BATRA HOSPITAL & MEDICAL RESEARCH CENTRE
HEALTH & HAPPINESS FOR ALL

# निरामयम् NIRAMAYAM

NABH ACCREDITED

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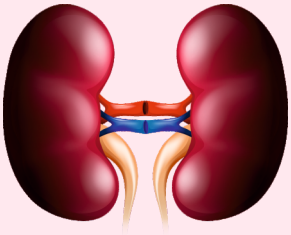
# KIDNEY DYSFUNCTION: WHAT WE NEED TO KNOW



Kidneys are two bean-shaped, small but vital organs that quietly perform life-saving functions, helping to remove waste and regulate fluid balance. They also regulate blood pressure, support the production of red blood cells, and maintain bone and mineral balance. When the kidneys are affected, toxins build up in the body, leading to various health complications.

Chronic Kidney (CKD) develops slowly over at least three months and is usually irreversible. As it progresses silently, many people do not realize they have it until it reaches an advanced stage. Awareness and simple urine & blood tests help in prevention and early treatment. Treatment focuses on retarding the progression of disease and decreasing symptoms. In advanced cases maintenance dialysis or kidney transplant may be required.

Acute kidney injury, on the other hand, is a short term condition. They can recover completely with proper diagnosis and timely care and will not progress to CKD. A careful history, examination and investigation are a must to diagnose.

**Case 1:** A 38-year-old man came with newly diagnosed high blood pressure, dizziness, and tiredness for 1 month. He did not have diabetes or other comorbidities. His B.P. was 160/98 mmHg, lower limb had mild edema and blood test showed high creatinine 2.5 mg/dl. He was being treated as CKD stage 3. However, repeat tests showed worsening kidney function creatinine (3.3 mg/dl) low hemoglobin, and low platelets. Urine analysis showed protein 1+, sugar nil, wbc-15-20/HPF, RBC 30-40/hpf.

In view of anemia, thrombocytopenia and azotemia, thrombotic microangiopathy was suspected. Investigations revealed LDH 700U/L (raised), low haptoglobin <10 mg/dl, PBS Schistocytes 2%, Retic count 3.5%, DCT negative, coagulation profile normal, stool culture no E coli and shigella.

In Thrombotic microangiopathy tiny clots damage blood vessels and kidneys. It is seen in thrombotic thrombocytopenic purpura (TTP) or hemolytic uremic syndrome (HUS). TTP was excluded as ADAMTS13 level was normal and typical HUS was excluded as stool sample was negative for shigella and E coli. He had atypical HUS that responded to 8 plasma exchange treatment. After this his kidney function improved dramatically. His creatinine returned to near normal levels, blood counts normalized, and his blood pressure stabilized. This case highlights how correct diagnosis can reverse what initially appears to be chronic kidney disease.

**Case 2:** A 25-year-old lady with no prior illness developed severe weakness, nausea, vomiting, low blood pressure and poor oral intake for 4 days. Investigations showed azotemia, hyperkalemia, serum creatinine 5.6 mg/dl, blood urea 144 mg/dl, Na 135 meq/l, K 6meq/l. Hemogram, Liver function tests were normal. Urine analysis showed protein, sugar nil wbc 30-40/HPF RBC 6-10/HPF and calcium oxalate crystals. Common causes like infection, dehydration, or indigenous drug intake were ruled out. On detailed questioning, she mentioned undergoing a recent hair straightening treatment. Oxalate Nephropathy was suspected. Tests revealed high oxalate excretion 96mg/24 hour urine (normal is 10-50mg/24hr.). Many "formaldehydefree" keratin hair straightening products contain chemicals that can convert into oxalate in the body. She was treated with intravenous fluids, vitamins (thiamine pyridoxine), and four sessions of daily hemodiafiltration as oxalate is dialysable. Within a month, her kidney function returned to normal.

Batra Hospital and Medical Research Centre offers round-the-clock comprehensive nephrology services, including advanced hemodiafiltration and plasma exchange facilities, ensuring pro-mpt and effective treat-ment for both acute and chronic kidney conditions.

***Consult with our Experts***

**Dr. Sanjay Gupta**
*Senior Consultant, Nephrology, Dialysis and Renal Transplant, Batra Hospital*

**OPD Timing:**
Mon, Tues, & Thurs:
12:00 pm - 5:00 pm
Wed, Friday & Sat:
10:00 am - 5:00 pm

# GIANT VIRILIZING ADRENAL CORTICAL CARCINOMA IN A YOUNG ADULT - A CASE REPORT

A 29-year-old woman with amenorrhea for one and a half years was under treatment of a gynaecologist. During an ultrasound examination, a large mass measuring about 7 × 7 cm was incidentally detected in the right suprarenal (adrenal) region. The mass had mixed solid and cystic areas with internal vascularity and was compressing the inferior vena cava (IVC) without invasion. She was referred to our department for further management.

She had experienced unintentional weight loss of around 5 kg over three months. Apart from amenorrhea, she had no signs of androgen excess such as hirsutism or male-pattern baldness. There were no clinical features of Cushing's syndrome, and she was not hypertensive. She had no significant past medical or family history of malignancy.

On examination, vital parameters were normal. Abdominal examination was unremarkable, with no palpable mass or organomegaly. Routine blood investigations showed normal renal function and hematological parameters.

Hormonal evaluation revealed elevated DHEAS levels (642 µg/dL), raising suspicion of a functional adrenal virilizing tumor. However, 24-hour urinary and serum catecholamines were normal, excluding pheochromocytoma. Serum cortisol levels were within normal limits.

Contrast-enhanced computed tomography (CECT) of the abdomen demonstrated a large heterogeneous right suprarenal mass measuring 10 × 8 × 7.3 cm. The lesion displaced the liver and right kidney, with preserved fat planes suggesting no definite invasion. Attenuation values were 47 HU on non-contrast, 73 HU in the venous phase, and 67 HU in the delayed phase, with absolute washout of 23.1% and relative washout of 8.2%, indicating an indeterminate lesion.

PET-CT showed a metabolically active (SUV max 13.1) well-defined heterogeneous suprarenal mass with cystic areas and focal calcifications.

The patient underwent open right adrenalectomy through an extraperitoneal, extrapleural approach via the 11th rib bed.

Intraoperatively, the tumor was well encapsulated but adherent to the right kidney and IVC, requiring careful dissection. Postoperative recovery was uneventful, and the patient was discharged on postoperative day 3.

Histopathological examination confirmed adrenocortical carcinoma. There was no capsular, venous, sinusoidal, or lymphatic invasion, and the mitotic index was less than 5 per 50 high-power fields.

Adrenocortical carcinoma (ACC) is a rare tumor with an annual incidence of approximately 1–2 cases per million population. Many cases are functional, but tumors producing only male hormones (pure virilizing tumors) are uncommon in adults. They are more frequently reported in children, making this prese-ntation extremely rare.

Functional ACC may secrete cortisol, aldosterone, estrogens, or androgens, with mixed hormonal secretion more common than isolated production. In adults, isolated androgensecreting ACC presenting mainly with amenorrhea without overt virilization is rare and may delay diagnosis. ACC often shows rapid growth with potential for local invasion and metastasis, and early detection is difficult due to nonspecific symptoms and the deep retroperitoneal location of the adrenal glands.

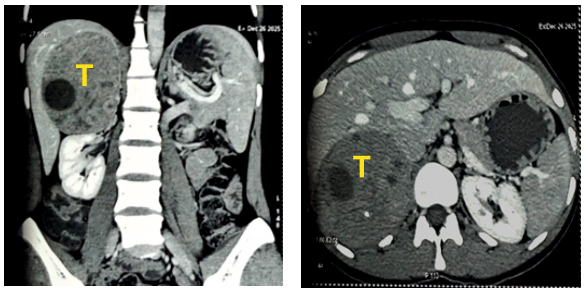



**Fig 1. Contrast-enhanced computed tomography (CECT) of the abdomen and coronal and axial view demonstrating a large right suprarenal heterogenous tumor (T) displacing liver and right kidney with maintained fat planes.**

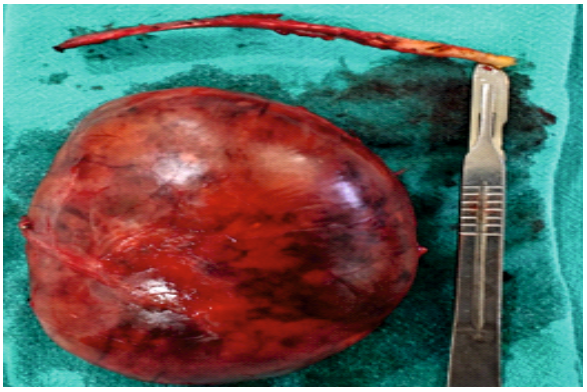


**Figure 2: Well-defined encapsulated resected specimen of the right adrenal tumor (T).**

CT and MRI are essential for evaluating tumor size, invasion, and resectability. While less than 2% of adrenal incidentalomas under 4 cm are malignant, the risk rises to about 25% in lesions larger than 6 cm. Prognosis depends on tumor stage, completeness of surgical resection, and histopathological features. Surgical excision is the mainstay of treatment, and long-term follow-up is necessary due to the risk of recurrence.

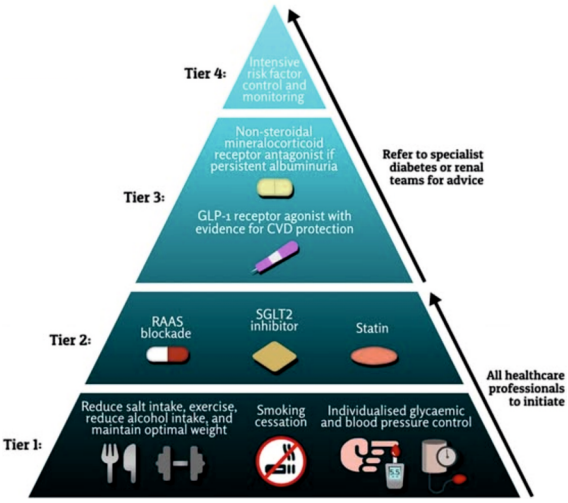
***Consult with our Experts***

**Dr. Manoj Talwar**

*Director, Urology, Batra Hospital*

**OPD Timing:**
Mon, Wed to Fri:
9.00 am - 5.00 pm

# DIABETIC NEPHROPATHY: THE SILENT KIDNEY COMPLICATION OF DIABETES




**Current management of chronic kidney disease in type-2 diabetes**

Diabetes is a metabolic disorder that is increasing at an alarming rate across the world. In our country too, the number of people living with diabetes is steadily rising. This increase is mainly due to genetic factors, unhealthy lifestyle, poor dietary habits, lack of exercise, obesity, and low awareness about preventive health practices. Stress, irregular sleep patterns, and increasing consumption of processed foods also contribute significantly to this growing problem. If diabetes is not well controlled, it can lead to several serious complications affecting the coronary artery, nerve (Diabetic Neuropathy), eye (Diabetic Retinopathy) and kidneys (Diabetic Nephropathy) (DN).

One of the most common and serious complications is diabetic nephropathy (DN), also known as diabetic kidney disease. It will affect nearly 30–50% of patients with type 2 Diabetes. In the early stages, DN usually does not cause noticeable symptoms, which makes it dangerous. Some patients may observe frothy or foamy urine. This happens because protein starts leaking into the urine, which is one of the earliest signs of kidney damage. Others may develop swelling in both feet, especially towards the end of the day, with swelling reducing by morning. These symptoms are often mild and ignored, leading to delayed diagnosis.

Early detection of diabetic nephropathy is very important. Simple tests such as urine examination for microalbumin and routine urine tests can detect early protein loss. Blood tests measuring serum urea and creatinine help assess kidney function. Doctors may also estimate the glomerular filtration rate (GFR) to understand how well the kidneys are working. Identifying the condition early provides a valuable opportunity to start treatment and slow down the progression of kidney damage.

The main goals in managing diabetic kidney disease are strict blood sugar control and maintaining target blood pressure levels. Lifestyle modifications play a major role. Regular physical activity, a balanced and healthy diet low in salt and processed foods, smoking cessation, and weight reduction are essential steps in preventing further kidney damage. Limiting excessive painkiller use and staying well hydrated are also helpful measures.

Several medications are available to help delay the progression of diabetic nephropathy. ACE inhibitors (like enalapril, lisinopril, and ramipril) and ARBs (like losartan, telmisartan, oimisartan and irbesartan) are commonly used drugs that block the renin-angiotensin aldosterone system (RAAS). This system regulates blood pressure and fluid balance. By blocking it, these medicines reduce pressure inside the kidneys and protect them from further damage.

SGLT2i and glucagon-like peptide-1 (GLP-1) receptor agonists, have proven effective in slowing kidney disease progression when combined with RAAS inhibitors. SGLT2i inhibits renal glucose absorption in the proximal tubule of kidney. This leads to increased excretion of glucose in the urine. SGLT2i inhibitors not only controls the sugar level, it also helps in protecting the kidney. Some of the SGLT2i available are dapagliflozin, canagliflozin, and empagliflozin.

Another important group of drugs is mineralocorticoid receptor antagonists (MRAs). Finerenone, a non-steroidal MRA, helps reduce inflammation and scarring in the kidneys and has shown promising results in slowing disease and is better than steroidal MRA. e.g. spironolactone, eplerenone. These newer therapies, when started at the right time and used regularly, can greatly reduce the risk of dialysis or kidney transplantation in the future.

In conclusion, diabetes and its complications are increasing rapidly. Diabetic nephropathy is common but often silent in the early stages. Awareness, regular screening, early medical consultation, healthy lifestyle changes, and appropriate medications can significantly slow disease progression and reduce the risk of serious kidney failure, thereby improving quality of life and long-term survival.

***Consult with our Experts***

**Dr. Sanjeev K. Behura**

*Senior Consultant, Nephrology, Batra Hospital*

**OPD Timing:**
Monday:
10:00 AM – 12:00 Noon
Tuesday:
10:00 AM – 12:00 Noon
Thursday:
10:00 AM – 12:00 Noon

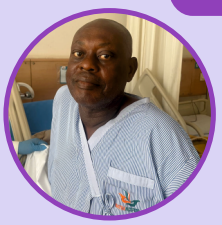
# CME & EVENTS

Batra Hospital & Deptt. of Cardiology organised an informative talk on "Healthy Life, Happy Life" on 31 January 2026 at the Hospital Auditorium, NER, Gorakhpur, Uttar Pradesh.

Batra Hospital organized a Multispeciality OPD Camp on 21 February 2026 at NER Hospital, Izzat Nagar, Bareilly, Uttar Pradesh.

Batra Hospital organised a Cardiology OPD Camp on 28 March 2026 at North Eastern Railway, Gonda, U.P.

## Our Patient Speak



### Walking Without Pain Again
### My Experience at Batra Hospital

I Adiwale Joseph Brown from Nigeria, had been suffering from severe and disabling knee pain that significantly affected my daily activities and overall quality of life.After a thorough evaluation by Dr. Lalji Kent, Senior Consultant – Orthopaedics, at Batra Hospital, I was advised to undergo Total Knee Replacement Surgery as the most effective and immediate solution for my condition.

I successfully underwent bilateral knee replacement surgery. Following the procedure, I experienced remarkable relief from the persistent pain and associated knee problems that had troubled me for years.

At Batra Hospital, Tughlakabad, New Delhi, I received expert care, precise surgery, and complete post-operative support for a smooth and speedy recovery.

**Happy Patient of Dr. Lalji Kent**

## Care That Fits Your Schedule — Because Your Health Can't Wait

# EXTENDED OPDs IN EVENING HOURS AT BATRA HOSPITAL

**Specialities Available:**

- Paediatrics
- General Medicine
- General Surgery
- Obstetrics & Gynaecology

**Special Offer**

**10% discount on drugs in hospital pharmacy**

9:00 AM – 7:00 PM (Mon. to Sat.)

Location: Block B

**To book an appointment Call +91 8595778376**

**BATRA HOSPITAL & MEDICAL RESEARCH CENTRE,** 1, Tughlakabad Institutional Area, M.B. Road, New Delhi-110062, Tel.: 91-11-29958747, 29902001, Website: www.batrahospitaldelhi.org

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