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KJK HOSPITAL PVT. LTD.

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EDITORIAL

The Role of Artificial Intelligence in Reproductive Medicine

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Artificial intelligence (AI) has become deeply integrated into various aspects of modern life, from virtual assistants to advanced medical diagnostics. In reproductive medicine, AI is now a central topic in scientific conferences and forums, with its potential being explored across different stages of fertility treatments.

AI Applications in Assisted Reproductive Technology (ART)

AI is being leveraged in multiple areas of reproductive medicine, including:

- **Treatment prognosis:** Predicting ovarian response and treatment success.
- **Ovarian stimulation optimization:** Personalizing hormone dosage.
- **Follicular monitoring:** Automated ultrasound analysis for follicle tracking and measurement.
- **Sperm selection:** Identifying sperm with optimal morphology and motility.
- **Oocyte and embryo quality assessment:** Predicting embryonic development through image analysis.
- **Donor selection:** AI-driven algorithms optimizing donor-recipient compatibility.

AI-Driven Fertility Prediction Platforms

Several platforms have emerged to predict in vitro fertilization (IVF) success rates. These include:

- **Free platforms:** Organizations such as the CDC and SART offer population-based predictions.
- **Subscription-based platforms:** Tools like Expect More provide individualized estimates based on multiple factors.

The interpretation of AI-generated predictions remains reliant on clinical expertise, as accuracy depends on the quality and representativeness of the training data.

Time-Lapse Technology and AI in Embryo Selection

A major advancement in AI-driven reproductive medicine is the use of time-lapse imaging technology to evaluate embryo development. Systems such as EmbryoScope utilize AI algorithms to assign viability scores, including IdaScore and KidScore.

These technologies aim to enhance embryo selection and improve implantation rates; however, evidence regarding their impact on live birth rates remains limited.

Challenges and Limitations of AI in Reproductive Medicine

Despite its promising applications, AI in fertility treatment faces several challenges:

- **Data quality and quantity:** AI models trained on limited or biased datasets may produce inaccurate predictions.
- **Reproducibility:** Many AI-driven tools are applicable only to specific clinics or populations.
- **Limited scientific evidence:** Most AI-based fertility tools have low or very low levels of supporting evidence.
- **Doctor-patient interaction:** Algorithmic reports can create confusion or unrealistic expectations for patients.

Final Thoughts: Is AI the Future of Reproductive Medicine?

AI represents an exciting frontier in reproductive medicine, offering potential benefits across various fertility treatment stages. However, its clinical adoption must be grounded in robust scientific evidence and rigorous validation.

The relative lack of stringent scientific evaluation should prompt improved studies and more reliable conclusions. As AI continues to evolve, medical professionals and researchers must remain cautious in their interpretations, prioritize well-designed studies, and focus on integrating the most beneficial technologies into clinical practice.

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Bell's Palsy In Pregnancy: The Silent Neurological Challenge"

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Introduction

Bell's Palsy (BP), also known as idiopathic acute facial paralysis, is the most common cause of sudden unilateral facial weakness. First described by Charles Bell in 1830, Bell's Palsy remains largely idiopathic, with a higher incidence in pregnant women, particularly in the third trimester and postpartum period. The condition is characterized by inflammation of the facial nerve, potentially linked to viral reactivation, immune changes, and vascular alterations. The exact cause remains unclear, but herpes simplex virus (HSV) reactivation or Herpes zoster virus is often implicated. This report discusses a case of Bell's Palsy in pregnancy and its management challenges.

Case Presentation

A 40-year-old primigravida, ICSI conception, DCDA twins at 33 weeks of gestation presented to the obstetrics outpatient department with a sudden onset of right-sided facial weakness and angle of mouth deviation and difficulty in closing her right eye. She had prior history of Chicken pox infection at the age of 22yrs but no prior history of neurological disorders, hypertension, or diabetes. Her pregnancy had been uneventful until this episode. No other neurological deficits were noted.

On examination, there was evident facial asymmetry, incomplete right eye closure (lagophthalmos), and a deviation of the mouth to the right side. Her vital signs were stable. Neurological examination confirmed lower motor neuron-type facial nerve palsy.

Blood tests, including screening for infections, were unremarkable. A multidisciplinary team, including a neurologist and obstetrician , was involved in her care.

The patient was started on oral prednisolone (10 mg four times daily for three days, followed by tapering doses over the next 2 weeks). Eye care was initiated with lubricating eye drops. Physiotherapy, including facial exercises and massage, was advised.

The patient had a gradual improvement in symptoms over the next few weeks. She underwent a lower segment caesarean section (LSCS) at 36 weeks and delivered twins healthy babies weighing 2.6 kg and 1.82kg . Her facial weakness has improved. She is on physiotherapy postpartum and follow up.

Discussion

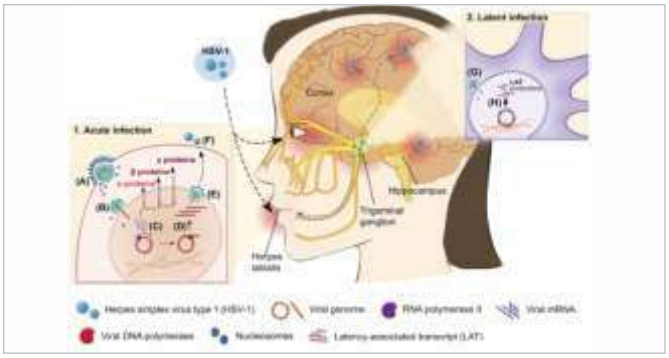
Bell's Palsy in pregnancy remains a rare but significant condition. The incidence of Bells Palsy in pregnancy is higher than in the general population, with peak occurrence in the third trimester. The condition is thought to result from viral reactivation immune suppression, and increased vascular permeability.

Viral Reactivation

The association between HSV reactivation and Bell's Palsy has been well-documented. During pregnancy, hormonal changes, immune suppression, and stress may act as triggers for HSV reactivation. The herpes virus, once reactivated, causes direct viral invasion, inflammatory response, and demyelination of the facial nerve. This mechanism aligns with the higher prevalence of Bell's Palsy in the later stages of pregnancy, when immune function is most altered. In addition to HSV, other viruses such as varicella-zoster virus (VZV) and cytomegalovirus (CMV) have also been implicated in cases of Bell's Palsy during pregnancy. These viruses, like HSV, can remain dormant in neural tissues and reactivate under conditions of immune compromise, contributing to inflammation and nerve damage. This broader viral etiology highlights the complex interplay of viral infections and pregnancy-related immune changes in the pathogenesis of Bell's Palsy.

Immune Suppression

Pregnancy is associated with a state of partial immune suppression to prevent foetal rejection. This altered immune response increases susceptibility to infections and may contribute to the reactivation of latent viral infections, such as herpes simplex virus (HSV). The decrease in T-cell-mediated immunity allows HSV to reactivate within the geniculate ganglion, leading to inflammation and oedema of the facial nerve. This immune dysregulation is believed to be a major factor in the increased incidence of Bell's Palsy in pregnant women.



Increased Vascular Permeability

Pregnancy induces significant hemodynamic changes, including increased blood volume, vascular permeability, and interstitial fluid retention. These changes can lead to oedema and compression of the facial nerve within the narrow confines of the fallopian canal. This compression can result in ischemia and impaired nerve function, further contributing to the onset of facial paralysis. Additionally, venous stasis and endothelial dysfunction in pregnancy may exacerbate nerve compression and inflammation.

The differential diagnosis of Bell's Palsy includes stroke, Ramsay Hunt syndrome, and Lyme disease, necessitating thorough evaluation. Bell's Palsy is a lower motor neuron disorder, affecting both the upper and lower facial muscles, whereas stroke-related facial weakness typically spares the upper face.

Corticosteroids remain the mainstay of treatment, although their use in pregnancy requires careful risk-benefit analysis. Studies suggest that prednisolone is safe in pregnancy and improves recovery rates. Eye protection is critical to prevent exposure keratitis.

Most cases of Bell's Palsy resolve spontaneously, with complete recovery in 70-80% of patients. However, some patients may experience residual weakness or synkinesis. Postpartum resolution is common, suggesting a link between pregnancy-related physiological changes and Bells's Palsy .

Conclusion

This case highlights the importance of early recognition and a multidisciplinary approach to managing Bell's Palsy in pregnancy. Patients often become alarmed when they develop such symptoms during pregnancy. Therefore, along with prompt initiation of corticosteroids, supportive care, patient counselling, and reassurance are key to ensuring optimal outcomes.

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A Rare Case of Cellular Leiomyoma - the Menace of Recurrence and a Masquerader of Malignancy

Case Report

A 34-years old female, P1L1, known case of cellular leiomyoma on follow-up presented with reports suggestive of raising CA 125(124 IU/L) levels with MRI suggestive of recurrence of multiple rapidly growing uterine fibroids. She had undergone laparoscopic myomectomy thrice due to recurring fibroids and was diagnosed to have cellular leiomyoma during the third surgery. She is on regular 6 monthly follow-up with CA 125, LDH levels and MRI abdomen, pelvis and chest.On comparison with previous MRI her fibroids had increased in size of about 7 cm , CA 125 increased to 124 from 25 IU/L and LDH was within normal limits.

She was evaluated with an FDG PET scan which showed low to moderate metabolic activity in multiple fibroids and no active lymph nodes or metastatic lesions were found. She was taken up for Total laparoscopic hysterectomy with in bag retrieval of specimen, but it was converted to total abdominal hysterectomy with bilateral salpingectomy due extensive adhesions and intraoperative difficulties.First histopathological evaluation showed STUMP(Smooth muscle tumour of unknown significance).Repeat histopathological evaluation with immunohistochemistry showed cellular leiomyoma with mild focal nuclear atypia and ruled out leiomyosarcoma .Ki 67 index was 6 to 7 % suggesting good prognosis of tumour. She was advised regular 6 monthly followup and discharged in stable condition.

Discussion

Leiomyoma is one of the most common benign uterine tumors with variable clinical presentation, and the management depends on the site, size, number, and symptomatology. However, leiomyosarcomas are rare uterine tumors with limited clinical experience. Cellular leiomyomas account for less than 5 % of leiomyomas. The distinction between leiomyosarcoma and highly cellular leiomyomamay pose a diagnostic challenge to the pathologists as both these tumors have considerable overlapping features on histology. Cellular leiomyoma can exhibit dense cellularity, prominent vascularity, and irregular margins and leiomyosarcoma and stromal sarcoma can have smooth musclelike differentiation. The difficulty in differentiating both the conditions is more pronounced in endometrial curetting or myomectomy specimens, as the relation to the surrounding endometrium or myometrium, or both, is lost.

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A panel of CD10, caldesmon, and desmin will help in distinguishing cellular leiomyoma from endometrial stromal tumours.Treatment options for patients with CM depends on age, desire to bear children and histopathology. Hysterectomy can be considered in patients who completed family and uterus preserving myomectomy can be offered to patients who desire fertility. Oophorectomy has no role in clinical improvement or prognosis outcome. Six monthly follow up is recommended in patients post surgery.

Conclusion

The importance of adequate interpretation of images before surgery to identify possible features that can guide a malignant diagnosis of leiomyosarcoma or, in better circumstances, an associate condition like adenomyosis is noteworthy. Also, it is relevant to consider the presence of histological variations of leiomyoma, like high cellularity, that could make the surgical approach more difficult during the excision in patients with fertility wishes. Clinicians and pathologists should be aware of the overlapping histological features between Endometrial stromal sarcoma and cellular leiomyoma both the conditions differ in clinical behaviour and treatment. IHC staining should be considered in all cases to resolve the diagnostic dilemma.

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Understanding Burch Colposuspension- Regaining Bladder Control

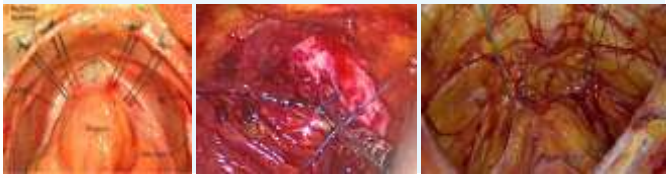
Burch colposuspension is a well-established surgical intervention for SUI particularly in patients with urethral hypermobility. Originally described by John Burch in 1961, this procedure involves suspending the anterior vaginal wall to Cooper's ligament to reinforce urethral support and restore continence. Despite the advent of mid-urethral slings (MUS), Burch colposuspension remains a valuable option, particularly for patients who prefer an autologous approach or have contraindications to synthetic mesh.

Case Report

- 65 years, P2L2, previous 2 NVD, hypertensive, k/c/o bronchial asthma, menopausal for 15 years came to OPD with chief complaints of involuntary passage of urine while laughing,coughing, blowing nose for the past two years requiring pads and affecting the quality of her life, not responding to conservative management and associated with postmenopausal spotting for the past six months. TVS- WNL, PVRU volume was 100 ml, PAP'S smear- NILM.
- On clinical examination- POP Q assessment showed no descent, Urine stress test - Involuntary dribbling of urine seen upon coughing in both supine and upright positions, Boney's test– Positive, Oxford scale of pelvic muscle power- 3/5, Q TIP test positive.
- After proper counselling, patient was planned for Total laparoscopic hysterectomy with Bilateral salpingo-oophorectomy with Burch colposuspension.

Post TLH, Retzius spacewas dissected to expose pubic symphysis and Cooper's ligament. Bladder dissected away from the pubic bone, ensuring clear visualization of the urethrovesical junction.Permanent, non-absorbable sutures (e.g., polypropylene) placed bilaterally at the level of the urethrovesical junction and mid-urethra.

The sutures were then anchored to Cooper's ligament, providing elevation and support to the urethrovesical junction.Excessive tension is avoided to prevent voiding dysfunction and urinary retention.



Intra Operative Image Showing Sutures Being Anchored to Cooper Ligament

Indications

- Stress Urinary Incontinence (SUI) with Urethral Hypermobility:
- Failure of Conservative Management
- Concurrent Pelvic Organ Prolapse (POP) Repair

Efficacy And Long-term Outcomes - Success Rates: Continence rates of 70–90% at five years and durable benefits extending up to 10–20 years in select populations.Recurrence Rates: Long-term studies indicate that SUI recurrence may occur in up to 20–30% of cases, particularly in the presence of intrinsic sphincter deficiency (ISD).

Complications and Risks

- **Intraoperative Complications:Bladder Injury:** Occurs in approximately 5% of cases, requiring intraoperative repair.
- **Urethral or Vascular Injury:** Uncommon but necessitates careful surgical technique.
- **Postoperative Complications:** Voiding Dysfunction (5–10%): urinary retention requiring intermittent catheterization or prolonged catheter use.
- **De Novo Urgency and Urge Incontinence (10–20%):** Possibly due to altered bladder dynamics, managed with anticholinergic therapy if symptomatic.
  Pelvic Organ Prolapse (20–30%): Burch colposuspension alters vaginal axis and pelvic floor support, increasing the risk of cystocele or enterocele formation.

COMPARISON WITH MID-URETHRAL SLINGS (MUS)

Feature	Burch Colposuspension	Mid-Urethral Sling (MUS)
Material	Autologous (no mesh)	Synthetic (polypropylene mesh)
Approach	Open/laparoscopic	Minimally invasive (transobturator/retropubic)
Success Rates	70-90% (long-term)	80-95% (short-term)
Risk of Mesh Complications	None	2-10% (erosion, dyspareunia)
Risk of Voiding Dysfunction	5-10%	2-5%
POP Risk	Increased risk	Neutral effect

Conclusion

The procedure offers long-term efficacy, but patient selection is crucial to minimize complications such as voiding dysfunction and pelvic organ prolapse. The laparoscopic technique offers reduced morbidity, shorter hospitalization, and faster recovery while maintaining comparable efficacy.Given the excellent long term outcomes Laparoscopic Burch colposuspension should be considered as a first line management of genuine stress urinary incontinence.

Heterotopic Pregnancy with Left Cornual Ectopic Rupture : A Case Report

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Introduction

Heterotopic pregnancy is a combination of intra and extrauterine pregnancy and incidence has increased sharply to 1 in 100 pregnancies with ART. A cornual pregnancy is implantation and development of gestational sac in one of the upper and lateral portions of uterus. Cornual pregnancy is rare, accounting for around 2% of ectopic pregnancies. This condition carries a significant maternal morbidity and mortality due to the risk of rupture of ectopic pregnancy and proximity of major blood vessels. Rupture usually occurs after 8 weeks gestation, however early rupture can still occur. Timely diagnosis and appropriate intervention is lifesaving.

Case Report

A 36-year-old pregnant woman (G2 A1) FET conception with a past history of laparoscopic myomectomy, asymptomatic in the present pregnancy was admitted with a diagnosis of unruptured left cornual ectopic pregnancy and an intrauterine gestation sac of 5 weeks. pregnancy. Ultrasound examination showed an intrauterine gestational sac corresponding to 5 weeks without cardiac activity and a gestational sac in left cornu of uterus corresponding to 6 weeks with cardiac activity. There was no free fluid in pelvis. She was posted for elective Laparoscopic cornual resection of pregnancy. However she developed severe pain in abdomen after admission and was taken for emergency laparoscopy. There was moderate hemoperitoneum in the pelvis and peritoneal cavity. Left cornual ectopic pregnancy rupture was seen .Both fallopian tubes were normal. She underwent left cornual ectopic resection and repair of uterus in 2 layers and Suction Evacuation was done for intrauterine pregnancy. She received total of 4 pints of PRBC and 4 pints of FFP. She recovered well in post-operative period. β-hCG levels were monitored weekly and was negative in 3 weeks.

Discussion

Early diagnosis is challenging as most patients are asymptomatic until complications from extrauterine pregnancy arises. This is often a late diagnosis, with associated with significant morbidity and mortality. The reason for late diagnosis is multifactorial - patients normally present with non-specific abdominal pain, imaging with ultrasound can either fail to detect heterotopic pregnancy or be misinterpreted due to presence of an intrauterine pregnancy, and the index of suspicion from the clinician is often low. Risk factors for Heterotopic pregnancy are ART, pelvic inflammatory disease, pelvic surgery, and previous damage or pathology to fallopian tube.

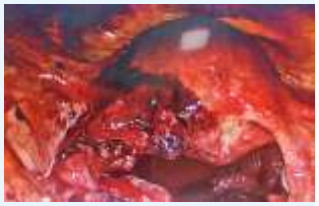
Our patient was FET conception and had ahistory of laparoscopic myomectomy. Symptoms of Heterotopic pregnancy are nonspecific. Heterotopic Pregnancy can be asymptomatic in 24% of cases or may present as abdominal pain (the most frequent symptom), vaginal bleeding and hypovolemic shock. Vaginal bleeding and hypovolemic shock often indicate the rupture of the Ectopic. Ultrasound remains the main imaging modality in ectopic and Heterotopic pregnancies.

There are several options for the treatment of heterotopic cornual pregnancy- surgical, medical or expectant treatment. If a patient diagnosed with heterotopic cornual pregnancy and is hemodynamically stable, nonsurgical treatment may be suggested. Systemic or direct injection of potassium chloride (Kcl), hypertonic solution, and methotrexate into the ectopic gestational sac if the intrauterine pregnancy is non-viable.

The patient can be treated surgically by cornual resection or hysterectomy either by laparotomy or laparoscopy. Surgical management is the definitive removal of the cornual ectopic mass either by laparoscopy or laparotomy. Laparoscopy is considered to be the gold standard for treatment in ectopic pregnancy. Even in women with significant hemoperitoneum, laparoscopic surgery can be safely conducted by experienced laparoscopic surgeons if hemodynamic stability is achieved by perioperative management. The advantages of laparoscopic management over exploratory laparotomy are the shorter hospital stay, fewer surgical wounds, and reduced use of antibiotics and analgesics. However, surgical resection of the uterine cornu also can lead to subsequent uterine rupture during future pregnancy.

Conclusion

Cornual ectopic pregnancies continue to be a challenge in terms of diagnosis and management. Early clinical diagnosis supported with ultrasonography may potentially provide conservative management and ultimately reduce mortality. Because diagnosis is typically not made until a rupture has occurred, it is important to recognize common signs and symptoms in an emergency setting to guide clinicians toward an appropriate management plan. With the increase in ART procedure, clinicians need to look for ectopic positions of pregnancy even when an intrauterine gestational sac has been seen in scan.



The Mystery of Unseen: A Case Report on Rare Uterine Anomaly

DR. SHAH DRASHTI PANKAJ

MBBS, MS (OBG)

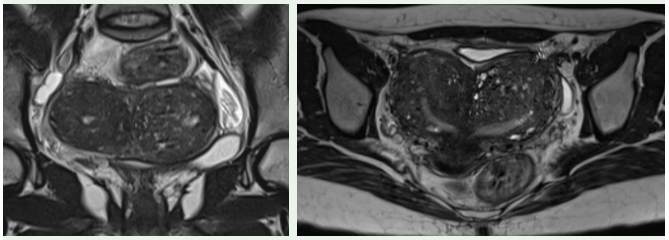
Fellow in Reproductive Medicine

Introduction

Müllerian duct anomalies represent a diverse spectrum of congenital malformations of the female reproductive tract, resulting from disruptions in the complex processes of embryological development, fusion, and resorption of the paramesonephric ducts. This comprehensive report explores the rare uterine anomaly known as combined bicornuate septate uterus, with septum extending upto the level of external os, examining its embryological basis, diagnostic criteria, clinical significance, and management modalities. While pure septate uteri account for approximately 90.2% of double-chambered uteri and pure bicornuate variants represent about 5%, hybrid forms constitute the remaining 4.8%, highlighting their relative rarity in clinical practice

Case Report

26 year old female presented with chief complaints of primary infertility and intermenstrual spotting. The diagnostic workflow typically begins with transvaginal ultrasonography, which can identify the presence of a divided uterine cavity but may not always distinguish between pure septate, pure bicornuate, or the hybrid variety. Three-dimensional ultrasonography has improved diagnostic accuracy by providing better visualization of both the external fundal contour and internal cavity shape. Magnetic resonance imaging (MRI) has emerged as a valuable non-invasive alternative to combined hysteroscopy-laparoscopy for complex cases, as it provides excellent soft tissue contrast and multiplanar imaging capabilities that can simultaneously demonstrate both internal and external uterine morphology. The differentiation between these varieties is clinically significant as it guides management decisions, particularly regarding the appropriateness of surgical intervention



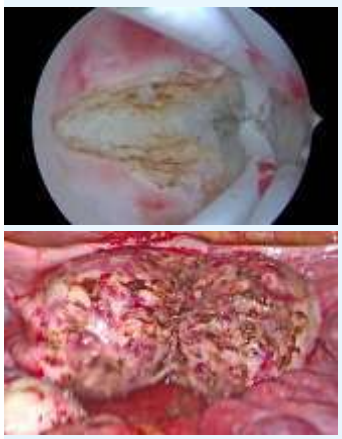
Diagnostic Challenges in Uterine Anomalies: Misdiagnosis of Bicornuate Septate Uterus as Uterus Didelphys on MRI, Highlighting the Limitations of MRI as the Investigation of Choice for Complex Uterine Malformations

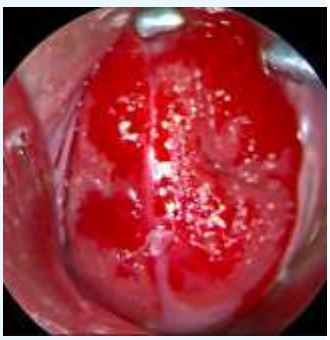
Management

The management of combined bicornuate septate uterus requires a tailored approach that accounts for both the bicornuate and septate components of the anomaly. The decision to intervene surgically depends on several factors, including the patient's reproductive history, fertility desires, symptomatology, and the specific anatomical features of the anomaly. Hysteroscopic septal resection represents the gold standard for addressing the septate component of the combined anomaly. In cases of combined bicornuate septate uterus, the procedure requires particular care due to the external fundal indentation, which increases the risk of uterine perforation. Research indicates a six-fold increase in perforation risk during hysteroscopic septal resection in hybrid septate varieties compared to pure septate uteri. Consequently, concurrent laparoscopic guidance is often recommended to enhance safety and improve outcomes.

Surgical Considerations

- After the diagnosis was confirmed decision for a septal resection was taken.
- 22 Fr resectscope along with saline bipolar cutting mechanism was used.
- It should be tried to keep the resectoscope in the centre equidistance from top and bottom so that to decrease risk of perforating walls of uterus.
- Short bursts of current should be given to avoid any collateral damage.
- It is advisable not to cut the entire length of septum in one go on one side , rather it is always a good idea to go from left to right and right to left in slow steps , so that one is able to to move back and a take a panaromic view to understand how to proceed further with resection - this will minimize the risk of complications.





STATISTICS

Oct 2024 to Feb 2025

	Total
TOTAL CASES	414
Laparoscopy	112
Hysteroscopy	101
Minor cases	83
Male cases	19
Obstetric cases	90
Others	9

	Total
HYSTEROSCOPY	101
Pre IVF	18
Diagnostic	20
Operative	63
SMF resection	5
Endometrial biopsy	28
Septal resection	7
Polypectomy	15
Lateral metroplasty	1
Tubal cannulation	5
RPOC removal	1
Scar ectopic resection	1

	Total
TOTAL CONCEPTION	102
Spontaneous conception	37
COH + Natural conception	5
IUI conception	16
IUI conception rate	10.12%

	Total
MALE CASES	19
TESA	12
NAB	
TESE	7

	Total
LAPAROSCOPY CASES	**112**
TLH	21
Myomectomy	28
Adenomyomectomy	5
Cystectomy	13
Salpingectomy	3
Salpingostomy	
para ovarian cystectomy	
Adnexectomy	
PCO puncturing	8
Recanalisation	
Abdominal circlage	
Sacrocolpopexy	
sterilisation	4
Surgery for endometriosis	6
ovarian detorsion	
Tubal delinking	
LAVH with PFR	1
TLH with bursch colposuspension	
Lap subtotal hysterectomy with pectopexy	1
Pectopexy	
Others	
VH with PFR	
Intrauterine PRP/GCSF instillation	5
ovarian PRP	1

	Total
MINOR CASES	83
Suction evacuation	23
Manual removal of placenta	
SSG	13
Cervical encirclage	10
Pipelle sampling	12
IUI under GA	1
Mirena insertion	8
Amniocentesis	7
Fetal reduction	3
Excision of scar endometriosis	2
Fractional curettage	3
Endometrial PRP instillation	
Bartholin cyst marsupilisation	

ART : IVF/ICSI STATISTICS	
Total no of cases	157
Total conception	51
Total conception rate	52%
Total conception in FET cycles	78
Conception rate after FET cycles	52.56%
Total conception in fresh cycle	20
Conception rate after fresh cycles	50%

	Total
OBSTETRIC CASES	90
FTND	25
LSCS	65
Elective LSCS	40
Emergency LSCS	26
Vaccum delivery	6

OUR TEAM MAIN SPECIALITIES

REPRODUCTIVE MEDICINE & LAPAROSCOPY
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Dr. Niranjana J MBBS, MD (OBG), DNB
Dr. Ashwin Jayakrishnan MBBS, MS (OB), DNB

IVF COORDINATOR
Dr. Anitha M MBBS

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Dr. Shibily Ruhman MBBS MD, Nnf fellow in Neonatology

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Dr. Vishnu N MBBS, MD

FELLOW IN REPRODUCTIVE MEDICINE
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Dr. Aadya Dixit MBBS, DNB
Dr. Asima Khan MBBS, DNB(OBG)
Dr. Shah Drashti Pankaj MBBS, MS (OBG)
Dr. Priyanka Naik MBBS, MS OBG, MRCOG, FMAS

COUNSELLING PSYCHOLOGIST
Dr. Selvaraj S MPHIL (PHY), PHD (PSY)

SONOLOGY
Dr. R N Ramesh MBBS, DMRD

FOETAL MEDICINE
Dr. Dhanya MBBS, MS (BG)
PDF (foetal Medicine)

FOETAL MEDICINE
Dr. Dhanya MBBS, MS (BG)
PDF (foetal Medicine)

EMBRYOLOGY
Dr. Jayaprakash D PHD
Mr. Abdul Salam
Mr. Sanalkumar

PATHOLOGY
Dr. Jayasree P V MD

UROLOGIST
Dr. Vinod K V MS, MCH (URO)

SURGEON
Dr. Subhash M S

DIETICIAN
Mrs. Remya P G
Diploma in Nutrition and Dietetics

PULMONOLOGY
Dr. Ann Mary Jacob MBBS, MD
DNB (PULMN)

VISITING CONSULTANTS (ALLIED SPECIALITIES)

GENERAL MEDICINE
Dr. Kalas N MBBS, DNB
Prof. of Medicine GMC, TYM

CARDIOLOGY
Dr. Anup Kumar S MBBS, MD, DM

ENDOCRINOLOGY
Dr. Mohan Shenoy MD, DM

ENT CONSULTANT
Dr. Lakshmi G MBBS, DLO, DNB