Proforma-I

Print Key: MjM5ODI4MDIyMDI0MTIyOA==

Inter district transfer of Judicial Officer

Remarks/assessment of Chief Medical Officer/Chief Medical Superintendent along with verified/countersigned papers

I, Dr Amod Kumar CMO/CMS SIC have perused the documents presented before me by Sri **JAINENDRA KUMAR PANDEY** (ID No **UP2398** Designation **Spl. J. (SC/ST, Pev.of Atroci Act), Azamgarh OR** on his behalf by Sri ..... Relation with the officer ..... Phone No. 9838111103

- I have personally examined Sri/Smt./Sushri. Nand lal Pandey who is suffering from the disease/syndrome/disability FUC of colonic perforation c GI S Milk bleed c Colostomy and in my opinion he/she may require frequent hospitalization for treatment/management.
- I also verify that Sri/Smt./Sushri. Nand lal Pandey ..... is suffering from the disease/syndrome/disability/disorder ..... [Name of the disease] ..... and this disease is mentioned at paragraph no. .... of the Annexure-I enclosed herewith.
- In my professional opinion and assessment, I am convinced that the treatment/management of the above-mentioned disease/syndrome/ disability/disorder in paragraph two above is possible ONLY at the districts mentioned by the officer in his/her application submitted to Hon'ble High Court.
- The treatment/management of the above-mentioned disease/syndrome/disability/disorder in paragraph two above is also available at the districts namely .. lucknow .....
- I am aware that this document may be presented by the competent authority/applicant for further use by a competent Medical Board.
- This document shall be valid only for ..... months only.

28/02/24

Signature with seal (C.M.O./C.M.S.)

मण्डलीय जिला चिकित्सालय आजमगढ़ प्रमुख अधीक्षक

Name: DR. AMOD KUMAR

ID No.: .....

Designation: SIC, ADH, Azm.

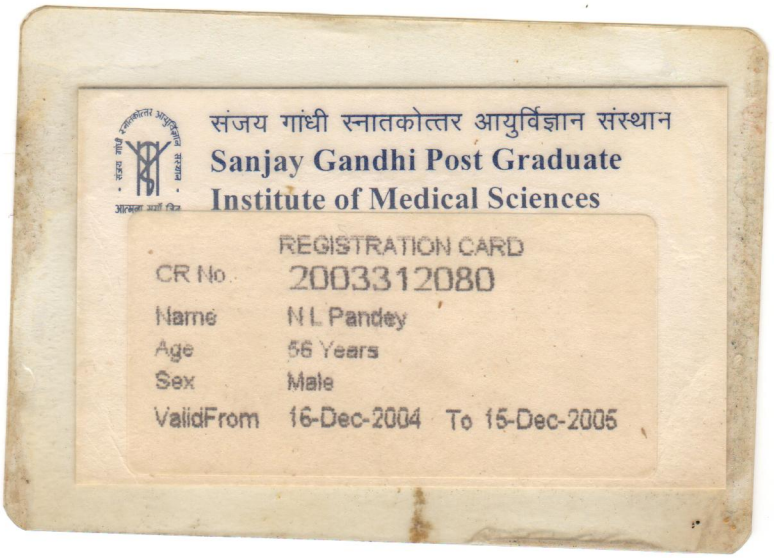
Telephone No. .....

Mobile No. 9415252327

1. *Concerned District Judges/Officers in equivalent rank to get these matter expedited from the office of CMO/CMS*

2. *The CMO/CMS are requested to retain the copy of this documents and documents placed before them for issuance of this document for future reference*

This document is printed on **28/02/2024 12:28:18**, By IP Address: **42.105.153.21**



संजय गांधी स्नातकोत्तर आयुर्विज्ञान संस्थान
Sanjay Gandhi Post Graduate
Institute of Medical Sciences

REGISTRATION CARD

CR No. 2003312080
Name N L Pandey
Age 56 Years
Sex Male
ValidFrom 16-Dec-2004 To 15-Dec-2005

Sanjay Gandhi Post Graduate Institute of Medical Sciences

Raebareli Road, Lucknow - 226 014 ,India

Discharge Summary

CRNO: 2003312080 **Name:** N L Pandey 72/ Y/M **Department:** Surgical Gastroenterology

Unit: UNIT-4 **Ward/Bed:** 1501 Emergency Wing A00 / GEN / 16

Admission No: ADM-202132519 **Admitted on:** 19-11-2021 13:48 **Discharged on:** 13-Dec-2021 11:02 AM

Patient Type: Emergency **Consultant:** Ashok Kumar **Discharge Type:**

Correspond. Address: 4/41 POSTAL COLONY,Aliganj **Distt.** Lucknow **State** Uttar Pradesh **Pin No.** **Phone No** 9415181865

Diagnosis- colonic perforation with massive lower GI bleed in case of SRUS st LAR with covering Loop ileostomy closure k/c/o HTN &BPH

Mr Nand lal pandey, 79/m r/o amedkar nagar retd govt employee (post director) / no addiction /allergy
k/c/o HTN for last 30yrs on anti HTN (telma 40 mg bd and clinidipine 10 mg od).
h/o pile surgery in 1973 (no documents)
h/o of TURP for BPH in (2003,2012)
h/o of blood transfusion

Antecedental h/o- presented with bleeding per rectum and pain in perianal region- diagnosed as Solitary rectal ulcer syndrome evaluated by sigmoidoscopy-4-11-03 -growth at 7cm post rectal wall.
Biopsy- well dx mucinous adenoca
underwent LAR (10 dec 2003)

PROCEDURE -LOW ANTERIOR RESECTION WITH COVERING ILEOSTOMY (DOUBLE STAPLED) 10/12/2003

FINDINGS - growth in lower rectum confined to wall .bulky rectal mesentry. multiple enlarged nodes in the rectal mesentry.normal colonic vascular anatomy.no L.N in lateral pelvic wall/root of inferior mesentric vein /RPLN .no pelvic /mesentric/peritoneal deposits . no free fluid/liver SOL .Multiple areas of fibrous thickening in the small bowel mesentry with interloop adhesions. mesentric fat creeping present.no mesentric L.N.c/sw -2 cm polypoid growth with broad pedicle in the lt.lateral wall of lower rectum 2cm from dentate line.distal margin 1.5 cm .distal doughnut incomplete.Rest of colonic segment normal.

post op course - pt had ASBO -resolved with conservative management.He also had fever with high counts--?localised pelvic collection--USG normal,resolved with antibiotics.
Later he was admitted for colostomy closure.
DRE-intact suture lines of previous LAR,no stricture or deposits.
HPE- The findings are suggestive of solitary rectal ulcer. No tumor tissue is seen.

colonoscopy (16-04-2004)-anastomosis at 8 cm,?diverticulum at 3 o clock position.
barium enema (27-04-2004) showed anastomotic leak,ileostomy closure deferred.
loopogram showed minimal extravasation above the anastomotic site, surgery was postponed.

admitted for stoma closure -

Operation details :Date of Operation: 07-Jul-2004 RT inguinal meshhernioplasty + stapled ileostomy closure
Findings: 7-7-04.Side to side (functional end to end) .widened sup.external ring. indirect incomplete sac.contents reduced.

BED HAS NOT BEEN VACATED FROM SYSTEM

Discharge Summary

CRNO: 2003312080 **Name:** N L Pandey 72/ Y/M **Department:** Surgical Gastroenterology

posterior fascia weak. loop ileostomy flimsy adhesions.cutends healthy and bleeding.

post operative course : re-exploration done for adhesive intestinal obstruction..

Date of Operation: 13-Jul-2004 : PROCEDURE -ADHESIOLYSIS+PEROPERATIVE PROCTOSCOPY

FINDINGS -dilated small bowel loops . caecum and entire colon till the pelvis distended .dense small bowel adhesions in the pelvis . flimsy adhesions around the ileal anastamosis which are tethered to the hernia repair site. flimsy interloop adhesions .minimal free fluid.no perforation.no intraabdominal /pelvic abcess .

post re- exploration : gradually imroved.loose stools persisting along with partial incontinence.frequency 14 times per day improved to 7 times per day.wound strapped on day 14 of initial exploration.oral from day 5 of re exploration

He was symptomatically free from feb 2004 to nov 2021

PRESENT ADMISSION :

c/o of bleeding per rectum for last 7 days

hematochezia for last 3 day

HOPI- he was apparently alright 7 day back then he developed suddenly painless intermittent small amount 20-50ml bleeding per rectum 2-3 times a day for last 5 day then for last 2 day he was presented with large amount hemotochezia and associated with syncope and dizziness.

No h/o fever ,jaundice ,abdominal pain and distension ,obstipation

No h/o Loss of weight and Loss of appetite

person h/o – veg diet , no addiction , bladder habit and sleep pattern normal

family h/o- not contributory

GPE – Conscious alert

PR 106/min, BP 116/76 mm of hg,Temp =AF,RR=16/min

SPO2-98@RM

Pallor+, no icterus,no pedal edema

chest-B/L clear ,no added sound BHT=30 sec

Per abdomen- soft, healthy , lower midline healthy scar , and one in RIF previous drain site no tenderness , and no organomegaly, ,no shifting dullness BS +

DRE- malaena present ,no growth and mass felt.

Evaluation –

CT scan -12/1/21-circumferential wall thickness of rectum with wall calcification present

Colonoscopy-13/11/21- scan till transverse colon .Anastomotic site edematous and ulcerated with blood in blind loop

No active intervention done bleeding stop at moment sponteneously and rest of colon normal.

Procedure : Exploratory laporotomy , clot evacuation, end colostomy with Distal stump closure done under GA on 21/11 /2021

BED HAS NOT BEEN VACATED FROM SYSTEM

Discharge Summary

CRNO: 2003312080 **Name:** N L Pandey 72/ Y/M **Department:** Surgical Gastroenterology

Findings :Dense bowel to parities and Inter bowel adhesions present.Gaseous distention of the large bowel and small bowel .No e, o any blood in small bowel / Ceacum/ ascending colon / Transverse colon and descending colon. Ileal loops densely stuck to the pelvis.On dissection There is a perforation of 5 x 3 cm present on the anteriolateral aspect of the colon with a cavity of 6 x 5 cm collected with Blood and pus present. Edges of the perforated part is unhealthy. Left colon is mobilised up to splenic flexure and division done with Relimax 80 approx 6 cm proximal to the perforation. Proximal bowel decompression done.End colostomy done in the left iliac fossa.Stapled distal stump is fixed to parities
Stoma matured with Vicryl 3-0 and fixed to sheath at 2 points.
A 28 fr drain placed in the pelvis at the perforation site.

POST OPERATIVE COURSE : Post Sx patient was shifted to POST OP ICU on mechanical ventilation. extubated next day and shifted to ward
on POD4, 100 ml blood was there in peri drain bag, suspecting source from skin / subcutaneous tissue at drain site, purse string sutures taken. Resuscitated with Adequate blood products. Hb/HCT monitored 6 hourly. sucralfate enema startred BD. by evevning 20 ml more clotted blood was there from peri drain region.
following this event 5-10 ml blood was coming daily in the drain and patient started throwing multiple high grade fever spikes. managed conservatively, adequate blood products transfused as and when required. and antibiotivs upgraded based on c/s. for which he responded.
on POD 9 (30/11/2021)- 100 ml fresh blood was there in the drain, patient had tachycardia and tachypnoea- resuscitated
urgent CECT was done after stabilisation- that showed 8 x 5 cm hematoma with air foci seen in pelvis right to the bladder, drain seen in the cavity placed during Sx
B/L mild to moderate pleural effusion with underlying atelectasis
ascites +
for hematoma- short colonoscopy was done to see site of bleeding **BY DR SAMIR MOHINDRA**
short colonoscopy (30/11/2021)- seen till 25 cm from anal verge. from 10cm extending till 15cm, a large perforation seen on lateral wall of rectum. the defect is lined with unhealthy granulation tissue and slough. no active bleeding / spurting / visible vessel could be identified
the mucosa of rectum appears ulcearted throughout the examined section with overlying slough
on same day he had c/o right lower limb weakness with pain right inguinla region and upper thigh- neurology opinion taken **(under unit 1) -** o/e- sensory system - normal with motor weakness on right side
cause - hypokalemia / pelvic collection causing pain
hypokalemia correction started
from drain saline irrigation / suction was done twice- gradually he started ambulating
chest - improved with incentive spirometry, chest physiotherapy and nebulisation and diuretics
rest throughtout this course he was tolerating complete oral diet- stoma is healthy, functional
WOUND- closed on POD 6, significant serous discharge was there from midline that gradually stopped

BED HAS NOT BEEN VACATED FROM SYSTEM

Sanjay Gandhi Post Graduate Institute of Medical Sciences

Raebareli Road, Lucknow - 226 014 ,India

Discharge Summary

CRNO: 2003312080 **Name:** N L Pandey 72/ Y/M **Department:** Surgical Gastroenterology

CONDITION AT DISCHARGE : hemodynamically stable
tolerating complete oral diet - stoma functional and healthy
stoma care explained
wound- healthy
drain - 50 ml/ day (no freash blood)
no fever spikes x 3 days
chest- no added sounds, spirometry - 3L
ambulating , self voiding

ADVICE : high protein diet
avoid high fibre diet, nuts, fruits and vegetables with seeds and skin
stoma care
suture removal at nearby hospital after 10 days
drain care (monitor daily output chart), if fresh blood is there in drain or per rectally, immediately visit nearby hopsital and SGPGI ERS
tab pan 40 mg ODAC – o
tab silodosin 8 mg OD – o
tab rosuvastatin 10 mg OD – o
tab amlodipine 5 mg OD – o
tab otski OD – o
tab IFA OD – o
tab A to Z OD – o
pour sucralfate 10 ml in drain and keep it clamp for half an hour x tds – o o o
to follow up in SGE OPD after 2 weaks under PROF ASHOK KUMAR on monday / thursday with prior appointment

Signature of Consultant

BED HAS NOT BEEN VACATED FROM SYSTEM

Name N.L. Pandey

Age 79 Sex M

CR No. 2003312080

SGE No. 49473

Blood Group B+ Weight at discharge

DOA 19/11/21 DOO 21/11/21 DOD 13/12/21

Consultnat I/C Prof Ashok Kumar

Final Diagnosis Colonic perforation c Massive Lower GI bleed in a PU/cO SRUS at CAR c CLT at Ileostomy closure in a KC/O HTN/BPH

Operative procedure performed:

exp lap. clot evacuation, end colostomy c distal stump closure

Histopathology/Cytopathology

No._____ Date_____

REPORT

Advice on Discharge High protein diet

- Avoid High fibre diet / Nuts / fruits and veg ē skin and seeds
- Stoma care
- Suture Removal at nearby Hospital after 10 days
- Drain care (Monitor daily output) if fresh blood is seen in drain / per rectally. Immediately visit nearby Hospital / SGHGH ER
- Tab pan 40mg OD AC
- Tab Silodosin 8mg OD
- Tab Rosuvastatin 10mg OD
- Tab Amlodipine 5mg OD
- Tab otski OD
- Tab IFA OD

Name _____

Age _____ Sex _____

CR No. _____

SGE No. _____

Blood Group _____ Weight at discharge _____

DOA _____ DOO _____ DOD _____

Consultnat I/C _____

Final Diagnosis _____

Operative procedure performed:

- Tab A to Z OD
- Pour Sucralfate 10ml in drain and keep it clamp for half an hour x TDS
- To follow up in SGE OPD after 4 weeks / Req Ashok Kumar on monday / thursday ē prior Appointment
- To follow up in cardiology OPD for HTN

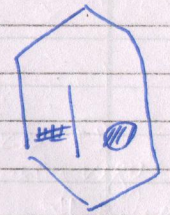
Dinya
SR SGE

Follow

Date	Weight	
21/4/2022		Asymptomatic, except that c/o Pain in (R) lower limb Colostomy healthy.
	Hb:	11.2gm% (30/3/2022)
		Adv: . Neurology Consultation Syp Cremaffin SOS
		FU/for SOS.

Up

Date	Weight	
19/10/2023		Asymptomatic
		No wt loss.
		Adv: Regular follow up. & if symptomatic for Hernia. → Surgery



Adv: Stoma bag