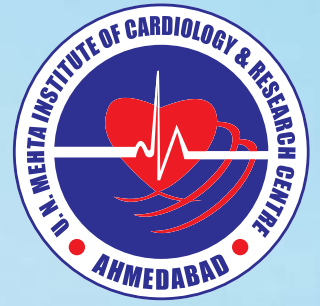


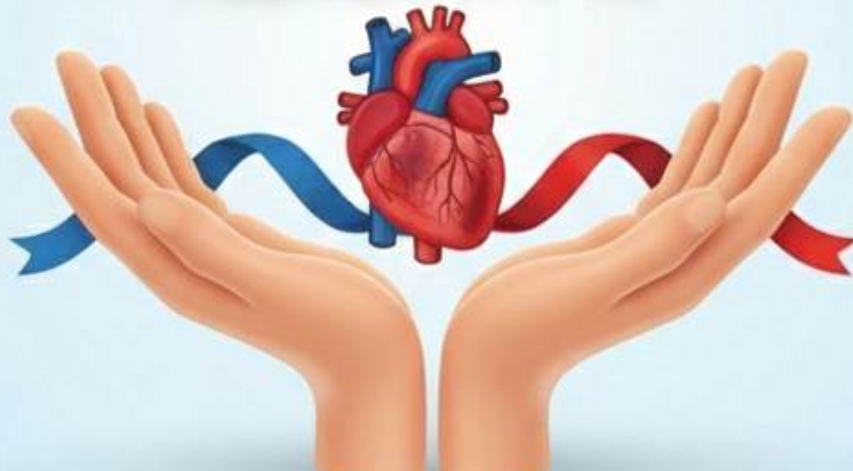
HEART "KNOW YOUR HEART FOR BETTER TOMORROW" TODAY



News Bulletin | ISSUE : 54 | February 2026



CONGENITAL HEART DEFECT AWARENESS WEEK — FEBRUARY 7-14 —



U. N. MEHTA INSTITUTE OF CARDIOLOGY & RESEARCH CENTRE

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The Grand Jury Panel and the Board of MedGate Today are pleased to confer upon

Winner

U.N. Mehta Institute of Cardiology & Research Centre

The title of
Best Single Speciality Hospital of the Year (Cardiology)

Presented on 30th January 2026, Bharat Mandapam, New Delhi



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Topic of awareness- Details & Importance of Cardiac Rehab

What is Cardiac Rehabilitation (CR/cardiac rehab)?

Cardiac rehabilitation, also known as cardiac rehab, is an organized approach for improving the quality of life, reducing the recurrence of cardiac events in persons suffering from heart diseases. Aims to improve the physical, emotional and functional life.

Cardiac rehabilitation is coordinated by an integrated multidisciplinary team of professionals comprising of cardiac specialist, general physicians and other health professionals including trained nurse, dietary consultant, physiotherapist, occupational therapist, psychologist, and pharmacist who work towards the person's well-being.

It is designed as per the needs of an individual and combines cardiac health education, cardiovascular risk reduction, stress management and cardiac exercises for optimum health of the person. It is recommended by the various medical associations like the American Health Association, American College of Cardiology and Cardiology society of India

Who needs cardiac rehabilitation and what are its benefit

Some of the cardiac diseases in which an individual is recommended to undergo cardiac rehabilitation include:

- Angina
- myocardial infarction
- Cardiomyopathy
- Coronary artery disease
- Heart failure
- Peripheral artery disease
- Repair or replacement of the heart valve
- Revascularization procedure
- Angioplasty
- Bypass surgery
- Congenital heart disease
- Heart attack
- Heart transplant

Benefits of cardiac rehabilitation are:

1. Better control over individual's health.
2. Reduced risk of future cardiac events.
3. Early recovery from heart diseases as well as cardiac surgeries.
4. Reduced mortality i.e. chances of early death due to cardiac diseases.
5. Improved exercise capacity, psychological well-being, and quality of life
6. Reduced risk of recurrent hospitalization.
7. Maintain cholesterol level, blood glucose, triglyceride level, and blood pressure.
8. It is a long-term maintenance program which requires a lifelong commitment in order to obtain maximum benefit. Individuals, after undergoing a rehabilitation program, can successfully develop their own exercise regimen, whether at home or at the gym.

Which exercises are included in a cardiac rehabilitation plan?

Warm-up exercise :

Warm-up exercise is required to gradually increase cardiac blood circulation and heart rate. The heart will gradually adapt to the exercise regimen and the risk of angina and arrhythmia is

significantly reduced. It also helps in stretching muscles which reduces the risk of injury. Warm-up exercise is generally done for 15 minutes, equally divided between pulse raising activities, stretching activities and movement activities. Warm up exercise includes walking, low-level cycling, upper back stretch, chest stretch, calf stretch, and hamstring stretch.

Main Exercise: The main exercise is done for about 15-40 minutes. The exercise is designed on a case-to-case basis. Types of exercise include treadmill exercise, aerobics, and swimming. Other exercises include marching on the spot, step ups, forward arm reaches and shadow boxing.

Cooldown exercise: Cooldown exercise helps the body to regain its resting state. Sudden stopping of exercise may lead to hypotension which may cause symptoms such as dizziness. It also helps in maintaining a constant slowing of heartbeat and rhythmic contractions of the heart. During the cool down phase, the speed of exercise should be gradually lowered until the body attains a resting state. The time period for cool down exercise is about 10-15 minutes.

Warm-up and cool down exercises are critical in an exercise regimen and should not be missed.

What are the phases of cardiac rehabilitation

There are three phases of cardiac rehabilitation and the phases are categorized on the basis of the time period after cardiac events.

How many phases are there in cardiac rehabilitation?

Phase I: In-hospital patient

This phase of cardiac rehab starts as soon as the patient has started recovering after treatment for heart disease. The cardiac rehabilitation team provides information regarding cardiovascular risk factors and specific signs and symptoms of cardio diseases. Individuals are also provided with information regarding a healthy diet and routine weight checks.

Phase II: Post-discharge early phase

This phase starts with monitoring the response of a person towards exercise such as heart rate, blood pressure, and other cardiovascular parameters. Any changes required in the exercise regimen are done in this phase.

Phase III: Post-discharge late phase

This phase is also known as the maintenance phase. The exercise done by the individuals are not monitored but they are supervised by competent and qualified staff. The person remains in the rehabilitation centre as recommended by the cardiologist. After completing phase III, a person may go home with exercise instructions given by the supervision staff.

For how long does Cardiac Rehabilitation last?

Generally, the cardiac rehab program may continue for about 3 months. The frequency of visiting the rehabilitation centre decreases with time as guidelines followed.



Ethics Committee Members Training Program on 3rd February, 2026



Executive Program on Health Policy, Leadership & Management & Strategic Approaches for Health Technology Assessment on 04 February, 2026



In Collaboration with Ahmedabad Medical Association (IMA) Registration For Delegates of Hospex : 20th February 2026



Research Abstract

Outcome of del Nido versus St. Thomas cardioplegia solution in adult mitral valve replacement surgery for rheumatic mitral valve disease

Perfusion. 2026 Feb 3:2676591261423026. doi: 10.1177/02676591261423026.

Dr. Akash Shah, Dr. Anil Jain, Dr. Ronak Raval, Ms. Himani Pandya

Background

Effective myocardial protection is essential for successful outcomes in open-heart surgery. Although both del Nido and St. Thomas cardioplegia solutions are widely used, comparative evidence in adult rheumatic mitral valve replacement remains limited. This study aimed to compare their myocardial protective efficacy and clinical outcomes.

Methods

A prospective comparative study was conducted between May 2022 and October 2024. Total 50 adult patients undergoing mitral valve replacement-20 with severe mitral regurgitation (MR) and 30 with severe mitral stenosis (MS) were included. Patients were divided into two groups based on cardioplegia type (del Nido or St. Thomas). Intraoperative parameters, postoperative left ventricular ejection fraction (LVEF), troponin I levels, inotropic and ventilatory support, and ICU/hospital stay were analysed.

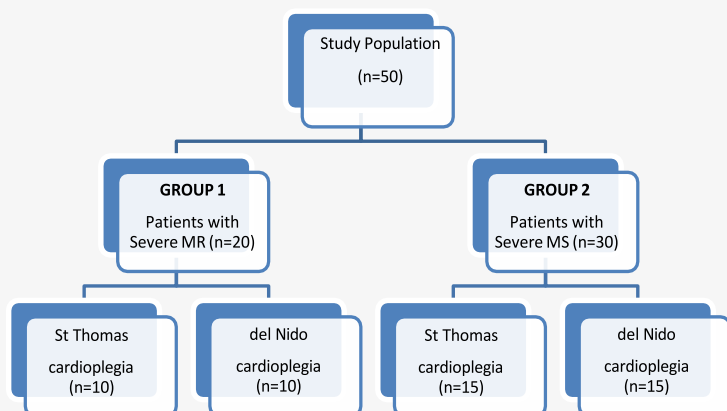
Results

Baseline characteristics were comparable across groups. The mean number of cardioplegia doses was significantly lower in the del Nido group (1.6 ± 0.5 vs 3.2 ± 0.8 ; $p < 0.001$). Postoperative LVEF was better preserved with del Nido cardioplegia (MS: $53.3 \pm 7.2\%$ vs $45.3 \pm 10.6\%$; $p = 0.023$). Troponin I levels at 6, 24, and 48 h were lower in the del Nido group, though not statistically significant. Patients receiving del Nido required less inotropic and ventilatory support, with shorter ICU and hospital stays. One in-hospital death occurred in the del Nido group due to sepsis.

Conclusion

Del Nido cardioplegia offers comparable or superior myocardial protection to St. Thomas solution in adult mitral valve replacement, with fewer interruptions, reduced dosing, and faster postoperative recovery.

Keywords : St. Thomas cardioplegia; del Nido cardioplegia; myocardial protection; rheumatic heart disease; valvular heart disease.



Case Report

Transcatheter closure of atrial septal defect device-related aortic erosion in a pediatric patient

Annals of Pediatric Cardiology 18(5):p 490-492, Sep-Oct 2025. | DOI: 10.4103/apc.apc.172.25

Dr. Kumar Anand Shrutiraj, Dr. Abhay Pota, Dr. Tarun Parmar, Dr. Shilpa Deodhar, Dr. Amit Kungwani, Dr. Bhavik Champaneri

A 5 year old, 15 kg female child presented with a 2 month history of chest discomfort and exertional dyspnea. She had undergone ASD (ostium secundum type) device closure 2 years prior with a 22 mm ASO device (St. Jude Medical, St. Paul, MN, USA) for an ASD, which measured 19 mm. The procedure was considered appropriate based on standard criteria despite a noted deficient aortic rim, as the other rims were of adequate size. She had tachycardia and a blowing, harsh, continuous murmur. Transthoracic two dimensional echocardiography revealed a small defect in the roof of the right atrium (RA) communicating directly into the adjacent noncoronary cusp (NCC) of the aortic root, caused by the impinging of the right atrial disc of the ASO device on the adjacent posterior aspect of the aorta. Color and spectral Doppler revealed continuous flow through this defect from the aorta to the RA and diastolic flow reversal in the descending thoracic aorta throughout diastole. The RA disc of the ASO device was observed touching the NCC of the aortic root at the site of the perforation only during systole [Figure 1]. This intermittent rubbing of the RA disc to the aortic root while staying away from the aortic root during diastole was considered to be the factor causing erosion of the torus aorticus and further erosion of the aortic root leading to the development of aorta to RA communication. We planned to close this defect with the idea that the disc at the atrial side would stay between the RA disc of the ASD device and the wall of the aorta, thus protecting it from further erosion by the in situ ASD device. There was no pericardial effusion. A computerized tomography pulmonary angiography was done; however, the defect could not be precisely defined due to motion artifact. The patient was taken up for cardiac catheterization and angiography. Aortic angiography was performed in the left anterior oblique view, which confirmed the finding of aortic root to RA communication. The defect was crossed from the arterial side, and an arteriovenous loop was made. Through the venous side, a 5 French JR guide catheter was advanced and parked in the aorta. An Amplatzer Duct Occluder (ADO) II device (St. Jude Medical, St. Paul, MN, USA), size 5 mm × 4 mm, was deployed at the defect from the venous side. After confirmation of device position and no residual flow shunt across the device with a repeat angiogram, the device was released [Figure 2]. The patient has been on regular follow up for more than 3 years with no reported procedure related issues.

To the best of our knowledge, this represents the first reported instance of such a device-based transcatheter closure for this specific complication.

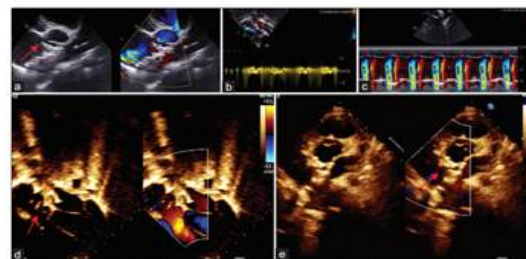


Figure 1: (a) Short axis view: defect b/w NCC of aorta and RA (arrow), note RA disc of ASD device touching aorta; (b) colour doppler: flow from aorta to RA; (c) suprasternal view: pan-diastolic flow reversal in DTA; (d) apical 4c view with slight anterior tilt: ADO II device seen in situ, no flow across the defect (arrow); (e) short axis view: ADO II device seen in situ, no flow across the defect (arrow)

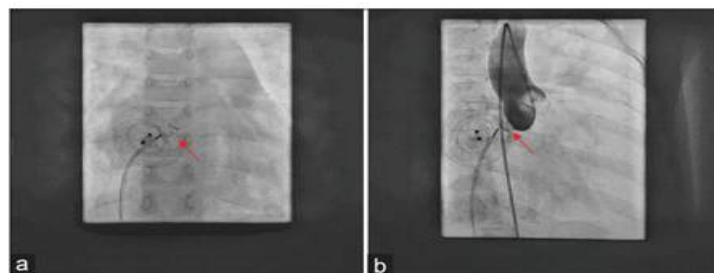






Figure 2: (a) AP view: ADO II device being deployed from venous side across the defect (arrow), (b) RAO view: ADO II device seen between the aorta and RA disc of ASD device (arrow)

UPCOMING EVENTS

Continuing Cardiac Education

| Date | Topics | Speakers |
|------------|---|---|
| 07-03-2026 | Endovascular Upper Extremity Interventions |  Dr. Jayal Shah Professor |
| 14-03-2026 | Embolization Techniques & Clinical Implication |  Dr. Pratik Raval Professor |
| 21-03-2026 | Medical Management vs. PCI in Chronic Stable Angina |  Dr. Dineshkumar Joshi Professor |
| 28-03-2026 | Artificial Intelligence (AI) in Cardiology |  Dr. Kamal Sharma Associate Professor |

Cardiology

Cardiovascular Thoracic Surgery




Cardiac Anesthesia

Continuing Nursing Education



ECG AT A GLANCE

Time : 2 pm to 5 pm

| Topics | Speakers |
|---|--|
| Introduction |  Ms. Parlin Deepak (Chief Assistant Matron) |
| Basics of ECG & ECG interpretation step by step |  Dr. Meena Parmar (Clinical Cardiologist) |
| ECG in MI & Its localization |  Mr. Dilipkumar Panchal (Trained Cardiac Staff Nurse) |

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Continuing Physiotherapy Education

Saturday
28th March, 2026



Dr. Rahul Patel
Cardiac Physiotherapist Grade-II

Topic
ICD & Physiotherapy Management

Continuing Nutrition Education

Ms. Urmila Gelotar
Assistant Dietician

Topic :
Role of Dietician in Therapeutic Diet

Sunday
29th March, 2026

02.00 PM to 03.00 PM



Anandit Hridayam-Activity of the February 2026 : Carrom/Ludo/Amdavad



Carrom

1. Mukeshbhai Vaghela (ECG)
2. Urvashi Solanki (PICU)
3. Manishaben Patel (HR/ADMIN)



Ludo

1. Dr. Dhruv Mistry (Quality)
2. Sunitakumari Chauhan (CTOT)
3. Urmila Chavda (HR/ADMIN)



Amdavad

1. Rupal Parmar (MICCU 1)
2. Drashti Panshara (CTOT)
3. Nanda Khandelwal (MICCU 2)

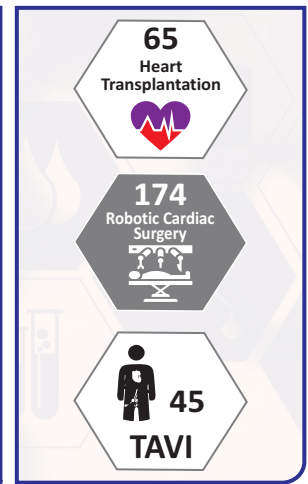
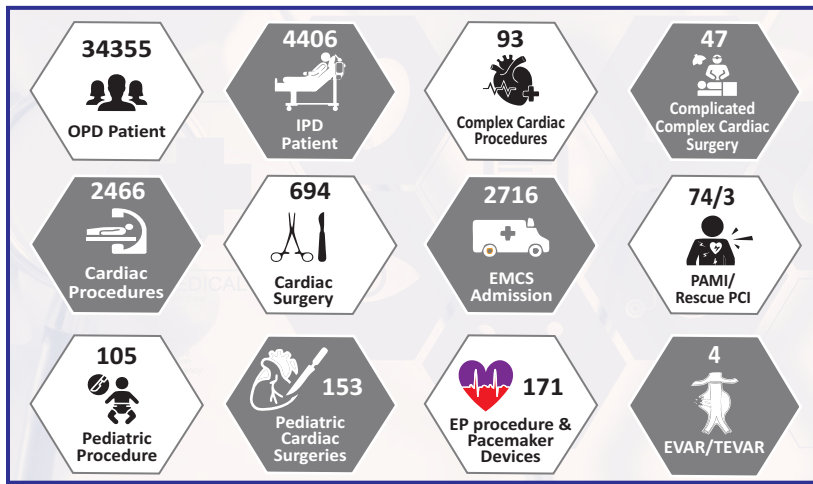
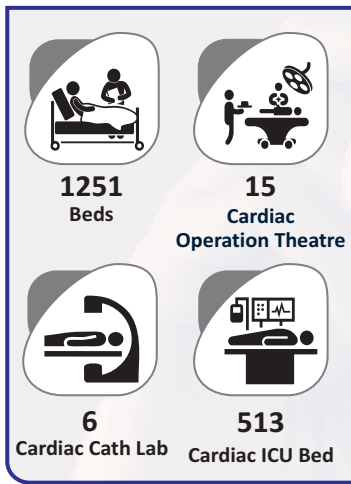
Cardiac Rehabilitation week 8th to 14th february 2026



On the occasion of Cardiac Rehabilitation Awareness Week 2026, a group of college students pursuing physiotherapy and allied health sciences visited the cardiac hospital to gain practical exposure to cardiac care and rehabilitation services. The visit was organized and handled by the Physiotherapy Department, with the aim of broadening the students' clinical understanding and inspiring them to contribute meaningfully to the field of cardiac physiotherapy.

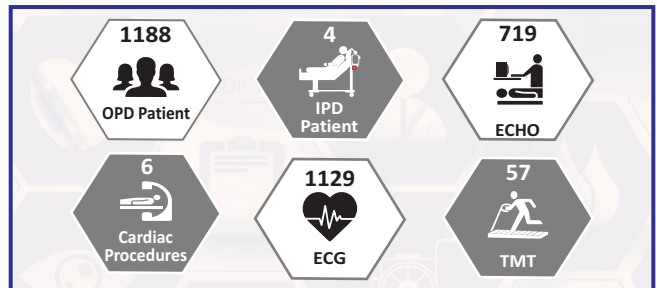
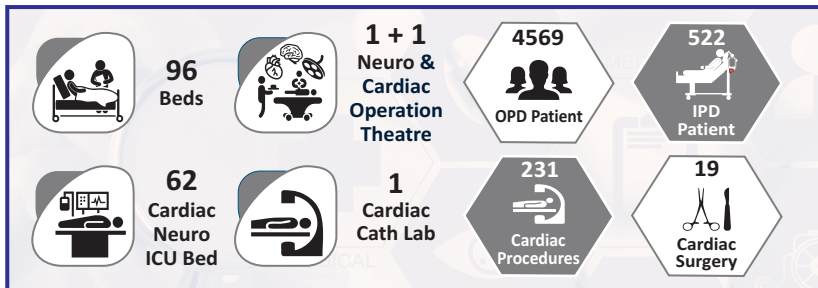
The program began with a formal welcome and an introductory session about the hospital, its vision, mission, infrastructure, and multidisciplinary approach to cardiac care.

During Cardiac Rehabilitation Awareness Week 2026, students were given a detailed overview of ICU & ward clinical care, Cardiac Rehabilitation, focusing on exercise training, risk factor modification, lifestyle management, and psychological support. The importance of individualized exercise prescription by physiotherapists was emphasized. Demonstrations of CPET and PFT helped students understand how exercise capacity and lung function are assessed to design safe and effective rehabilitation programs. The session enhanced their clinical knowledge and inspired them to pursue excellence in cardiac physiotherapy. We express our sincere gratitude to the hospital management and all staff members who dedicated their time and effort to make this educational visit successful.



UNM Gandhinagar Satellite Centre

UNM Rajkot Satellite Centre



CARDIAC REHABILITATION PROGRAM

at U. N. Mehta Institute of Cardiology & Research Centre, Ahmedabad

Who needs cardiac rehabilitation?

Adult patients with the history of

- Heart Attack
- Angina

Before and After following procedures:

- Heart surgery, bypass surgery, or valve surgery
- Coronary angioplasty/stent procedure
- Heart Transplant
- Heart Failure

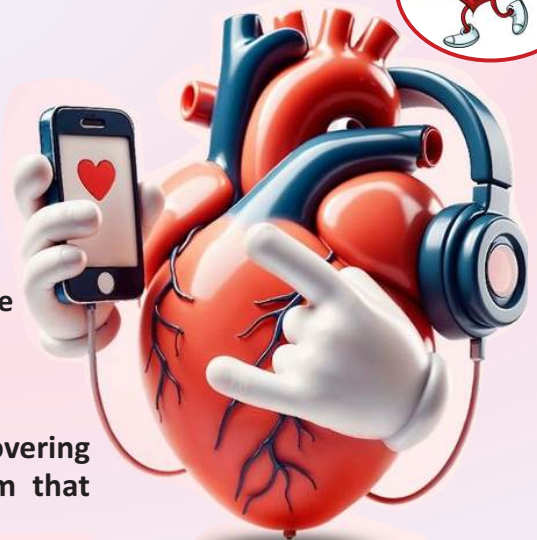
Paediatric cardiac patients can also benefit from an exclusive Paediatric Rehabilitation Program.

What Is Cardiac Rehabilitation?

Cardiac rehabilitation is an important program for anyone recovering from a heart attack, heart failure, or other heart problem that required surgery or medical care.

LOCATION :

106, Cardiac Rehabilitation Department, 1st Floor, A-Block, UNMICRC



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Additional Chief Secretary, Health & Family Welfare Dept., Govt. of Gujarat and Chairman G. B., UNMICRC

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