अ० भा० आ० सं० अस्पताल/A.I.I.M.S. HOSPITAL
बहिरंग रोगी विभाग /Out Patient Department
धूम्रपान करना मना है। / SMOKING IS PROHIBITED IN HOSPITAL PREMISES

GI SURGERY

IInd Floor

MON - WED -

01:30 PM to 03

OPR-6

एकक/Unit

विभाग/Dept.

Regn. No.

नाम/Name

पता/Address

New Patient
Dept Reg. 2018/018/0001789
G.I. Surgery/Unit-I कमरा/Room: 6 G.I. Surgery General/# 10
Name: ANITA CHAUDHARY Days : Mon,Wed,Fri
नाम: अनिता चौधरी
W/O VIJNEET CHAUDHARY 45Y महिला/F
पति : विजनीत चौधरी
Ph.8826212865
UHID : 103862659 Date.11/07/2018

निदान/Diagnosis CARCINOMA ASCENDING COLON (HEPATIC FLEXURE).

दिनांक/Date

उपचार/Treatment

DM ⊖
HTN ⊖
CAD ⊖
TB ⊖

HBSAg ⊕

chief complaints.

Breathlessness } x 5 months
easy fatiguability
LOA / LOW (3kg)

patient complaints of Breathlessness & easy fatiguability since 5 months for which she was evaluated at local hospital, where was found to have low Haemoglobin (8g) so she underwent work up

O/E - P/A - soft
PR - normal.

11/7/18

The I/c Hosp. adm. provide a pvt room elin pt for lap surgery.

N R Dash.

CECT (9/7/18) PVT → Annular thickening in the ascending colon measuring approx 9mm. Fat planes preserved with liver, kidney and duodenum.
Few Subcentimetric pericolonic lymph node (largest 7mm)

Colonoscopy - (9/7/18) PV7

Ascending colon → circumferential ulcerated polypoidal growth just beyond the hepatic flexure

Rest - (N).

Histopathology (1825639) - Moderately differentiated adenocarcinoma

MRI Brain (26/5/18) PV7. → pituitary micro adenoma.

PET Scan (12/7/18) PV7 → metabolically active thickening in ascending colon.

Rest - (N). Adv

- DIRC
- Liver clinic consultation for Hepatitis B.
- Neurosurgery ex for pituitary
- Review on wednesday.

Inv:
Hb - 7.7
urea - 16
creatinine - 0.6

21/07/18
TUESDAY
TO 10.30 AM
LIVER CLINIC
NEXT APPOINTMENT
DATE ..... 4.30 PM

18 JUL 2018

DIRC (9/7/2018 / 18/7/2018) : Annular thickening in ascending colon growth (+). pericolic fat stranding (+). Resectable.
chest → fibrotic changes in (L) chest.

NIKHILESH SPR 913

Plan:- 1) CEA.
2) Surgery → R.NO:-5.

बाह्य रोगी विभाग /Out Patient Department

अस्पताल के अन्दर धूम्रपान मना है। / SMOKING IS PROHIBITED IN HOSPITAL PREMISES

LIVER CLINIC
SAT. MORNING

OPR-6

कक्ष/Unit _____

विभाग/Dept. _____

ब०रो०वि० पंजीकृत सं०/O.P.D. Regn. No. _____

नाम/Name	पिता/पुत्र/पत्नी/पुत्री F / S / W / D of	लिंग Sex	आयु Age	पता/Address
Amrita chaudhry		F/45		10386259

निदान/Diagnosis

दिनांक/Date	उपचार/Treatment
1 JUL 2018 R-4 pan Sw	Anemia ↓ evaluation on evaluation found to have CRC- Growth in Ascending colon Moderately differentiated planned for Surgery Incidentally detected HBsAg +ve DNA Not done HBeAg - Neg Started on Tenfovir 300 mg OD Adv - Continue tenofovir 300 mg - R/u c Report
UGIE - N USGabd - Normal Bilirubin - 15/23 ALP - 122 Alb - 4.1 plan Fibroscan HBV DNA (Quantity)	

एकक/Unit Dr. A.S

विभाग/Dept.

DR. B.R.A. IRCH,AIIMS,NEW DELHI

IRCH No. 218197 Reg.Date-10/09/2018

Clinic Adult Medical Oncology Clinic Clinic No. 27537/2018

Deptt. MEDICAL ONCOLOGY
General

Name AMITA CHAUDHARY UHID-103862659

W/O- VINEET CHAUDHARY Sex/Age F/45Y

Phone No. 8826212865 Room 6 (Shift Morning)

Address JUDGE NOIDA, UTTAR PRADESH, Pin:0, INDIA

No. ADMOC-

नाम/Name

जन्म तिथि/Date of Birth

6-140

निदान/Diagnosis

2 4/9

दिनांक/Date

10.9.18

Ca Rt Colon pT3 No (IIA) mod. diff adeno CA

P/Rt hemicolectomy 31.7.18

PS-1

HBSAg +ve on Tenofovir

MSI-(H)

LVI (+)

Plan adjuvant chemotherapy CAPOX x 6 m

may truncate @ 3m (i/v/o Idea trial)

ado BSA - 1.53 sq m (Ht - 150 / Wt - 58 kg)

↓

Inj emset 8mg
Inj dexa 8mg | 100 ml NS | 30 min
Inj Rantac 50mg |

- Inj Oxaliplatin 200mg / 1 ⊙ D5 / 2 hr (000)
- Tab Capecitabine 1500 mg BD (D1 – D14) 3 tabs morning / 3 tabs evening (000)
Take with water within half hour after meals

- Post Chemo
- o/o/o Tab emset 8 mg tabs × 3 day [खाली पेट]
- ·/· – Tab Rantac 150 mg BD × 5 d
- ·/· – Tab dexa 8 mg BD × 3 d (खाने के बाद)

F/u c CBC / LFT / RFT on 24.9.18

अधिक दस्त :-
- WHO-ORS – 3L/day
- Cap. Immodium – 2 cap stat then 1 cap after each loose stool → New Emergency.

Genetic testing for lynch Sy – CORE 9654248623

(From 24/11)
19/11 – C4 CAPOX
– F/u 10/12/18 c CBC/BC

no toxicity
D+3
18: OPD 10/10/18 → CBC/urea/creat.
no toxicity
go for C#2 CAPOX as overleaf.
OPD – 31/10/18 – CBC/urea/creat

31/10/18 3/11/18
C#3 Capox as written overleaf
F/U – 29/11/18 c CBC/KFT

10/12/18

डा. बी. आर. अम्बेडकर संस्थान रोटरी कैंसर अस्पताल
Dr. B.R. Ambedkar Institute Rotary Cancer Hospital

OPR-6

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IRCH No. 218197

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Sex/Age F/45Y

Room 6 (Shift Morning)

एकक/Unit

विभाग/Dept.

नाम/Name

Regn. No.

जन्म तिथि/Date of Birth

निदान/Diagnosis Ca Colon, Adj.

दिनांक/Date	उपचार/Treatment
	10.12.18
	C_5 – 15.12.18 of CBC WNL
	– Inj Emeset 8mg + Inj Dexona 8mg.
	– Inj. Oxaliplatin 150mg IVI
	– Tab. Capecitabine 500mg 2-3X 14 days
	– Cap. Irochure [illegible]
	– Other supportive treatment as before
	– Review 2 weeks
	CBC, – CMP
	CBC + Biochem + LFT
2 weeks 18/2/19	10.12.18

सेंटरी कैंसर अ...
DR. B.R.A. IRCH...
...cology Clinic
...GY

18.2.19 — C. may be given — Genetic counseling
— Test for MLH-6
Pl. rpe as above
|
18.2.19

27.3.19

27/3/19
→ CEA, USG Abdo/Pelvis — Review after 3 months on 26/6/19
→ Annual CA125, Transvaginal USG } To screen for endometrial / ovarian tumor

SR/MO

27/6/19 → Gyne Review
→ F/u 3m c CEA c CBC
→ Colonoscopy → (9B)

18/9/19
18/09/2019
① F/U 30/12/2019 c CBC/S.CEA/USG to Review
②

KM
(Dr Harish)

OPD - 31/10/18 — CBC/USG/...
F/U — 29/11/18
c CBC/KFT

डा. बी. आर. अम्बेडकर संस्थान रोटरी कैंसर अस्पताल
Dr. B.R. Ambedkar Institute [illegible] Cancer Hospital
अ.भा.आ.सं. अस्पताल/
बहिरंग रोगी विभाग/Out
अस्पताल के अन्दर धुम्रपान मना है।/SMOKIN

DR. B.R.A. IRCH,AIIMS,NEW DELHI
IRCH No. 218197 Reg.Date-10/09/2018
Clinic Adult Medical Oncology Clinic Clinic No. 27537/2018
Deptt. MEDICAL ONCOLOGY
General
Name AMITA CHAUDHARY UHID-103862659
W/O- VINEET CHAUDHARY Sex/Age F/45Y
Phone No. 8826212865 Room 6 (Shift Morning)
Address JUDGE NOIDA, UTTAR PRADESH, Pin:0, INDIA

IRCH No. ___

एकक/Unit _____

विभाग/Dept. _____

नाम/Name	पिता/पुत्र/पत्नी/पति/पुत्री F/S/W/H/D of
Amita Chaudhary	45/F

निदान/Diagnosis: Lynch Synd / Cecolon (R) side.

दिनांक/Date	उपचार/Treatment
30/12/19	MSH-6 PT3NO → 8HCAPOX in CR Adv – UGIE (9B) – Daughter - Germline MSH6 testing - Son - CEA, CECT chest/Abdomen/Pelvis – F/U on 30/03/2020 ī CBC/CEA

डा. बी. आर. अम्बेडकर संस्थान रोटरी कैंसर अस्पताल
Dr. B.R. Ambedkar Institute Rotary Cancer Hospital

अ.[illegible] http://192.168.15.8/ehospital/opdreport/AIIMS_IRCH_opd_ticket_b...TAL OPR-6

अस्पताल EMISES

एकक/Unit _____
विभाग/Dept. _____
नाम/Name

DR. B.R.A. IRCH,AIIMS,NEW DELHI
IRCH No. 218197 Reg.Date-10/09/2018
Clinic Adult Medical Oncology Clinic Clinic No. 27537/2018
Deptt. MEDICAL ONCOLOGY
General
UHID-103862659
नाम अमिटा चौधरी
Name AMITA CHAUDHARY
W/O- VINEET CHAUDHARY Sex/Age F/47Y
Phone No. 8826212865 Room 6 (Shift Morning)
Address JUDGE NOIDA, UTTAR PRADESH, Pin:0, INDIA

n. No. _____
जन्म तिथि/Date of Birth

निदान/Diagnosis Lynch syndrome. / Ca Colon (R) side.
~~MSH6 mut~~

दिनांक/Date	उपचार/Treatment
10/8/20	Adv • LGIE (Colonoscopy) → 9B • USG Abd. + Pelvis. - F/U after 3 months
27/01/2021 Review 05/03/21	8/3/21 Review on 1/9/21 c LECT Abdo/Pelvis Doing OK F/u on 1/12/2021 c USG abdomen + pelvis CEA to document ET thickness
1/9/21	

Sravan
9052848508

Pal
9992905644

अंगदान-जीवन का बहुमूल्य उपहार/ORGAN DONATION - A GIFT OF LIFE
O.R.B.O., AIIMS, 26588360, 26593444, www.orbo.org Helpline - 1060 (24 hrs service)
बाहर से आने वाले रोगियों के लिए धर्मशाला की सुविधा उपलब्ध है/Dharamshala facility is available for outstation patients

01/12/21
Review → 09/03/2022
CBC / CEA.
Colonoscopy.

Rune
SR/MO.

/3/22 f/u c̄ CBC, CEA
after 6mon 21/9/22

[signature] SMMO

/9/22 f/u c̄ CBC, CEA on 21/12/2022
CECT chest/abd pelvis

Tab. A to Z 1 — 0 — x1month [illegible]

2/2022 f/u c̄ CBC CEA on
Annual Transvaginal USG – endometrium
Colonoscopy
UGIE

f/u x ~~22/3/2023~~ c̄ Report
21/6/2023

/23 f/u c̄ CBC LFT/KFT
CEA on ~~21/12/23~~ 14/6/24
CECT C/A/P

[signature]

...oscopy (N)

Endo

Fortis HOSPITAL Noida

International Oncology
Cancer Therapy Centres
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Cancer Therapy Centres
(A unit of International Oncology Services Pvt. Ltd.)
Fortis Hospital, B - 22, Sector - 62,
Noida 201 301, Uttar Pradesh (India)
Cancer Helpline No. +91 99909 11444

DEPARTMENT OF PET CT AND NUCLEAR MEDICINE

Ms. Amita Chaudhary	**Patient Id: FHL5.664189**	**Age/Sex:44/F**
	Ref. By. Dr. Anurag Tandon	**Date:12/07/2018**

WHOLE BODY PET-CECT SCAN

Whole body PET-CECT scan was performed after injection of about 10 mCi of F-18 FDG on multidetector PET-CT scanner from vertex to mid thigh. Serial multiplanar sections were obtained after intravenous contrast injection. A separate sequence with breath hold was performed for lung examination. A semiquantitative analysis of FDG uptake was performed by calculating SUV value corrected for dose administered and patient lean body mass.

Patient is a suspected case of carcinoma descending colon. PET-CT scan is being done for further evaluation.

FINDINGS:

The overall biodistribution of FDG is within normal physiological limits.

No focal abnormal increased FDG concentration seen in bilateral cerebral or cerebellar hemispheres.

Note: If there is strong suspicion for brain metastasis then MRI is suggested for further evaluation, as smaller lesion may not be detected on FDG PET CT.

The thyroid gland is sharply demarcated and shows homogeneous pattern on CT scan. No abnormal FDG uptake is seen in the thyroid. No focal lesion with abnormal FDG uptake is seen involving nasopharynx, oropharynx or hypopharynx.

There is no significant cervical lymphadenopathy.

The heart and mediastinal vascular structures are well opacified with I/V contrast. The trachea and both main bronchi appear normal.

Bilateral breast/ axillae appear unremarkable.

There is no significant mediastinal/ hilar lymphadenopathy is noted.

Non FDG avid subpleural fibro calcific lesion noted in apical and posterior segment of right upper lobe - likely benign. Non FDG avid tiny calcific foci noted in right lower lobe.

There is no evidence of pleural effusion/ infiltrates noted.

Liver is enlarged in size with a span of 15.5cm and normal in shape and CT attenuation pattern. The intra hepatic biliary radicals are not dilated. The portal vein is normal. No focal lesion / abnormal FDG accumulation seen in the liver parenchyma.

The gall bladder is well distended with no evidence of an intraluminal radio-opaque calculus noted (USG is the modality of choice to evaluate for cholelithiasis / choledocholithiasis).

The spleen is normal in size and demonstrates physiological FDG uptake.

The pancreas demonstrates normal attenuation with no evidence of abnormal FDG uptake.

Both adrenal glands demonstrate near normal size, homogeneous enhancement on CT and no abnormal FDG uptake.

Bilateral kidneys appear normal in size, shape and attenuation and FDG uptake. No evidence of calculus or hydronephrosis noted.

Continued....1

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FDG avid thickening noted in ascending colon measuring 53 mm in length and thickness 19mm (SUVmax~14.0) with pericolonic fat stranding. Fat planes are preserved with liver, kidney and duodenum.

The stomach and small bowel loops appear normal in calibre and fold pattern. No focal lesion / abnormal FDG uptake is seen in relation to them.

Non FDG avid few subcentimetric sized lymph nodes are seen in pericolonic region.

No free peritoneal fluid is seen.

Non FDG avid thickening noted in anterior wall of urinary bladder – likely cystitis.

The uterus and bilateral adnexae appear unremarkable with no abnormal FDG uptake.

Mild degenerative changes noted in visualized spine. No lytic/ sclerotic lesions in the whole body bone surveyed.

IMPRESSION:

PET-CT SCAN REVEALS

- **Metabolically active thickening in ascending colon) with pericolonic fat stranding as described – likely neoplastic.**
- **Metabolically inactive subcentimetric sized pericolonic lymph nodes.**
- **No other abnormal FDG avid lesion seen in rest of the body region surveyed.**

dvise clinical and histopathological correlation.

Dr. M U Siddiqui
Consultant and Head

- *This report is for diagnostic use only and not for medicolegal purposes*
- *Kindly bring all previous s reports and PET CT CD for follow up PET CT scans*
- ALL TEST HAVE TECHNICAL LIMITATIONS .CORRELATION OF CLINICAL FEATURES AND OTHER INVESTIGATIONS ARE MANDATORY TO ARRIVE AT CLINICAL DIAGNOSIS. THIS REPORT IS PROFESSIONAL OPINION AND NOT DIAGNOSIS

he report is based upon the glycolytic activity in the tumor cells. FDG concentration may not be seen in lesions with low metabolic / glycolytic activity and low tumor density.

Department Of Pathology
All India Institute Of Medical Sciences
Delhi
Tel:+91-11-26588500/26588700,Fax:+91-11-26588500/26588700

Patient Name:	**Amita Chaudhary**	Acc. No:	**1828639**
F/H Name:	Vinit Chaudhary	Hosp. Reg. No.:	**103862659**
Age/Sex:	45 Y/Female	UHID No.:	---
Clinic/Dept/Unit:	G. I. Surgery/Unit 1	Consultant Incharge:	Dr. N/A
Reg Date:	11-07-2018	Reporting Date:	14-07-2018

Histopathology Report

Report Findings:

Received two HE slide and one block (NO: 1445/18) for review as colonoscopic biopsy.

- Sections examined show features of moderately differentiated adenocarcinoma.

Reporting Incharge: Dr. Saumyaranjan Mallick

Reporting SR: Dr. Nishu

Verify By: Dr. Hemlata

we treat....HE CURES

METRO PATH LABS

Metro Hospitals & Heart Institutes, Noida
(a unit of Metro Institutes of Medical Sciences Pvt. Ltd.)
CIN No : U00000DL1990PTC039293
NABH, NABL (Cert No. M-0295) Accredited ISO 9001: 2008 Certified)

b ID	: 10905477	Age	: 45 YEARS
tient	: MRS. AMITA CHAUDHARY	Sex	: FEMALE
ospital ID	: OPD Cash Customer	Sam. Rec. Dt/Tm	: 10/07/2018 10:23:10AM
ef. Doctor	: ANURAG TANDON	Report Dt/Tm	: 10/07/2018 1:34 pm
JHID	: 2018017900	OPD/IPD	: OPD
Reference No.	: 180044239	Ward/Bed No	: 0
Primary Sample	: TISSUE SPECIMEN		

HISTOPATHOLOGY NO.MMH/1445/18

SPECIMEN :

- Colonoscopic biopsy

GROSS:

- Received multiple grey white soft tissue pieces together measuring 0.3 x 0.3 x 0.2 cm.
- MMH/1445/18 All processed

MICROSCOPIC EXAMINATION :

- Colonoscopic biopsy is fragmented shows necrotic debris and well formed glands with uniform, basally oriented nuclei. At places the glands are seen in between the necrotic debris.

IMPRESSION :

- **Dysplastic glands with necrotic debris. Suspicious for well differentiated adenocarcinoma (colonic growth).**

NOTE : As the biopsy is fragmented, no comment can be made on invasion. Adviced correlation with colonoscopic findings / PET Scan.

Report Electronically Validated By :-

Dr. Charul Dabral
HOD PATHLAB

Dr. Rajan Chopra

Dr. Radha Kumari Rokkam

Completed By :BHUMIKA

Dr. Charul Dabral
HOD PATHLAB

Department of Gastrointestinal Surgery

All India Institute of Medical Sciences, New Delhi

DISCHARGE SUMMARY

Name Mrs. amita chaudhary | Age 45 | Sex Female | C. R. No. 942986 | GIS No 502/2018

Permanent Address: NRI city, Judge camp, noida, UTTAR PRADESH
Ph. 9318446463 Fax
Email 103862659

Temporary Address
Ph. Fax

D.O.A. 21-07-2018
D.O.O. * 31-07-2018,
D.O.D. 05-08-2018

Diagnosis :* Carcinoma colon,

58 kg
150 cm
25.7 kg/m2

Previous admission : No

Advice :
care of wound as advised
diet as advised
tab crocin 500 mg 1 sos for pain fever
tab pantocid 40 mg 1 OD x 10 days
Tab emset 4 mg 1 sos vomit
review after 10 days in GIS opd on MON/WED/FRI
repor to emergency in case of fever/vomitng/poor oral intake

Tab ultracet 1 sos for pain

History :

H/o easy fatiguability and palpitation and occassional chest pain for which she was evaluated and found to be TMT +ve and 2 D echo was normal. She was found to have anemia and stool occult blood was positive. And she was also found to be naving HBsAg+ve and was started on Tenofovir. No h/o abdominal pain. No vomiting/constipation. No GI bleed. No LOA/LOW. No fever. H/o jaundice in 2006 releieved sponataneously. h/o b/l galactorrhoea- evaluated and found to have hyperprolactinemia and pituitary microadenoma for which she is taking cabergoline. Received 2 units blood transfusion prior to admission. Known diabetic. H/o 2 LSCS in the past.

Examination :

conscious oriented
pallor+
no jaundice/LNE/oedema
PR_86/'BP 138/72 mm Hg
P/A soft. No mass. Lower midline scar present- healthy
chest clear
DRE- NAD

Counselled for 1500 cal c 60 g prot oral diet
Anjali
Dietician
2/8/18

Operative Procedure and Findings :

* (31-07-2018) RIGHT HEMICOLECTOMY,

circumferential constricting growth just proximal to hepatic flexure of colon. Multiple small lymphnodes along mesocolon. Liver normal. No ascites. No e/o dissemination

Hospital Course :

Pre Op: optimised and taken up for surgery

Post Op: started on oral liquids on POD 3 increased to normal diet by POD 6 which she tolerated. On discharge vitals stbale, wound clean, tolerating normal diet

20/8/18 – Doing well, wound healthy
– pl. remove clips
– Binder application

circumferentially upto 6 cm length of colon. Depth of infiltration is 1.2cm.

Tumor appears to be infiltrating into the muscularis layer and reaching upto subserosa, however circumferential resection margin /serosa is free of tumor.

Tumor lies 15cm away from the distal resected end and 12 cm away from the proximal resection margin.

Cut surface of appendix is unremarkable.

Twelve lymphnodes identified (0.3cm to 0.5cm).

Multiple sections examined from tumor shows histomorphological features of a moderately differentiated adenocarcinoma with focal solid sheet like growth pattern.

Tumor is infiltrating transmurally through the wall and reaching upto subserosal fat, however, the circumferential resection margin is free of tumor (closest distance is 2mm).

Lymphovascular emboli are noted.

Perineural invasion is not seen.

Ileal and colonic resection ends are free of tumor.

Appendix is histologically unremarkable.

Eleven lymphnodes identified microscopically, all are free of tumor (0/11).

2. Lymphnode tissue yielded eight nodes (0.5 to 0.6cm) all free of tumor 0/8).

Diagnosis moderately differentiated adenocarcinoma, right hemicolectomy.

Pathological stage; PT3 N0.

AJCC).

tage group; IIA.

Reporting Incharge: Dr. Adarsh Barwad

Department Of Pathology
All India Institute Of Medical Sciences
Delhi
Tel:+91-11-26588500/26588700;Fax:+91-11-26588500/26588700

Patient Name:	**Amita Chaudhary**	Acc. No:	**1828639**
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Age/Sex:	45 Y/Female	UHID No.:	---
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Advise clinical and histopathological correlation.

Dr. M U Siddiqui
Consultant and Head

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- *Kindly bring all previous s reports and PET CT CD for follow up PET CT scans*
- ALL TEST HAVE TECHNICAL LIMITATIONS .CORRELATION OF CLINICAL FEATURES AND OTHER INVESTIGATIONS ARE MANDATORY TO ARRIVE AT CLINICAL DIAGNOSIS. THIS REPORT IS PROFESSIONAL OPINIO AND NOT DIAGNOSIS

Note: The report is based upon the glycolytic activity in the tumor cells. FDG concentration may not be seen in lesions with low metabolic / glycolytic activity and low tumor density.

Contiguous axial sections were obtained from dome of [illegible] oral contrast and bolus I.V. nonionic contrast administration.

The study reveals annular thickening (7.0 mm) of ascending colon measuring approx. 7.0 cm in length with pericolonic fat stranding. Fat planes of this lesion are preserved with liver, kidney and duodenum. Few subcentimetric size pericolonic lymph nodes are noted largest measuring approx. 7.0 mm in short axis diameter. No obvious necrosis noted (Adv:- Histopathological correlation for neoplastic etiology). Stomach and remaining visualized gut loops are normal and contrast filled.

Liver is normal in shape, size and attenuation. No intrahepatic venous channels or biliary radicles dilatation noted. No intrahepatic space occupying lesion noted.

GB is well distended with homogeneous luminal contents and smooth wall. Pancreas is normal in contours and attenuation. No peripancreatic collection noted. No pancreatic ductal dilatation noted. Spleen is normal in size, contours and shows homogeneous attenuation.

Both kidneys are normal in shape, size, attenuation and enhancement. No focal lesion seen. No pelvicalyceal system dilatation noted.

No ascites noted.

Thickening (11.0 mm) of anterior wall of urinary bladder is noted (Adv:- Cystoscopy).

Uterus appears normal in attenuation. No utero adnexal mass lesion noted.

Muscle planes, great vessels and bones are normal.

Please correlate clinically.

Dr. S. Ameer Ahmed, MD
Sr. Consultant Radiologist

Dr. Vidit Sethia, DMRD, DNB
Consultant Radiologist

Dr. Gouri Garg, MD
Consultant Radiologist

❖ This is a professional opinion based on imaging finding and not the diagnosis. ❖ Not valid for medico-legal purposes.
❖ In case of any discrepancy due to machine error or typing error, please get it rectified immediately.

DEPARTMENT OF MEDICAL IMAGING

NAME	Mrs. Amita Chaudhary	AGE/SEX	45 Y/ F	OPD/IPD	2018002575
Ref.by	Dr. P. Lal	DATE	19.03.18	CT NO	2030

EXAMINATION PERFORMED – CECT WHOLE ABDOMEN

Contiguous axial sections were obtained from domes of diaphragm through the pelvis after bowel opacification with oral contrast and bolus I.V. nonionic contrast administration.

The study reveals circumferential thickening (8 mm) in ascending colon with surrounding fat stranding measuring approx. 4 cm in length likely inflammatory/ infective in etiology. Few subcentimetric size loco regional lymph nodes seen largest measuring approx. 6.6 mm in short axis diameter. No obvious necrosis noted.

Stomach and remaining visualized gut loops are normal and contrast filled.

Liver is normal in shape, size and attenuation. No intrahepatic venous channels or biliary radicles dilatation noted. No intrahepatic space occupying lesion noted.

GB is well distended with homogeneous luminal contents and smooth wall. Pancreas is normal in contours and attenuation. No peripancreatic collection noted. No pancreatic ductal dilatation noted. Spleen is normal in size, contours and shows homogeneous attenuation.

Both kidneys are normal in shape, size, attenuation and enhancement. No focal lesion seen. No pelvicalyceal system dilatation noted.

No ascites noted.

Urinary bladder is well distended with smooth wall outline.

Uterus appears normal in attenuation. No utero adnexal mass lesion noted.

Left ovary shows simple cyst measuring approx. 1.7 x 1.5 cm.

Right ovary is normal in size, shape and attenuation.

Muscle planes, great vessels, fat planes and bones are normal.

Adv – Colonoscopy for further evaluation.

Dr. S. Ameer Ahmed, MD
Sr. Consultant Radiologist

Dr. Vidit Sethia, DMRD, DNB
Consultant Radiologist

Dr. Gouri Garg, MD
Consultant Radiologist

Contiguous axial sections were obtained from domes of diaphragm through the pelvis after bowel opacification with oral contrast and bolus I.V. nonionic contrast administration.

***Clinical details* : Follow up case of CA colon post op - right hemicolectomy.**

Liver measures 15.4 cm with normal shape and attenuation. No intrahepatic venous channels or biliary radicles dilatation noted. No intrahepatic space occupying lesion noted.

GB is well distended with homogeneous luminal contents and smooth wall. Pancreas is normal in contours and attenuation. No peripancreatic collection noted. No pancreatic ductal dilatation noted. Spleen is normal in size, contours and shows homogeneous attenuation.

Both kidneys are normal in shape, size, attenuation and enhancement. No focal lesion seen. No pelvicalyceal system dilatation noted.

No ascites or significant lymphadenopathy noted.

Stomach and remaining visualized gut loops are normal and contrast filled. No obvious residual / recurrent lesion seen.

Urinary bladder is well distended with smooth wall outline.

Uterus appears normal in attenuation. ***A simple follicular cyst measuring approx. 1.2 x 1.3 cm seen in left ovary.*** No adnexal mass lesion noted on right side.

Muscle planes, great vessels, fat planes and bones are normal.

Please correlate clinically.

Dr. S. Ameer Ahmed, MD
Sr. Consultant Radiologist

Dr. Vidit Sethia, DMRD, DNB
Consultant Radiologist

Dr. Gouri Garg, MD
Consultant Radiologist

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Contiguous axial sections were obtained on spiral mode from thoracic inlet to domes of diaphragm after IV administration of contrast and studied in lung and mediastinal windows.

Findings:-

The study reveals area of fibrobronchiectasis and nodular calcification in right upper lobe likely secondary to old Koch's. Remaining lung parenchyma and pulmonary vasculatures are normal in attenuation pattern.

Trachea and major bronchi are normal. No significant compression noted.

No significant hilar / mediastinal lymphadenopathy noted.

Mediastinal vascular structures appear normal.

No pleural / pericardial collection noted.

Bones, fat planes and muscle planes are normal.

Please correlate clinically.

Dr. S. Ameer Ahmed, MD
Sr. Consultant Radiologist

Dr. Vidit Sethia, DMRD, DNB
Consultant Radiologist

Dr. Gouri Garg, MD
Consultant Radiologist

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Contiguous axial sections were obtained from domes of diaphragm through the pelvis after oral contrast and bolus I.V. nonionic contrast administration.

The study reveals annular thickening (7.0 mm) of ascending colon measuring approx. 7.0 cm in length with pericolonic fat stranding. Fat planes of this lesion are preserved with liver, kidney and duodenum. Few subcentimetric size pericolonic lymph nodes are noted largest measuring approx. 7.0 mm in short axis diameter. No obvious necrosis noted (Adv:- Histopathological correlation for neoplastic etiology). Stomach and remaining visualized gut loops are normal and contrast filled.

Liver is normal in shape, size and attenuation. No intrahepatic venous channels or biliary radicles dilatation noted. No intrahepatic space occupying lesion noted.

GB is well distended with homogeneous luminal contents and smooth wall. Pancreas is normal in contours and attenuation. No peripancreatic collection noted. No pancreatic ductal dilatation noted. Spleen is normal in size, contours and shows homogeneous attenuation.

Both kidneys are normal in shape, size, attenuation and enhancement. No focal lesion seen. No pelvicalyceal system dilatation noted.

No ascites noted.

Thickening (11.0 mm) of anterior wall of urinary bladder is noted (Adv:- Cystoscopy).

Uterus appears normal in attenuation. No utero adnexal mass lesion noted.

Muscle planes, great vessels and bones are normal.

Please correlate clinically.

Dr. S. Ameer Ahmed, MD
Sr. Consultant Radiologist

Dr. Vidit Sethia, DMRD, DNB
Consultant Radiologist

Dr. Gouri Garg, MD
Consultant Radiologist

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OR LIVER & DIGESTIVE DISEASES Dr. Anurag Tandon
M.D., DM.
TUTE (MULTSPECIALITY WING). SENIOR CONSULTANT GASTROENTEROLOGY
1301. Ph: 0120-2533491, 2442666, 4366666 (Ext. 416) Fax: 0120-2522056.

AUDHARY ID No. : 60660 DATE : 09-Jul-18

ALE REF. BY : COLON. NO. : 33067

COLONOSCOPY REPORT

ANAL CANAL
Normal mucosa seen.

RECTUM AND SIGMOID
Normal mucosa seen.

DESCENDING COLON
Normal mucosa seen.

TRANSVERSE COLON
Normal mucosa seen.

ASCENDING COLON
Circumferential ulcerated polypoidal growth present just beyond the hepatic flexure. Multiple biopsies taken.

CAECUM
Not seen.

TERMINAL ILEUM
Not seen.

IMPRESSION :
RIGHT COLONIC GROWTH.
? MITOTIC.
BIOPSY TAKEN.

ENDOSCOPIST
Dr. Anurag Tandon

OR LIVER & DIGESTIVE DISEASES
TUTE (MULTISPECIALITY WING).
Dr. Anurag Tandon
M.D., DM.
SENIOR CONSULTANT GASTROENTEROLOGY
01301. Ph: 0120-2533491, 2442666, 4366666 (Ext. 416) Fax: 0120-2522056.

AUDHARY ID No. : **60660** DATE : **09-Jul-18**

ALE REF. BY : **ENDO. NO. : 60660**

GASTROSCOPY REPORT

OESOPHAGUS

NORMAL MUCOSA SEEN AT THE LOWER END.
NO VARICES SEEN.

STOMACH

NORMAL MUCOSA SEEN IN THE CARDIA, BODY, FUNDUS AND ANTRUM.

DUODENUM

NORMAL D1 & D2.
NO ULCER SEEN.

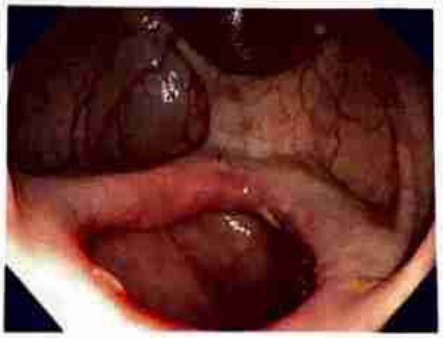
IMPRESSION

NORMAL STUDY UPTO D2.

ENDOSCOPIST
Dr. Anurag Tandon

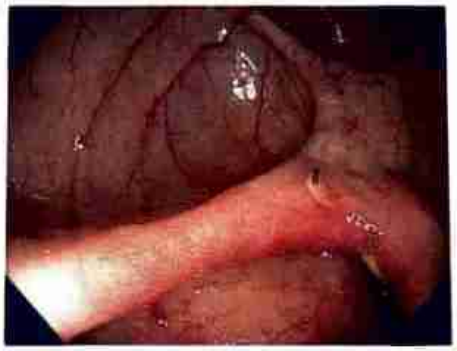
...ALS & HEART INSTITUTE
4th Floor, L-94,Sector-11, Noida-201301
METRO CENTRE FOR LIVER & DIGESTIVE DISEASES

Patient ID	: 60660	**Visit Date**	: 06-Sep-19
Patient Name	: MRS. AMITA CHAUDHARY	**Referred by**	: COLON. NO. : 36218
Age/Gender	: 44Yrs, Female	**Consulted by**	: Dr Anurag Tandon(M.D, D.M)



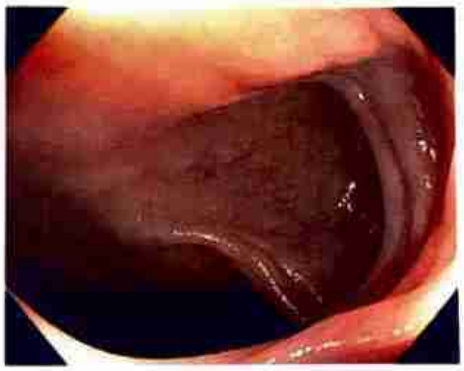
COLONOSCOPY REPORT

POST RIGHT HEMICOLLECTOMY STATUS.

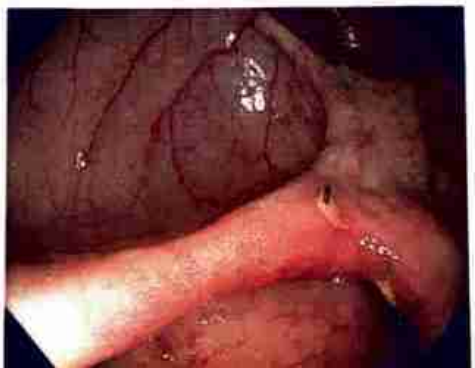


NORMAL MUCOSA SEEN IN THE RECTUM,
SIGMOID, DESCENDING AND TRANSVERSE COLON.

MILD HYPEREMIA AND SUPERFICIAL ULCERS
PRESENT AT THE ANASTOMOTIC SITE.



Impression : **SUPERFICIAL ANASTOMOTIC SITE ULCERS.**
BIOPSY TAKEN.



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CIN No : U00000DL1990PTC039293
(NABH, NABL & ISO 9001: 2008 Certified)

DEPARTMENT OF MEDICAL IMAGING

NAME	Mrs. Amita Chaudhary	AGE/SEX	45 Y/F	OPD/IPD	OPD
Ref. by	Dr.	DATE	22.06.2019	USG NO	670
EXAMINATION PERFORMED – USG WHOLE ABDOMEN					

Liver is normal in shape, size, contours and echopattern. No focal lesion seen. No IHBR dilatation noted.

GB is physiologically distended and echofree. No calculus / sludge seen. GB wall thickness is normal. No pericholecystic collection noted. CBD and PV are of normal caliber.

Pancreas is normal in size and echotexture. No focal lesion noted. No peripancreatic collection noted. No MPD dilatation noted.

Spleen is normal in size and shows homogeneous echotexture.

Both kidneys are normal in shape, size, position and echopattern. Corticomedullary demarcation is maintained. No calculus or mass lesion seen. No pelvicalyceal system dilatation noted. RK: 9.2 x 4.6 cm, LK: 9.2 x 4.0 cm.

No ascites or obvious retroperitoneal lymphadenopathy noted. No bowel loops dilatation noted.

Urinary bladder is well distended with smooth outline. No echo-drop seen.

Uterus is retroflexed, bulky in size measuring approx. 10.5 x 3.1 x 5.2 cm and showing homogenous myometrial echotexture and no focal lesion. Endometrial echo complex is central and meas. 4.6 mm in thickness. Cervix is normal in length and echotexture. Both ovaries are normal in shape, size and echotexture. RO: 1.8 x 1.0 cm, LO: 2.6 x 1.1 cm.

Please correlate clinically.

Dr. S. Ameer Ahmed, MD
Sr. Consultant Radiologist

Dr. Vidit Sethia, DMRD DNB
Consultant Radiologist

Dr. Gouri Garg, MD
Consultant Radiologist

Dr. Amit Garg, MD
Consultant Radiologist

NAME		DATE	
Ref.by	Dr.		

EXAMINATION PERFORMED – USG TVS

Uterus is retroflexed and bulky in size measuring approx. 10.5 x 3.1 x 5.2 cm.

Myometrial echotexture is homogeneous. No focal lesion seen.

Endometrial echo-complex is central and normal in thickness (4.6 mm).

Cervix is normal in length. No altered echogenicity noted.

Os is closed.

Both ovaries are normal in size and echogenicity with normal follicular structures.
RO: 1.8 x 1.0 cm, LO: 2.6 x 1.1 cm.

No collection seen in posterior pouch.

Please correlate clinically.

Dr. S. Ameer Ahmed, MD
Sr. Consultant Radiologist

Dr. Vidit Sethia, DMRD DNB
Consultant Radiologist

Dr. Gouri Garg, MD
Consultant Radiologist

Dr. Amit Garg, MD
Consultant Radiologist

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Multispeciality Wing
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Tel. : +91 120 2522 959, 2442 666
Fax : +91 120 2442 555

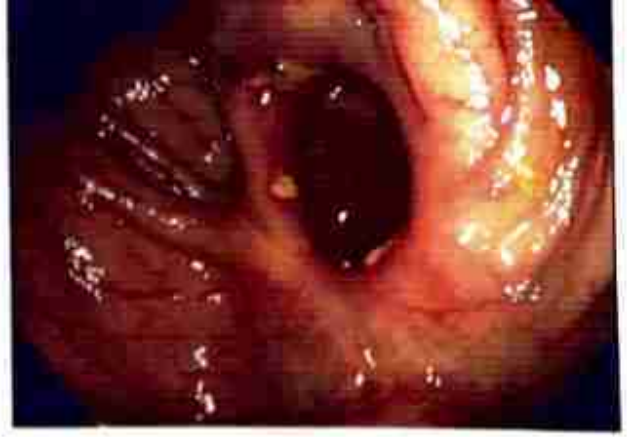
E-mail : metro@metrohospitals.com, Website: www.metrohospitals.com
Regd. Office : 14, Ring Road, Lajpat Nagar IV, New Delhi-110024

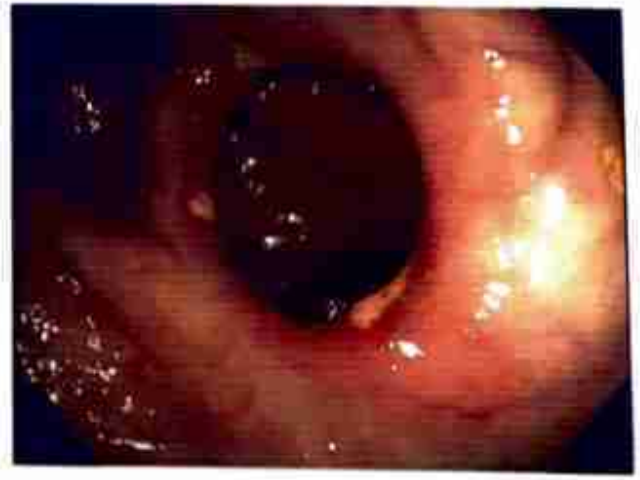
COLONOSCOPY REPORT

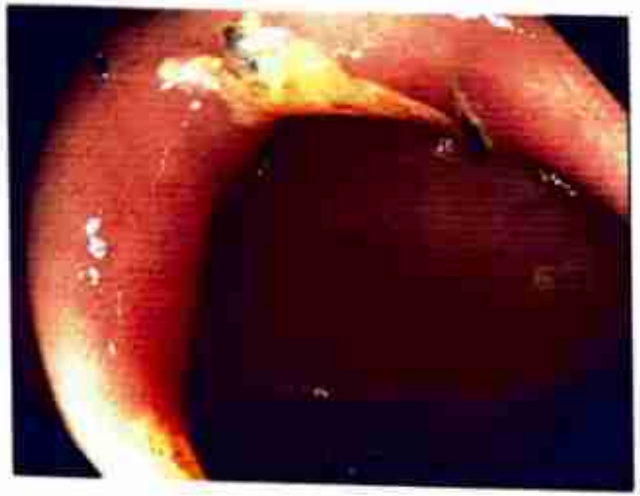
Premedication :

P/R : Nil

Preparation : GOOD







POST RIGHT HEMICOLECTOMY STATUS.

NORMAL MUCOSA SEEN IN THE LEFT, MID AND RIGHT COLON.

SUPERFICIAL ANSTOMOTIC ULCERS PRESENT AT THE SUTURE LINE.

BIOPSY TAKEN.

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(NABH, NABL & ISO 9001: 2008 Certified)

DEPARTMENT OF MEDICAL IMAGING

NAME	Mrs. Amita Choudhary	*AGE/SEX*	48Y/F	OPD/IPD	OPD
Ref.by	Dr. Anurag Tandon	DATE	30.08.21	CT NO	7234
EXAMINATION PERFORMED – CECT WHOLE ABDOMEN					

Contiguous axial sections were obtained from domes of diaphragm through the pelvis after bowel opacification with oral contrast and bolus I.V. nonionic contrast administration.

Clinical details: Operated case of Ca ascending colon.

Liver is mildly enlarged in size measuring approx. 15.5 cm in cranio caudal extent and shows normal attenuation No intrahepatic venous channels or biliary radicles dilatation noted. No intrahepatic space occupying lesion noted.

GB is well distended with homogeneous luminal contents and smooth wall. Pancreas is normal in contours and attenuation. No peripancreatic collection noted. No pancreatic ductal dilatation noted. Spleen is normal in size, contours and shows homogeneous attenuation.

Both kidneys are normal in shape, size, attenuation and enhancement. No focal lesion seen. No pelvicalyceal system dilatation noted.
RK: 9.0 x 4.5 cm LK: 9.5 x 4.6 cm

No ascites or significant lymphadenopathy noted.

Evidence of hemicolectomy seen. Stomach and remaining visualized gut loops are normal and contrast filled.

Urinary bladder is well distended with smooth wall outline.

Uterus appears anteverted and appears mildly bulky in size (9.0 x 4.0 x 5.7 cm). Bilateral ovaries appears normal.

Degenerative changes seen in visualized spine.
Please correlate clinically.

Dr. S. Ameer Ahmed, MD — ***Sr. Consultant Radiologist***
Dr. Vidit Sethia, DMRD DNB — ***Consultant Radiologist***
Dr. Amit Garg, MD, FSCCT (USA) — ***Consultant Radiologist***

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❖ *In case of any discrepancy due to machine error or typing error, please get it rectified immediately.*

DEPARTMENT OF MEDICAL IMAGING

NAME	Mr. Vineet Chaudhary	AGE/SEX	47Y/M	OPD/IPD	OPD
Ref.by	Dr.	DATE	22.01.2022	USG NO	468

EXAMINATION PERFORMED – USG WHOLE ABDOMEN

Liver is normal in shape, size, contours ***and shows diffuse increase in echogenicity suggestive of grade I fatty infiltration.*** No focal lesion seen. No IHBR dilatation noted.

GB is well distended ***and shows subcentimeteric non-acoustic echogenic foci measuring approx 4.6 mm along the posterior wall adjacent to fundus s/o - GB polyp (Advice: Follow up).*** GB wall thickness is normal. No pericholecystic collection noted. CBD and PV are of normal caliber.

Pancreas is normal in size and echotexture. No focal lesion noted. No peripancreatic collection noted. No MPD dilatation noted.

Spleen is mildly enlarged in size measuring approx. 12.6 cm and shows homogeneous echotexture.

Both kidneys are normal in shape, size, position and echopattern. Corticomedullary demarcation is maintained. No calculus or mass lesion seen. No pelvicalyceal system dilatation noted. RK: 9.6 x 4.1 cm LK: 11.4 x 3.8 cm.

No ascites or obvious retroperitoneal lymphadenopathy noted. No bowel loops dilatation noted.

Urinary bladder is well distended with smooth outline. No echo-drop seen.

Prostate is normal in size, (approx 19.4 cc in volume) contours and shows normal echotexture.

Please correlate clinically.

Dr. S. Ameer Ahmed, MD
Sr. Consultant Radiologist

Dr. Vidit Sethia, DMRD, DNB
Consultant Radiologist

Dr. Sara Thakur, DNB
Consultant Radiologist

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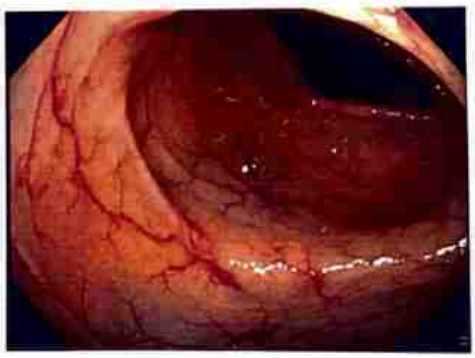
METRO HOSPITALS & HEART INSTITUTE

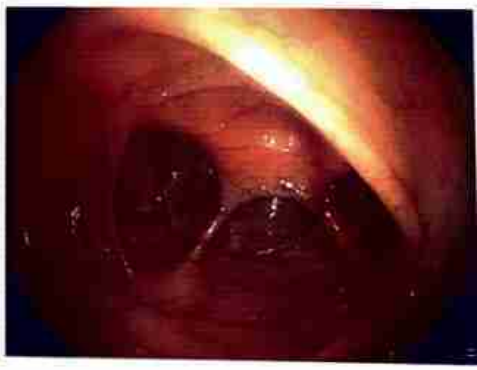
4th Floor, L-94,Sector-11, Noida-201301

METRO CENTRE FOR LIVER & DIGESTIVE DISEASES

Patient ID	: 60660 A	**Visit Date**	: 26-Feb-22
Patient Name	: MRS. AMITA CHAUDHARY	**Referred by**	: COLON. NO. : 39105
Age/Gender	: 48Yrs, Female	**Consulted by**	: Dr Anurag Tandon(M.D, D.M)

COLONOSCOPY REPORT



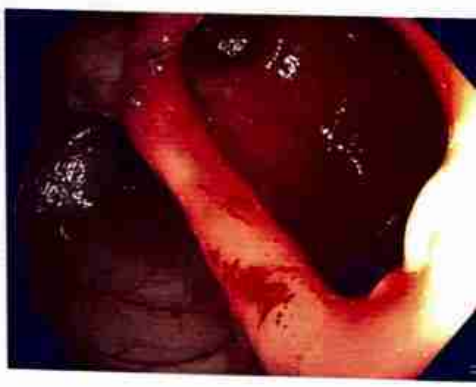


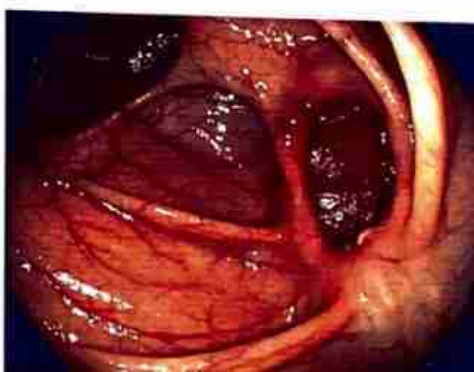
POST RIGHT HEMICOLECTOMY STATUS.

NORMAL MUCOSA SEEN IN THE LEFT, MID AND RIGHT COLON.

SUPERFICIAL ANASTOMOTIC ULCERS PRESENT AT THE SUTURE LINE.

BIOPSY TAKEN.





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CIN No : U00000DL1990PTC039293
(NABH, NABL & ISO 9001: 2008 Certified)

DEPARTMENT OF MEDICAL IMAGING

NAME	Mrs. Amita Chaudhary	AGE/SEX	48Y/F	OPD/IPD	OPD
Ref.by	Dr. Anurag Tandon	DATE	13.12.2022	CT NO	10395
EXAMINATION PERFORMED – CECT THORAX					

Contiguous axial sections were obtained on spiral mode from thoracic inlet to domes of diaphragm after IV administration of contrast and studied in lung and mediastinal windows.

Findings:-

The study reveals area of fibrobronchiectasis in right upper lobe with few foci of calcification in both lung fields, likely secondary to old Koch's. Remaining lung parenchyma and pulmonary vasculatures are normal in attenuation pattern.

Trachea and major bronchi are normal. No significant compression noted.

No significant hilar / mediastinal lymphadenopathy noted.

Mediastinal vascular structures appear normal.

No pleural / pericardial collection noted.

Bones and muscle planes are normal.

Impression: - CT Findings are suggestive of:

- **Area of fibrobronchiectasis in right upper lobe with few foci of calcification in both lung fields, likely secondary to old Koch's.**

Please correlate clinically.

Dr. S. Ameer Ahmed, MD
Sr. Consultant Radiologist

Dr. Vidit Sethia, DMRD, DNB
Consultant Radiologist

Dr. Ankita,MD, DNB, MNAMS
Consultant Radiologist

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gene CŌRE™ Predict

Patient Name	: Amita Chaudhary	Physician Name	: AIIMS
Date of Birth	: 09/02/1973	Hospital Name	: AIIMS
Gender	: Female	Report ID	: 19006139
Test Ordered Date	: 18/01/2019	Specimen	: Saliva
Report Date	: 15/02/2019	History	: Moderately differentiated adenocarcinoma, right hemicolectomy

Patient Test Result Details

Result : Positive Clinically Significant Mutations Identified

GENE	MSH6
CHROMOSOME	chr2
POSITION	48026257
REFERENCE	AGAGAT
ALT	A
AMINO ACID CHANGE	p.Asp380AlafsTer6
CONSEQUENCE	frameshift_variant
CLINVAR ASSERTION	Pathogenic
CLINVAR URL	https://www.ncbi.nlm.nih.gov/clinvar/variation/89175/

Landrum MJ, et al. Nucleic Acids Research. 2014;42:D980-D985.

Patient Test Result Summary

Your testing shows that you have a pathogenic mutation in the *MSH6* gene. Deleterious MSH6 mutations in women are associated with Hereditary Nonpolyposis Colorectal Cancer (HNPCC), also referred to as Lynch syndrome. In addition to colon cancer, you may also be subjected to an increased risk of developing endometrial, ovarian, stomach, and possibly other types of cancer.

Your first degree relatives have 50% chance of having the same mutation that you carry. This information may be helpful to your doctor for personalizing a management plan for you and your family's improved care.

No known or potential disease-causing mutations were detected in any other genes tested.

Dr. Aparna Dhar – 9650066503

Dr. Avshesh Mishra, Ph. D., Molecular Scientist

Dr. Shivani Sharma, Pathologist
Reg. No. 1906

gene

Patient Test Result Details

Summary Result : Positive

Clinically Significant Genetic Mutations Detected

Gene	Inheritance Mode	Associated Syndromes
MSH6	Autosomal Dominant	Hereditary Nonpolyposis Colorectal Cancer HNPCC (Lynch Syndrome)

Information for the patient

Risk of Cancers With MLH6 Mutation

Deleterious *MSH6* mutations in women are associated with Hereditary Nonpolyposis Colorectal Cancer (HNPCC), also referred to as Lynch syndrome. Women with deleterious *MSH6* mutations may be at a higher risk for developing endometrial (uterine) cancer and colorectal cancer.

Colorectal [1,2,3]

Endometrial (Uterine) Cancer [1,2,3]

Elevated Risk of Other Cancers With *MSH6* Mutation

Women with a *MSH6* mutation may have an elevated risk for ovarian cancer, stomach cancer, pancreatic cancer, small intestine cancer, urinary tract and bladder cancer, and central nervous system tumors/cancers.

	General Risk	Risk with *MSH6* Mutation
Ovarian		
To age 70	0.5%	Elevated [4]
Stomach		
To age 70	0.5%	Elevated [1, 2, 4]
Pancreatic		
To age 70	0.5%	Elevated [5, 6]
Urinary Tract and Bladder		
To age 70	1%	3.5% [7]
Small Intestine		

References:

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This test consists of advanced genetic sequencing of 98 genes to check for multiple different cancers

AIP	ALK	APC	ATM	BAP1	BARD1	BLM	BMPR1A	BRCA1	BRCA2
BRIP1	BUB1B	CDC73	CDH1	CDK4	CDKN1C	CDKN2A	CEBPA	CEP57	CHEK2
CYLD	DDB2	DICER1	DIS3L2	EGFR	EPCAM	ERCC2	ERCC3	ERCC4	ERCC5
EXT1	EXT2	EZH2	FANCA	FANCB	FANCC	FANCD2	FANCE	FANCF	FANCG
FANCI	FANCL	FANCM	FH	FLCN	GATA2	GPC3	HNF1A	HOXB13	HRAS
KIT	MAX	MEN1	MET	MLH1	MSH2	MSH6	MUTYH	NBN	NF1
NF2	NSD1	PALB2	PHOX2B	PMS1	PMS2	PPM1D	PRF1	PRKAR1A	PTCH1
PTEN	RAD51C	RAD51D	RB1	RECQL4	RET	RHBDF2	RUNX1	SBDS	SDHAF2
SDHB	SDHC	SDHD	SLX4	SMAD4	SMARCA4	SMARCB1	STK11	SUFU	TMEM127
TP53	TSC1	TSC2	VHL	WT1	WRN	XPA	XPC		

Screening Guidelines for Patient and Family

NCCN recommends several options for females with a *MSH6* mutation and at highe
Hereditary Nonpolyposis Colorectal Cancer (HNPCC), also referred to as Lynch syndrome

Ovarian Cancer

Procedure	Starting Age	Frequenc
Risk-reducing bilateral salpingo-oopherectomy	35 to 40 years, after completion of child bearing, or individualized to a younger age based on the earliest diagnosis in the family	-
Transvaginal ultrasound and CA-125 blood test	30 years, or individualized to a younger age based on the earliest diagnosis in the family	-

Colorectal Cancer

Procedure	Starting Age	Frequency
Sigmoidoscopy or colonoscopy	20 to 25 years, or individualized to a younger age based on the earliest diagnosis in the family	Every 1 to 2 ye