the base of intussusception and are full thickness. First one to be placed is at 12 o'clock position than 10 and 2 o'clock position parachute sutures are placed. To protect the posterior hemi-circumferential rectal mucosa from being bitten by PPH01, a spatula is introduced on the rectal mucosal through the 6 o'clock slotin the CAD. This protects the posterior half from any entanglement in the jaws of PPH01. The free threads of 10 o'clock suture and one arm of the free thread of 12 o'clock suture are jointly pulled through the left thread slot of PPH01. The remaining arm of the free thread of 12 o'clock suture and the two arms of the free thread of 2 o'clock suture are pulled through the right slot in PPH01. Adequate traction is applied on the threads to pull in the prolapse before the instrument is tightened, fired and removed as in a standard stapled hemorrhoidopexy. The same steps are repeated in a mirror like fashion to complete the posterior hemi-circumferential resection with the fresh PPH01 instrument. The staple line is examined for its integrity and hemostasis. This can be reinforced by box- mattress sutures (as designed by me- mattress suture placed across the staple line, being parallel to the staple line with the two buried strips of mattress suture being equidistant from the staple line.) placed at 12, 3, 6 and 9 o'clock positions, using either chromic catgut or synthetic absorbable sutures. The sutures at 9 and 3 o'clock position ensure the "dog-ear of tissue" left at the junction of anterior and posterior resection, being buried. This ensures the recto-rectal anastomosis being smooth, secure and dry. Postoperative management is same as for standard stapled hemorrhoidopexy.

ACKNOWLEDGEMENT

Blessings of my Guru Prof N Singh and Mentor Prof K C Mahajan have enabled me to innovate, pioneer and establish such procedures in India. Thanks are due to my 'team surgery' specially Dr. Kumar Manish, Dr.(Major) Himanshu Pandey, Dr. Shruti Sharma, Surjit Singh, Harpreet Kaur & Pankaj, for making STARR a reality in India.

REFERENCES

1. *Longo A: Treatment of hemorrhoids disease by reduction of mucosa and hemorrhoidal prolapse with a circular suturing device: a new procedure. Proc. 6th World Congress of Endscopic Surgery, 1998: 777-84.*
2. *Longo A. Obstructed defecation because of rectal pathologies. Novel surgical treatment: stapled transanal resection (STARR). Proceedings of the 14th Annual International Colorectal Disease Symposium, Ft Lauderdale, Florida, February 13-15 2004.*
3. *Agarwal BB, Manish K, Sinha B, Mahajan KC, Saxena KK. Stapled trans-anal rectal resection (STARR) for obstructed defecation syndrome - early results of a prospective study. Surg Endosc (2010) 24: O 094-S29.*
4. *Agarwal BB, Manish K, Sarangi R, Mahajan KC. Stapled transanal rectal resection (STARR) for obstructive defecation syndrome - a prospective study with 6 months follow up . Surg Endosc (2010) 24: P123 -S384.*
5. *Agarwal BB. Do dietary spices impair the patient-reported outcomes for stapled hemorrhoidopexy? A randomized controlled study. Surg Endosc. 2010 Oct 26. Epub ahead of print.*
6. *Agarwal BB. Prospective randomized controlled study for effects of practice of yoga on the patient reported outcomes in day care minimally invasive surgery. Surg Endosc (2010) 24:S73.*
7. *Agarwal BB, Manish K, Sahu T, Sarangi R, Mahajan KC. Do dietary spices impair the patient reported outcomes in stapled hemorrhoidopexy ? a randomized controlled study. Surg Endosc (2010) 24:SO 91.*
8. *Agarwal BB, Sarangi R, Mahajan KC. Effect of yoga on the speed of convalescence after uncomplicated outpatient Laparoscopic cholecystectomy—a case controlled study. Surg Endosc (2010) 24:S 585.*
9. *Agarwal BB, Mahajan KC. Effect of yoga exercises on outcome of stapled hemorrhoidectomy: results of a prospective randomized controlled study. Surg Endosc (2008) 22:S150.*
10. *Yoga Effective Against Complications of Stapled Hemorrhoidectomy CME Ed Ungar. http://www.medscape.com/viewarticle/573152*

LITERATURE REVIEW

Nondiabetic Kidney Disease in Type 2 Diabetic Patients: A Single Center Experience

U Das, KV Dakshinamurty, A Prayaga, MS Uppin Ind. Jr. Neph.: 2012, Volume : 22, Issue : 5, Page : 358-362

Nondiabetic renal disease (NDRD) is seen as a cause of proteinuria and renal failure in type 2 diabetes mellitus (DM). The clinical differences between NDRD and diabetic glomerulosclerosis (DGS) are not clear. This study was done to find the spectrum of NDRD in type 2 DM patients and differences in clinical profile between NDRD and DGS patients. Data of patients with type 2 DM who underwent renal biopsy in this institute from 1990 to 2008 were analyzed retrospectively. Patients were categorized as isolated NDRD, NDRD with DGS, and isolated DGS. A total of 75 patients were included. Mean age was 45 ± 10.2 years, male to female ratio was 3.1 : 1, median duration of DM was 12 months (range, 1 year-15 years), proteinuria was 4.2 ± 3.4 g/day, and serum creatinine was 4.3 ± 3.9 mg/dl. Hypertension was observed in 63 (84%) cases and microscopic hematuria in 24 (32%) cases. Nephrotic syndrome (38.7%) was the commonest clinical presentation. Forty-eight (64%) cases had NDRD and 27 (36%) had DGS. The commonest NDRD was minimal change disease (12.5%). Three (6.3%) patients had lupus nephritis. Tubulointerstitial nephritis has been observed in 10.4% patients. No significant differences between NDRD and DGS patients were found except hypertension which was significantly high in the DGS group. Acute kidney injury and nephritic syndrome were not observed in the DGS group. In conclusion, the incidence of biopsy-proven NDRD in type 2 DM in this study was high. Kidney biopsy aided in the detection of NDRD in clinically suspected patients.

LITERATURE REVIEW

Are We Overconcerned about Secondary Hyperparathyroidism and Underestimating the More Common Secondary Hypoparathyroidism in Our Dialysis Patients?

Tarun Jeloka, Manish Mali, Anjali Jhamnani, Santosh Konde, Vikas Jadhav JAPI 2012, VOL. 60,102-105

The aim of the study was to determine the prevalence of hyper and hypo-parathyroid state in prevalent dialysis patients. The second part of the study was to look for the prevalence of vascular calcification (abdominal aortic) and factors predicting calcification in these patients. All adult patients, who were more than 1 month on dialysis, were included in the study. A total of 68 patients, of which 75% were on hemodialysis and 25% on peritoneal dialysis, were finally studied. Patients' parathyroid status was defined as per target recommendation of KDOQI – hypoparathyroid with iPTH < 150 pg/ml and hyperparathyroid with iPTH > 300 pg/ml. Vascular calcification was determined by X ray of lateral lumbar spine to look for abdominal aortic calcification (AAC). The AAC was scored as validated. The prevalence of hyper- and hypoparathyroidism in dialysis patients was determined as percentage of total dialysis patients. The prevalence of AAC and factors predicting it was analyzed by 'univariate' and 'multiple logistic regression analyses. The mean age of patients was 50.04 ± 14.15 years, 58.82% were males and 42.64% were diabetics. Mean duration of dialysis was 22.36 ± 19.17 months. Hyperparathyroidism was seen in only 27.94 % of all dialysis patients, while hypoparathyroidism was in 45.58%. Abdominal aortic calcification was seen in 79.41% of overall patients and 13.23% had significant calcification (score 7-24). On univariate analysis, age (0.000) and iPTH (0.03) were the only variables predicting AAC and on logistic regression analysis, age was the only independent predictor of abdominal aortic calcification (p=0.002, OR 1.11, CI 1.038-1.186). Hypoparathyroidism is more common (46%) in our dialysis patients as compared to hyperparathyroidism (28%). There is high prevalence of vascular (abdominal aortic) calcification (80%) in our dialysis patients.