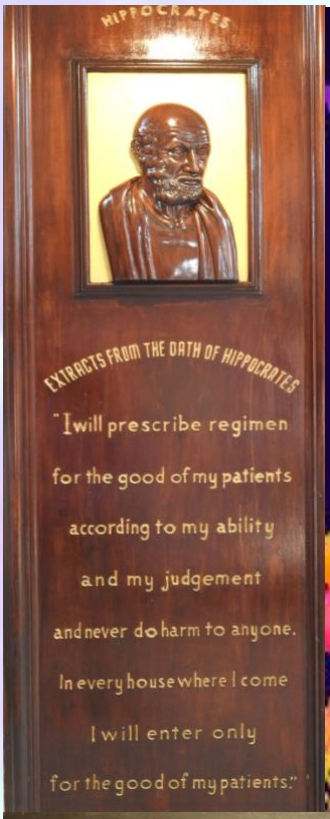
E SWASTHYA DARPAN

Jagjivanram Hospital Western Railway
Volume-I/Issue- II
OCT-DEC 2023



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Dr Dinesh Kumar Sahu

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ACHD(ANAESTH & PAIN MED)
JAGJIVANRAM HOSPITAL

From the editor's desk ……

At the outset I would like to thank Dr Hafeezunnisa, PCMD/WR & Dr Mamta Sharma, MD/JRH for giving me this responsibility to come-up with the e-magazines of our own JRH, a long awaited desire of the all who belongs to JRH, present and past.

I am glad to present you all with the SECOND EDITION of "JRH Swasthya Darpan" !

In the first issue we presented important information regarding Scope of services, availability of Doctors, OPD Days etc along with incredible stories of innovation and dedication in Patient care. This e -magazine also showcases literary and creative potential of our doctors and staff. The same will be continue in upcoming issues.

In this issue, we have highlighted the work and the facility available in the DEPARTMENT OF ORTHOPAEDICS AND JOINT REPLACEMENT.

Hope you will find the content helpful for availing services at JRH. In sub sequent issues we will will cover all the department one by one.

Will like to have your feedback !

I would like to thank my team of editors for their untiring efforts in bringing out the next edition of "JRH Swasthya Darpan".

Wishing you all a happy and healthy New Year !!!

(Dr Dinesh Kumar Sahu)

Mumbai.
JANUARY 2024.

OUR JOURNEY ……

The Western Railway was inaugurated on 5th November, 1951 by merging the Bombay, Baroda and Central Indian Railway (BB & CI) with the state railways of Saurashtra, Rajasthan and Jaipur. The medical facilities for the Railway employee and their family were provided by Railway dispensaries, Byculla Hospital and if necessary, Municipal Hospitals. This was obviously not sufficient and hence the birth of Jagjivan Ram Hospital.

The Jagjivan Ram Hospital was opened on 24th June 1960 by then Maharashtra Honourable Governor Shri Shriprakash as a modern referral centre, where the employees of the Western Railway and their families would receive the benefit of advanced medical care and advice. It caters to the needs of Railway employee, and families in Bombay (Mumbai) and in Mumbai Division.

It was built at a cost of Rs. 58.91 lakhs with basement plus 3 story. The hospital was built purely as a reference hospital and to start with, had bed strength of 150 beds. Over the years the hospital has grown into 5 story building with bed strength of 340. This institution has added renewed skills to its diagnostic and therapeutic techniques and maintained its purpose of providing modern and advanced health facilities. New Annex building with G + 7 story is completed and functioning from 2019.

Jagjivan Ram Hospital currently has bed strength of 361 with 32 ICU beds. The Hospital now has a reputation of one of the premium institutes of Indian Railways providing all basic specialties services with super specialties in Cardiology, Cardio vascular thoracic Surgery, Neurosurgery, Joint Replacement Surgery, Gastro-intestinal Surgery, Gastroenterology Medicine, Cardiology and Cardiothoracic Vascular Surgery, Urology, Renal dialysis Neurosurgery, Onco-surgery, Advanced Pain Clinic & Corneal Transplantation etc. It is equipped with best gadgets available to provide best of the medical services to railway beneficiaries,

JRH caters not only to patients from Western Railway but patients from all over Indian Railways are referred to JRH for treatment in various specialties. Annually around 2,55,000 patients are given treatment in OPD and 15,000 patients are managed in Indoor wards. Around 5 lakh diagnostic and 8,000 surgical procedures are carried out in an year in JRH.

The Hospital is recognized by National Board of Examinations in Medical Sciences, New Delhi (NBEMS) for imparting Post Graduate and Post-Doctoral Training Courses. It is also recognized by the various Teaching Institutes for Internship/training of courses like MBBS, Nursing, Lab technician, X- Ray Technician, Hospital management (TISS).

Hospital organizes Annual Conference every year and CMEs, Guest Lectures, Training programmes and Poster Exhibitions through the year for the benefit of Doctors, Staff and Patients round the year.

MEDICAL OFFICERS

S No	Name	Design	Grade	Department	CUG
1	Dr Mamta Sharma	**MD**	NFHAG	Admin & OBGY	9004490520
2	Dr Ashok Kumar	CSS	NFHAG	Admin &Obgy	9004490550
3	Dr B Nataraj	ACHD	NFHAG	Orthopaedics	9004490570
4	Dr Uma Nataraj	ACHD	SAG	ENT	9004490545
5	Dr Sushama Rahate	ACHD	SAG	Ophthalmology	9004490541
6	Dr Poonam Sharma	ACHD	SAG	Public Health	9004499512
7	Dr C P Khatawkar	ACHD	SAG	Admin	9004490556
8	Dr Pradeep Ranabijuli	ACHD	SAG	Paediatrics	9004490565
9	Dr Dinesh Kumar Sahu	ACHD	SAG	Anaesthesiology	9004490532
10	Dr Ajit Kumar Mehta	ACHD	SAG	Orthopaedics	9004490571
11	Dr Savita Gangurde	ACHD	SAG	Medicine	9004499513
12	Dr Arun Kumar	ACHD	SAG	Dentistry	9004490535
13	Dr Ashok Kr Sharma	ACHD	SAG	Surgery	9004490580
14	Dr Shishir Kumar Roul	ACHD	SAG	Cardiology	9004490572
15	Dr Yoganand Patil	Sr DMO	SG	Pathology	9004490576
16	Dr Indu Pandey	Sr DMO	SG	Ophthalmology	9004490587
17	Dr Ajay Khobragade	Sr DMO	SG	Medicine	9004449710
18	Dr Anuja Kulkarni	Sr DMO	SG	ENT	9004490563
19	Dr Prashant Rishi	Sr DMO	JAG	Surgery	9176456479
20	Dr Kishor Jain	Sr DMO	JAG	GI Surg	9004490588
21	Dr Avinash Akre	Sr DMO	JAG	Cardiology	9004490534
22	Dr Shramishtha	Sr DMO	JAG	Radiology	9004490551
23	Dr Alpa Sonawane	Sr DMO	JAG	Anaesthesiology	9004449712
24	Dr Yogesh	Sr DMO	JAG	Neurosurgery	9004355624
25	Dr Ajay Pandey	Sr DMO	JAG	CVTS	9004490529
26	Dr Harshvardhan	Sr DMO	JAG	Medicine	9821600427
27	Dr Preeti Gupta	Sr DMO	JAG	Medicine	9004473993
28	Dr Trupti Pisal	Sr DMO	JAG	Medicine	9004449711
29	Dr Mrunal	DMO	SS	Pathology	9004490521
30	Dr Rohini Kashide	DMO	SS	ENT	9004490547
31	Dr Swati Meena	DMO	SS	OBGY	9004499505
32	Dr Sunayna	ADMO	SS	Radiology	9989498268
33	Dr Robin Athota	ADMO	JS	Surgery	9004490586
34	Dr Anil Tambe	ADMO	JS	Gastroenterology	9004490561
35	Dr Saurabh Bhangale	ADMO	JS	Obst & Gyn	9004490533
36	Dr Anukool Deshpande	ADMO	JS	Ophthalmology	9004490540
37	Dr Sireesha	ADMO	JS	Medicine	9004490575
38	Dr Suvendu Panda	ADMO	JS	Anaesthesiology	9004499567
39	Dr Nazparveen	ADMO	JS	Paediatrics	9004471360
40	Dr Chandini Robinson	ADMO	JS	Anaesthesiology	9004490530
41	Dr Ravi Teja	ADMO	JS	Dermatology	9177980895
42	Dr Kareena Xavier	ADMO	JS	PSYCHIATRY	9048397571
43	Dr Maten Shaikh	CMP/FT	7th tm	Family Medicine	9833350335

OPD SCHEDULE

OPD Timing: 9am – 3.30pm
Saturday all OPD: 9am-1 pm
Emergency Room time: 1pm – 9am

Clinic Name	Doctor name	DAYS	TIME	PLACE
Obst & Gyn	**Dr Mamta Sharma**	Mon, Thurs	9am to 3.30 pm	OPD 1
Obst & Gyn	Dr Ashok Kumar	Mon, Thurs	9am to 3.30 pm	OPD 1
Obst & Gyn	Dr Swati Meena	Mon, Thurs	9am to 3.30 pm	OPD 1
Obst & Gyn	Dr Saurabh Bhangale	Mon, Thurs	9am to 3.30 pm	OPD 1
ANC CLINIC	Dr Mamta, Dr Ashok, Dr Swati, Dr Saurabh	Wed, Sat	9am to 3.30 pm	OPD 1
Radiology	**Dr Sharmishtha**	Mon, Tue, Wed, Thurs, Fri, Sat	9am to 3.30 pm	Ground Floor
Psychiatry	**Dr Kareena Xavier**	Mon, Tue, Wed, Thurs, Fri, Sat	9.00 am to 3.30 pm	OPD 32
Psychiatry	Dr Malay Dave	Wed/Fri	9.00 am to 12.00pm	OPD 32
Medicine	Dr Trupti Pisal	Mon/2nd Sat	9.00 am to 3.30 pm	OPD 2
Medicine	Dr Preeti Gupta	Tues/3rd Sat	9.00 am to 3.30 pm	OPD 2
Medicine	**Dr Savita Gangurde**	Wed/5th Sat	9.00 am to 3.30 pm	OPD 2
Medicine	Dr Sireesha Chilveri	Thurs/4 Th Sat	9.00 am to 3.30 pm	OPD 2
Medicine	Dr Ajay Khobragade	Fri/1st Sat	9.00 am to 3.30 pm	OPD 2
Nephrology	Dr Savita Gangurde	Tues/Fri	11 am to 1 pm	AKD
HIV Clinic	Dr Preeti Gupta	Wed	11 am to 1 pm	AKD
Rheumatology	Dr. Sameer Rajadhyaksha	Tues (Strictly By Prior Appointment)	2pm to 4pm	OPD 2
Neurology	**Dr Harshvardhan Bhamare**	Mon/ Tue / Fri	11 am to 1 pm	OPD 40
Neurology	Dr Syed Zafer	Thurs(Ony by prior appointment)	2pm to 3.30 pm	OPD 40
Hematology	Dr Pritam Jain	Wed(strictly by prior appointment)	3pm to 4 pm	OPD 2
Chest OPD	Dr Sonam Solanki	Thurs (strictly by prior appointment)	11am to 1 pm	AKD
Gastroenterology	-	Mon/Thurs	11 am to 1 pm	OPD 7
Cardiology	**Dr Shishir Roul**	Tues, Thurs, Sat	9.30 am to 3.30 pm	2nd Floor OPD
Cardiology	Dr Avinash Arke	Mon, Wed, Fri	9.30 am to 3.30 pm	2nd Floor OPD
Paediatric Cardiology	Dr Avinash Arke	Wed	9.30 am to 3.30 pm	2nd Floor OPD
CVTS	Dr Ajay Pandey	Mon, Tue, Wed, Thurs, Fri	2.30 pm to 4.00 pm	2nd Floor OPD
Paediatrics	**Dr Pradeep Ranabijuli**	Mon, Tue, Wed, Thurs, Fri, Sat	9.00 am to 3.30pm	OPD 8

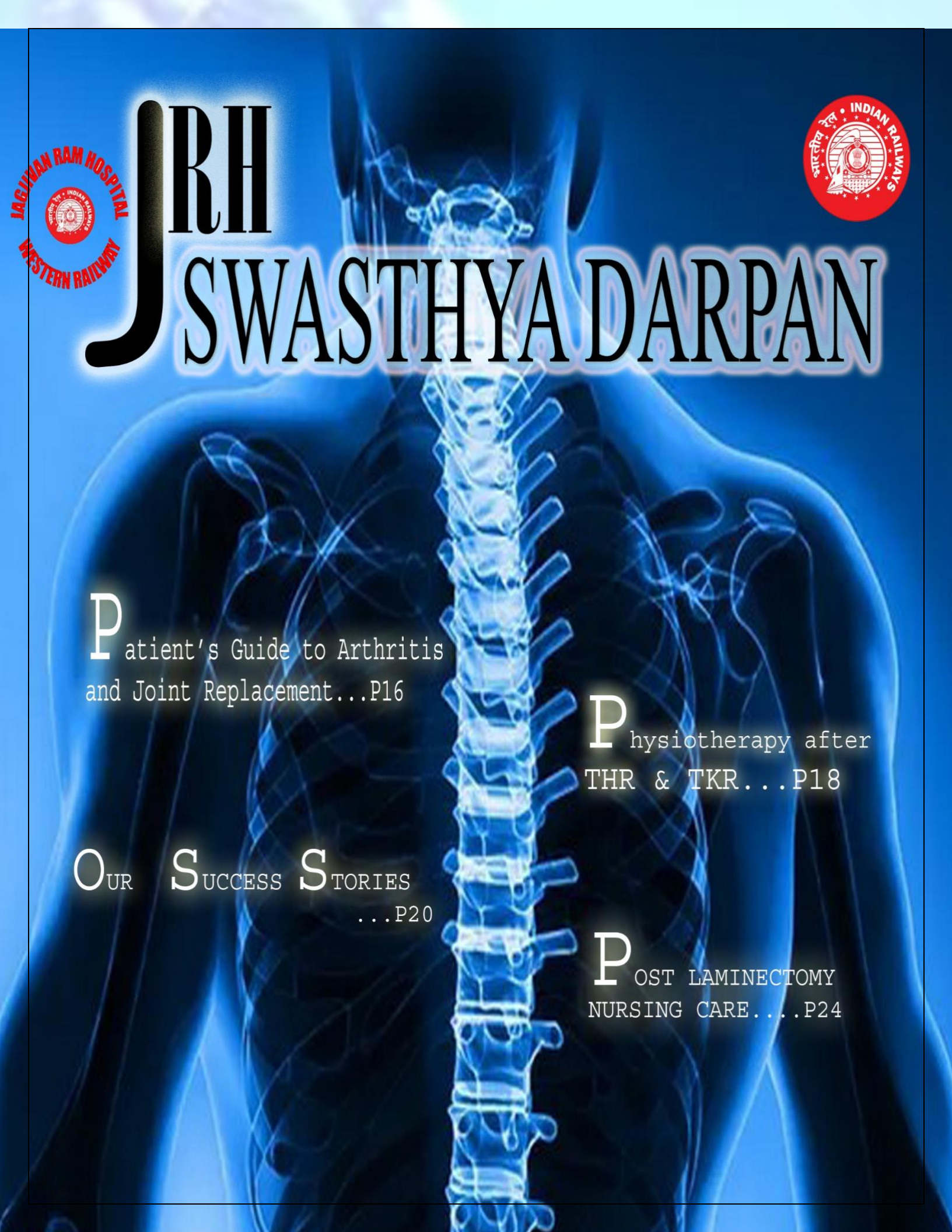
Paediatrics	Dr Naaz Parveen	Mon, Tue, Wed, Thurs, Fri, Sat	9.00 am to 3.30 pm	OPD 8
Immunization	Dr Pradeep Ranabijuli	Thurs	9.00 am to 3.30 pm	CASUALTY
Orthopaedics	**Dr B Nataraj**	Tue, Fri, Sat	9.00 am to 3.30 pm	OPD 7
Orthopaedics	Dr A K Mehta	Tue, Fri, Sat	9.00 am to 3.30 pm	OPD 7
Surgery	**Dr Ashok Sharma**	Mon/Tues 2nd and 4th Thurs Sat(1ST/3RD/5TH)	9.00 am to 3.30 pm	OPD 6
Surgery	Dr Robin Athota	Wed/Fri 1ST , 3RD,5TH Thurs Sat(2ND/4TH)	9.00 am to 3.30pm	OPD 6
Urology	**Dr Prashant Rishi**	Mon, Thurs, Sat	9.00 am to 3.30 pm	OPD 6
GI Surgery	**Dr Kishore Jain**	Tues/Wed/Fri	9.00 am to 3.30 pm	OPD 6
Neurosurgery	**Dr Yogesh Sawkare**	Mon/Thurs	2 pm to 4 pm	OPD 6
Spine Clinic	Dr Yogesh Sawkare	Wed	9 am to 1 pm	OPD 7
Ophthalmology	**Dr Sushama Rahate**	Mon, Wed, Fri	9.00 am to 3.30 pm	3rd Floor NEW bldg.
Ophthalmology	Dr Indu Pandey	Tues, Thurs, Sat	9.00 am to 3.30 pm	3rd Floor NEW bldg.
Ophthalmology	Dr Anukool Deshpande	Mon, Wed, Thurs, Sat	9.00 am to 3.30 pm	3rd Floor NEW bldg.
ENT	**Dr Uma Natraj**	Tue/Fri	9.00 am to 3.30 pm	OPD 5
ENT	Dr Anuja Kulkarni	Thurs/Sat	9.00 am to 3.30 pm	OPD 5
ENT	Dr Rohini Bhimrao Kashide	Mon/Wed	9.00 am to 3.30 pm	OPD 5
Pre Anaesthetic Checkup	**Dr Dinesh Kumar Sahu**	Mon, Tue, Wed, Thurs, Fri, Sat	11.00 am to 3.30pm	OT 1st Floor
Pre Anaesthetic Checkup	Dr Alpa Sonawane	Mon, Tue, Wed, Thurs, Fri, Sat	11.00 am to 3.30pm	OT 1st Floor
Pre Anaesthetic Checkup	Dr Chandini	Mon, Tue, Wed, Thurs, Fri, Sat	11.00 am to 3.30pm	OT 1st Floor
Pain Clinic	Dr Dinesh Kumar Sahu	Mon, Tue, Wed, Thurs, Fri	11.00 am to 3.30pm	OT 1st Floor
Dentistry	**Dr Arun Kumar**	Mon, Tue, Wed, Thurs, Fri, Sat	9.00 am to 3.30 pm	
Dermatology	**Dr Ravi Teja**	Mon, Tue, Wed, Thurs, Fri, Sat	9.00 am to 3.30pm	OPD 32
Dermatology	Dr Shwetha Jain	Fri(strictly by prior appointment only)	12.00 to 1 pm	OPD 32
Arurveda	Dr Kirti K Thakkar	Mon, Tue, Wed, Thurs, Fri, Sat	9.00 am to 3.30pm	5th Floor
Homeopathy	Dr Vinod Rakshe	Mon, Tue, Wed, Thurs, Fri, Sat	9.00 am to 3.30pm	5th Floor
Unani	Dr Allauddin Shaikh	Mon, Tue, Wed, Thurs, Fri, Sat	9.00 am to 3.30pm	5th Floor
Yoga	Dr Jancy Sekar	Mon, Tue, Wed, Thurs, Fri, Sat	9.00 am to 3.30 pm	5th Floor
Siddha	Dr Inbha Jothi	Mon, Tue, Wed, Thurs, Fri, Sat	9.00 am to 3.30 pm	5th Floor

Kind attention IRHS colleagues…….

1. Please use Helpdesk number for enquiry about availability of respective IRHS, OPD days etc before sending patient to JRH.
2. Before referring patient please consult and discuss case details with concerned IRHS.
3. Please correct baseline parameters before sending patients for elective surgery so that PAC fitness can be obtained and surgery planned at earliest.
4. Please counsel patients that they may have to stay in Mumbai for few days to complete their evaluation.
5. Due to limited availability of attender accommodation only 1-2 relatives should accompany patient.
6. ***Please advise patients to approach Helpdesk in case of any difficulty in JRH. If Problem persists they may approach ANO/JRH.***

Contact Us

HELP DESK JRH				
Name	**Rly Ph**	**P&T**	**CUG**	**Time**
HELP DESK	**43333**	**022 67643333**	**9004448519**	**24 x7**
RECEPTION				
Name	**Rly Ph**	**P&T**	**CUG**	**Time**
Mrs Sunita	43224	23017860		9am – 5 pm
EMERGENCY ROOM				
Name	**Rly Ph**	**P&T**	**CUG**	**Time**
Casualty Sister I/c	43301, 43291	23017876	9004499566	7 am – 3 pm
Casualty Dresser	**43200,** 43291	23017877		24 x7
Casualty Doctor	43300	23080755		24 x7
AMBULANCE SERVICE				
Name	**Rly Ph**	**P&T**	**CUG**	**Time**
Ambulance Driver	43170	23017877		24 x 7
WELFARE INSPECTOR				
Name	**Rly Ph**	**P&T**	**CUG**	**Time**
Mr R D Mohite	43160	23017867	9004490528	10am – 5 pm
ESTABLISHMENT / RECRUITMENT SECTION				
Name	**Rly Ph**	**P&T**	**CUG**	**Time**
Chief Office Superintendent	43180	022 67643180	--	11am – 5 pm
PA TO MD				
Name	**Rly Ph**	**P&T**	**CUG**	**Time**
Mr Rahul Kumar	43100	022 67643252	8384090801	10am – 5 pm


JAGJIVAN RAM HOSPITAL
WESTERN RAILWAY
INDIAN RAILWAYS
JRH
SWASTHYA DARPAN
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Department of Orthopaedics and Joint Replacement Center

Department of Orthopaedics and Joint Replacement Center at JRH is the most advance center in the country. All types of complicated Orthopaedic cases are referred from western and other Zonal railway and treated with excellent results. Joint replacement center at JRH has earned the reputation at National and International level. Total Joint Replacement operations like Total Hip Replacement (THR), Total Knee Replacement (TKR), which are highly sophisticated and technically demanding operations are regularly performed since last 26 years. It has now established as center of excellence in the country and cases are referred from all over Indian railways and outside. This center is well equipped with most modern and highly sophisticated equipment required for even most complicated primary and revision Total Knee and Hip Replacement surgeries. This center has been recognized as learning center in the field of joint replacement surgeries for surgeons from India and abroad.

State-of-the-art Orthopaedic and Joint Replacement operation theatre complex of international standard was developed in the year 2002 is in regular use which is first of its kind in the country. The work done and the facility have been appreciated by surgeons from India and abroad.

BED STRENGTH IN THE DEPT.

Total No. Beds - 38 (Male - 20 Female – 16)
ICU - 02

MANPOWER IN THE DEPARTMENT

IRMS: Dr B Nataraj (ACHD),
Dr A K Mehta (ACHD),

Honorary Visiting Specialist (HVS): One (1)

Visiting Specialist (Case to case basis): Seven (7)

CMP Ortho: One (1)

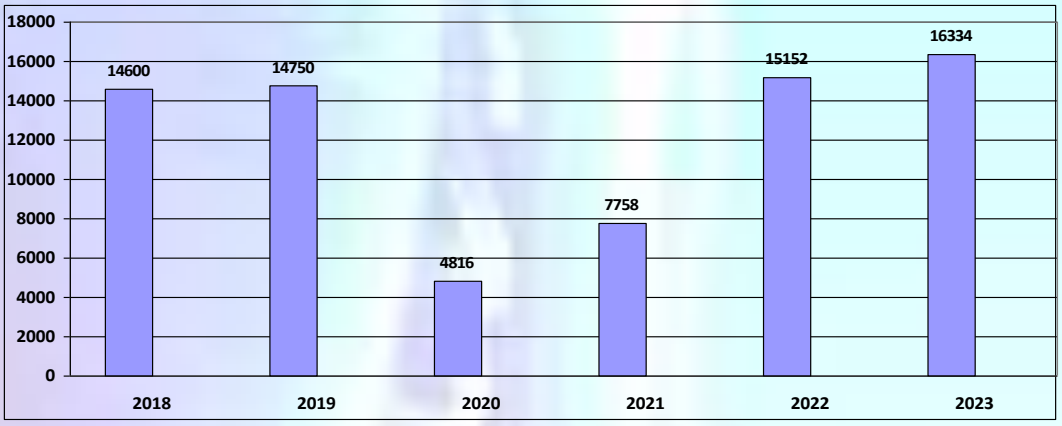
Resident Doctors (CPS Diploma): Two (2)

SERVICES OFFERED BY THE DEPARTMENT

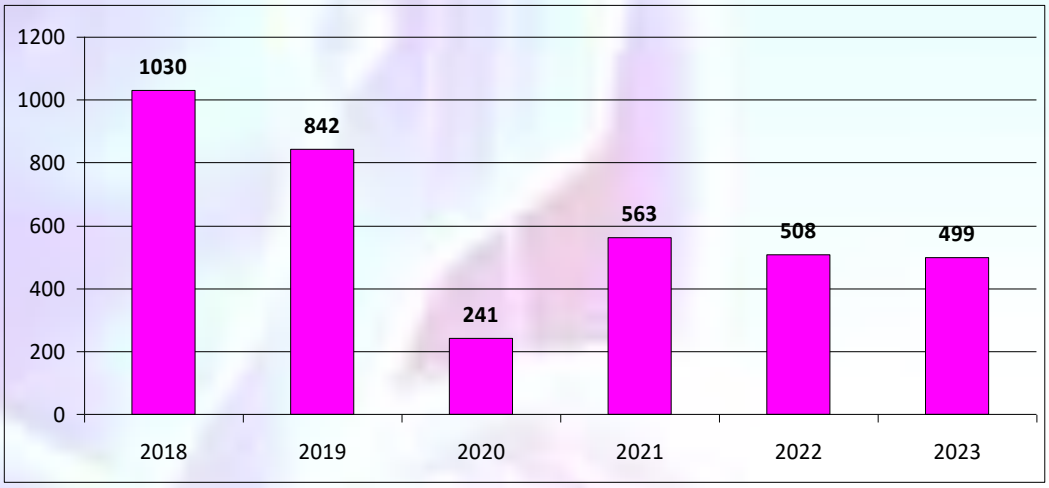
Approximate 4600 total knee and hip replacements have been performed till date with excellent results. It has **saved approximate. Rs. 76 crores of railway revenue** as compared to if these cases are referred outside. Other advance procedures like management of various kinds of fractures and complicated trauma cases are treated by modern AO techniques, Arthroscopic surgeries, High Tibial Osteotomy by Hemicallotasis, Illizarov's technique, Limb reconstruction surgeries by LRS and other surgeries are performed regularly.

WORKLOAD OF THE PAST 5 YEARS IN GRAPH PATTERN

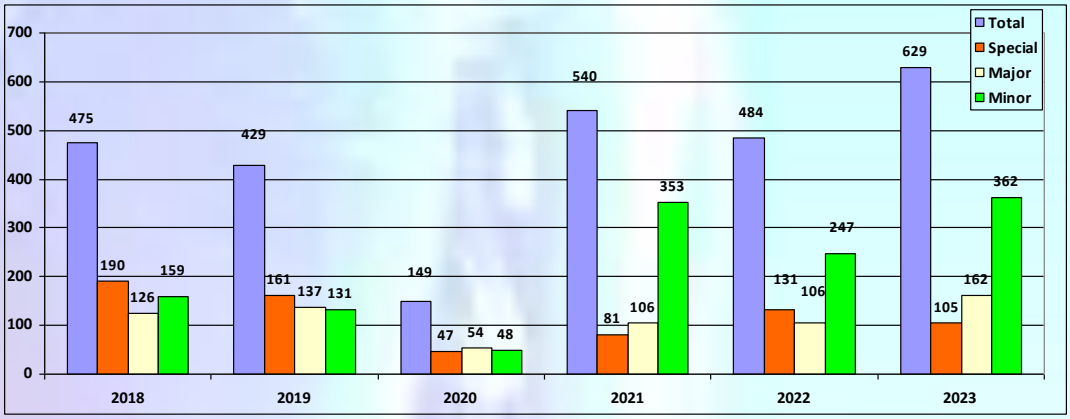
Orthopaedic OPD



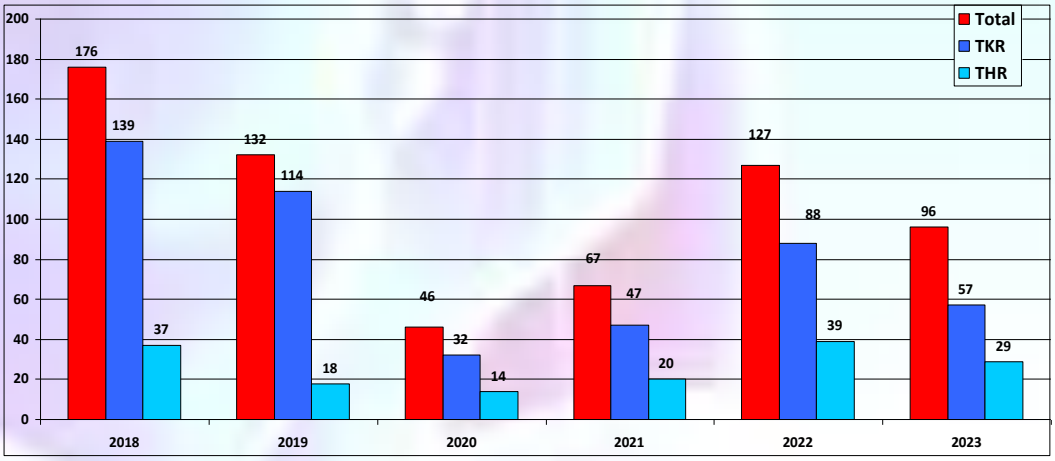
Indoor Admissions



Ortho Operations



Total Knee and Hip Replacement



SCHEDULE OF OPERATING MANUAL FOR WORKING IN DEPT. OF ORTHOPAEDICS

OUT PATIENT DEPARTMENT

OPD is conducted three days a week on Tuesday, Friday and Saturday. All old & new cases are seen. Approx. 130 to 190 cases are seen on each OPD day.

INDOOR FACILITIES

Indoor cases are seen every day. Detailed round is taken on Tuesday, Wednesday, Thursday, Friday and Saturday.

OPERATION THEATRE WORKING

Two OT are utilized 3 days a week Monday, Wednesday and Thursday. We have requested the administration to continue OT days on all the 5 days including Tuesday and Friday as was being done previously to avoid long waiting list.

TEACHING FACILITIES FOR PG STUDENTS

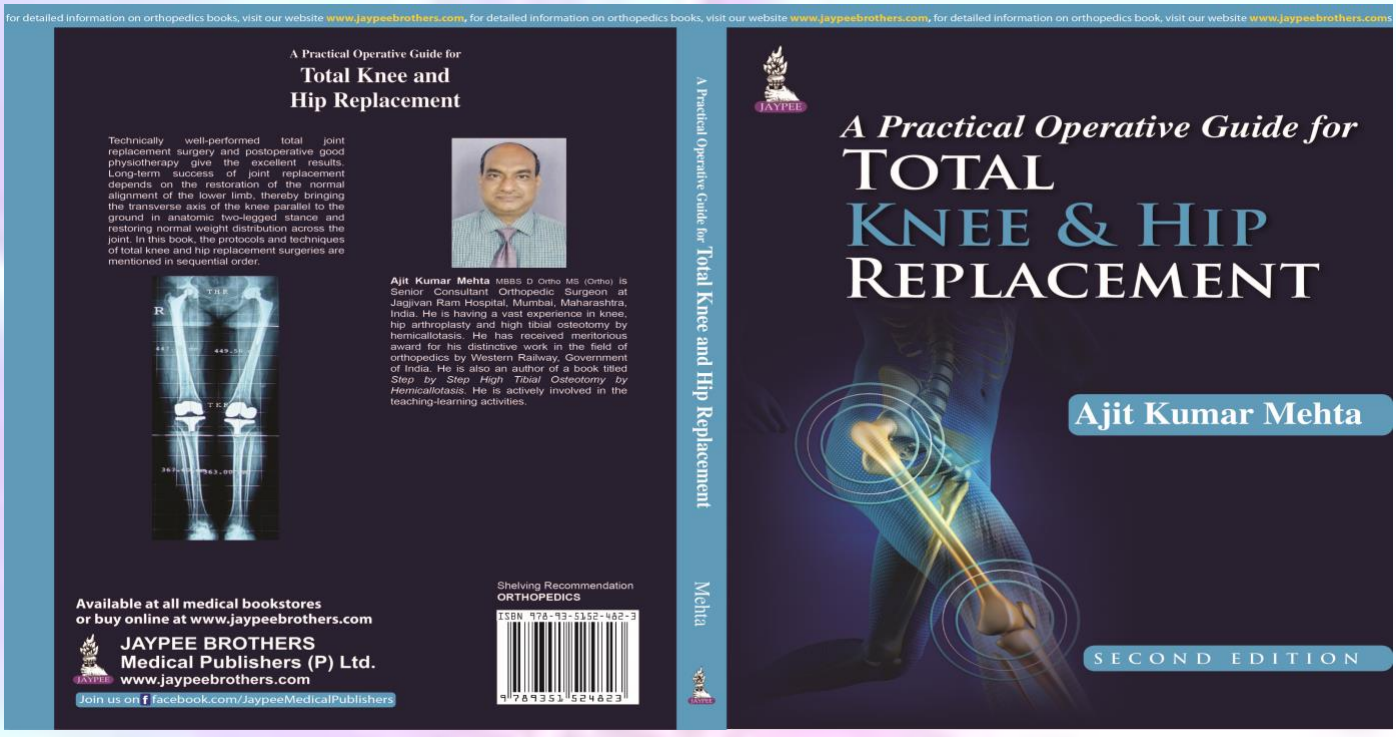
Dept. is recognized for PG – Diploma (D. Orth.) courses by college of physicians and surgeons (CPS) of Bombay and MCI (Medical council Of India). Regular teaching is done in OPD, indoor rounds, OT & special clinic and journal club once a week.

PATIENT EDUCATION PROGRAMME

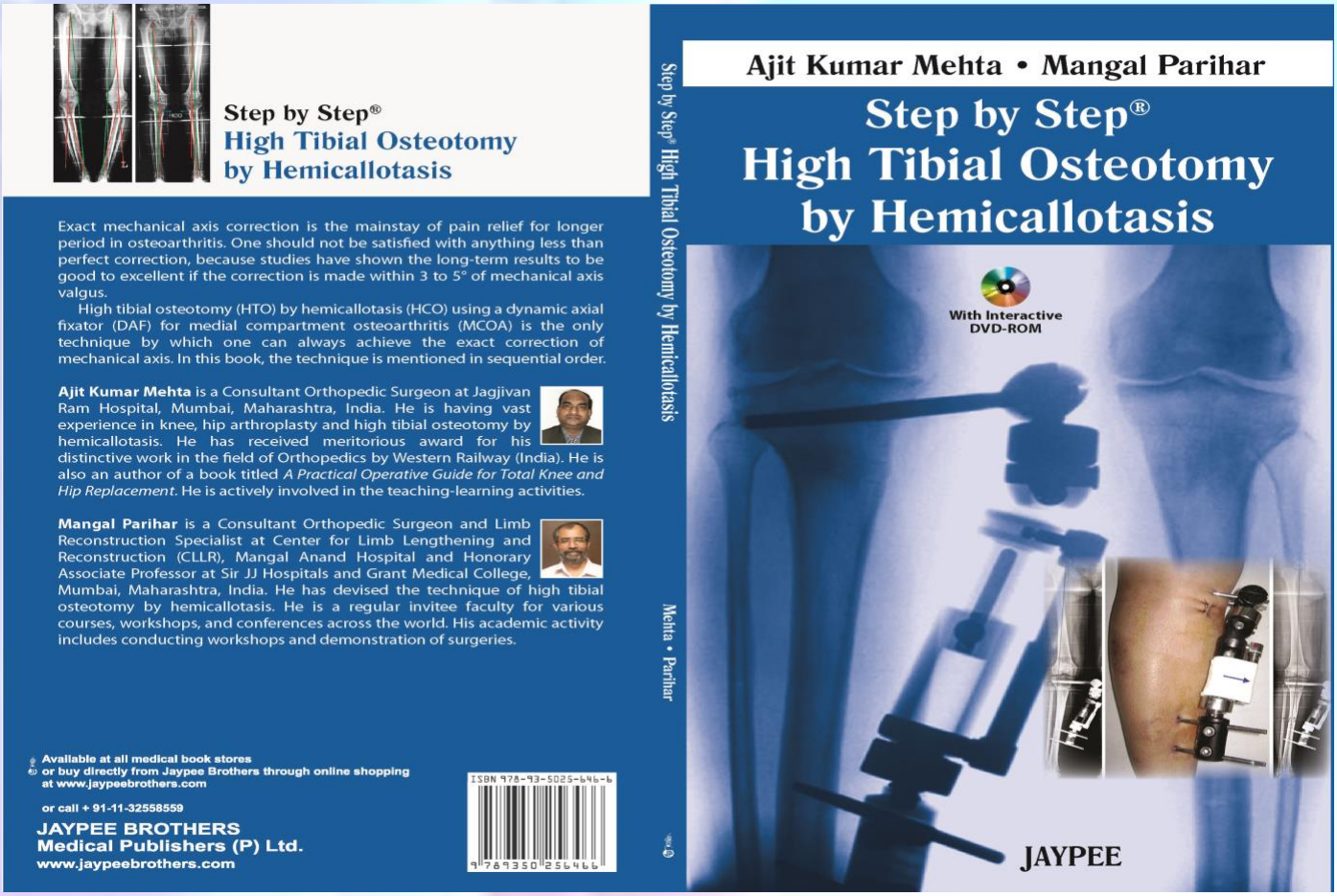
Education on various Orthopaedicconditions especially on arthritis and total joint replacement is given in the form of audio-visual and by education literature.

PUBLICATION OF ORTHOPAEDIC TEXTBOOKS FROM THE DEPARTMENT OF ORTHOPAEDICS

1. **A Practical Operative Guide for Total Knee and Hip Replacement (Second edition, 2015)** – Published by Jaypee Brothers Medical Publishers (P) Ltd., New Delhi, London, Philadelphia, Panama (ISBN: 978-93-5152-482-3). Authored by Dr. Ajit Kumar Mehta, ACHD (Ortho)/JRH/BCT/W. Rly.



2. **Step by Step High Tibial Osteotomy by Hemicallotasis (First edition, 2012)** - Published by Jaypee Brothers Medical publishers (P) Ltd., New Delhi, Panama City, London (ISBN: 978-93-5025-646-6). Authored by Dr. Ajit Kumar Mehta, ACHD (Ortho)/JRH/BCT/W. Rly.



AWARDS AND APPRECIATIONS – Dr. Ajit Kumar Mehta

1. Certificate of Merit by PCMD for Meritorious Service in 2007-2008.
2. National Award by Ministry of Railways for Outstanding Service in 2016.
3. Certificate of Appreciation for hard work by Medical Director in 2019 & 2020.
4. Certificate of Appreciation for writing TKR, THR and HTO books by PCMD in 2020.
5. Certificate of Commendation by DRM for exceptional and devoted services in 2020.

ACHIEVEMENTS -

Modern and sophisticated equipment and implants are procured regularly. High tech. equipment for fracture treatment, joint replacement surgery, arthroscopy, high tibial osteotomy, spinal surgeries, Illizarov's technique, limb reconstruction by LRS are available.

Modernization of Physiotherapy Dept. with latest physiotherapy equipment have been done.

REHABILITATION FACILITY

Physiotherapy is an integral part in the management of orthopaedic patients and other medical and surgical patients.Post-operative physiotherapy to patients undergone various orthopaedic operations, total hip and

total knee replacement surgeries and others is extremely important for faster and better recovery. At present, there is one physiotherapist with one vacant post and one occupational therapist who look after all the patients of JRH including of other departments. The dept. has well equipped and modern physiotherapy and occupational therapy units to provide faster rehabilitation for post-operative cases and various orthopaedic problems.

Physiotherapy department covers a broad spectrum of age from paediatric to geriatric population. It aims at functional rehabilitation of a person to its pre ailment or disease status through use of physical agents like heat or cold, or sound waves or electromagnetic radiations or electrical stimulation in order to relieve pain and maintain or improve musculoskeletal strength with help of graded exercise programme designed to suit individual needs.

DETAILS OF PHYSIOTHERAPY DEPARTMENT EQUIPMENTS

Name of Equipment	
Un weighing system	Continuous pulsed SWD
Upright ergometer	Lumbar Traction
Recumbent ergometer	Laser
3 section treatment table Two units	Lumbar Traction
Magnetic shoulder wheel	Paraffin wax bath
Wireless professional	Muscles stimulator with TENS (Two units)
CPM	Cervical Traction
SWD	Infrared lamp
Two Channel electrotherapy and Ultrasound Combo Unit	Ultrasound

Patient's Guide to Arthritis and Joint Replacement

INTRODUCTION

Arthritis is a painful disabling condition of joints which cripples millions of people around the world every year. In advanced stage it leads to severe disability and makes a person dependent on others even for his routine essential activities. This adversely affects the quality of life. But now, Total Joint Replacement offers relief from pain and improved quality of life.

Arthritis is the wearing away of smooth surface (cartilage) of a joint. This causes pain and swelling of the joint. In advanced stage the cartilage is completely worn out and bone ends rub together producing severe pain and disability.

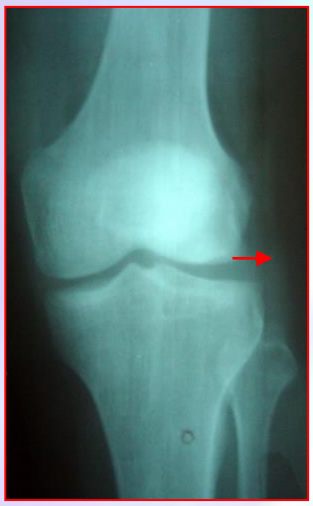


Fig. 1 Normal Knee

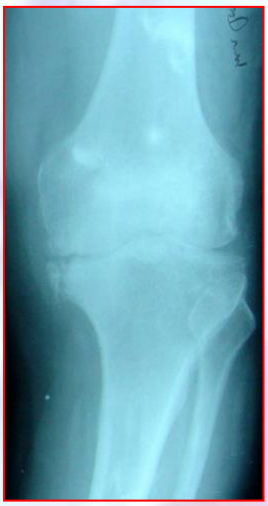


Fig. 2 Arthritic Knee

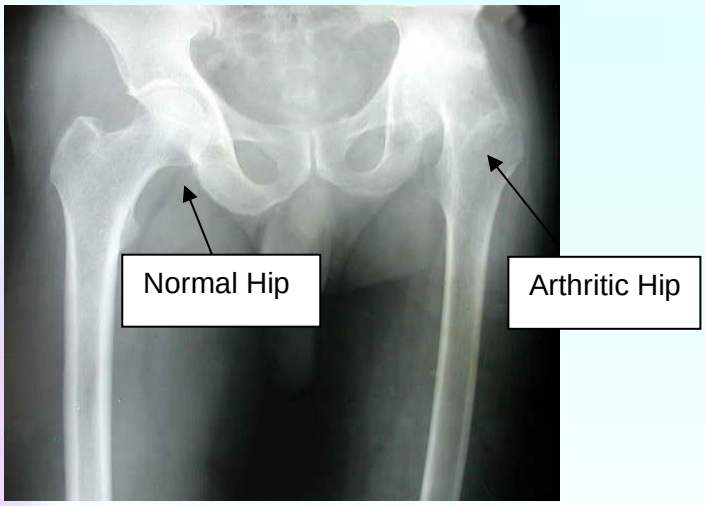


Fig. 3 Normal and Arthritic Hip

Arthritis can develop because of old age, previous injuries, fractures, infections and diseases like rheumatoid arthritis. There are over one hundred types of arthritis. Some common types are osteoarthritis, rheumatoid arthritis, ankylosing spondylitis and Gout. Most common type, also called degenerative, aging arthritis or osteoarthritis. It starts in middle age due to wear and tear of the joints. In the beginning there is mild pain but in advanced stage cartilage is completely worn out causing severe pain and disability. Rheumatoid arthritis is more crippling chronic condition affecting immune system of body. It can affect at any age and is more common in females. Ankylosing spondylitis affects the spine and joints which get inflamed and loose their flexibility and become stiff. Arthritis is probably due to a combination of many factors which include age, heredity, overweight, injury or overuse, occupation or lifestyle and infection.

Arthritis is diagnosed by Patient's symptoms (Pain, crackling sound in joints, difficulty in walking up and down stairs), Clinical examination, X-ray, Blood tests. Once the surface of joint is damaged it is not usually possible to prevent arthritis from progressing. However, most forms of arthritis can be controlled with appropriate treatment. In early stages medicines, physiotherapy, weight reduction, heat therapy, splints, use of walking stick can give relief in pain. In advanced stages where these methods are unable to give relief, patients need total joint replacement surgery. A person will need joint replacement when pain becomes chronic and constant, not getting relieved with medicines, pain does not allow walking even short distances, pain disturbs sleep and adversely affecting social, professional and personal life. The benefits of Joint Replacement are freedom from pain, easier movement and mobility, better quality of life through greater independence, ability to perform most of routine essential activities.

In total joint replacement surgery, the damaged bone ends and cartilage are replaced with artificial surfaces, which are designed like normal bone ends called artificial joints to restore normal functions and movements.

An artificial joint can last for 15-20 years. It is made up of specialized steel, titanium, cobalt, chromium alloy and plastic (high density polyethylene). The hip and knee joints are commonly affected and replaced. Hip is a ball and socket joint. The ball is removed and replaced with a metal ball fixed to the thighbone. The socket is cleaned and fitted with a plastic cup with bone cement or uncemented metallic cup with plastic, metal or ceramic liner. The damaged surfaces of knee bones are removed and replaced with metal surfaces and fixed to bone with bone cement and plastic inserted in between. The surface of knee cap is also replaced with plastic implant.Before surgery, patient has to undergo complete medical check-up, Blood tests, ECG etc. Patient has to learn specific exercises to speed up the recovery, loose excessive weight and stop smoking. Patients having medical problems like Diabetes, hypertension can also undergo total jointreplacement under medical supervision.

Surgery is usually performed under spinal or epidural anaesthesia where only lower part of the body is anaesthetized. In some cases general anaesthesia is also given to make patient fully unconscious. Modern anaesthetic techniques are quiet safe. The average time taken for surgery is 2 hours. After total hip or total knee surgery patient is in bed for 2 days. On 1st day, regular active and passive exercises of the operated leg is started. On 3rd day, the drain is removed and the patient is made to stand and walk, initially with walker or crutches. After 4-6 weeks, the patient can walk independently without support and can climb steps up and down. Hospital stay is approximately 2 weeks.

Any major operation involves certain risks and complications. With advanced anaesthetic and surgical techniques these risks and complications are very low. Patient however, should be aware of these. Infection is a serious complication. All precautions are taken to avoid the risk of infection. Despite all these care about 1% patients may have the risk of developing infection which can be treated with antibiotics. If no response, then removal of implant is required to clear out the infection. Another joint can be implanted later on. Thrombosis (blood clots) may occur in veins of legs in 8-10% of patients. Various techniques are used to prevent it. Death due to this is extremely rare less than 0.1%. Wear-out or loosening of implant can happen after 10-15 yrs. It depends on design, quality, material and load on the joint. When excessive wear occurs it needs revision. Limb length discrepancy (usually < 2.5 cm) may occur following Total Hip Replacement (THR) which is usually compensated at pelvis and spine in due course and rarely requires raising of the sole of shoe.

To have a successful joint replacement, choose a surgeon who has adequate training and experience in joint replacement surgery, operation theatre set up is of highest standard for joint replacement surgery, good quality of implant, meet and talk to several other patients who have been operated by the surgeon, follow the instructions given by the surgeon and understand the limitations. The instructions are use of western style toilet, walk with moderate speed, sit on high chair – approximately 20 inches height, regular quadriceps exercises, control of weight, watch to prevent infection of any kind particularly urinary and dental infection, regular visit to surgeon. Limitations are to avoid squatting or sitting on floor, jogging or running, local massage or heat therapy and cross-legged sitting. Patienthas to come for follow up one month after surgery then 3 months, 6 months, 1 year and subsequently once a year or if there is any problem.

“A Pain free joint may not add years to life but it will certainly add life to years.”

SUGGESTIONS TO THE PATIENTS

- Have a western style toilet of 18 - 20 inches height. If the height is not adequate, an additional height can be added by commercially available commode elevated seat.

➢ Those who are not having western style toilet, they can use the commercially available portable commode chair with Indian style toilet. A horizontal bar fixed in the wall near the toilet at approximately 28-30 inches height is useful support for the elderly patient in sitting and standing from western style toilet.

JOB RECOMMENDATION FOR PERSON WHO HAS UNDERGONE TKR AND/OR THR

Recommended for permanent change of job not involving heavy manual work, lifting heavy weight, prolonged walking, frequent climbing up and down stairs, running, jogging, jumping, playing, parade, squatting and cross-legged sitting.

The purpose of such recommendation is to prevent early wear and tear of cup and head, loosening of implant and dislocation of joint.

"If you take care of replaced joint, the joint will take care of you for longer period."

Physiotherapy after Joint Replacements

Total Knee Replacement

In preoperative phase, knee strengthening programme is started. Special emphasis is given on getting full extension or reducing fixed flexion deformity (FFD) by means of splintage (knee brace) and quadriceps strengthening. This decreases intraoperative soft tissue release. Explain Do's and don'ts to patient.

Do's –

- Use western style toilet.
- Walk with moderate speed.
- Climb up and down stairs.
- Sit on high chair approximately 20 inches height.
- Regular exercises as explained.
- Control of weight.
- Watch to prevent infection of any kind particularly urinary and dental infection.
- Regular visit to operating surgeon.
- Follow the instructions as explained.

Don'ts –

- No squatting or sitting on floor.
- No jogging or running.
- No contact sports and other impact activities.
- No local massage or heat therapy.
- No cross-legged sitting.

In postoperative stage, emphasis is given to overcome quadriceps inhibition. Static quadriceps and ankle toes movements (ATM) are encouraged as early as possible in first 24 hours. 10 to 15 repetitions every hour will minimize haematoma collection and oedema of leg and foot. Once drain is removed, gradually increase the knee flexion exercise, isometric quadriceps exercise and vastus medialis obliquus (VMO) exercise. Usually by 4^{th} postoperative day, most patients achieve $80\text{-}90^0$ of knee flexion. Use of CPM is usually not required unless patient is confined to bed in initial few days for some other postoperative complication or in cases where preoperative movement of knee is limited. Knee flexion is guarded in 1^{st} week if there is extensive soft tissue release especially with knee valgus and gross flexion deformity. As soon as the drain is out, patient

can be mobilized with walking aids (walker/crutches) with knee brace on operated side. If other knee is having gross flexion and varus deformity, patient may have limb length discrepancy. In such cases other knee is operated as soon as possible to encourage ambulation. Patient increases distance of walking on day to day basis as per his/her comfort. Short equidistance steps are encouraged. Poor quadriceps strength in preoperative phase requires longer time for recovery in postoperative phase. Sometimes eccentric quadriceps training is required before progressing to concentric strengthening programme. It is important to note that sometimes non-weight bearing (NWB) gait training is required if fracture occurs during surgery below prosthetic fitting, even though it is fixed with bone cement. Considering bone quality, weight bearing may be delayed in certain specific cases. Patients are encouraged to do partial-weight bearing (PWB) walking with knee brace and walker till soft tissue healing occurs i.e. 3 weeks. In this stage, emphasis is given on restoring heel toe gait pattern. As waddling gait has become patient's gait pattern for many days in preoperative stage and patient has to relearn normal gait pattern. Usually after one month from date of surgery, independent gait advised along with stair climbing. By this time patientis able to perform his activities of daily living (ADL) comfortably.

Total Hip Replacement

Preoperative physiotherapy begins 1 to 2 weeks prior to surgery. Exercise programme is introduced to the patient like static glutei, quadriceps, hip abduction and extension training and ankle pumps (ankle toe movements). Patient is made to learn transfer technique from bed to assume erect position without flexion at hip. Explain Do's and don'ts.

Do's –

- Use western style toilet (height should be according to tibial length of the patient).
- Walk with moderate speed.
- Climb up and down stairs.
- Sit on high chair approximately 20 inches height.
- Go in and out of car by keeping legs together and advancing legs first.
- Regular exercises as explained.
- Control of weight.
- Watch to prevent infection of any kind particularly urinary and dental infection.
- Regular visit to operating surgeon.
- Follow instructions as explained.

Don'ts –

- Not to cross legs in sitting or lying.
- Avoid squatting and crossed legged sitting.
- Avoid sitting on low stool or sagging chair.
- Avoid hip adduction (use wedge pillow between legs).
- Prevent hip rotation in early stage (use derotation bar).
- Avoid flexion beyond 90^0, adduction and internal rotation at hip or combination of these movements.
- No jogging or running.
- No contact sports and other impact activities.
- No local massage or heat therapy.

Postoperative exercise programme consists of static hip extension and abduction exercise, ankle toes movements, static quadriceps and breathing exercise.

Bridging can be started with operated leg in complete extension. This will be helpful for toilet activities and gives some pressure relief to gluteal region. Patient will be confined to bed for minimum 2 weeks except for gait training if permissible. Resuming erect position may lead to postural hypotension on day one as patient

is confined to bed for longer time. Keep a close watch on pulse and progression to walking is done gradually. Usually after stitch removal i.e. 2 weeks postoperative, hip flexion is gradually progressed to 90^0 and further sitting at the edge of bed is permitted. Ambulation is done with walker either non-weight bearing (NWB) or partial weight bearing (PWB) depending upon cemented or uncemented THR. In cemented THR, partial weight bearing can be started from 2^{nd} post operative day and full weight bearing after one month. In uncemented THR, patient starts non weight bearing walking for initial 6 weeks then partial weight bearing walking for 3 months. After completion of 3 months, patient starts full weight bearing (FWB) walking. However, depending on intraoperative stability of prosthesis, soft tissue release, 1^{st} surgery or revision surgery, weight bearing and hip joint mobilization varies.

Hip extension, abduction training continues as home exercise programme post discharge. Between 6 to 12 weeks, patient is mobilized with stick in opposite hand. It increases base of support, gives leverage to abductors thereby decreasing joint reaction force. Full weight bearing walking and most of normal activities are allowed after 3 months.

Challenging cases done successfully ……..

SPINAL CORD STIMULATION FOR FAILED BACK SURGERY SYNDROME

A challenging case of chronic and complex neuropathic back and leg pain - A case of Post Spine surgery pain (condition also infamously called as 'Failed Back Surgery Syndrome') treated with advanced pain management neuromodulation modality known as *Spinal cord stimulator implantation *

Case description

A 67 year female c/o severe low back pain with intractable neuropathic bilateral lower limb pain. The pain was of the severity of 8-9/10 for back pain & both lower limbs.

Patient underwnt Laminectomy L2-L5 in 2005; Screw fixation and titanium disc implant at 2 levels performed L3-4 and L4-5 in 2011;
Reexploration and instrumentation spine surgery performed in 2016;
Symptoms persisted and did not responded to conservative line of management.
In 2019 again patient was operated for Decompression of L4-5 L5-S1 disc and fusion.
All the above treatments were done outside railway hospital.
The patient visited JRH pain clinic. After thorough evaluation we tried following minimally invasive pain interventions (MIPSI procedures)
- Jan 2023 - caudal epidural and adhesiolysis was done with good relief for short term.
There after she again started getting unbearable pain at same place.
There is no further surgery or nerve blocks possible at this point.
Hence for long term relief 'Spinal cord stimulator implantation' (SCS) was planned.
What is SCS -
It's a pacemaker which delivers high frequency current through 16 electrodes of 2 leads placed over the dorsal column of spinal cord in epidural space. (Similar to cardiac pacemaker)

Two stages of implantation-

Stage 1- The SCS trial 3/11/23

- an electrode lead is placed in epidural space in mid thoracic level under fluoroscopic guidance. Using external battery dorsal column is stimulated for 3-7days. Pain relief and functional improvement is monitored.

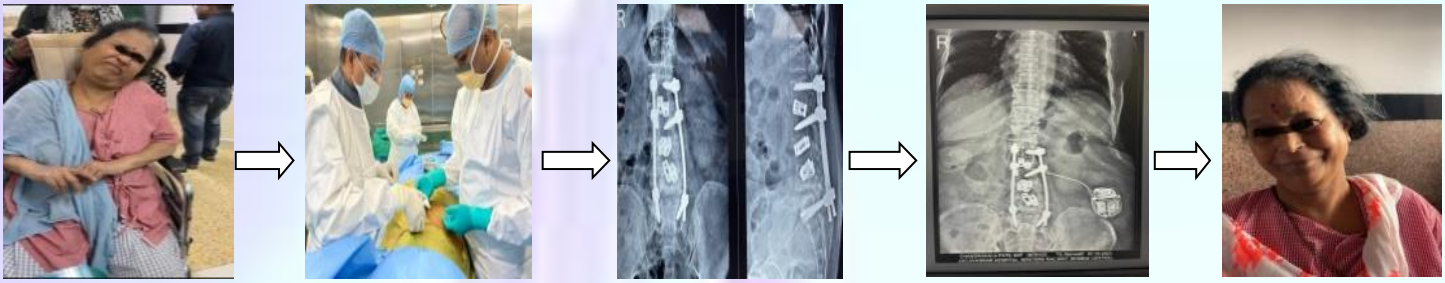
This patient had an excellent relief 70% with good functional improvement.

Stage 2 - permanent implementation of the SCS battery.

A very small pacemaker battery is implanted surgically in subcutaneous pocket either in upper gluteal or lower abdomen. It's connected to the electrode wire which is tunneled subcutaneously from epidural space to the pacemaker pocket.

The permanent Generator implant done on 06/10/2023.

Procedure is done under fluoroscopic guidance under local anaesthesia

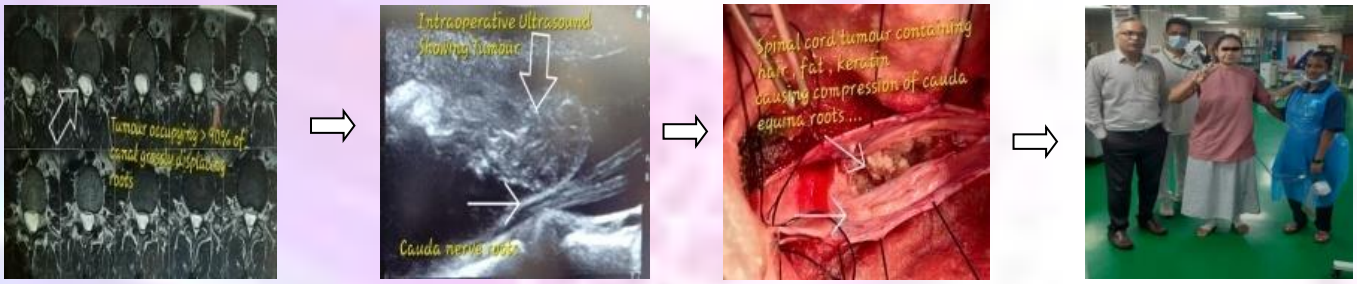


INTRADURAL LUMBAR DERMOID EXCISION

35 YEAR OLD FEMALE WITH COMPLAINT OF LOW BACKACHE AND LOWER LIMB RADICULOPATHY SINCE 2 MONTHS.MRI SHOWED INTRADURAL LUMBAR DERMOID AT L3 L4 LEVEL.INTRAOPERATIVE ULTRASOUND WAS DONE FOR PRECISE LOCALISATION

COMPLETE EXCISION OF TUMOUR WAS ACHIEVED. LAMINA WAS RECONSTRUCTED AND FIXED BACK WITH RESTORATION OF NATURAL ANATOMY OF SPINE.

PATIENT HAD COMPLETE RECOVERY IN BACK PAIN, LOWER LIMB RADICLUOPATHY AND WAS SYMPTOM FREE TOTALY.



POST LAMINECTOMY NURSING CARE

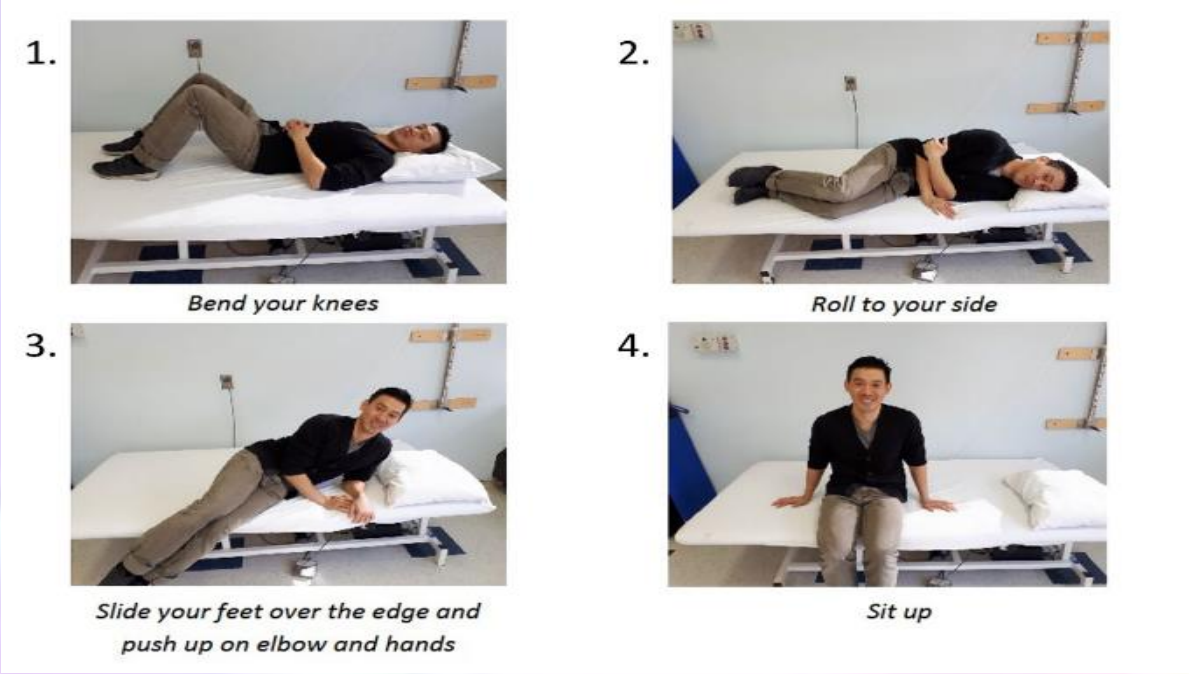
A laminectomy is a surgical procedure that removes a portion of a vertebra called the lamina, which is the roof of the spinal canal. It is a major spine operation with residual scar tissue and may result in post-laminectomy syndrome. Depending on the problem, more conservative treatments (e.g., small endoscopic procedures, without bone removal) may be viable.

PREOPERATIVE TEACHING

- Demonstrate and ask the patient to practice logrolling; explain that it will be done by the nurses for the first day or two, and then the patient can do it alone. To ensure healing, the spinal column must remain in alignment when turning and moving.

Sleeping and Getting Out of Bed

- You may sleep on your back or side.
- If you sleep on your side, you may want to hug a pillow and put a pillow between your legs for comfort.
- Use the log-roll technique, when you are getting out of bed.



- Explain the importance of taking pain medications regularly and of asking for them before the pain is severe. Include information about the possibility of the pain being much the same after surgery.
- Demonstrate the use of a fracture bedpan and ask the patient to practice its use. The patient usually must remain flat in bed for a period of time following surgery. A fracture bedpan is more comfortable for patients who must lie flat.
- Explain that the patient may need to eat while lying flat. This position prevents flexion of the spine.

- Demonstrate and ask the patient to practice deep breathing, the use of the incentive spirometer,and leg exercises.Ask the client to practice these skills. These measures prevent respiratory and circulatory complications.

POSTOPERATIVE CARE

- Maintain the patient in a position that minimizes stress on the surgical wound.

For patients with cervical laminectomy:

- Elevate the head of the bed slightly.
- Position a small pillow under the neck.
- Maintain the position of the cervical collar.

For patients with lumbar laminectomy:

- Keep the bed flat or elevate the head of the bed slightly.
- Place a small pillow under the head.
- Place a small pillow under the knees, or use a pillow to support the upper leg when the patient lies on one side.

These positions minimize stress on the surgical wound and suture line. A cervical collar provides stability and prevents flexing or twisting the neck.

- **Turn the client every 2 hours, using the logrolling technique.** Teach the patient not to use the side rails to change position. Maintain proper body alignment in all positions. The patient's body is turned as a single unit (usually with a turning sheet) to avoid movement of the operative area. Pulling on the side rails puts stress on the operative area and may also cause misalignment of the vertebral column.

Monitor the patient for signs of nerve root compression.

- ***Cervical laminectomy:*** Assess hand grips and arm strength, ability to move the fingers, and ability to detect touch.
- ***Lumbar laminectomy***: Assess leg strength, ability to wiggle the toes, and ability to detect touch. Compare bilateral findings. Report muscle weakness or sensory impairment to the physician immediately. Loss of motor and sensory function may indicate nerve root compression.
- **Assess for hematoma formation** as manifested by severe incisional pain that is not relieved by analgesics and decreased motor function. Report these findings to the surgeon immediately. A hematoma may form at the surgical site. If untreated, it may cause irreversible neurologic deficits, including paraplegia and bowel/bladder dysfunctions (Hickey, 1997).
- **Assess for leakage of cerebrospinal fluid**. Assess the dressing for increased moisture. Check the sheets for wetness when the client is lying supine; check for clear liquid running down the back when the patient is sitting or standing. Gently palpate the sides of the wound to detect a bulge. Use a

Dextrostrix strip to assess any leakagae for the presence of glucose, a positive indicator of cerebrospinal fluid. Although uncommon, leakage of cerebrospinal fluid greatly increases the risk for infection of the wound and of the meninges.

- **Assess for nerve root injury**. Assess the patient's ability to dorsiflex the foot (lumbar laminectomy) and the patient's grip strength (cervical laminectomy). Assess the patient who has had a cervical laminectomy for hoarseness. Report hoarseness to the physician and further assess the patient's ability to swallow.
- **Assess for urinary retention.** The patient should void within 8 hours after surgery. If the physician allows, let males stand to void. Compare intake and output for each 8-hour period. All patients who have received a general anesthetic are at risk for urinary retention. The patient who has had a lumbar laminectomy may have even more difficulty voiding as a result of stimulation of sympathetic nerves during surgery.
- **Assess for pain** using a scale from 0 (no pain) to 10 (severe pain). Discuss patient concerns about pain that is unrelieved by surgery. Compression of the nerve root over time results in edema and inflammation. Because of surgery-induced edema, the patient is likely to experience either the same pain or perhaps more severe pain in the period immediately after surgery.. In addition, many patients who have had a lumbar laminectomy have muscle spasms in the lower back, abdomen, and thighs for the first few days after surgery.
- **Assess for infection** by taking and recording vital signs at least every 4 hours; report increased body temperature. Assess the wound and dressing for signs of infection: increased redness, drainage, pain, and pus. Use sterile technique to change dressings. The surgical patient is always at risk for infection; the patient with a laminectomy is also at risk for arachnoiditis.
- **Encourage deep breathing and the use of the incentive spirometer** every 2 hours; coughing may be discouraged. Anesthesia and immobility depress respiratory function. Coughing may be discouraged because it can disrupt healing tissues, especially in patients having a cervical laminectomy.
- **Increase mobility as prescribed.** (The time frame for ambulation is prescribed by the physician; the routine here is representative.) patients often sit on the side of the bed and dangle their legs the evening after surgery or the first day thereafter. Many patients ambulate the first or second postoperative day. To help the patientout of bed, first elevate the head of the bed. Then bring the patient's legs over the side of the bed at the same time that the upper, body moves into the upright position. Patients should not ambulate without assistance until they are no longer dizzy or weak. Early ambulation increases respiratory and circulatory function and decreases the risk of thrombophlebitis of the lower extremities. The vertebral column should remain in alignment while the patient sits and stands. Safety must be considered throughout care.

Mrs Febin Blesson Mathew, SNS/ JRH-BCT

WE CARE, WE CELEBRATE …..

CPR DEMO ON WORLD HEART DAY

WITH THE MOTTO,*USE HEART;KNOW HEART*, JRH CARDIAC TEAM CONDUCTED AWARENESS PROGRAMME ON 29

With the motto: *A HEALTHIER FUTURE FOR MOTHERS AND CHILDREN*

World Polio Day was celebrated in JRH.
Informative talk on the disease, and it's prevention was delivered by Dr Atiullah, JR and Dr Naaz, DMO, Paediatrics Department, JRH.
Dr Pradeep, HOD, Department of Paediatrics, JRH held an interactive session for the public and cleared the queries.....

POLIO AWARENESS CLASS

WORLD ANAESTHESIA DAY

With the motto: *ANAESTHESIA AND PAIN RELIEF*

World Anaesthesia Day (16 October) celebrated in JRH. Dr Chandini & Dr Alpa addressed the patient and relatives about awareness towards Anaesthesia, Anaesthesiologist and type of anaesthesia. Dr Dinesh Kumar Sahu informed about other role of Anaesthesiologist like cancer and chronic pain management and critical care.

With the motto:*CLEAN HANDS ARE WITHIN REACH*

Global Hand washing day at celebration at JRH.
There was active participation from patients, attendees with slogans

GLOBAL HANDWASHING DAY

NATIONAL CANCER DAY

With the motto:*CLOSE THE CARE GAP*

'National Cancer Day' observed at JRH, Interactive awareness session conducted with cancer awareness talk by Dr Anuja Kulkarni Sr DMO SG ENT, Dr Kush DNB ENT resident, DR Suhana Intern.

WITH THE MOTTO,*TOGETHER WE ARE #GREATER THAN STROKE*,

JRH NEUROLOGY AND MEDICINE TEAM CONDUCTED AWARENESS PROGRAMME ON 29 OCTOBER 2023.

WORLD STROKE DAY

WORLD ARTHRITIS DAY

With the motto:*LIVNG WITH AN RMD AT ALL STAGES OF LIFE*

World Arthritis day celebrated in JRH .
Dr A K Mehta andDr Nataraj gave awareness lecture and answered queries from patients and their relatives . Poster presentation done in OPD area

With the motto: *KEEPING HER IN THE PICTURE*

A talk on Breast cancer awareness delivered at JRH by Dr Viju Murthy on 27.10.23. Around 50 number of doctors and staff participated in interactive session focusing on early detection of breast cancer and new modalities of treatment.

BREAST CANCER AWARENESS

FIRE DEMO CLASS CONDUCTED BY MR REJIKUMAR NAIR(SNS) TO THE HOSPITAL STAFFS

PROUD ACHIEVERS …..

Mr RAMROOP MEENA,CNS/JRH RECEIVED **VISHIST RAIL SEVA PURASKAR (VRSP)** FROM HON'BLE GM WESTERN RAILWAY ON 30 DECEMBER 2023

Mr KAVISHMAHALE, SSE/JRH RECEIVED **VISHIST RAIL SEVA PURASKAR (VRSP)** FROM HON'BLE GM WESTERN RAILWAY ON 30 DECEMBER 2023

कार्यस्थल पर यौन उत्पीड़न

एक लड़की थी, भोली सी, एक कंपनी में वह काम करती थी
जितनी भोली वह दिखती, उतनी ही कार्यकुशल थी

वह मुस्कुराती, खिलखिलाती थी, सबकी मदद वह करती थी
बहुत बतियाती सबसे पर, औरों की कुछ न सुनती थी

अचानक व्यवहार में उसके, कुछ बदलाव सा आया था
उसके पीछे उसके, दुष्कर्मी बॉस का साया था

उसे घूरता, इशारे करता, बहाना कर उसके पास वह जाता
मीठी मीठी बातें कर, अवांछित स्पर्श उसे वह करता

वहम नही मन गुर्राती थी, असहज महसूस करती थी
संभालकर अपना पल्लू, सिमट कर बैठ जाती थी

बॉस के खिलाफ वह, कुछ बोल ना पाती थी
बदनामी, उलझने, जॉब खोने से, वह डरा करती थी

काम में अब मन न लगता, डिप्रेशन में वह रहती थी
छोटी छोटी बात का गुस्सा, अपने बच्चों पर निकालती थी

बॉस की छेड़खानी, पति से झगडे, वह जिंदगी से ऊब गई थी
कई बार खुदखुशी की सोच, उस के मन में दस्तक देती थी

गुमसुम देख उसको, दोस्तों को कुछ शक हुआ
हमेशा जो चहकती रहती, अब क्यों उसका मुंह चुप हुआ ?

जबरन पूछने पर उसने, अपना मुंह खोल दिया
यौन उत्पीड़न का किस्सा, दोस्तो को सुना दिया

चिंता मत करऐ दोस्त, दूसरे दोस्त ने समझाया
बॉस को अच्छी सबक सिखाएंगे, उसको धीरज बंधाया

सुरक्षित कार्यस्थल, यह अपना मौलिक अधिकार है
ऐसे दुष्कर्मी बॉस का, हम सबको धिक्कार है

कार्यस्थल पर हो लैंगिक समानता, सुरक्षा और आत्मसम्मान
यदि करे कोई उल्लंघन, तो यह है, संविधान का अपमान

कार्यस्थल पर यौन उत्पीड़न, एक कानूनन गुनाह है
धारा ३५४A के तहत, दंडनीय अपराध है।

जहां कर्मचारियों के, मौलिक अधिकार सुरक्षित है
ऐसे संस्थानो की ही, प्रगति सुनिश्चित है।

Dr Avinash Arke
Sr DMO/ JRH-BCT

मां

जब अकेला रहा तो उसकी याद आयी, अँधेरे में था तो उसकी याद आयी। जब भूख लगी तो उसकी याद आयी, नींद नहीं आयी तो उसकी याद आयी। सोचने में कितनी आसान लगती थी ये ज़िंदगी, जब खुद से जीना सीखा तो उसकी याद आयी। तभी भी लगा की माँ इतनी मतलब कैसे हो सकती है, हमसे भी ज्यादा हमारे लिए कैसे सो सकती है। लेकिन सच तो ये है की वो माँ ही होती है जो हमारा पेट भरकर खुद भूकी सो सकती है।

मैं अपनी हर ख़ुशी माँ से साझा करता हूँ, अपने दर्द-तक़लीफो में माँ को याद करता हु। ऐसा नहीं है की ऐ खुदा मैं तुझे मानता नहीं, पर मैं अपने माँ से ऊपर किसी दर्जे को जानता नहीं। मैं सबसे ऊपर अपने माँ का दर्जा रखता हु और इस बात पे मैं गुमान करता हूँ। मेरे इस बात से न तू कोढ़ न रखना, जरा मेरे माँ के जतनो का भी मान रखना।

माँ और माँ का प्यार निराला, उस ने ही है मुझे सम्भाला। मेरी मम्मी बड़ी प्यारी, मेरी मम्मी बड़ी निराली, क्या मैं उनकी बात बताऊ, सोचू, उन्हें कैसे मैं जान पाऊ!

सुबह सवेरे मुझे उठाती, कृष्णा कह कर मुझे जगाती। जल्दी से तैयार मैं होता, उसके कारण स्कूल जा पाता, स्कूल से आते ही खुश होता, जब मम्मी का चहेरा देखता। पोष्टिक भोजन मुझे खिलती, गृहकार्य भी पूरा करवाती।

माँ और माँ का प्यार निराला, पर मैं जब करता गड़बड़ घोटाला, मैं जो करता कोई गलती, समझाने की कोशिश करती, लुटाती मुझ पर अधिक प्यार, करती मुझ से अधिक दुलार।

मुझ पर गुस्सा जब हैं आता, दो मिनट में उड़ भी जाता, मेरी मम्मी मेरी जान, रखती मेरा पूरा ध्यान। माँ और माँ का प्यार निराला, उसने ही है मुझे सम्भाला

Mr Parikshit Madhav
NS/ JRH

FROM THE DEPTHS OF MY HEART

How I love to be a nurse

To comfort and to be dare

In situations for the patients I care

How I love to be a nurse

To stand in silence mere

In the darkness of sickness

To the patients I care

How I love to be a nurse

When I wait for my weekend leave

Oh! my patients wait for his discharge leave

In the hope of meeting their dears

How I love to be a nurse

To you oh Lord I pray

To give me strength and say

To be a voice for the sufferings

To be a joy for the nurslings

Mrs Neeva Ambrose
CNS/ JRH-BCT

वह... जो सबसे खास

कोविड के दिनों वह, मेरी जिंदगी में आया था
सुंदरसा वह रूप सुहाना, मेरे मनको भाया था

रोज मेरी सुबह उसके, चहकने से ही होती थी
मेरे मन की बगिया उसके, होने से ही महकती थी

कभी हाथ में, कभी साथ में, जिंदगी बड़ी सुहानी थी
वह मेरे लिए, मैं उसके लिए, अजीब हमारी कहानी थी

सुख दुख के पलों में वह, मेरा साथ देता था
दूर थे सब अपने फिर भी,नजादिकियों का अहसास था

मां पापा सब कहते थे, संगत इसकी अच्छी नहीं
जादा इससे मत खेलो, अब तुम छोटी बच्ची नहीं

जब उलझजाऊँ किसी बात में, वह बन जाता शिक्षक मेरा
मुसीबत की घडी में, वह बन जाता रक्षक मेरा

वह सिर्फ मेरी ही नहीं,आप सबकी बना है जान
उसके बिना असम्भव है, हाथ लिया हर एक काम

वनप्लस, आयफ़ोन, सैमसंग, विवो बहोत सारे है उसके नाम
हाँ ढूंडो ढूंडो उसे, मेरा मोबाइल है सबसे खास

उसके बिना जिंदगी, हो गई है उदास
जल्दी से मिल जाए मेरा मोबाइल
इतनी सी है भगवन से दरखास्त

Mrs Savita Pandhrinath Chandramore
CNS/ JRH-BCT

बीता बचपन

आज फिर याद आयी,बीते बचपन की.
सीधे, सलोने सचपन की .
इक उंगली से कट्टी थी, दो उंगलिया बट्टी की.
सारा आँगन हमारा था, किसी का वहां न पहरा था.
धूपछाँव इक जैसे थे, खेल भी कुछ ऐसे थे .
फर्श पर दाव रचते थे, पत्थर, कंकर सजते थे.
गुड्डा, गुड़िया का खेल था, आपस में खूब मेल था.
उनकी शादी का ठाठ था, कविता ही मंत्रपाठ था.
जाड़े के दिन भी सुहाने थे, बिस्तर ना छोड़ने के बहाने थे.
जमकर ठंड लगती थी, सूसू नाक बहती थी.
रद्दी, अखबार जमातेथे, जलाकरसेंकलेते थे.
धूप में बैठ कर पढ़ाई होती थी, ऊनी स्वेटर की बुनाई होती थी.
दिवाली का बड़ा इंतजार था, नए कपड़ों का उपहार था
चक्र, फुलझड़ी चलाते थे,बारूद से आग जलाते थे.
बारिश में खूब भीगते थे, माँ बाबा की डांट खाते थे.
काग़ज की कश्ती चलती थी, डूबी तो आंखे, बहती थी.
गर्मी के मौसम की बात ही और थी, ननिहाल जाने की खुशी ज्यों थी.
नाना, नानी से हमारी यारी थी, दूध की मलाई ज्यों प्यारी थी.
फरमाइशें सभी पूरी होती थी, मामी भी आगे खड़ी होती थी.
छत पर शाम गुज़रती थी, खाने में चांदनी उतरती थी. छत गरम और बिस्तर ठंडा. लेकिन खुश था हर एक बंदा चलो आज फिर बचपन जीते है.याद ही करके खुश होते हैं.

Dr Savita GangurdeACHD / JRH / BCT

जमीन

न मेरा कोई रूप है, न है मेरा कोई भेस
मुझको टुकड़ों में बांटकर, बना लिए कई देस
ऐसे टुकड़ों की रक्षा खातिर, मै लहूलुहान हो जाती हूं
सरहद के आर-ओ-पार, लालरंग से रंगी जाती हूं।
मुझ पर कब्जा पाने कोई, खून की नदियां बहाता है,
तो, मेरी लाज रखते रखते, कोई मुझ में समा जाता है।
बेकार ही यह लड़ते है, मजहब के नाम पर
किस धर्म का नाम लिखा है, बहाए गए खून पर ?
खाली हाथ आए थे, खाली हाथ ही जाओगे
दो गज जमीन ही काफी है, वह भी पिछे छोड़ जाओगे!
चंद पल की जिंदगी है, अमन से यह गुजर जाए
धरती एक परिवार है, यहां भाई चारा ही नजर आए।

Dr Avinash Arke
Sr DMO/ JRH-BCT

रेल्वे स्वास्थ्य सेवायें

हमारा मिशन

सहिष्णुता पूर्ण व्यवहार,
उत्कृष्ट तकनीकी व आधुनिकतम संसाधनों
के
तर्कसंगत और मूल्योचित उपयोग
द्वारा
रोगियों की सम्पूर्ण संतुष्टि
ही
प्रत्येक रेल स्वास्थ्यकर्मी
का
एकमात्र लक्ष्य
उसकी
एकमात्र साधना

RAILWAY HEALTH SERVICES

MISSION STATEMENT

TOTAL
PATIENT SATISFACTION
THROUGH
HUMAN APPROACH
&
SHARED COMMITMENT
OF
EVERY SINGLE DOCTOR & PARAMEDIC
TO PROVIDE
QUALITY HEALTH CARE
USING
MODERN, COST EFFECTIVE TECHNIQUES & TECHNOLOGIES

जगजीवनराम अस्पताल

हमारा लक्ष्य

मानव स्पर्श के साथ चिकित्सा क्षेत्र में प्रगति के साथ तालमेल रखते हुए रेलवे लाभार्थियों को गुणवत्तापूर्ण निवारक और उपचारात्मक स्वास्थ्य सेवा प्रदान करने के लिए जेआरएच को उत्कृष्टता का केंद्र बनाना

JAGJIVANRAM HOSPITAL

VISION STATEMENT

Making JRH as center of excellence for providing quality preventive and curative healthcare to railway beneficiaries keeping pace with advancement in medical field with human touch

Suggestions

"Fantastic work, All the very best to the editorial board"

"Really appreciable"

Very good initiative. It should be continue with good scientific content.

"I really appreciate the decision to start e magazine by our hospital administration. It's going to be really beneficial in the coming days with more useful contents. I wish all the very best to entire JRH team to contribute valuable contents in the coming editions."

"One of the best hospital...for the employees no compromising in health perspective not a bit.."

"Pictures can be more clear.. More health related articles can be included.. If possible, include All doctors photos.. Overall really appreciable effort."

"Fantastic work, All the very best to the editorial board "

Once again, thank you for the time to share your ideas with ous.We look forward to continuing to work together to improve our magazine.

WE NEED

YOUR FEEDBACK

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