INSTITUTE OF LIVER & BILIARY SCIENCES
(An Autonomous Society under Government of NCT of Delhi)
D-1, Vasant Kunj, New Delhi, India
ilbs Phone No: 011-46300000 Ext, 7055 & 7056, 011-26706700 - 02, 64703890
Fax No.46300010
Email : info@ilbs.in, Website: http://www.ilbs.in

Discharge Summary

Patient :	Mr. RAJEEV SHUKLA	UHID :	ILBS.0000253905
Age :	47 Year(s)	Inpatient No :	IPID.0072446
Gender :	Male	Admission Date :	14 Aug 2021 01:20 PM
Ward :	Private Room 4th floor (Ph-2)	Discharge Date :	17 Aug 2021 04:22 PM
Speciality :	Hepatology Unit 1	Bed No :	2478
Consultant :	Dr S. K. SARIN		

DIAGNOSIS:

Portal Hypertension-(Non Bleeder, Gr.III varices with RCS, mild PHG, antral GAVE with ulcer, S/P - EVL)- 16/08/2021

CLD Ethanol related(LI- Dec 2020)

Decompensated- Ascites(High SAAG, low protein, no SBP)

CTP- 8,CHILD-B , MELD Na-121

Current issues- fever

- Severe anaemia(Hb-4.7--> 6.4)

Comorbidity- post COVID 19(recovered-Dec 2020)

- T2DM

Self Attested

PRESENTING COMPLAINTS:

Fever x 2 days

Generalised weakness

INDICATION FOR ADMISSION:

Evaluation and the management of the symptoms

HISTORY:

Mr. Rajeev Shukla is a 47 years old male, ethanolic(LI-Dec 2020), non-smoker, with h/o COVID 19 (recovered-Dec 2020) and comorbidities of T2DM. Post COVID he had severe generalised weakness for which he was evaluated and found to have severe anaemia i/v/o which he had 5 units of BT. He had his index presentation in March 2021 in the form of abdominal distension which was insidious in onset, painless, gradually progressive, associated with B/L pedal edema, not associated with clay coloured stool. He underwent UGIE which showed GAVE and PAC was done. Now he has come with the complain of high grade fever, intermittent in nature and not associated with chills. There is no h/o jaundice, cough, vomiting, abdominal pain, altered bowel habits, hematemesis, malena, altered sensorium, burning micturition or decreased urine output. With these complains he came to ILBS and got admitted for further evaluation and management. There is no h/o any

Discharge Summary

Patient	Mr. RAJEEV SHUKLA	UHID	LBS.0000253905
Age	47 Year(s)	Inpatient No	PID 0072446
Gender	Male	Admission Date	14 Aug 2021 01:20 PM
Ward	Private Room 4th floor (Ph-2)	Discharge Date	17 Aug 2021 04:22 PM
Speciality	Hepatology Unit 1	Bed No	2478
Consultant	Dr S. K. SARIN		

intoxications, indigenous medications, blood transfusions or IV drug abuse prior to onset of the disease. There is no h/o HTN/CAD/COPD/thyroid disorders.

EXAMINATION:

Pt. was conscious, oriented to time place and person.

BP: - 100/758 mm Hg, Pulse: - 98/min, RR: - 20/min and febrile.

Pallor++, Icterus-, Cyanosis-, Clubbing-, Pedal edema (pitting type) - , LNP-, JVP normal

On systemic examination

Respiratory system:--B/L vesicular breathing, B/L airway equal air entry, no wheeze, no crepts

Cardiovascular system: - S1 S2 normal, no murmurs

CNS: - conscious, oriented with no sensorimotor deficit,

Per Abdomen examination

ON INSPECTION: - distended abdomen, umbilicus central and inverted, skin over the abdomen is stretched with no visible venous prominences, no visible pulsations.

ON PALPATION: - soft, non-tender, liver- palpable 2 cm BCM, Spleen - just palpable, No guarding, no rigidity, no rebound tenderness.

ON PERCUSSION: - dull note, free fluid present.

ON AUSCULTATION-normal bowel sounds present,

SYSTEMATIC REVIEW:

Patient was admitted with the above mentioned complaints. His examination findings were as mentioned above. His initial lab data revealed Hb/TLC/PLT-4.7/15.3/9.86/75,PT/INR-18.7/1.68, BU/S.Creat-20.5/0.82 with serum Na/K/Cl-132/3.65/102. LFT showed S.Bil-(total/direct/indirect:1.48/0.4/1.08,AST/ALT-27/20, SAP/GGTP-83/85, Alb/Glob-3.09/2.97. Sepsis screen was sterile. PCT-0.72. I/V/O severe anaemia he was transfused with 2 units of PRBC . NCV was also done which showed which showed normal study. He underwent UGIE which showed Gr.III varices with RCS, mild PHG, antral GAVE with ulcer and EVL was done on 16/08/2021. The procedure was uneventful and there was no post procedural complications. Patient was treated with iv antibiotics, nutritional support and other supportive medications. He recovered symptomatically following the management and now he is being discharged in hemodynamically stable state with the advice to follow up in OPD.

Discharge Summary

Patient	Mr. RAJEEV SHUKLA	UHID	LBS 0000253905
Age	57 Year(s)	Inpatient No	PID 0072446
Gender	Male	Admission Date	14 Aug 2021 01:20 PM
Ward	Private Room 4th floor (Ph-2)	Discharge Date	17 Aug 2021 04:22 PM
Specialty	Hepatology Unit 1	Bed No	2478
Consultant	Dr S. K. SARIN		

At the time of discharge his lab reports were Hb/TLC/PLT-6.4/7.4/150,BU/S.creat-24.8/0.82, Na/K-,131/4.35, S.Bil(T/D/I)-2.08/0.5/1.58,AST/ALT-37/20,SAP/GGT-90/94,Alb/glo-3.2/3.4

PLAN / ADVICE AT DISCHARGE (Including duration of medication if any):

1800 Kcal/day 90 grams protein/day, low salt (<2grams/day), diabetic diet

Weight reduction with daily 30 min exercise

Tab Taxim O 200 mg PO BD — 1-0-1 x 5 days — 10am 10pm After meal.

Tab Levoflox 500 mg PO OD — 1-0-0 x 5 days — 1 tab.

Tab Lasilactone 20/50 mg 1/2 tab PO OD — 1/2-0-0 (monitor KFT)

Tab Ciplar LA 20 mg PO BD — 1-0-0(stop if HR <55/min, BP<90/60 mm/Hg)

Tab Midodrine 2.5 mg PO TDS — 1-1-1(monitor BP)

Tab Nuheme 12 mg PO OD — 1-0-0 2pm.

Cap Vitaneuron OD PO OD — 1-0-0 10am After meal.

Tab Amlodipine 5 mg PO SOS — Emergency. when B.P. too high.

Efezac Sachet 1 sach PO BD — 1-0-1

Syp Lactihep 30ml PO SOS — if Constipation.

Inj. Lantus 10 unit morning, 8 unit S/C HS — 10am.

Self Attested BSharma

Inj. Albumin 20% 100 ml IV once a week under medical supervision over 4-6 hours

Adv: Regular blood sugar charting at home, hypoglycaemia education given

Review in Hepatology OPD with CBC/LFT/KFT/INR reports after 4 weeks

Next follow up - Virtual / Physical OPD after 1 week.

WHEN TO OBTAIN URGENT CARE:

1. Vomiting of blood / blood in stool or black colour stool.
2. Any alteration in state of consciousness
3. Sever Dizziness or fainitng spells
4. Fever, new onset or worsening of abdominal pain.
5. Worsening of jaundice.
6. Chest pain / shortness of breath
7. Severe nausea, vomiting.
8. Any other _____

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Discharge Summary

Patient :	Mr. RAJEEV SHUKLA	UHID :	ILBS.0000263905
Age :	47 Year(s)	Inpatient No :	IPID:0074082
Gender :	Male	Admission Date :	09 Oct 2021 11:28 AM
Ward :	Private Room 5th floor (Ph-2)	Discharge Date :	13 Oct 2021 05:03 PM
Speciality :	Hepatology Unit 1	Bed No :	2528
Consultant :	Dr S. K. SARIN		

DIAGNOSIS:

PHTN- Bleeder/Large high risk varices with RCS with mild PHG, antral GAVE / S/P EVL+ APC- 09/10/2021

CLD Ethanol related (LI- Dec 2020)

Decompensated- Ascites/ High SAAG, low protein/ no SBP

Jaundice

CTP- 8 CHILD-B MELD Na-16

Co morbidities- Type II Diabetes

post COVID 19 status

self Attested

Current issues- melena

- worsening ascites

PRESENTING COMPLAINTS:

Abdominal distension and sudden weight gain from last 2 weeks

INDICATION FOR ADMISSION:

Evaluation and the management of the symptoms

HISTORY:

Mr. Rajeev Shukla is a 47 years old male, ethanolic(LI-Dec 2020), non-smoker, with h/o COVID 19 (recovered-Dec 2020) and co morbidities of T2DM. Post COVID he had severe generalized weakness for which he was evaluated and found to have severe anemia which was managed by blood transfusions. He had his index presentation in March 2021 in the form of abdominal distension which was insidious in onset, painless, gradually progressive, associated with B/L pedal edema, not associated with clay colored stool. He underwent UGIE which showed GAVE and APC was done. Now he has come with complains of progressive abdominal distension and sudden weight gain (approx ~

Discharge Summary

Patient	Mr RAJEEV SHUKLA	UHID :	ILBS.0000253905
Age	47 Year(s)	Inpatient No :	IPID.0074082
Gender	Male	Admission Date :	09 Oct 2021 11:28 AM
Ward	Private Room 5th floor (Ph-2)	Discharge Date :	13 Oct 2021 05:03 PM
Speciality	Hepatology Unit 1	Bed No :	2528
Consultant	Dr S. K. SARIN		

11kg in 2 weeks). There is no h/o jaundice, cough, vomiting, abdominal pain, altered bowel habits, hematemesis, malena, altered sensorium, burning micturition or decreased urine output. With these complains he came to ILBS and got admitted for further evaluation and management. There is no h/o any intoxications, indigenous medications, blood transfusions or IV drug abuse prior to onset of the disease. There is no h/o HTN/CAD/COPD/thyroid disorders.

EXAMINATION:

Pt. was conscious, oriented to time place and person.

BP: - 100/758 mm Hg, Pulse: - 98/min, RR: - 20/min and febrile.

Pallor++, Icterus-, Cyanosis-, Clubbing-, Pedal edema (pitting type) + , LNP-, JVP normal

On systemic examination

Respiratory system:--B/L vesicular breathing, B/L airway equal air entry, no wheeze, no crepts

self Attested BSharma 09

Cardiovascular system: - S1 S2 normal, no murmurs

CNS: - conscious, oriented with no sensorimotor deficit,

Per Abdomen examination

ON INSPECTION: - distended abdomen, umbilicus central and inverted, skin over the abdomen is stretched with no visible venous prominences, no visible pulsations.

ON PALPATION: - soft, non-tender, liver- palpable 2 cm BCM, Spleen - just palpable, No guarding, no rigidity, no rebound tenderness.

ON PERCUSSION: - dull note, free fluid present.

ON AUSCULTATION-normal bowel sounds present,

SYSTEMATIC REVIEW:

Patient was admitted with the above mentioned complaints. His examination findings were as mentioned above. His initial lab data revealed Hb/PCV/TLC/PLT-7.1/21.3/3.7/52, PT/INR-18.3/1.56, BU/S.Creat-36.8/1.18 with Na/K-134.7/4.5. LFT showed S.Bil(T/D/I)-0.94/0.2/0.74, AST/ALT-44/26, SAP/GGT-73/112, Alb/Glob-3.16/3.28. NH3-80.7/PCT-1.02/ Fibrinogen-249.2/ AFP-3.4. Urine routine

Discharge Summary

Patient	Mr. RAJEEV SHUKLA	UHID	LBS 0000253905
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Consultant	Dr S. K. SARIN		

showed normal study. USG abdomen showed enlarged liver measures 16.4 cm in cranio-caudal span and shows irregular, lobulated outlines with coarsened echotexture. Left and caudate lobes are hypertrophied. Intrahepatic biliary radicles are not dilated. No evidence of focal lesion is seen. Main portal vein at porta is patent and shows normal colour filling, waveform pattern with hepatopetal flow and phasicity. It measures 15.8 mm in calibre. PSV is approximately 26 cm/sec. In view of low Hb he was transfused with 1 unit LD-PRBC. Sepsis screen was sterile. NCV was also done which showed which showed axonal sensory motor neuropathy. He underwent UGIE which large high risk varices with RCS, mild PHG, Antral GAVE and EVL+APC was done on 09/10/2021. The procedure was uneventful and there were no post procedural complications. Patient was treated with IV antibiotics, nutritional support and other supportive medications. He recovered symptomatically following the management and now he is being discharged in hemodynamically stable state with the advice to follow up in OPD.

At the time of discharge his lab reports were Hb/PCV/TLC/PLT-8.1/25.2/4.3/42, PT/INR-19.0/1.62, BU/S.Creat-27.60/1.18 with Na/K-133.7/3.83. LFT showed S.Bil(T/D/I)-2.14/0.5/1.64, AST/ALT-386./24, SAP/GGT-54.7/96.4, Alb/Glob-2.91/3.04

PLAN / ADVICE AT DISCHARGE (Including duration of medication if any):

1800 Kcal/day 90 grams protein/day, low salt (<2grams/day), diabetic diet

Weight reduction with daily 30 min exercise

Tab Taxim O 200 mg PO BD 1-0-1 x 5 days then stop 8am-8pm

Tab Magnetor PO BD 1-0-1 10-10pm 8m

Tab Pantop 40mg PO OD 1-0-0 6am, 1 emptysto.

Tab Febustat 40mg PO OD 1-0-0 10am

Tab ME12 PO OD 1-0-0 10am

Cap Henzovit PO OD 1-0-0 10am

Tab Cirrosam 400mg PO OD 1-0-0 10am

Tab Lasix 20 mg PO OD 1-0-0 (monitor KFT)

(10am 4pm)

self Attested

Discharge Summary

Patient	Mr. RAJEEV SHUKLA	UHID :	ILBS.0000253905
Age	47 Year(s)	Inpatient No :	IPID.0074082
Gender	Male	Admission Date :	09 Oct 2021 11:28 AM
Ward	Private Room 5th floor (Ph-2)	Discharge Date :	13 Oct 2021 05:03 PM
Speciality	Hepatology Unit 1	Bed No :	2528
Consultant	Dr S. K. SARIN		

Tab Aldactone 50mg PO OD 1-0-0 (monitor KFT) 8 am

Tab Ciplar LA 20mg PO BD1-0-0(Stop if BP<90/50 mmHg or HR < 55bpm) 10 pm

Tab Midodrine 5 mg PO TDS 1-1-1(monitor BP) 9-2-10

Tab Nuheme 12 mg PO OD 1-0-0 10 am

Tab Thalidomide 50mg PO OD 1-0-0 10 pm

Hepsure Sachet 1 sach P0 BD 1-0-1 10-10

Syp Lactihep 30ml PO SOS half warm water

Syp Sucralfate 1 tsf PO TDS 1-1-1 9-3-10

Inj. Lantus 10 unit morning, 8 unit S/C HS

Inj. Albumin 20% 100 ml IV once a week under medical supervision over 4-6 hours

Adv: Regular blood sugar charting at home, hypoglycaemia education given

Review in Hepatology OPD with CBC/LFT/KFT/INR reports after 4 weeks

ER SOS.

Self Attested

Next follow up - Virtual / Physical OPD after 1 week.

WHEN TO OBTAIN URGENT CARE:

1. Vomiting of blood / blood in stool or black colour stool.
2. Any alteration in state of consciousness
3. Sever Dizziness or fainitng spells
4. Fever, new onset or worsening of abdominal pain.
5. Worsening of jaundice.
6. Chest pain / shortness of breath
7. Severe nausea, vomiting.
8. Any other _____

Senior Resident:

Dr. Satender Singh	Dr. Ajay Mishra	Dr. Abhijit Ranjan	Dr. Pinakee	Dr. Golamari Srinivasa Reddy	Dr. Navin Kumar M.	Dr. Venishetty Shantan
9013210873	9532870267	7388886826	7669611345	7760384694	9597373776	9030798867

Dr. Hitesh Singh	Dr. Priti	Dr. Manasa Alla	Dr. Vishnu Girish	Dr. Chandan Kumar	Dr. Opinder Kumar Bhagat	Dr. Akhil
7280930234	7042745437	9742919329	9645560617	9532770958	7006238077	8078120847