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Original Article

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Enterobacter Hormochae in a Diabetic Wound

Afzal Muhammed Fysel[1], Ravi Kumar Chittoria[2], Jacob Antony Chakiath[3]

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Abstract

In the treatment of chronic wounds, the amount to which bacteria obstruct wound healing is a point of contention. Clinicians must evaluate a large number of chronic wounds using identical sequencing and bioinformatics methods in order to select appropriate empiric therapies due to the high diversity and extreme variability of the microbiota between individual chronic wounds, which leads to inconsistency in small cohort studies. The oxidase-negative gram-negative rod Enterobacterhormaechei (E. hormaechei) was initially discovered as a distinct species in 1989. The fungus E. hormaechei can be found in a variety of habitats. It's widely thought to be a pathogen that causes nosocomial infections, however it doesn't normally infect animals other than humans.

Keywords: Diabetic ulcer; Wound; Enterobacterhomochae.

Introduction

Diabetic foot is ulceration in the lower leg associated with neuropathy and/or peripheral vascular disease in a diabetic patient. It is one of the most significant and disabling symptoms of the disease. Diabetes foot ulcers affect 4–10 percent of diabetics, with the elderly being more susceptible.[1–3] Foot ulceration affects about 5% of people with diabetes mellitus, and the overall lifetime risk of patients with diabetes who are prone to developing this problem is 15%.[1–3] The vast majority of diabetic ulcers, 60–80%, will heal, although 10–15% will remain very active, and 5–24% of these people will require limb amputation within 6–18 months of the initial evaluation. Neuropathy-related wounds heal in about 20 weeks, whereas neuroischemic ulcers take longer to heal and are more likely to require amputation.[4] Diabetic individuals account for 40–70% of all non-traumatic lower limb amputations, according to research.[5] Furthermore, diabetic foot ulcers are seen in roughly 85% of all diabetes amputations, according to various research.[5]

Author's Affiliation: [1]Junior Resident, Department of General Surgery, [2]Professor, [3]Senior Resident, Department of Plastic Surgery & Telemedicine, Jawaharlal Institute of Post graduate Medical Education and Research, Pondicherry 605006, India.
Corresponding Author: Ravi Kumar Chittoria, Professor, Department of Plastic Surgery & Telemedicine, Jawaharlal Institute of Post graduate Medical Education and Research, Pondicherry 605006, India.
E-mail: drchittoria@yahoo.com
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With age and the duration of diabetes, the total risk of foot ulceration and limb amputation rises.[6,7] Because of the poor impact on a patient's quality of life and the associated financial burden on the healthcare system, diabetic foot prevention is critical.[8]

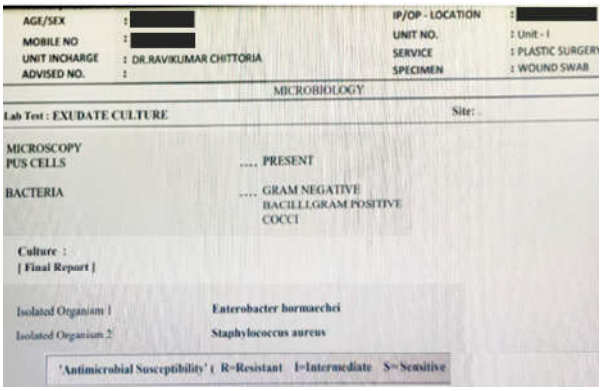
Diabetic foot ulceration is a serious medical condition that necessitates a multidisciplinary treatment plan. This review aims to provide a

comprehensive overview of current diabetic foot ulcer care methods, ranging from prevention to treatment options. In 1989, Enterobacterhormaechei (E. hormaechei) was found as a distinct species of oxidase-negative gram-negative rods. E. hormaechei can be found in a variety of environments. It is generally thought to be the cause of nosocomial infections, yet it seldom causes sickness in animals other than humans.

Materials and Methods

The study was carried out in a tertiary care hospital in South India, after receiving approval from institutional ethical council. The patient is a 40-year-old male with history of accidental abrasion over back of right ankle following which he developed unbearable pain and applied kerosene oil over the wound after which the wound progressed to an ulcer. Exudate and tissue culture showed Enterobacterhormochea (Figure 1).

He was managed with multiple sittings of hydrojet debridement, prolotherapy, insulin therapy heterografting, APRP, LLLT, and RONPWT for wound bed preparation. He received culture based antibiotics and underwent split thickness skin grafting STSG, LLLT, APRP for raw area cover. Then the response was assessed by Vancouver scar scale score. Scar was managed with coconut oil massage, silicon sheet application, compression garments.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Lab Test : EXUDATE CULTURE Site:

MICROSCOPY
PUS CELLS .... PRESENT
BACTERIA .... GRAM NEGATIVE BACILLI,GRAM POSITIVE COCCI

Culture :
[Final Report]

Isolated Organism 1 Enterobacter hormaechei
Isolated Organism 2 Staphylococcus aureus

'Antimicrobial Susceptibility' (R=Resistant I=Intermediate S=Sensitive

Fig. 1: Exudate culture showing Enterobacter Hormochae.

Results

Enterobacterhormochae is found in exudates and tissue cultures. Hydrosurgery and fast debridement using LLLT, APRP, and antibiotics based on culture. After two months of monitoring the patient with the aforementioned methods, the wound healing was much improved, and the graft uptake was effective.

Discussion

The most significant risk factors for foot ulcers include diabetes neuropathy, peripheral artery disease, and subsequent foot injuries. Diabetic neuropathy is responsible for over 90% of diabetic foot ulcers.[9] as well as the motor, sensory, and autonomic nerve fibres are all damaged by diabetes. Motor neuropathy causes muscle loss and atrophy.[10,11] Pain, pressure, and heat are no longer interpreted as protective signals due to sensory neuropathy. Vasodilation and decreased sweating are caused by autonomic dysfunction, which adds to skin deterioration and makes it sensitive to microbial infection.[12]

Diabetics have peripheral artery disease early, advances faster, and is often more severe than the general population. It most commonly occurs between the knee and the ankle. It has been shown to be a predictor of the prognosis of foot ulcers as well as an independent risk factor for cardiovascular disease.[13] When small injuries are aggravated by infection, the demand for blood in the feet increases, and a shortage of blood flow can lead to foot ulceration and limb amputation.[14] The majority of foot ulcers are of mixed aetiology (neuroischemic) 15, notably in the elderly.

Patients with peripheral diabetic neuropathy may develop foot ulcers as a result of recurrent minor injuries from either internal (calluses, nails, foot deformities) or external (shoes, burns, foreign substances) sources. This can cause an ulcer, which can lead to amputation of the foot, particularly in people with peripheral vascular disease. Poor glycemic control, cigarette smoking, and diabetic nephropathy, as well as a history of foot ulceration or amputation, are all risk factors for foot ulcers. In certain research, foot ulcers have been connected to diabetes.[14,16] Foot ulcers have also been linked to social factors like low socioeconomic level, limited access to healthcare, and a lack of educational accomplishment.[16,14]

Assessment and Classification

The skin, as well as the vascular, neurological, and musculoskeletal systems, are assessed during a diabetic foot physical examination. A visual assessment of the skin of the legs and feet, particularly the dorsal, plantar, medial, lateral, and posterior surfaces, as well as a careful examination of each toe nail, are all part of the dermatological examination. Another symptom to watch for is peeling skin, as well as maceration or fissuring of the interdigital skin. If autonomic neuropathy and

sudomotor dysfunction are visually identifiable, they are more likely to be diagnosed. Peripheral vascular insufficiency can obstruct ulcer healing, resulting in chronic, infection-prone ulcers.[15]

An ABI of less than 0.9 indicates peripheral vascular disease, which is associated with 50% or more stenosis in one or more main arteries. An ABI of 0.4–0.9 implies claudication related arterial obstruction to some degree. An ABI of less than 0.4 or a systolic ankle pressure of less than 50 mmHg indicate advanced ischemia.

An ABI of more than 1.3 indicates calcified vasculature. By measuring the blood pressure in the toe and computing the toe–brachial index, an accurate pressure can be achieved in such patients. ABIs and segmental pressures should be taken before and after treadmill exercise if ABIs are normal at rest but symptoms strongly imply claudication. This could reveal hemodynamically substantial subclinical stenosis that isn't noticeable at rest but becomes noticeable when exerted.

Diabetic neuropathy can be detected with a brief clinical history and a thorough examination. Burning, tingling, shooting, acute, or agonising symptoms, and muscular spasms, which are diffused uniformly in both appendages ("loading and glove dispersion") and are often more uncomfortable around evening time, are all prevalent side effects of fringe neuropathy. The Neuropathy Symptom Measure (NSS), a validated side effect score with a good predictive value for evaluating diabetic fringe neuropathy, can also be used to assess diabetic fringe neuropathy.

During the physical examination of the foot, the perception of superficial pain (pinprick), temperature feeling (with a two-metal rod), light sensation (with the edge of a cotton-wool twist), and pressure (with the Semmes–Weinstein 5.07 monofilament) are all measured. The doctor should also use a tuning fork and/or a biothesiometer to measure vibration perception. It's also a good idea to examine your proprioception (position sense) and deep tendon reflexes (Achilles tendon, patellar tendon).[4]

According to the American Diabetes Association, a foot that has lost its protective sensibility is termed a "foot at risk" for ulceration. The presence of a foot at risk is confirmed by a positive 5.07/10-g monofilament test, as well as one of the following tests: vibration test (using a 128-Hz tuning fork or a biothesiometer), pinprick feeling, or lower leg reflexes. If the patient has diabetes fringe neuropathy but no ischemia, the ulcer is defined as neuropathic; ischemic if the patient has diabetic fringe neuropathy but no ischemia; and neuroischemic if the neuropathy and ischemia are present at the same time. Other attempts have been made to classify foot ulcers according to severity, size and depth, location, contamination, and ischemia, in addition to this wide classification. One of the most well-known foot ulcer classifications is the Meggitt-Wagner order. Other frameworks for characterising diabetic foot ulcers have also been presented and approved.

E. hormaechei infection is common in intensive care patients and neonates, who typically contract it from contaminated food. These findings imply that E. hormaechei can infect immunologically deficient hosts. Previous studies have indicated that E. hormaechei can contaminate neonatal formula, and cases have been found in Italy, the Czech Republic, and Holland[11], demonstrating that the risk of animal-to-human transmission is not zero.

Conclusion

EnterobacterHormochae in a Diabetic Wound culture was a rare finding. We demonstrate that hydrosurgery is an effective and rapid debridement method that can be used safely along with LLLT, APRP and culture based antibiotics.

Conflicts of interest: None

Declarations: None

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Original Article

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Role of Lymphoscintigraphy Assisted Lymphatic Vessel Sparing Fibro-Lympho-Lipo Aspiration in Lymphedema

Ravi Kumar Chittoria

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Abstract

Chronic lymphedema is characterized by the accumulation of fibro-fatty tissue. Traditional excisional and debulking procedures may lead to unacceptable scarring. The liposuction may be done to avoid it. But it may cause damage to pre-existing lymphatic. Lymphoscintigraphy, an imaging modality to diagnose lymphedema, may be used as a guide for liposuction. In this article, we describe the role of lymphoscintigraphy in liposuction in a case of lower extremity lymphedema.

Keywords: Lymphoscintigraphy; Lymphedema; Liposuction; Lymphatic vessel sparing.

Introduction

Lymphedema is characterized by the accumulation of protein-rich fluid in the subcutaneous tissue due to an abnormality in lymphatic drainage. Whether congenital or acquired, once the fluid accumulates it leads to a chronic inflammatory response and stimulates lipogenesis with gradual connective tissue overgrowth and fat deposition. An array of investigations has to be carried out for establishing the diagnosis and classification of lymphedema. Nuclear study (lymphoscintigraphy) is considered one of the main investigations for diagnosing damaged lymphatics. Management of lymphedema includes conservative and surgical approaches. Liposuction is one of the options for surgical management of lymphedema though, fear always exists of damaging the existing lymphatics, thus worsening of the lymphedema. In this article, we described lymphoscintigraphy-assisted liposuction.

Author's Affiliation: Professor, Department of Plastic Surgery & Telemedicine, Jawaharlal Institute of Post graduate Medical Education and Research, Pondicherry 605006, India.
Corresponding Author: Ravi Kumar Chittoria, Professor, Department of Plastic Surgery & Telemedicine, Jawaharlal Institute of Post graduate Medical Education and Research, Pondicherry 605006, India.
E-mail: drchittoria@yahoo.com

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Methodology

This is a prospective case study of a 29-year female patient admitted to the Plastic Surgery department in August 2019, with h/o swelling of the left lower limb for 16 years. The patient was assessed and investigated thoroughly. The patient was diagnosed with chronic primary lymphedema of the left lower limb with secondary skin changes (WHO grade-7). The patient was given standard care as per the International Society of Lymphology (ISL) guideline.[1] As the patient was not willing for any microsurgical or excisional procedure, a decision was made to perform lymphoscintigraphy-assisted liposuction.

Lymphoscintigraphy was performed in the Department of Nuclear Medicine. For lymphoscintigraphy, 500 microcurie of Tc99m sulfur colloid (radiochemical purity of Tc-99m sulfur colloid - 98%) was injected intradermally into 1st webspace of left foot followed by 500 microcurie of Tc99m sulfur colloid subcutaneous injection into 1st webspace of right foot. Static images of bilateral lower limbs and the whole body were acquired immediately after injection, post-exercise, 2 hours (with transmission acquisition), 4 hours, and 24 hours after injection in anterior and posterior views on the 128 x 1024 matrix (figure-1 and 2).

The image was examined and based on dye distribution, liposuction was planned. The power-assisted liposuction was done with 3mm and 4mm cannula (Figure 3). Two sessions of liposuction were done at 3 weeks interval followed by standard care of the limb.

Result

In the left lower limb, the lymphoscintigraphy showed the presence of lymphatic channels mainly in the lower one-third of the leg and sparse lymphatics in lateral and medial borders of the leg

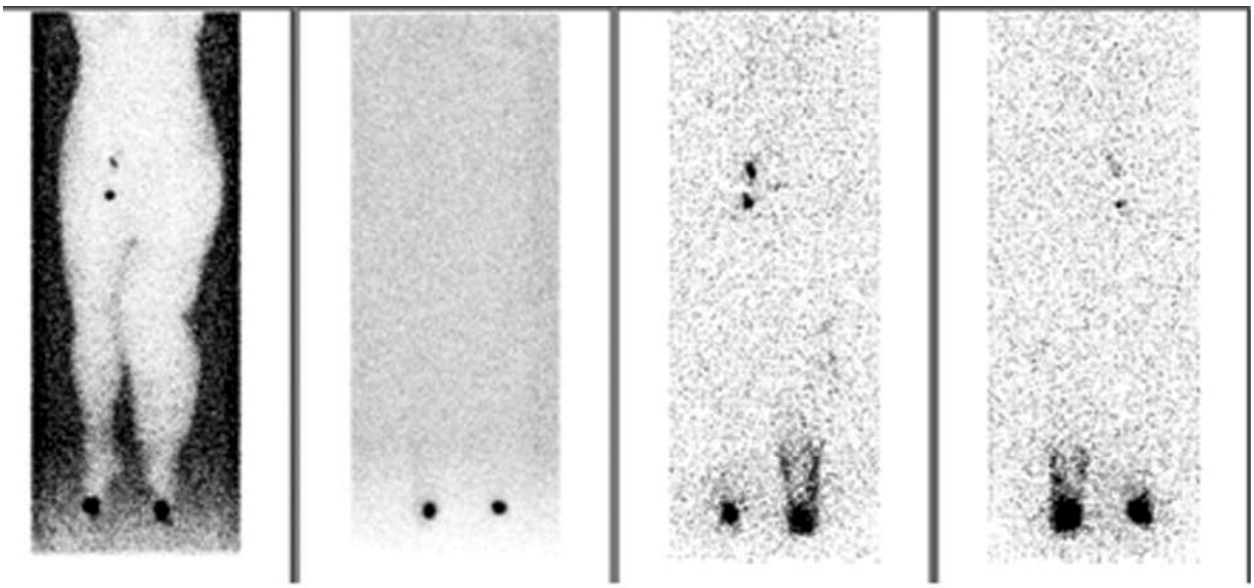

Fig. 1: Lymphoscintigraphy image.

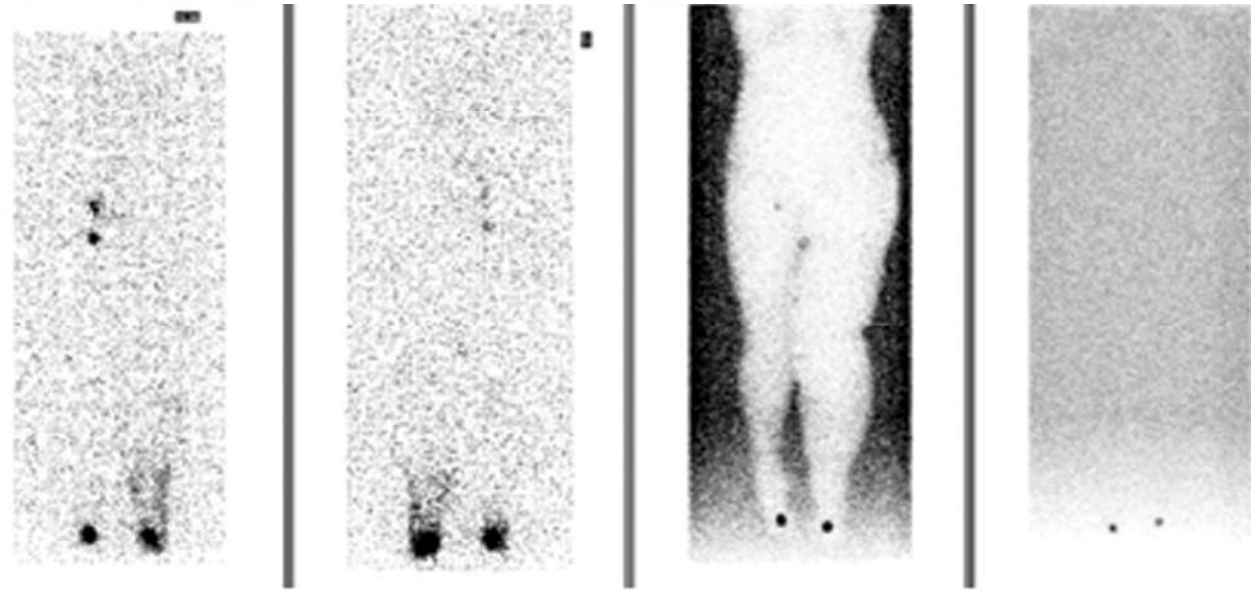

Fig. 2: Lymphoscintigraphy image.

and thigh. So liposuction was planned accordingly. The area, where the lymphatics were present, was marked and liposuction was done in the rest part of the leg. After three sessions of lymphoscintigraphy guided liposuction, there was a good reduction in limb girth. (Figure 4) There was no worsening of lymphedema, signifying no further damage to lymphatics by liposuction.

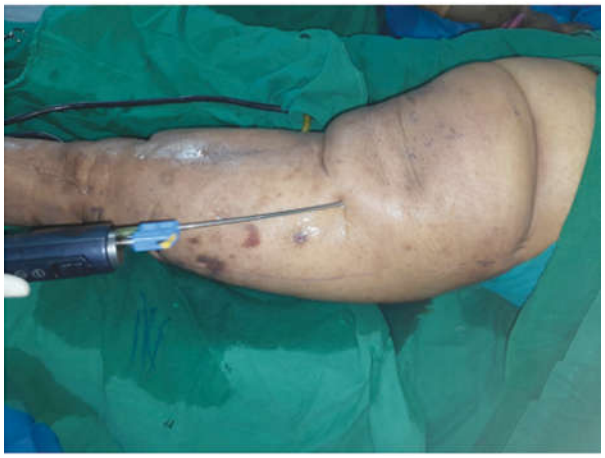

Fig. 3: Liposucttio after marking the zones.

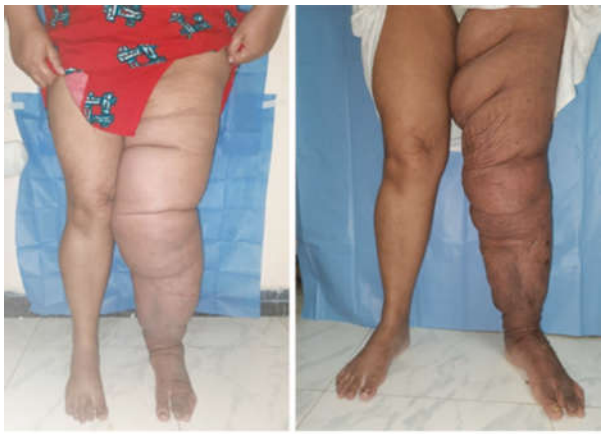

Fig. 4: Significant reduction in limb volume after liposuction (right) compared to before (left).

Discussion

Lymphoscintigraphy is considered a main diagnostic modality to detect abnormal functional lymphatics. Lymphoscintigraphy can be performed by either macromolecule (albumin, dextran) or colloids (sulfur). Macromolecules have rapid transit and clearance and help in better imaging of the vessels. On the other hand, colloidal suspensions clear more slowly from the injection site, amounts of radioactivity present in the lymphatic vessels at any one time is lesser, thus reducing the ability to visualize these vessels. However, colloidal particles can better delineate the draining lymph nodes.[2] Currently, Tc-99m sulfur colloid is the most frequently used agent and was used in our study also. Lymphoscintigraphy is useful in the diagnosis of lymphedema and differentiation of lymphedema causes. It can also grade the severity of the disease. It may also help in assessing the surgical outcome following lymph vessel transfer.[2] Lymphoscintigraphy has limited temporal and spatial resolution thus poor identification and localization of individual lymphatic channels.[3] For preoperative imaging and planning, a high-resolution dynamic 3D magnetic resonance imaging (MRI) can be used which detects the location and number of individual lymphatic channels for surgical planning.[4] Various dyes are currently used intraoperatively for better visualization of lymphatic channels.[4,5]

Liposuction is a less invasive procedure to remove the excess fibro-fatty tissue in patients with chronic lymphedema.[6] It avoids large scars and other morbidities associated with the excisional procedures.[7] But liposuction may cause damage to existing lymphatics.[8] Intraoperative Indocyanine green (ICG) dye and blue patent violet (BPV) dye has been used for avoiding such damage.[9] This technique require specialized camera and dye which may not be available in all centre. As most of the lymphedema patient has undergone lymphoscintigraphy as diagnostic work-up, we have used lymphoscintigram for mapping the lymphatics and choosing the port site and area for liposuction.

Though the image of lymphoscintigraphy may not be of high quality, with proper planning, satisfactory images can be obtained and lymphatic channels may be visualized, especially in an early stage of the disease. We have followed up with the patient for a month, but no worsening of lymphedema was noted. Long-term follow-up is required to see the final result of our study.

Conclusion

Chronic lymphedema is characterized by the accumulation of fibrous and fatty tissue along with lymphatic fluid. Liposuction may help in reducing the bulk of the limb. Intra-operative ICG and dye study are better in guiding the surgeon about the area of liposuction, lymphoscintigraphy may also help in decision making. This is a single case study, a large multicentric study is needed to substantiate our finding.

Declarations

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Gestational Diabetes Mellitus: An Overview

Arjoo Rathor[1], Bandhu Sharma[2], Rose Pushkarna[2], SP Subashini[4]

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Abstract

Diabetes is a risk during pregnancy and diabetes during pregnancy is Gestational diabetes. During pregnancy, blood sugar levels rise to dangerously high levels. Even women who have never been diagnosed with diabetes may be affected. Class A1 and Class A2 are the two categories of gestational diabetes. Diet and exercise can help you control gestational diabetes type A1. Class A2 gestational diabetes, on the other hand, necessitates insulin therapy.

Obesity has been identified as a significant risk factor for gestational diabetes mellitus. GDM must be diagnosed as soon as possible in order to reduce prenatal and neonatal problems. The mother's and newborn's long-term monitoring is critical.

Keywords: Gestational Diabetes Mellitus; Pregnancy; Blood Sugar; Miscarriage; Hypertension; Diet; Exercise.

Introduction

Gestational diabetes mellitus and treatment Recognize common problem of (GDM) in Pregnancy and the condition in which a hormone Made by the placenta prevent the body from using Insulin effectively. Glucose builds up in the blood Instead of absorbed by the cell. Gestational diabetes means high blood sugar levels during pregnancy. In many women, it is a temporary condition that goes away after birth.

Risks Factors

1. Older maternal age.
2. Family history of type-2 diabetes.

Author's Affiliation: [1,2]B Sc. Nursing 3rd year Student, [3]Tutor, [4]Dean, Galgotias School of Nursing, Galgotias University, Greater Noida, Uttar Pradesh 201308, India.

Corresponding Author: Bandhu Sharma, Tutor, Galgotias School of Nursing, Galgotias University, Greater Noida, Uttar Pradesh 201308, India.

E-mail: bandhusharma@galgotiasuniversity.edu.in

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3. Obesity in the women.
4. Poor obesity history.
5. The presence of a birth defect in previous Pregnancy
6. Gestational diabetes in previous pregnancy.
7. A previous delivery of a large baby.
8. Wrong eating habits during pregnancy.
9. Previous still-birth or spontaneous miscarriage.
10. A history of pregnancy induced UTI, HTN etc.
11. Previous stillbirth with pancreatic islet hyperplasia revealed on autopsy.
12. Unexplained perinatal loss.
13. Presence of polyhydroniums or recurrent vaginal candidiasis in present Pregnancy.
14. Persistent glycosuria

Prevention of GDM

Counseling before conception. Diet and exercise for a healthy life style Obesity should be avoided. Obese people that want to lose weight it has the potential

to prevent miscarriage and congenital deformity. Women with PCOS should take metformin before and during pregnancy. Miscarriages in the first trimester are significantly reduced. There was no increase in fetal abnormalities or teratogenicity as a result of the increased live birth rate.

Before Pregnancy

- Identify risk of diabetes and, if high, suggest follow-up with HbA1c testing.
- Provide general lifestyle advice, including the importance of optimising weight and managing overweight and obesity. Management of obesity before, during and after pregnancy is a critical issue in women of childbearing age.
- Discuss smoking cessation and alcohol avoidance.
- Recommend routine laboratory tests.
- Commence folate supplementation at least one month before pregnancy.

Early Pregnancy

- Test for 'diabetes in pregnancy' or dysglycaemia, according to the risk profile.
- Provide general advice about gestational weight gain and healthy lifestyle.
- Commence insulin treatment if required or refer for specialist advice. Urgent referral is to be necessary for overt diabetes.

During Pregnancy

- Test for GDM and provide appropriate management. If in rural or remote practice, consider telemedicine options or shared care.

Postpartum

- Testing
- Follow-up

Long term

- Provide ongoing surveillance for diabetes and metabolic risk factors.
- Facilitate healthy lifestyle for mother and baby.

Conclusion

Gestational diabetes mellitus is common problem in all over the world. Risk stratification and screening is essential to teach all pregnant women for prevention.

Worldwide there are a dramatic increase in the prevalence of overweight and obesity in women of childbearing age. These two overweight and obese women have an increased risk of developing GDM leading to complications during pregnancy, birth and neonatal. The clinical management of obese pregnant women and women with GDM is a challenge and puts additional stress on the healthcare system.

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