence, return to work, resume physical activity, and smile without self-consciousness is immensely fulfilling. Those moments remind me that ***surgery is ultimately about restoring lives, not simply repairing tissues.***

Being actively involved with the **Executive Committee of the Abdominal Wall Reconstruction community** in India has provided opportunities to learn from pioneers, collaborate with colleagues across the country, and contribute to academic discussions. Invitations to speak at national and international scientific meetings have further reinforced an important lesson: **excellence in AWR comes from continuous learning, sharing experiences, and embracing innovation.** Teaching has become another source of inspiration. Guiding young surgeons through the complexities of abdominal wall anatomy and reconstruction is both a privilege and a responsibility.

At Zen Multispeciality Hospital, I have had the opportunity to work in an environment that encourages innovation, multidisciplinary collaboration, and academic excellence. Managing complex abdominal wall problems alongside dedicated anesthesiologists, physicians, radiologists, nutritionists, and rehabilitation teams has reinforced my belief that successful reconstruction is truly a team effort. **Every successful outcome reflects not only surgical expertise but also coordinated patient care.**

People often ask me why AWR has become my chosen field. My answer is simple. It combines the science of surgery with the art of reconstruction and the privilege of transforming lives. My journey in abdominal wall reconstruction continues to evolve with every patient I meet. Each case teaches humility, patience, and respect for the remarkable complexity of human anatomy. The field constantly challenges me to improve my skills, question established practices, and seek better solutions. That pursuit of excellence keeps the passion alive.

That is why AWR is, and will always remain, my passion.



Dr Vishakha Kalikar presenting at EHS 2026

Zen Hospital Receives DNB Medicine Accreditation

Dr Nilakshi Sabnis, Dr Vikrant Shah - Department of General Medicine

Zen Multispeciality Hospital is proud to announce a significant milestone in its journey towards academic and clinical excellence. The hospital has been granted accreditation by the National Board of Examinations in Medical Sciences (NBEMS) to conduct the **DNB General Medicine programme**, with an approved intake of **two postgraduate trainees per year** commencing from the 2026 academic session.

This prestigious accreditation recognises the hospital's continued commitment to **delivering high-quality patient care** while maintaining the infrastructure, clinical standards, and academic environment required for postgraduate medical education. It marks an important step in strengthening Zen Hospital's role as a centre for clinical excellence, teaching, and professional development.

The DNB trainees will benefit from extensive clinical exposure across a wide spectrum of medical conditions, supported by modern diagnostic facilities and guided by an experienced team of physicians committed to mentorship and academic excellence. The programme is designed to foster **sound clinical judgement, evidence-based practice, and a culture of lifelong learning.**

We extend our sincere gratitude to all our consultants, physicians, nursing staff, and administrative teams whose dedication, teamwork, and unwavering commitment have made this achievement possible. Their collective efforts have laid the foundation for this important academic initiative.

We look forward to welcoming our first batch of DNB residents and remain committed to nurturing the next generation of physicians while continuing our mission of excellence in patient care, education, and research.



A New Chapter in Renal Transplantation at Zen Hospital

On **22 July 2026,** Zen Multispeciality Hospital **successfully performed a renal transplant,** marking an important milestone in the hospital's journey towards providing comprehensive and advanced healthcare.

Renal transplantation is a complex procedure that requires careful planning, close monitoring, and seamless coordination between several departments. The transplant was carried out by a **dedicated multidisciplinary team** comprising transplant surgeons, nephrologists, anaesthetists, intensivists, nursing staff, operation theatre personnel, technicians, and support staff. Their combined expertise and teamwork played a vital role in ensuring that every stage of the procedure was managed with precision and care.

The programme also involved detailed preoperative assessment, donor and recipient evaluation, perioperative management, infection control, and close postoperative monitoring. Such coordinated care is essential for ensuring patient safety and supporting a smooth recovery after transplantation.

This achievement reflects Zen Hospital's growing capabilities in specialised renal care and its commitment to offering advanced treatment options to patients with end-stage kidney disease. It also highlights the importance of **strong teamwork, modern infrastructure, and patient-centred care** in building a successful transplant programme.

The successful transplant marks the beginning of a **new chapter for Zen Hospital.** It strengthens the hospital's vision of expanding access to high-quality renal services and bringing renewed hope to patients and families facing advanced kidney disease.



QUIZ

Choose the single best answer.

1. Which surgical plane is utilised in PeTep repair?

A. Onlay

B. Intraperitoneal

C. Preperitoneal

D. Retrorectus

2. Which diabetes medication should generally be discontinued at least three days before elective surgery?

A. Metformin

B. Sitagliptin

C. Empagliflozin

D. Glimepiride

3. In Kaplan–Meier analysis, crossing survival curves most commonly suggest:

A. Immediate treatment benefit

B. Treatment effects vary over time

C. Poor study quality

D. Absence of statistical significance

4. According to the communication article, the HEAL framework begins with:

A. Help

B. Hear

C. Hope

D. Honour

5. The primary goal of abdominal wall reconstruction is:

A. Cosmetic improvement alone

B. Mesh reinforcement only

C. Restoration of anatomy and function

D. Minimising operating time

Answers: *1-C • 2-C • 3-B • 4-B • 5-C*

Publications from Zen Hospital

ANZ Journal of Surgery
Royal Australasian College of Surgeons

LETTER TO THE EDITOR

Always-On ICG Fluorescence: A New Normal in Laparoscopic Cholecystectomy?

Prasad M. Bhukebag, Roy Patankar, Avinash Supe

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Case Report

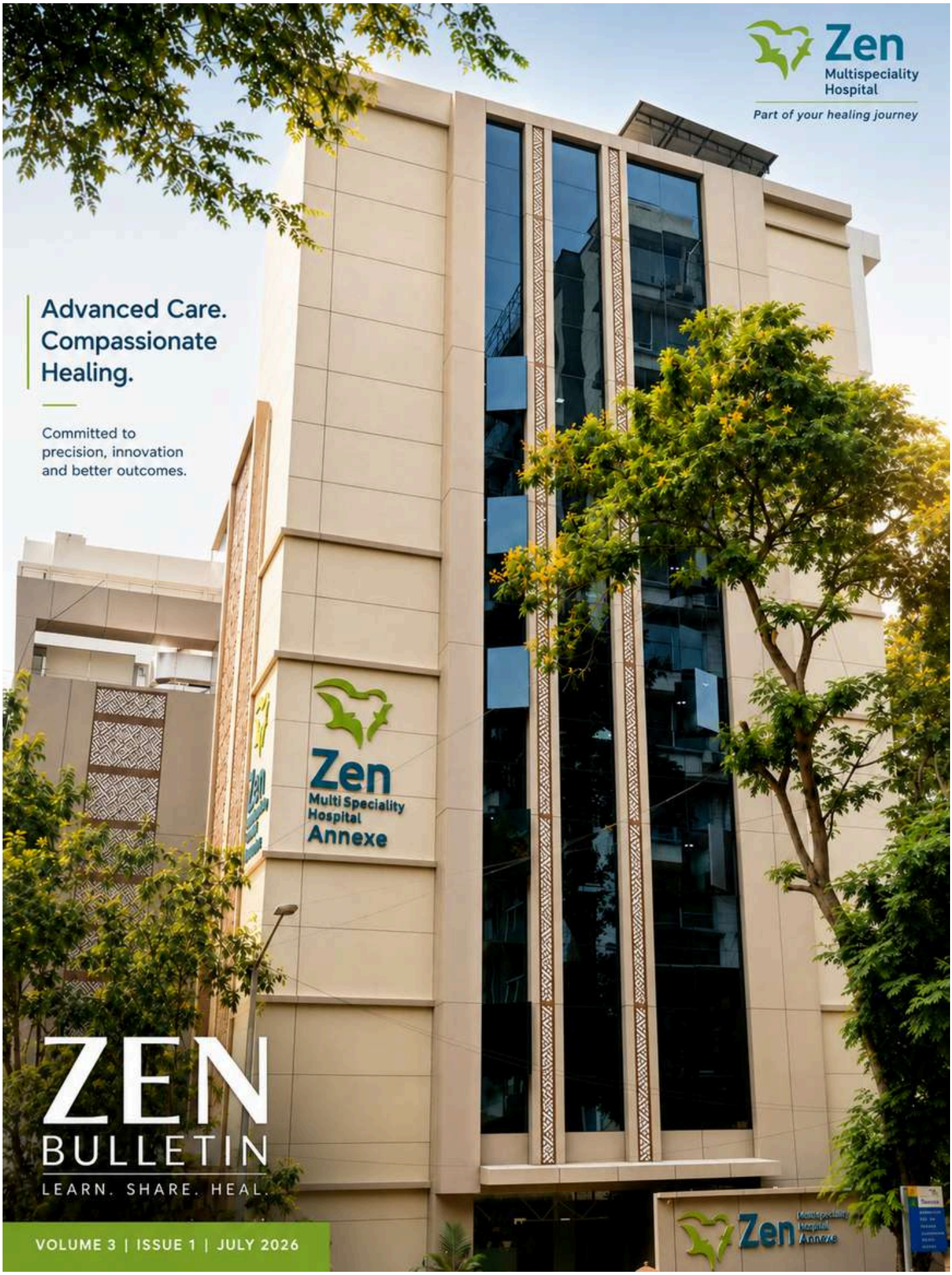
Unveiling the uncommon: Strongyloides stercoralis infection as a rare contributor to distal duodenal obstruction- case report and literature review

Priya Gupta [a,*], *Sanatan Bhandarkar* [a], *Roy Patankar* [b], *S.K. Mathur* [c]

An Urgent Need to Educate Tomorrow's Doctors on Pandemic Response, Mental Health, and Precision Medicine

Pathiyil Ravi Shankar[1], Avinash Supe[2], Rano Mal Piryani[3]
Authors and Affiliations >

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