medanta

THE EXCHANGE

Issue 79
October 2024

A Knowledge Sharing Initiative by Medanta

Antenatally Diagnosed Gastroschisis Managed Successfully with Multidisciplinary Care

Development of perinatal services is important for decreasing maternal and neonatal mortality. The impact is more marked for correctable congenital anomalies, whose antenatal detection gives time for planning treatment. This case is an excellent example where antenatal diagnosis, close follow-up, delivery at a tertiary care centre and subsequent multidisciplinary treatment led to a good outcome in the successful treatment of gastroschisis.

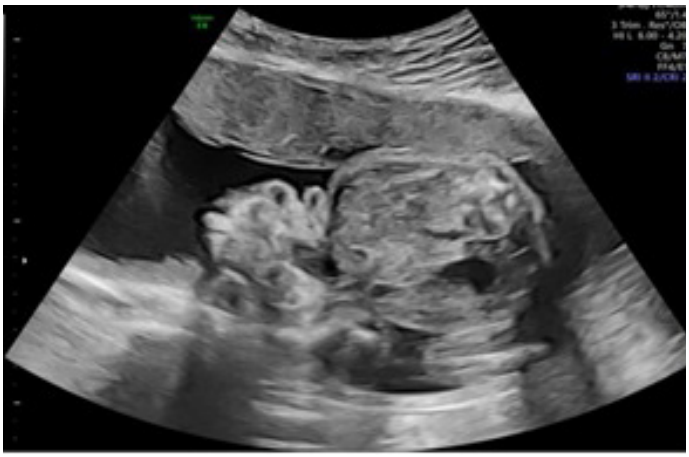
We describe a 38-week pregnant female with antenatally diagnosed gastroschisis, which was successfully managed by a multidisciplinary team of doctors at Medanta Gurugram's Institute of Women and Children. The child was monitored by our fetal medicine expert and at detection of intrauterine growth retardation (IUGR), delivered at 38 weeks. After delivery, immediate resuscitation and surgery was done with good outcomes.

Case Study

The mother presented to the Institute of Women and Children at Medanta Gurugram following the diagnosis of gastroschisis on a level-2 scan at a centre in Punjab at 18-20 weeks of pregnancy. There was a paraumbilical anterior abdominal wall defect through which the bowel loops herniated and were freely floating in the amniotic fluid. She was seen by our fetal medicine expert who did a detailed scan to rule out other structural defects. (Figure 1) The condition of the bowel and the fetal growth was also assessed and repeat scans were done to monitor the baby.

She was counselled by a multidisciplinary team of experts including fetal medicine, obstetrics, neonatology, paediatric surgery and paediatric anaesthesia, under whose watch the pregnancy continued till 38 weeks, when the mother was taken up for lower segment Caesarean section because of IUGR. The baby girl weighing 2340 gms was delivered uneventfully.

The neonatology and paediatric surgery team were present at the time of birth, and her management began right at birth starting with efforts to prevent loss of heat and water.



(Figure 1) Antenatal scans showing gastroschisis, ruling out other defects.

While the neonatal team was resuscitating the baby, the paediatric surgery team secured the intestines in a plastic bag ensuring that the intestines are not malrotated.

The baby was rushed to the NICU where the baby was stabilised, a nasogastric tube was inserted to decompress the bowel and IV access obtained. Essential investigations, including an X-ray of the chest and abdomen and an echocardiogram of the heart, were done. The baby was electively intubated and ventilated.

While this was going on, simultaneously, the OT was prepared. The room was warmed and the OT mattress was pre-heated to prevent heat loss. The baby was shifted to the OT in an incubator under close monitoring. In the OT, the neonate was connected to the monitor and ECG, NIBP, SPO2, ETCO2 and temperature were monitored and adequate intravenous access was established. The neonate was then anaesthetised with Fentanyl, and Sevoflurane. Atracurium was started to provide surgical relaxation.

Once the baby was sedated and hemodynamically stable, the surgical repair was started. The entire length of the intestine was inspected to ensure that there were no narrow or atretic segments. Then meconium was milked

out of the intestine to reduce the volume of the intestine. This was done because the volume of the abdominal cavity was small as the intestines had developed outside the abdomen. The intestines were then placed correctly in the abdomen and skin flaps were mobilised. Since the intestines had not had time to become oedematous, it was possible to reduce the contents of the intestine into the abdomen and close the abdomen without a prosthetic patch. (Figure 2)

The total time taken during the surgery was 90 minutes. All this while, the paediatric anaesthetist monitored the baby closely, watching the temperature and haemodynamic parameters. Blood glucose and blood gases were monitored regularly. It is important to rule out compartment syndrome after surgical closure. Hence, any increase in ventilator pressures were noted. After ruling out the above, the abdomen was closed and the child was shifted to NICU on ventilator support.

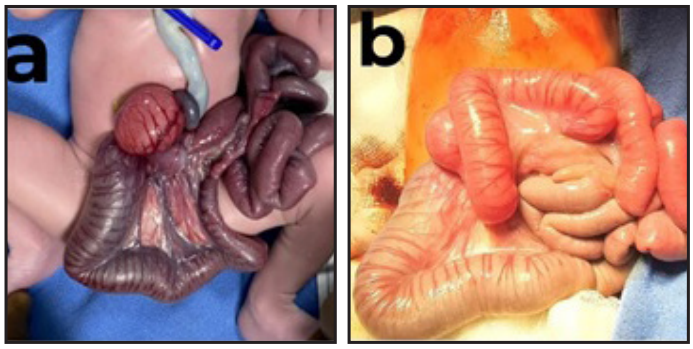
Once back in the NICU, the baby was continued on ventilator support, and was monitored closely. Analgesia was continued. She did not require any significant support to maintain her blood pressure and her ventilator support was gradually reduced.

She was extubated about 48 hours after surgery. Feeds could be started on Day 5 of life. She was initially given small tube feeds, these were gradually built up and she reached full feeds by Day 8 of life. Slowly, the baby was shifted to the mother's feed, and she was fit for discharge by Day 12 of life. Since discharge, she has been on regular follow-up, is asymptomatic and is growing well.

Discussion

Antenatal diagnosis of anomalies has significantly altered the natural history of many diseases, particularly those affecting the gastrointestinal and renal tracts. Gastroschisis, characterised by a full-thickness paraumbilical abdominal wall defect (typically to the right of the umbilicus) with evisceration of the bowel, exemplifies the importance of early detection and coordinated care. In some cases, the stomach, liver, and bladder may also be herniated. The exposed bowel often appears thick and matted due to prolonged exposure to amniotic fluid.

The fetal medicine specialist's role in management begins with diagnosis, typically during the 20-week scan. As growth restrictions can be seen in up to 60% of cases, regular growth assessments are crucial. Fetal growth and amniotic fluid volume are measured at 3 to 4-week intervals starting at 24 weeks of gestation. The primary aim of these assessments is to differentiate between simple and complex gastroschisis. Simple gastroschisis is isolated, while complex cases involve additional complications such as intestinal atresia, stenosis, bowel perforation, necrosis, malrotation, or volvulus. In isolated gastroschisis, the risk of chromosomal anomalies is similar to the baseline population. However, in complex cases, amniocentesis may be required for parental decision-making and newborn management due to a higher incidence of chromosomal anomalies.



(Figure 2) a. Prolapsed intestine at birth b. Intestine at surgery after milking

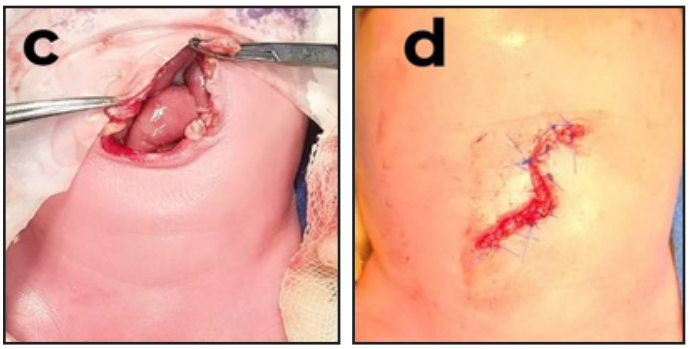
The obstetrician's role involves close monitoring of the mother and coordinating with the multidisciplinary team. They are responsible for determining the timing and mode of delivery. While infants with gastroschisis can have vaginal delivery, the timing is based on gestational age (lung maturity), ultrasound findings (fetal growth profile, bowel appearance), and fetal testing results. Studies have shown that the mean gestational age for spontaneous delivery in these cases is around the 36th week. A recent survey of maternal-fetal medicine specialists revealed varied practices: 40% deliver infants at 37 weeks, 30% at 39 weeks if the condition is stable, and the remainder before 37 weeks. In cases complicated by intrauterine growth restriction (IUGR), as in the presented case, elective operative delivery may be planned, typically around 38 weeks.

Upon delivery, the neonatologist's immediate focus is on maintaining the newborn's body temperature and hydration. The exposed bowel can increase fluid loss by up to 2.5 times compared to normal newborns. However, over-resuscitation must be avoided as it can lead to bowel and total body edema, increasing the risk of abdominal compartment syndrome. Placing the exposed intestines in a plastic bag is a critical initial step in management.

The paediatric surgeon's involvement spans from the antenatal period through to postnatal care. During pregnancy, they provide realistic prognosis and guidance to the parents. At delivery, they aid in the initial preservation of the prolapsed intestine. Postnatally, the surgeon performs the definitive repair, choosing between primary closure or delayed closure using a temporary silo. Recent studies, particularly from the USA, have shown that early closure (within 1-2 hours of birth) may be associated with better outcomes. The availability of the neonatology and

THE EXCHANGE

Issue 79
October 2024



(Figure 2) c. abdominal wall flaps being raised d. completed repair

paediatric surgical team in the operating room at the time of delivery, as in this case, facilitates prompt management and potentially improves outcomes.

The paediatric anaesthesiologist plays a vital role during surgical repair, maintaining the child's stability throughout the procedure. They are responsible for administering appropriate anaesthesia, which in this case was general anaesthesia, and monitoring for potential complications such as compartment syndrome.

The coordinated efforts of this multidisciplinary team are crucial for optimal outcomes in gastroschisis cases. Advanced maternal and neonatal care significantly improve survival rates, which can exceed 90% in well-equipped facilities with specialised teams. This is in stark contrast to some studies from India reporting overall survival rates as low as 45%. The disparity underscores the importance of managing such cases in tertiary or quaternary care centres such as Medanta that have superior infrastructure, teams specialising in high-risk pregnancies, Level-3 NICU facilities, and dedicated paediatric surgical and anaesthesia teams.

Conclusion

The management of gastroschisis exemplifies the need for a well-coordinated, multidisciplinary approach in modern perinatal care. The combined expertise of fetal medicine specialists, obstetricians, neonatologists, paediatric surgeons, and anaesthesiologists, supported by advanced healthcare infrastructure, can significantly improve outcomes for these complex cases. The success seen in centres like Medanta highlights the potential for achieving international standards of care in the management of gastroschisis and similar congenital anomalies in India.

Dr. Shandip K Sinha
Director - Department of Paediatric Surgery and Paediatric Urology
Medanta - Gurugram

Dr. Sangeeta Khanna
Senior Director - Department of General Anaesthesia
Medanta - Gurugram

Dr. T J Antony
Director - Department of Neonatology
Medanta - Gurugram

Dr. Geetanjli Behl
Senior Consultant - Department of Fetal Medicine
Medanta - Gurugram

Dr. Preeti Rastogi
Director and HOD
Obstetrics and Gynaecology
Medanta - Gurugram

ClinicalGuide

Optimising Screening for Improving Breast Cancer Survival Outcomes

Risk-Stratified Guidelines, Modalities

Breast cancer remains one of the most common cancers affecting women worldwide, with a sharp increase in incidence in India over recent decades. In India, it accounts for about 25% of all cancer cases among women. Encouragingly, this disease has one of the highest 5-year survival rates when detected early, with cure rates approaching 100% for Stage 0 and 1. However, in India, breast cancer is mostly detected in advanced stages, leading to poor survival outcomes.

The disparity between potential outcomes and reality in India is stark. Recent studies show a 3-year median survival rate of 68%. in India, compared to 84% globally. This gap is further widened by regional variations, with urban areas reporting higher incidence rates due to lifestyle factors and increased awareness leading to more frequent diagnoses. These statistics highlight a pressing challenge: how can we

THE EXCHANGE

Issue 79
October 2024

Screening guidelines

Asymptomatic women at average risk

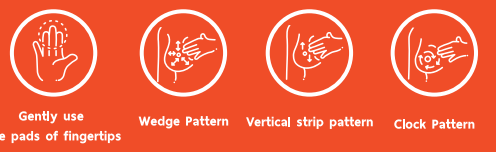
AGE
25-40

- Clinical examination every 1-3 years
- Breast cancer symptom awareness
- Monthly self-examination

AGE
40 & 40+

- Annual or biennial mammogram (with tomosynthesis)
- Annual clinical examination
- Breast cancer symptom awareness

Breast Self Examination



Asymptomatic women at high risk

1st degree relative with breast, ovarian, pancreatic cancer

Breast MRI: Annual screening at 30 or 10 years earlier than the age at which the youngest relative was diagnosed.

Mammography: Annual screening at 30 or 10 years earlier than the age at which the youngest relative was diagnosed.

Clinical Breast Exam: Every 6-12 months starting at age 25.

Genetic Counseling: Considered if there is a strong family history suggesting a possible genetic mutation.

Radiation exposure to chest at <30 years of age

Breast MRI: Annual screening starting 8 years after radiation therapy or at age 25, whichever is later.

Mammography: Annual screening starting 8 years after radiation therapy or at age 25, whichever is later.

Clinical Breast Exam: Every 6-12 months starting 8 years after radiation therapy.

BRCA 1 and BRCA 2-positive

Breast MRI: Annual screening starting at age 25-30.

Mammography: Annual screening starting at age 30, often alternating with MRI every 6 months.

Clinical Breast Exam: Every 6-12 months starting at age 25.

optimize breast cancer screening in a diverse country like India, where resources and awareness vary dramatically between regions?

India's Distinct Challenges

India faces a unique set of challenges in breast cancer screening that demand tailored solutions. The disease often strikes a decade earlier in Indian women compared to Western populations, with a significant 16-20% of cases diagnosed in individuals under 40 years of age, rendering traditional age-based screening guidelines inadequate. This earlier onset requires us to rethink our screening strategies, particularly given the limited availability of specialized breast imaging facilities across much of the country. The situation is further complicated by regional disparities in healthcare access and awareness, creating a patchwork of detection capabilities. Moreover, the applicability of global screening guidelines, typically designed for women over 40, also falls short for us.

These intertwined challenges underscore the urgent need for clinicians to adopt and promote innovative screening strategies.

This article explores these risk-stratified guidelines for breast cancer screening and diagnosis in the Indian context. We will discuss various screening modalities, recommended intervals, and protocols for accurate diagnosis. By adapting global best practices to the Indian scenario, we aim to bridge the gap between the high cure rates possible with early detection and the current poor survival outcomes due to late-stage diagnoses. (See box above)

Understanding Various Screening Modalities

As clinicians, it's crucial to understand the strengths and limitations of various breast cancer screening tools to make informed recommendations for our patients. Each modality plays a specific role in early detection and diagnosis.

Mammography: It remains the cornerstone of breast cancer screening. A meta-analysis of randomised controlled trials showed that mammography screening reduces mortality by approximately 20% in women aged 50-69 years (Marmot et al., 2013). However, its effectiveness can vary based on factors such as breast density and age.

- **Digital Mammography:** This technique offers improved imaging quality, particularly beneficial for women with dense breast tissue. A study by Pisano et al. (2008) found that digital mammography was significantly more accurate than film mammography in women under 50, premenopausal and

perimenopausal women, and women with dense breasts.

- **3D Mammography (Tomosynthesis):** This advanced technique provides three-dimensional images of the breast. A large retrospective study by Friedewald et al. (2014) demonstrated that 3D mammography, when added to digital mammography, was associated with a 41% increase in the detection of invasive breast cancers and a 15% decrease in false-positive results.

Ultrasound: This tool is particularly useful for women with dense breasts, where mammograms often produce less clear images. Ultrasound can effectively identify solid masses and cysts within dense breast tissue, especially of women younger than 40 years of age. Even in women who do not have dense breasts, irrespective of the age, once the clinician sees an anomaly in the screening mammogram, an ultrasound should be done. Ultrasound is not just a complimentary confirmatory tool. It is the preferred imaging method during pregnancy and lactation due to the absence of radiation exposure.

To standardise the reporting of mammogram and ultrasound findings, the American College of Radiology developed the Breast Imaging-Reporting and Data System (BI-RADS). This system categorises findings into seven assessment categories (See box on next page). Understanding BI-RADS helps interpret imaging reports more effectively and make appropriate decisions regarding further testing or treatment. It's crucial to communicate these categories clearly to patients to ensure they understand their results and any recommended next steps.

Breast MRI: A Breast MRI offers superior sensitivity compared to mammography but has a higher rate of false positives. It is recommended as a supplementary screening tool, especially for women at high risk of breast cancer. It is often recommended for women with BRCA1 or BRCA2 mutations, a strong family history of breast cancer, or other genetic syndromes.

Diagnostic Procedures

When screening results indicate abnormalities, accurate diagnosis becomes crucial. Diagnostic procedures not only confirm the presence of cancer but also provide essential information about its characteristics, guiding treatment decisions.

Diagnostic mammography: This involves more detailed X-ray images focusing on areas of concern.

Targeted ultrasound: Used to evaluate specific areas of the breast, ultrasound can distinguish between solid masses and fluid-filled cysts with high accuracy.

Breast MRI: Particularly useful for evaluating the extent of cancer within dense breast tissue.

Biopsy (tissue diagnosis): This is the definitive method for diagnosing breast cancer. Core needle biopsy or Tru-cut biopsy (CNB) is the gold standard for diagnosing breast cancer. However, in certain cases, a surgical biopsy may be done as an outpatient procedure. Tissue samples are examined histologically to confirm the diagnosis of breast cancer. Once the disease is confirmed, additional tests like axillary ultrasounds, chest X-rays, CT scan (abdomen), bone scans, or PET scans are conducted to determine the cancer's stage and extent of spread. In advanced centres, where PET-CT scan facility is available, clinicians need not do these tests as it combines the other three.

Diagnostic procedures, delivered through the most advanced technology, are crucial for accurate breast cancer detection and characterisation, but numerous misconceptions can impede clinical efforts and patient compliance. As healthcare providers, it is essential to address common myths to ensure patients have a clear understanding of the screening and diagnostic process.

- **Myth:** Mammograms cause harmful radiation exposure.
- **Myth:** Biopsies can cause cancer to spread.
- **Myth:** Breast compression during mammography can cause cancer to spread.

Conclusion

Adhering to established screening guidelines help detect breast cancer early, significantly improving treatment outcomes and survival rates. While mammography remains the cornerstone of screening, supplementary tools like ultrasound and MRI play critical roles, especially for high-risk individuals. Personalised screening strategies and accurate diagnostic procedures ensure that breast cancer is detected early and managed effectively, ultimately reducing the burden of this prevalent disease. Healthcare providers educate and support patients in making informed decisions about their screening options, thereby fostering a collaborative approach to breast cancer prevention and care.

Dr. Kanchan Kaur
Senior Director - Breast Cancer
Medanta - Gurugram

Dr. Richa Garg
Associate Consultant - Breast Cancer
Medanta - Gurugram

BI-RADS	Description	Clinical implication
0	Incomplete	- Need additional imaging evaluation (additional mammographic views or ultrasound and / or - For mammography, obtaining previous images not available at the time of reading
1	Negative	- Symmetrical and no masses, architectural distortion, or suspicious calcifications
2	Benign	- 0% probability of malignancy
3	Probably Benign	- <2% probability of malignancy - Short interval follow-up suggested
4	Suspicious For Malignancy	- 2-95% probability of malignancy - For mammography and ultrasound, these can be further divided: o BI-RADS 4A: low suspicion for malignancy (2-9%) o BI-RADS 4B: moderate suspicion for malignancy (10-49%) o BI-RADS 4C: high suspicion for malignancy (50-94%) - Biopsy should be considered
5	Highly Suggestive of Malignancy	- >95% probability of malignancy - Appropriate action should be taken
6		- Known biopsy-proven malignancy

CelebratingMilestones

10 Years of 'Mission TB-Free', 10 Lakh People Screened

Medanta Gurugram's 'Mission TB Free' initiative, a pioneering public health campaign that has revolutionised tuberculosis (TB) detection and treatment across Haryana and beyond, completed 10 years of its inception.

Over the past decade, teams from Medanta screened 10 lakh people for tuberculosis, carried out 80,000 chest X-rays and diagnosed over 10,000 cases of TB in Haryana and the bordering states of Delhi and Uttar Pradesh. The programme has substantially improved TB care by enabling healthcare professionals to increase case detection quickly and accurately, even especially in remote areas with where access to medical facilities is limited.

Dr. Naresh Trehan, Chairman and Managing Director, Medanta, said, "As we mark a decade of 'Mission TB-Free', we remain steadfast in our commitment to achieving India's national TB objectives. Our growth from a single mobile unit in 2014 to five units in 2023, supported by generous donations and strategic partnerships, exemplifies our commitment to scaling up these vital interventions to improve public health. Our focus on enhancing access to improved diagnostic methodologies and advanced treatments by leveraging cutting-edge technologies underscores our dedication to a patient-first approach. I extend my gratitude to Team Medanta, the ASHA workers, paramedics, and partners for their steadfast work. Together, we continue to strive toward a TB-free India, with a vision to expand our successful model to other high-burden areas."

In partnership with public and private sector entities, Medanta announced project Arogya Karmee to strengthen awareness, early diagnosis, and treatment of TB, co-morbidities, and non-communicable diseases among industrial workers. A mobile van, donated by Krishna Maruti, was also flagged off.

The occasion was graced by Smt Anupriya Patel, Hon'ble Minister of State for Health and Family Welfare and Chemicals and Fertilizers, Government of India, Dr Naresh Trehan, Chairman and Managing Director, Medanta, Dr. Bornali Datta, Director of 'Medanta's Mission TB-Free', Deputy Director General - Tuberculosis, Central TB Division, and Director General of Health Services, Haryana State.

THE EXCHANGE

Issue 79
October 2024

IBSCON 2024: Advancing Brachytherapy in India

The 14th Annual Conference of the Indian Brachytherapy Society (IBSCON-2024) was held from August 30 to September 1, 2024, in Gurugram, marking a milestone for the society as it came of age in its 18th year.

Dr. Naresh Trehan, Chairman and Managing Director, Medanta and Chief Patron of the conference, delivered a powerful inaugural address. He emphasised India's significant role in global brachytherapy, performing 10% of treatments worldwide. Dr. Trehan urged attendees to innovate aggressively, aiming to expand access to brachytherapy throughout India.

"Our goal should be to develop and 'Indianize' brachytherapy technologies and techniques, significantly reducing costs while improving efficacy and patient comfort. The MAOLO device we recently patented at Medanta is just the beginning. Consider how we can manufacture equipment locally, create India-specific protocols, and train a new generation of specialists. By doing so, we can bring world-class brachytherapy to smaller towns and rural areas, ensuring that no cancer patient has to travel hundreds of kilometers for treatment. The future of oncology in India depends on our collective ability to innovate, reduce costs, and expand access," he said.

Sharing her vision for brachytherapy, Dr Tejinder Kataria, Chairperson, Radiation Oncology, Medanta Gurugram, and IBSCON organising chairperson said, "Brachytherapy is the ultimate conformal therapy with a high therapeutic ratio for cure of cancer. Ideginnisation of applicators will make us self sufficient and training of younger radiation oncologists will add to armamentarium of cancer care. IBSCON 2024 was the first step towards the achievement of this aim."

The conference featured in-depth teaching sessions, peer discussions, and a pre-conference workshop for residents. With its focus on innovation and accessibility, IBSCON-2024 set a clear vision for the future of brachytherapy in India – one that promises to democratise cancer care.

Kudos

Celebrating **3000 Kidney Transplants** at **Medanta Gurugram** since 2010

- Experienced transplant team
- State-of-the-art facility

Welcome Onboard

Dr. Sourav Shukla

Director - Orthopaedics & Joint Replacement

Medanta - Lucknow

Specialises in direct anterior approach for total hip replacement, addressing complex upper and lower limb trauma, hemi, total and reverse shoulder arthroplasty, total hip replacement (complex primary and revision).

Dr. Charu Chaudhary

Senior Consultant - Ophthalmology

Medanta - Lucknow

Specialises in diabetic and hypertensive retinopathy, retinal vein occlusion, retinitis central serous, retinopathy uveitis, neuro ophthalmology, macular degeneration.

Dr. Jitendra Mishra

Senior Consultant - Clinical & Preventive Cardiology

Medanta Mediclinic - Golf Course Road

Specialises in addressing primary and secondary atherosclerotic cardiovascular disease induced by genes and lifestyle-related heart and vascular problems.

THE EXCHANGE

Issue 79
October 2024

Dr. Sangeet Sahai

Senior Consultant - Clinical & Preventive Cardiology

Medanta Mediclinic South Delhi

Expertise in colour Doppler echo, speckled tracking, dobutamine stress echo, TEE and echo for adult congenital heart disease, stress echo, Holter analysis, ambulatory BP analysis, Cardiac MRI.

Dr. Kavish Kumar Chaurasia

Consultant - Interventional Radiology

Medanta - Lucknow

Expertise includes hepatobiliary, portal vein and oncological interventions, image-guided procedures in pain management, endovascular neurosurger.

Dr. Ashish Baweja

Consultant - Clinical Immunology & Rheumatology

Medanta - Gurugram

Experience in managing rheumatoid arthritis, SLE, vasculitis, spondylarthritis, psoriatic arthritis, inflammatory myopathies, gout, systemic sclerosis.

Dr. Rajiv Ranjan

Associate Consultant - Aesthetic, Plastic & Reconstructive Surgery

Medanta - Patna

Dr. Ranjan specialises in microsurgical procedures, hair transplantation, fat grafting, platelet-rich plasma (PRP) treatment, and cosmetic procedures.

Dr. Narendra Kumar

Associate Consultant - Internal Medicine

Medanta - Patna

Dr. Kumar specialises in diagnosis and treatment of infectious diseases, hematologic disorders, rheumatologic diseases, gastrointestinal issues, diabetes, hypertension, thyroid disorders, pulmonary diseases, poisoning , clinical cardiology, and neurological diseases. He is also an expert in ICU care and specialised interventions such as intubation, central line insertion, bone marrow biopsy, and kidney biopsy. Dr. Kumar has experience in disaster management.

IN CASE OF EMERGENCY DIAL 1068

Medanta Network

Hospitals

Medanta - Gurugram
Sector - 38, Gurugram, Haryana | Tel: 0124 4141 414 | info@medanta.org

Medanta - Lucknow
Sector - A, Pocket - 1, Sushant Golf City, Amar Shaheed Path, Lucknow I Tel: 0522 4505 050

Medanta - Patna
Jay Prabha Medanta Super-Speciality Hospital, Kankarbagh Main Road, Kankarbagh Colony, Patna Tel: 0612 350 5050

Medanta - Ranchi
P.O. Irba, P.S. Ormanjhi, Ranchi | Tel: 1800 891 3100

Medanta - Indore
Plot No. 8, PU4, Scheme No. 54, Vijaynagar Square, AB Road, Indore I Tel: 0731 4747 000

Mediclinics

Defence Colony
E - 18, Defence Colony, New Delhi | Tel: 011 4411 4411

Cybercity
UG 15/16, DLF Building 10 C, DLF Cyber City, Phase II, Gurugram I Tel: 0124 4141 472

Subhash Chowk
Plot No. 743P, Sector - 38, Subhash Chowk, Gurugram I Tel: 0124 4834 547

Cyber Park
Shop No. 16 and 17, Tower B, Ground Floor, DLF Cyber Park, Plot No. 405B, Sector-20 Udyog Vihar, Gurugram I Tel: 93541 41472

Medanta Helpline: 8904395588

medanta.org Upcoming Hospital: Noida