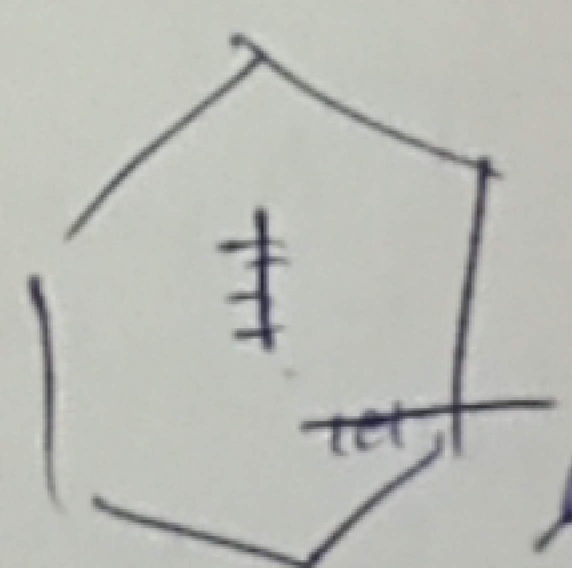
EUS : Duodenal GIST
(1/1/15) No report available No action taken

CECT : (no films) 1/1/19. Lesion with morphology
Luminal projected vessels.
Endo-exophytic lesion → ū transmural extension
from D_3-D_4 : abutment of prox. jejunal loops ū vessels
~3.9 × 3.4 × 3.5 cm. Fat planes

UGIE: Early upper GI V_E.
GIST + D_3
Alcoholic → x 1 yr, Tobacco chewer x till 15 days
K/C/O → HTN → on Rx
hypothyroidism on Rx.
Last H/O gum bleeding And → 2002
↳ EL + ulcerating fits mostly
done.
Evaluated in Medanta → Dx for Whipples

19/1/19 ? % P° (D)/(S)/(U)/(PE)/ Sur
LFT: 27.8/0.32 %E
CBC: 9.1/ 86 W/ 304.
LFT: 0.7/0.2 | 26/46 | 143/131 | 5.4/2.5 | 1/A : Agt
PT-INR: 13.0/11.6
It explained about
nature of disease
further decision only possible
after reviewing imaging) - PET-CT



Imp: CLD ū GIST
alcohol related (LS: 11/2 m. back) - CBC, LFT, KFT, PT
after 2 weeks

Inj. FLU QUADRI 0.5 ml IM Stat. Inj Pneumovax

23099 11:06Am

INSTITUTE OF LIVER & BILIARY SCIENCES

(An Autonomous Society under Government of NCT of Delhi)

D-1, Vasant Kunj, New Delhi, India

Phone No: 011-46300000 Ext: 7055 & 7056, 011-26706700 - 02

Fax No: 46300010, Email: info@ilbs.in, Website: http://www.ilbs.in

Out Patient Consultation Record

ILBS 0000213447
Mr RAJESH KUMAR MANI
49 Year(s) / Male
A-6 GOVINDPUR

ALLAHABAD, UTTAR PRADESH

Date 09-Oct-2019 10:14 am
Doctor Name S. K. SARIN / Sr. Resident
Designation Sr. Professor
Hepatology Unit 1

ILBS.0000213447

/80	Pulse (per min) 66	Waist (cm) 102
.5	Weight (kgs) 72.3	BMI (kg/m^2) 26.7

Allergies :

SPO2 98%.

Dr. Aarsh SR10

→ DM - / HTN (+) | CAD - / Hy (+) ↓ eltrom 62.5 | B.A - / PT.B -

→ Alcohol → L.I - 14.9.2019 — Max weight → 75kg
→ Contogen dose
→ AUDIT-C - 5
→ Tobacco chewer (+)
→ Father - Hypertension

Pm h/o Colonoscopy & Cardiac stent and closure - (2008)

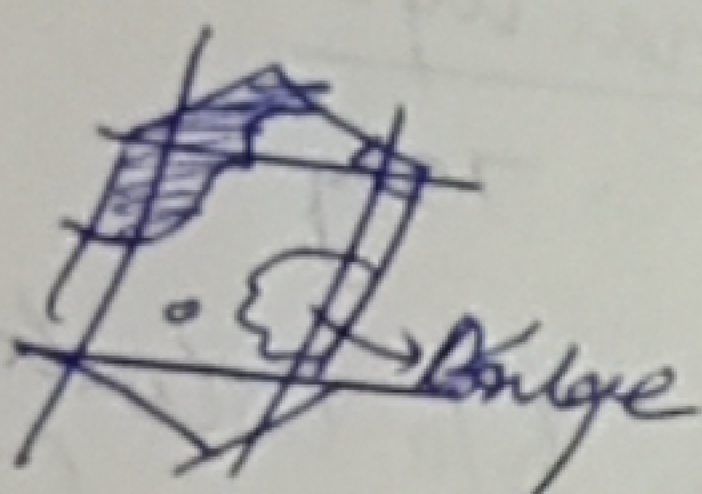
→ h/o Malena × 1 mth
→ associated c̄ postural symptoms
- associated c̄ giddiness (+)
→ hypovolemia (+)
→ no h/o PRBC transfusion
→ Underwent UGI → ? Duodenal
- Hb - 7 - no PRBC transfusion (T)

Hb - 7.4 (4.4)
TLC - 7800
Plt - 300
Bil - 0.9
AST - 45
ALT - 36
Alb - 3.2
Creat - 0.70

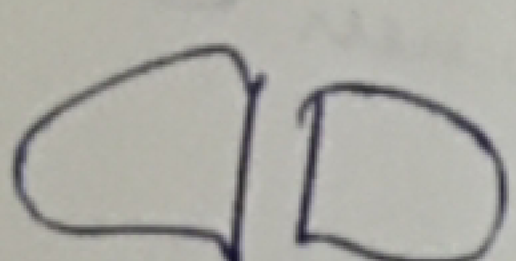
UGI → → referred to Medanta
early ersophy Vx – undewent 5 O units PRBC
D3 – GIST – diagnosed ō liver disease
↓
undewent – planned lappy
EUS → GIST h/o mechanical Ventilation
CT-Angio → ↓
endoexophytic extubated
lesion - D_3-D_4 h/o Altered ↑
sensorium (+) Admitted for Surgery.

Na – 128
Un and – 9.5
TSH – 7.78

O/E – Conc/oriented/
responding to voice
P+ I – Cy – Clu – Ly – ed +
B/C



P/A – Soft, non tender
liver palpable 4 cm ↓ r.c.m
firm, non tender, no pul ext
moving ē respiration
Spleen (+) 2 cm ↓ cm – firm, non tend
(L) Abdomen bulge



CVS – S1 S2 (+) / No mur
R/S – NVBS (+)
CNS – Conc/oriented/Responding to
Commands / Plant-flexor

Dx
3 – D4 Mass
✓ \
AIS
...min ?GIST →
...clopn
...m – glu
DH7 (Bleeding, grade 1 Vx
– CLD – ethanol ? D3 – D4 – Mass)

U QUADRI 0.5 ml IM Stat.
Repeat every year

Inj Pneumovax
0.5 ml IM Stat.

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Discharge Summary

Patient:	Mr RAJESH KUMAR MANI	UHID:	ILBS 0000213447
Age:	49 Year(s)	InpatientNo:	IPID 0056910
Gender:	Male	Admission Date	25 Nov 2019 03:05 PM
Ward:	General Ward B Second Floor	Discharge Date:	
Speciality:	HPB Surgery	Bed No:	2010-01
Consultant:	Dr T K Chattopadhyay		

DIAGNOSIS:

1. Duodenal (D3-D4 junction) GIST with GI bleeding
2. Background - CLD-ethanol, decompensated with ascites/?HE, Child A, MELD Na- 11, HVPG 6
3. Large incisional hernia S/P EL + colostomy for gunshot injury in 2002, S/P colostomy closure in 2002

CO-MORBIDITIES: Hypertension x 10 years, Hypothyroidism x 2 months (on Tab thyronorm 62.5 µg/ day)

PROCEDURES PERFORMED: Segmental duodenal resection (D3, D4) of GIST containing segment + Roux en Y gastrojejunostomy + duodenojejunostomy (D3 jejunum) + feeding jejunostomy + liver biopsy on 28/11/2019

INDICATION FOR ADMISSION: Surgery

HISTORY: Mr Rajesh, a 49yrs old male, presented to ILBS with complaints of malena 2 months back which persisted for a week, with 4-5 episodes per day. Patient took over the counter treatment for diarrhea mistaking malena for diarrhea. He developed severe dizziness following which he was evaluated and diagnosed with severe anemia and required blood transfusion. Further workup was s/o CLD. UGIE showed duodenal GIST and patient went to Medanta hospital for further management. At Medanta, he was transfused 4 units of PRBC following which was he was intubated ?fluid overload. There was also doubtful h/o altered sensorium. He was evaluated with Imaging, UGIE+EUS which were s/o duodenal GIST (D3-D4) with stigmata of Bleed with esophageal varices and CLD. Following this he came to ILBS for further management. He was evaluated on OPD basis and planned for surgery. In the interim he had dizziness and fall (? Low Hb) sustaining chest trauma. Patient was admitted on 07/11/2019 for evaluation and surgery but was discharged as patient wanted to obtain 2nd opinion regarding plan of management. Now the patient is being readmitted with complaints of malena in the past 5 days.

Chronic alcoholic x 6 years- 100 ml to 180ml/day

Last intake - in September 2019

H/o Tobacco chewing stopped after last admission.

No h/o UGI/ LGI bleeding.

No H/o jaundice

No h/o loss of appetite, loss of weight

No h/o urinary complaints

H/o exploratory laparotomy with colostomy for gunshot injury in 2002

Inj. FLU QUADRI 0.5 ml IM Stat.
Repeat every year

Inj Pneumovax
0.5 ml IM Stat.

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ON EXAMINATION:
Conscious, oriented
Afebrile, PR-80/min, BP-110/70 mm Hg, RR-16/min
Pallor present
No Icterus/ cyanosis/ Clubbing/ LNP/ Edema
RS: Air entry bilateral equal
P/A: Soft, Non tender, no lump, no organomegaly, no free fluid, large incisional hernia present with distorted abdominal contour more towards left side. Midline scar mark of exploratory laparotomy. BS +ve
P/R- grade III heamorrhoids

SYSTEMATIC REVIEW:
USG Abdomen (25/11/2019): K/c/o GIST in duodenum, present ultrasound shows : Chronic liver disease with findings suggestive of portal hypertension (splenomegaly with prominent splenoportal axis).Large hernia seen in left lower abdomen with bowel loops and mesentric fat as content. No free fluid in peritoneal cavity.

PET CT (16/10/2019): Metabolically active exoenteric soft tissue mass arising from the fourth part duodenum suggestive of primary malignant pathology (likely GIST). Advised HPE for confirmation.
2. Metabolically active enlarged right lower paratracheal and subcarinal lymph nodes likely infecti (granulomatous) in etiology. However FNAC may be worthwhile to exclude remote possibility of metastases
3. CLD with non-metabolic LR-3 lesion (likely atypical hemangioma) in segment VII with features of P (splenomegaly with mild ascites and bilateral pleural effusion).

CECT Abdomen (Outside, 1/10/2019): cirrhotic liver morphology. Endoexophytic lesion with transm extension from D3-D4 with abutment of proximal jejunal loops. 3.9 x 3.4 x 3.9cm in size

Upper GI endoscopy (outside): early esophageal varices, GIST of D3.

HVPG (15/11/2019): No clinically significant portal hypertension. HVPG - 6 mm hg

Fibroscan(9/10/2019)
CAP_MED 269
CAP_IQR 13
E MED 70.6
E IQR 5.2
E IQR MED 7%

HPE (04/12/2019, H-5425/19): Duodenal D4 segment with tumorGastrointestinal stromal tumor spindled cell type, Low grade.

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stologic Grade G1:Low grade;mitotic rate 5/5 mm2
section margins- Resection margins (duodenal) are free of tumor.
mphovascular invasion not seen
rineural invasion- not seen

er biopsy (H- 5426/19, 29/11/2019): Liver (Trucut) biopsy- Steatohepatitis with Cirrhosis

ERATIVE FINDINGS:
er nodular. No ascites. No peritoneal nodules. No significant collaterals
sy adhesions interbowel and bowel to pariety.
ental and bowel adhesions to right side of liver, gall bladder and parietal wall and liver to wall adhesions
ge incisional hernia on left side. Content: small bowel and sigmoid colon
our of size 4 x 5 cm involving D3-D4 part of duodenum.
m segment of bowel resected from distal D3 to 5 cm beyond DJ flexure.
of mesentery fused with mesocolon due to post-operative adhesions
en Y gastrojejunostomy done (retrocolic, posterior, isoperistaltic).
gastric tube positioned in duodenum.
to side duodeno(D3)-jejunal anastomosis performed in2 layers with the same roux en y loop 45 cm dista

test done with methylene blue: Negative
ne 20 cm distal to DJ

RSE IN THE HOSPITAL: Mr Rajesh was admitted with the above mentioned history at ILBS. Patie
nemic (Hb 5.1) at presentation. 5 unit PRBC were transfused after which his Hb stabilized at 9.6. Patie
is relatives were explained in detail regarding disease, its treatment options and complication and ri
ated with surgery. Also he was explained in detail about risk of mortality i/v/o CLD. After obtaining d
nt, he underwent Segmental duodenal resection (D3, D4) of GIST containing segment + Roux en
jejunostomy + duodenojejunostomy (D3 jejunum) + feeding jejunostomy + liver biopsy on 28/11/20
erated the procedure well, was extubated on table and shifted to SICU for monitoring. He was mana
V fluids, IV antibiotics, parenteral analgesics, and inj albumin. He was started on TPN from POD2
on as FJ output was persistently high. FJ test feed was given on POD4 which he tolerated well. He pa
and motion on POD4. He was shifted to the ward on POD4 and allowed oral sips of water as tolerate
thorax and abdomen with oral contrast was done on POD5 (3/11/2019) to check for any anaston
which was s/o no leak and passage of contrast in small bowel and he was allowed oral clear liqui
d on POD5. Foleys catheter was clamped and removed on same day. He was gradually advanced to
h diuretics from POD6 and FJ was clamped. Normal diet was allowed on POD7. Drain output grad
ed and pelvic drain was removed on POD8 and left sided ADK was removed on POD11. M
y opinion was sought and no further treatment was required (low risk GISt). He is pain free, af
rating normal diet, hemodynamically stable.

Repeat every year

Inj Pneumovax
0.5 ml IM Stat.

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High protein high calorie diet
Absolute abstinence from alcohol and tobacco
Incentive Spirometry
Tab Lasilactone 20/50 1 BD x 3 days then stop
Tab Cardivas 3.125 mg OD to continue
Tab Thyronorm 62.5 mg OD
Tab Shelcal M 1 tab TDS x 1 month
Tab Crocin pain relief SOS
Tab Pantocid 40 mg OD x 1 week
Cap A- Z 1 OD x 1 week
Tab Zinconia OD x 1 week
FJ site care as advised
Daily drain output measurement (Left side)
To follow up in HPB surgery on Monday for clip removal.
To follow up in hepatology OPD for management of CLD
To follow up in Medical Oncology OPD for need of adjuvant treatment.

WHEN TO OBTAIN URGENT CARE:
Severe nausea, vomiting, abdominal pain, fever, jaundice

Senior Resident:
Sign of Senior Resident Dr. Dhananjay
Name of Senior Resident

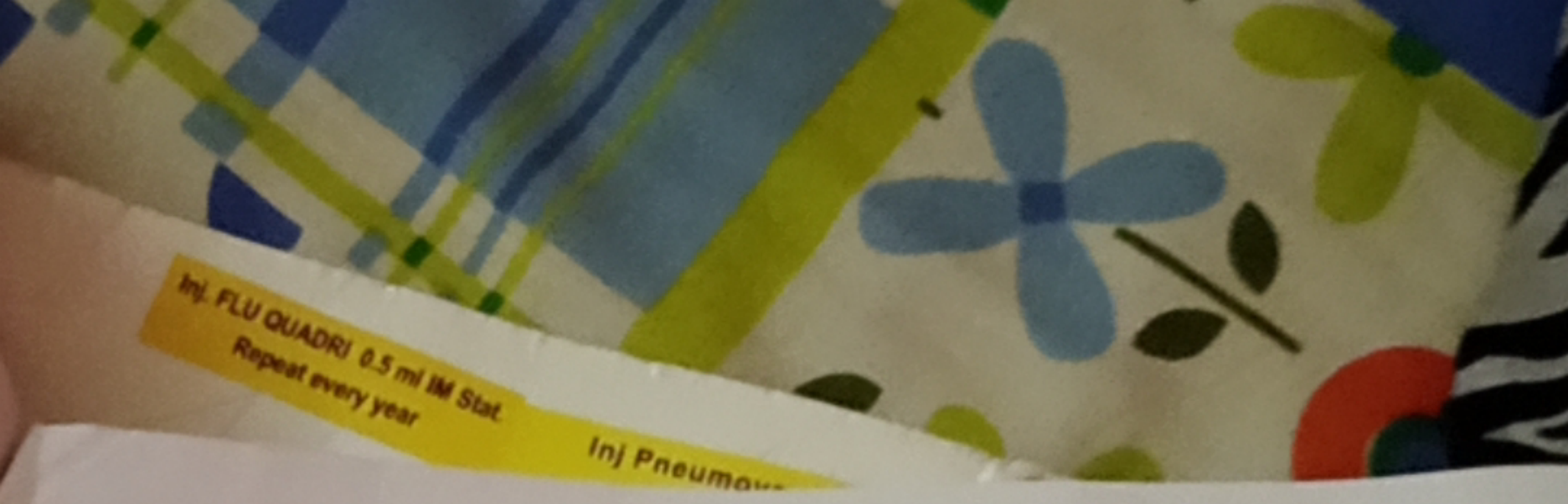
Treating Faculty:
Sign of Treating Faculty
Name of Treating Faculty

Senior Resident:

Dr. Shashwat Sarin	Dr. Brahmadatt Pattnaik	Dr. Devi Singh	Dr. Sahil Gupta	Dr. Dinesh	Dr. Venkatesh	Dr. Vivek R	Dr. Tharun	Dr. Sanyam
8756139	8437201202	9873415878	9873291642	8561907161	8838299325	8800984217	9953778947	8448884099

Treating Faculty:

Dr. Vinayak Chattopadhyay Consultant	Dr. Viniyendra Pamecha Professor	Dr Senthil Kumar Additional Professor	Dr Shridhar V Sasturkar Associate Professor	Dr Piyush Kumar Sinha Assistant Professor	Dr Nihar Mohapatra Assistant Professor	Dr Nilesh S Patil Assistant Professor	Dr Ragini Kilambi Assistant Professor	Dr Rup Goswami Consultant



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