Dwarfism may be due to several musculoskeletal and hormonal growth disorders. The most common cause is considered to be achondroplasia, a condition due to a mutation affecting the Fibroblast Growth Factor Receptor (FGFR) gene 3. Achondroplasia occurs with equal frequency in males and females. It is inherited in an autosomal dominant manner. At least 80% of cases result from a random new mutation. In sporadic cases, a paternal age older than 36 years is common. Most parents are of average size and have no family history of a dwarfing condition. The risk of the parents producing a second affected child is almost negligible. These patients' sitting height is within normal range.

Despite an estimated prevalence is 1:25,000 in the general population, there is little literature concerning the diagnostic and treatment challenges faced by doctors dealing with CAD in such patients requiring myocardial revascularization.

CASE REPORT
A 46-year-old Iraqi male with achondroplasia presented with intermittent rest angina & dyspnoea for last 1–2 months relieved by sublingual nitrate. His height was 85 cm, his weight was 70 kg, and he had severely atrophic limbs with kyphoscoliosis (Figure 1). He was having hypertension and hyperlipidemia as risk factors. The electrocardiogram showed Q wave in inferior leads with T wave inversion (Figure 2). Echocardiogram revealed LV ejection fraction of 45-50% with RWMA.

CAG was planned via radial artery route in view of femoral artery access issues and to avoid local bleeding complication. Left radial artery access was taken as preferred route in view of anticipated tortuosity. There was severe tortuosity in brachial artery (Figure 3) and great difficulty was encountered in tracking diagnostic catheter. Angiography revealed TVD with critical disease in LAD, major diagonal, major OM and RCA proximal which was 100% occluded (Figures 4 & 5). Surgical revascularization was the initial plan. Heart team was involved. CABG required multiple grafts but in view of severe musculoskeletal deformity, surgeons were not optimistic of suitable grafts. So PTCA was planned after taking informed consent. Patient was preloaded with Ticagrelor 180 mg, aspirin 325 mg and atorvastatin 80 mg. Unfractionated heparin was used as the anticoagulant. PTCA
PTCA was done via right femoral artery access using 7Fr femoral sheath. Ultrasound guided femoral artery puncture was done. The RCA was cannulated with 7 Fr, 3.5 curve Judkins right guiding catheter with the catheter tracked over an amplatzer super stiff wire because of the severe iliac artery and abdominal aortic tortuosity (Figure 6). Lesion was crossed with 0.014” whisper guidewire with the support of a 1.25 x 15 mm balloon. A 3.5 x 36 mm DES was deployed across the lesion in RCA at 14 atm after pre-dilatation. After dilating proximal 100% RCA lesion, another critical lesion was evident in proximal segment of a very large PLB. Prolonged low pressure dilatation to proximal PLB lesion was done with 2.5 x 10 semi-compliant balloon at 6 atm. Distal TIMI 3 flow was achieved at the end of the procedure (Figure 7 & 8).

Then LCA was cannulated with 7 Fr, 3.5 curves EBU guiding catheter. A 0.014” whisper guidewire was then used to cross the OM2 lesion. A 2.5 x 14 mm DES was deployed across the lesion from LCX-OM at 14 atm after pre-dilatation. Post-dilatation distal TIMI 3 flow was achieved (Figure 9 & 13).

Then whisper wire was crossed across diagonal lesion and 0.014” BMW wire was crossed across LAD lesion. Balloon dilatation was done to proximal diagonal lesion with 2.5 x 10 semi-compliant balloon at 8 atm. A 2.5 x 33 mm DES was deployed across the mid LAD lesion at 14 atm after pre-dilatation. Post-dilatation distal TIMI 3 flow was achieved (Figure 11 & 12). Right femoral artery puncture was closed with Proglide PERCLOSETM femoral closure device after completion of the procedure. Later course in the hospital was uneventful and he was discharged in a stable condition on day 3 of hospitalization. After discharge, the patient was placed on aspirin, ticagrelor, statin, beta-blocker and ACE inhibitor.

DISCUSSION

Mortality in general in these individuals for all age groups is 2.27 times more than that of the general population, cardiovascular problems being the most frequent causes of death in persons aged 25-54 years. Apart from the traditional risk factors, there seems to be other occult genetic or other unknown factors responsible for this increased risk. No large cohort studies have been done to delineate these additional factors till date. There is dearth of literature regarding the technical aspects of coronary intervention in this group of individuals. There are a few reports of coronary artery bypass surgery in these patients, and a single report on PCI to RCA as rescue PCI post thrombolysis.

Optiion of CABG in the setting of multivessel CAD in an achondroplastic patient may be ruled out because of non-availability of adequate grafts as in our case. However there is a report of successful CABG after a percutaneous on CAGB of the limbs revealed adequate saphenous veins, but the patient had a height of 137 cm height, in our case patient’s height was 85 cm only. So in such short patients with multi-vessel CAD multivessel PTCA may be the only option to achieve myocardial revascularization. To our knowledge, this is the first case report of multivessel PTCA in an achondroplastic patient. Radial intervention may prove to be particularly challenging in such cases, but with proper hardware and adequate skills it may still be feasible to do non-complex PTCA. Local bleeding complications were minimized by using USG guided femoral artery puncture and post procedure use of Per-close femoral artery closure device. Our case demonstrates that patients with achondroplasia can safely undergo multivessel coronary angioplasty without additional risk.

CONCLUSION

Achondroplastic patient having multivessel CAD pose a great challenge for myocardial revascularization. CABG as an option may be limited by non-availability of normal saphenous vein grafts in such patients having severely dysmorphic limbs. Multivessel PTCA can be safely performed in patients with dwarfism due to achondroplasia with the available technical knowhow and hardware. Further studies need to be done to look into the increased risk of CAD in such population.

REFERENCES
Figure 3: Tortuosity in Brachial artery

Figure 4: RCA proximal 100% occluded

Figure 5: Critical disease in LAD, major diagonal and major OM

Figure 6: Right femoral artery access with iliac artery tortuosity

Figure 7: RCA after predilatation 2.5 x 10 mm balloon at 6 atm

Figure 8: RCA after stent deployment and dilatation to proximal PLB

Figure 9: Predilation to OM with the 2.5 x 10 mm balloon at 14 atm

Figure 10: Whisper wire in D1 and BMW wire in LAD

Figure 11: 2.5 x 33 mm DES was deployed in the mid LAD lesion at 14 atm

Figure 12: LAD after post-dilatation with 2.5 x 10 mm balloon at 14-16 atm

Figure 13: 2.5 x 14 mm DES deployed in LCX-OM, after post-dilatation
Mr. H, a 61-year-old male, is a known case of is a known case of alcoholic liver disease with cirrhosis with portal hypertension diagnosed on the basis of biochemistry (Hb - 6.9 gm/dL, INR - 1.68, Total bilirubin 3.3 mg/dL, Total Protein 7.1g/dL and platelet count 150,000) and USG findings (evidence of cirrhosis with portal hypertension with splenomegaly with ascites). Patient had hematemesis on Aug 19th, 2014s back in his hometown for which he came to Max Hospital, Saket, 3 days later. Upper Gastro Intestinal Endoscopy (UGE) was done which revealed Grade-II oesophageal varices and a large gastric varix. No evidence of bleeding could be ascertained. He again presented on Aug 27th, 2014 with complaints of sudden onset of hematemesis. Initial investigations revealed an Hb of 6.9 g/dL, INR of 1.82, Platelet count of 105,000, Ammonia was 213 and TLC of 6.8.

UGE done on Aug 27th, revealed evidence of Grade-II oesophageal varices and a large gastric varix with cherry red spot suggestive of recent bleeding. Endoscopically, glue was inserted into the gastric varix. Patient remained stable for 2 days, when he had another bout of hematemesis. Repeat endoscopy was performed which revealed a large clot in the stomach secondary to the bleeding gastric varix. A repeat injection of glue was performed which was unable to stem the flow of blood. Subsequently, the patient was intubated and a Sengstaken – Blackmore tube was introduced and the gastric balloon was inflated in an effort to stop the bleed. At this point, placement of a TIPS shunt was considered for reducing the pressure in the portal system. After detailed discussion with the patient’s relatives a TIPS shunt was placed connecting the branches of the right hepatic vein and right portal vein. Also a large gastric varix was identified which was obliterated by gelfoam injection through the TIPS shunt. Post placement of the TIPS shunt, the portal systemic gradient fell from 20 to 14 mm Hg. The TIPS shunt was successful and the patient remained hemodynamically stable (Hb stabilized at 9.0 gm/dL) and there was no hematemeses or melena. The Sengstaken tube was deflated after 72 hrs and monitoring was done to watch for signs of upper GI bleeding and hepatic encephalopathy.

USG was done on a periodic basis to ascertain patency of the shunt. Ammonia levels were carefully monitored to assess for hepatic encephalopathy. No fresh upper GI bleed has been was observed since then and patient has remained hemodynamically stable. Patient is now being worked up for hepatic transplant.

**TRANSJUGULAR INTRAHEPATIC PORTOSYSTEMIC SHUNT**

Transjugular Intrahepatic Portosystemic Shunt (TIPS) is the percutaneous formation of a tract between the hepatic vein and the intrahepatic segment of the portal vein in order to reduce the portal venous pressure. The blood is shunted away from the liver parenchymal sinusoids, thus reducing the portal pressure. TIPS, therefore, represents a first-line treatment for complications of portal hypertension, typically in patients with decompensated liver cirrhosis.

**HEMODYNAMICS**

Portal blood pressure is normally low with decompensated liver cirrhosis.

**CONTRAINDICATIONS**

Absolute
1. Severe and progressive liver failure (Based on Childs-Pugh Score - Scores A and B have a better outcome than C)
2. Severe encephalopathy
3. Polycystic liver disease
4. Uncontrolled systemic infection or sepsis
5. Severe right heart failure
6. Unrelieved biliary obstruction

Relative
1. Portal and hepatic vein thrombosis
2. Pulmonary hypertension
3. Hepatopulmonary syndrome
4. Active infection
5. Tumor within expected path of shunt

**PROCEDURE**

Access is usually gained through the right Internal Jugular Vein. The right hepatic vein is accessed using a wire catheter technique. Subsequently, a direct puncture is done through the liver parenchyma to access a branch of the portal vein and after dilatation of the tract a metallic stent is placed in this tract from the right hepatic vein to the portal vein.

**INDICATIONS**

1. Acute and Uncontrolled variceal hemorrhage from esophageal, gastric, and intestinal varices that do not respond to endoscopic and medical management
2. Prevention of recurrent gastro-esophageal bleed unresponsive to medical therapy
3. Refractory ascites
4. Refractory hepatic hydrothorax
5. Budd-Chiari syndrome
6. Bridge to transplantation
7. Hepatorenal syndrome (HRS)
COMPLICATIONS
1. Hepatic encephalopathy
2. Liver dysfunction
3. Sepsis

PROCEDURE RELATED
1. Transcapsular rupture of liver
2. Bleeding – Intrapertoneal/hemobilia
3. Stent malposition / occlusion
4. Morbidity and mortality (2 %)

TIPS AS A BRIDGE TO TRANSPLANT
The definitive treatment of liver cirrhosis is liver transplant. Unlike surgical shunts, a TIPS shunt does not interfere with subsequent liver transplantation. Pretransplantation TIPS shunt placement has shown to improve the general condition and nutritional status of the patient, reduce operative blood loss and procedure time and decrease hospital stay.

REFERENCES
6. Comparison of transjugular and surgical portosystmic shunts on the outcome to liver transplantation; Menegaux F, Keeffe E B et al; Arch Surg 1994;129:1018
Laparoscopic Surgery in Emergency: Gastric Volvulus with Hiatus Hernia

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ABSTRACT
Mesenteroaxial Volvulus with Hiatal Hernia is an uncommon problem and is caused by rotation at the transverse axis of the stomach. This can lead to ulceration, strangulation and necrosis of the strangulated segment. This can present in a variety of ways ranging from dysphagia and upper abdominal pain to acute abdomen in emergency. We present a case of 54 year old male who presented with dysphagia. He was investigated and found to have Mesentero axial volvulus with hiatus hernia which was delt laparoscopically with reduction of the hernia with Nissen’s fundoplication and mesh repair.

CASE REPORT
45 year old male presented in emergency with acute onset dysphagia. There was no past history of dysphagia, weight loss of odynophagia. Abdomen was soft. X-ray plain picture abdomen showed a large air pocket in chest with air fluid level. Contrast enhanced CT confirmed the findings of x-ray and a diagnosis of mesenteroaxial gastric volvulus with hiatal hernia was made. After resuscitation in emergency, he was prepared for Surgery. It was found that a large hiatal hernia was present which had a mesetroaxial volvulus in it. The gastric contents in the thoracic cavity were reduced Laparoscopically. He underwent Laparoscopic Nissens Fundoplication to correct the hiatal hernia and the hiatal defect was reinforced with composite mesh. Stomach was fixed to avoid the recurrence of volvulous.

DISCUSSION
Most of the patients of hiatal hernia do not have any symptoms. Two type of gastric volvulus are identified, organoaxial and mesenteroaxial. Intrathoracic mesenteroaxial volvulus is an uncommon condition. It can be repaired with gastropexy along with repair of the defect in the hiatus.

The recurrence rate after hiatal hernia repair can be reduced after application of mesh. Repair can be done transthoracic or transabdominally. The gastroesophageal junction should be infradiaphragmatic post-operatively. Fundoplication treats GERD and prevents future intrathoracic migration of stomach.

CONCLUSION
Repair of the hiatus hernia with gastric volvulus can be done laparoscopically. Nissen’s fundoplication with mesh hiatus hernia repair along with gastropexy give satisfactory results.

REFERENCES
BACKGROUND

Left ventricular aneurysm (LVA) is defined as circumscribed, thin-walled, non-contractile out-pouching of the ventricle\(^1\). True aneurysm of left ventricle (LV) develops after completed myocardial infarction resulting in the out-pouching of thinned and scarred myocardium which becomes dyskinetic in systole. LV aneurysms predispose to thrombo-embolism, congestive cardiac failure, and ventricular arrhythmias\(^2\).

CASE

The patient is a 65 years old man admitted to the hospital with past history of myocardial infarction treated with PTCA and now having chest pain. Echocardiography showed a large infarction treated with PTCA and now having chest pain. Echocardiography showed a large aneurysm arising from the posterior-lateral wall of left ventricle measuring \(70 \times 65\) mm with evidence of a large thrombus within it. (Figure 1)

Cardiac MRI (CMRI) showed a well-defined large thin walled aneurysm arising from posterior-lateral wall of left ventricle measuring \(70 \times 64\) mm size with a large thrombus in it (Figure 2 & 3). The aneurysm showed paradoxical movement. There was delay in contrast delivery in the aneurysmal wall as seen in resting perfusion. Delayed contrast MRI showed trans-mural enhancement of the aneurysmal wall (Figure 4). Rest of the myocardium showed no delay enhancement consistent with viable myocardium.

Large thin walled aneurysm arising from posterior-lateral wall of left ventricle with a large thrombus in it. The aneurysm showed paradoxical movement. Delayed contrast MRI showed trans-mural enhancement of the fibrotic aneurysmal wall. Rest of the myocardium was viable.

DISCUSSION

Transthoracic echocardiography plays an important role and provides assessment of LV structure and function, however, inferior wall aneurysm can be difficult to visualize particularly in patients with sub-optimal image quality. In patients with poor acoustic windows, contrast echocardiography is useful in identifying presence of aneurysm. Transoesophageal echocardiography has a limited role due to its semi-invasive nature and the availability of superior non-invasive imaging modalities like cardiac MRI and CT (3).

Cardiac CT offers complementing information regarding the anatomy of aneurysm as well as that of coronary arteries, though at an expense of ionizing radiation. Cardiac MRI provides a comprehensive assessment of the morphology of the aneurysm and adjacent myocardium. Furthermore, it demonstrates the continuity of the myocardial wall, thus differentiating between a real and a pseudo-aneurysm. If surgical repair is being considered, the identification of viable myocardium is important and tissue characterization by MRI delivers additional key information not available with other techniques. Furthermore, the dynamic nature of MRI scanning and its ability to quantify LV ejection fraction, LV volumes, and mitral regurgitation allow operative planning and appropriate risk stratification\(^6\).

Management of aneurysm largely depends on presenting symptoms and nature of aneurysm i.e. true aneurysm or pseudoaneurysm. Perceived high risk of spontaneous rupture associated with pseudoaneurysm and its catastrophic consequences dictate urgent surgical repair whereas true LV aneurysm can be managed both surgically and medically. Medical management focuses on reducing the risk of embolism and treating underlying congestive cardiac failure. The aim of surgical therapy is restoration of LV geometry, LV volume reduction, and the relief of ischemia by CABG in the presence of concomitant coronary artery disease in viable myocardial territory (4).

REFERENCES

INTRODUCTION

Upper Crossed Syndrome

Upper crossed syndrome (UCS), characterized by the facilitation of upper trapezius, levator, sternocleidomastoid and pectoralis muscle, as well as the inhibition of the deep cervical flexors, lower trapezius and serratus anterior. Janda noted that these changes in muscular tone create a muscle imbalance, which leads to movement dysfunction. Upper crossed syndrome can have detrimental effects on anyone from an everyday blue collar worker to a professional athlete as it is characterized by hypersensitive points called trigger points found in one or more muscles and/or connective tissues. An active trigger point is defined as a hyperirritable spot in skeletal muscle that is associated with a hypersensitive palpable nodule in a taut band. They are tender on compression and may give rise to referred pain, motor dysfunction and autonomic responses. Muscles with active trigger points appear hypertonic, weak and are also sensitive to stretch. Physical therapy modalities such as hot packs, Interferential Therapy and ultrasound along with exercises and dry needling are used in the treatment of this frequently encountered disease.

Dry Needling

Over the years, dry needling has become a popular treatment technique in manual physical therapy. Although various dry needling approaches exist, the more common and best supported approach targets myofascial trigger points. Contemporary schools approach dry needling from a broad pain sciences perspective. Dr. Yun Tao Ma, PhD, educator, researcher, founder of the American Dry Needling Institute, is an internationally recognised and highly respected authority in the field of Rehabilitation. Ma has developed a dry needling approach based on clinical applications of pain sciences and he maintains that his ‘integrative systemic dry needling’ is required to restore and maintain normal physiology of soft tissues and to reduce systemic stress to improve homeostasis.

The ‘intramuscular stimulation’ dry needling approach developed by Gunn is one of the first medical dry needling approaches. Gunn considers myofascial pain to be secondary to neuropathy. A few studies demonstrated the efficacy of intramuscular stimulation. Dommerholt and Huijbregts focused on dry needling of trigger points, which occasionally has been interpreted erroneously as a more ‘local’ approach. Trigger point dry needling has local and widespread effects and influences remote parts of the body. A superficial and a deep technique have been developed, whereby proponents of superficial needling suggest that the intervention targets primarily peripheral sensory afferents, while deep trigger point dry needling targets mostly dysfunctional motor units.

Outcome Measures

- Numeric pain rating scale (NPRS)
- Neck disability index: Neck Disability Index (NDI) was used to evaluate the extent of disability in the activities of daily living. The NDI which is a 10-item questionnaire that measures a patient’s self-reported neck pain related disability was found to be 9.

Patient: ____________________________

File#: ___________________ Date: ____________

PLEASE READ INSTRUCTIONS:
This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any section relate to you, but just make the box which most closely describes your problem.
PAIN SCALE:
Rate the severity of your pain by checking one box on the following scale.

No Pain         Excruciating
0   1   2   3   4   5   6   7   8   9   10

Neck Disability Index
- Craniovertebral (CV) angle: Previous studies have found an association among forward head posture (FHP), neck pain and disability. The studies found that subjects with head, neck, and shoulder discomfort are more likely to have a smaller CV angle that indicates a FHP than that of asymptomatic individuals. To assess the severity of forward head posture, CV angle is measured by drawing a horizontal line through the spinous process of C7 vertebra with the tragus of the ear on a still photograph from lateral view with patient in sitting position.
- Manual muscle testing
- Range of motion
- Muscle tightness

CASE REPORT
A 32 year old male patient working as an IT professional complained of pain in the nape of neck for the past few days. He also complained of inability to rotate neck on either side and work on the computer for long durations. There was no complaint of numbness, tingling or radiating pain in the arms. Patient has had similar episodes in the past. The patient scored his pain as 6/10 on NPRS which he reported would be aggravated while working on computers for a long time and rotating the head to terminal ranges of neck movement. The pain decreased with rest and hot water fomentation. On observing closely, the patient had a forward head posture and protracted shoulders. The CV angle of the patient was 22.27 degrees.

Examination revealed restricted ranges of motion in neck rotations and side flexion. Muscle strength was decreased in lower and middle trapezius, serratus anterior, rhomboids, deep neck flexors and scaleni. Muscle tightness was observed in Pectoralis major, upper trapezius, levator scapulae, sternocleidomastoid muscles. Trigger points were palpated in the bilateral upper fibres of trapezius.

TREATMENT PROTOCOL
The treatment protocol used for the patient was hot packs on upper back covering the nape of the neck for 15 minutes. This was followed by stretching of the Pectoralis major, upper trapezius, levator scapulae and sternocleidomastoid muscles. Each stretch was held for 30 seconds and was repeated thrice.

The trigger points that were palpable in bilateral upper fibres of trapezius, sternocleidomastoid (SCM) and scalene were addressed with dry needling. Standard acupuncture (0.25mmX 25mm) needles were inserted into the skin over trigger points (Fig. 2-4) to a depth of approximately 20 mm. usually during dry needling there is an initial twitching of muscles or a feeling of dull pain which was noted in this patient too. The needle was kept inserted for 10 minutes. Hot packs and stretching exercises were continued for a week and dry needling was done twice a week.

RESULTS
After seven days, the outcome measures were reassessed. The NPRS was 2/10 and pain was only felt during long driving hours. The CV angle was measured to be 27.41 degrees and the NDI score was 2 and the neck range of motion was full and pain free.
DISCUSSION

The patient who complained of pain while working on computer for long hours had decreased pain after seven days of treatment. As per previous studies, long working hours on computer leads to prolonged flexion at cervical spine with consequent higher activity in the cervical erector spinae and upper trapezius muscles, with a posture in which the trunk is slightly inclined backward. This forward head posture reduces the average length of muscle fibres, which contributes to extensor torque at the atlanto-occipital joint, and it is possible that this shortening reduces the tension generating capabilities of muscles. The reason for discomfort during driving could be because of sustained postures adopted during those long hours. Prolonged sitting (static posture) or muscular inactivity can exert tension (load) on the musculoskeletal structures, thus leading to musculoskeletal discomfort. A relationship between longer duration of driving and musculoskeletal discomfort is supported by various studies.

The outcome of decreased pain and improved ranges was seen as NDI decreased from 9 to 2 as in Figure 5. The intervention of hot water fomentation, stretching and dry needling for seven days was given. The hot packs given during the session helped in relaxing and then releasing the tight muscles. The stretching exercises helped stretch the tight muscles to their optimal length thus, rectifying the muscle imbalance. The dry needling helped in proper muscles activation which was earlier not in optimal use due to weakness. And also it led to release of trigger points which limit full excursion of the muscles and are also a source of pain. NDI decreased from 9 to 2 as in Figure 5. The intervention of hot water fomentation, stretching and dry needling for seven days was given. The hot packs given during the session helped in relaxing and then releasing the tight muscles. The stretching exercises helped stretch the tight muscles to their optimal length thus, rectifying the muscle imbalance. The dry needling helped in proper muscles activation which was earlier not in optimal use due to weakness. And also it led to release of trigger points which limit full excursion of the muscles and are also a source of pain.

The advantages of dry needling are increasingly documented and include an immediate reduction in local, referred, and widespread pain, restoration of range of motion and muscle activation patterns, and a normalization of the immediate chemical environment of active myofascial trigger points. Dry needling can reduce peripheral and central sensitization.

FUTURE SCOPES

Studies with large sample size should be conducted to see the effect of Dry needling in patients with Upper crossed syndrome.

CONCLUSION

The use of dry needling and muscle stretching exercises may be beneficial in the treatment of upper crossed syndrome.

REFERENCES

Funny Bone

I Was Going To Be A
DOCTOR
But My Handwriting
Was Too Good

PHARMACY

I Think it says
take 2 capsules
300 times
A DAY...
or something...

"It's good that you're eating more fresh
fruit and vegetables, but be careful
to chew more thoroughly."

"You caught a virus from your computer and
we had to erase your brain. I hope
you've got a back-up copy!"

An Alternative Medical Dictionary:

1. Artery - The study of paintings
2. Barium - What Doctors do when patients die
3. Morbid - A higher offer
4. Outpatient - A person who has fainted
5. Post Operative - Letter carrier
6. Recovery Room - Place to do upholstery
7. Seizure - Roman Emperor
8. Labour Pain - Hurt at Work
9. Terminal Illness - Getting sick at the airport
10. Urine - Opposite of 'you're out'