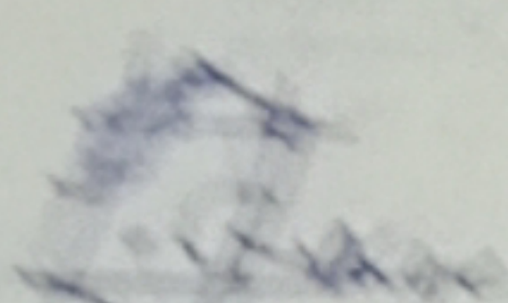

INSTITUTE OF LIVER & BILIARY SCIENCES
(An Autonomous Society under Government of NCT of Delhi)
D-1, Vasant Kunj, New Delhi, India
ilbs Phone No: 011-46300000 Ext. 7055 & 7056, 011-26706700 - 02, 64703890
Fax No.46300010
Email : info@ilbs.in, Website: http://www.ilbs.in

Discharge Summary

Patient:	Mr RAJESH KUMAR MANI	UHID:	ILBS 0000213447
Age:	49 Year(s)	InpatientNo:	IPID 0058910
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 wa evaluated with Imaging, UGIE+EUS which were s/o duodenal GIST (D3-D4) with stigmata of Bleed with earl esophageal varices and CLD. Following this he came to ILBS for further management. He was evaluated o 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 obta 2nd opinion regarding plan of management. Now the patient is being readmitted with complaints of malena f 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

Discharge Summary

Patient:	Mr RAJESH KUMAR MANI	UHID:	ILBS.0000213447
Age:	49 Year(s)	InpatientNo:	IPD 0068910
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		

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 of duodenum suggestive of primary malignant pathology (likely GIST). Advised HPE for confirmation.
2. Metabolically active enlarged right lower paratracheal and subcarinal lymph nodes likely infective (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 PHT (splenomegaly with mild ascites and bilateral pleural effusion).

CECT Abdomen (Outside, 1/10/2019): cirrhotic liver morphology. Endoexophytic lesion with transmural 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)
LP_MED 269
LP_IQR 13
MED 70.6
QR 5.2
QR MED 7%

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

Discharge Summary

tient:	Mr RAJESH KUMAR MANI	UHID:	ILBS.0000213447
ge:	49 Year(s)	InpatientNo:	IPID:0058910
ender:	Male	Admission Date	25 Nov 2019 03:05 PM
ard:	General Ward B Second Floor	Discharge Date:	
eciality:	HPB Surgery	Bed No:	2010-01
nsultant:	Dr T K Chattopadhyay		

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

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

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

st done with methylene blue: Negative
20 cm distal to DJ

SE IN THE HOSPITAL: Mr Rajesh was admitted with the above mentioned history at ILBS. Patient mic (Hb 5.1) at presentation. 5 unit PRBC were transfused after which his Hb stabilized at 9.6. Patient relatives were explained in detail regarding disease, its treatment options and complication and risk d with surgery. Also he was explained in detail about risk of mortality i/v/o CLD. After obtaining due he underwent Segmental duodenal resection (D3, D4) of GIST containing segment + Roux en Y nostomy + duodenojejunostomy (D3 jejunum) + feeding jejunostomy + liver biopsy on 28/11/2019. ed the procedure well, was extubated on table and shifted to SICU for monitoring. He was managed luids, IV antibiotics, parenteral analgesics, and inj albumin. He was started on TPN from POD2 for s FJ output was persistently high. FJ test feed was given on POD4 which he tolerated well. He passed motion on POD4. He was shifted to the ward on POD4 and allowed oral sips of water as tolerated. A rax and abdomen with oral contrast was done on POD5 (3/11/2019) to check for any anastomotic h was s/o no leak and passage of contrast in small bowel and he was allowed oral clear liquids as n POD5. Foleys catheter was clamped and removed on same day. He was gradually advanced to soft iuretics from POD6 and FJ was clamped. Normal diet was allowed on POD7. Drain output gradually and pelvic drain was removed on POD8 and left sided ADK was removed on POD11. Medical pinion was sought and no further treatment was required (low risk GISt). He is pain free, afebrile

Discharge Summary

Mr RAJESH KUMAR MANI	UHID	IUBS 0000213447
48 Year(s)	InpatientNo	IPID 0058910
Male	Admission Date	25 Nov 2010 03:05 PM
General Ward B Second Floor	Discharge Date	
HPB Surgery	Bed No	2010-01
Dr T K Chattopadhyay		

in high calorie diet
bstinence from alcohol and tobacco
spirometry
tazac 20/50 1 BD x 3 days then stop
as 3.125 mg OD to continue
norm 62.5 mg OD
M 1 tab TDS x 1 month
pain relief SOS
d 40 mg OD x 1 week
OD x 1 week
a OD x 1 week
as advised
output measurement (Left side)
in HPB surgery on Monday for clip removal.
in hepatology OPD for management of CLD
in Medical Oncology OPD for need of adjuvant treatment.

OBTAIN URGENT CARE:
ea, vomiting, abdominal pain, fever, jaundice

ent:
r Resident Dr. Dhananjay
ior Resident

Treating Faculty:
Sign of Treating Faculty
Name of Treating Faculty

ent:

Dr. Brahmadeo Patnaik	Dr. Devi Singh	Dr. Sahil Gupta	Dr. Dinesh	Dr. Venkatesh	Dr. Vivek R	Dr. Tharun	Dr. Sanyam
8457201202	9873415878	9873291642	8561907161	8838299325	8800984217	9953778947	8448884099

ulty:

Dr Senthil Kumar	Dr Shridhar V Sasturkar	Dr Piyush Kumar Sinha	Dr Nihar Mohapatra	Dr Nilesh S Patil	Dr Ragini Kilambi	Dr Rup Goswami
		Assistant	Assistant	Assistant	Assistant	Consultant

Discharge Summary

Mr RAJESH KUMAR MAH	UHID	[illegible]
40 Years(M)	Inpatient No	[illegible]
Male	Admission Date	26 Nov 2018 03:05 PM
General Ward B Second Floor	Discharge Date	
CVTS Surgery	Bed No	[illegible]
Dr T R Chelliyan		

Health Care Imaging Centre

43,Shivaji Road, Near N.A.S. College, (Opp. Shankar Ashram) Meerut. (U.P.)
Ph.: 0121-2652434, 2650506 Helpline : 9760011538

- 3 Tesla Platform MRI (HFO)
- Multi-Slice CardiacCT
- 3D & 4D Ultrasound
- Digital C.R.
- Digital X-Rays
- DEXA Scan (BMD)
- Digital Mammography

HCIC No. :	012011000941	Reg. Date :	07 Nov 2020
Patient Name :	Mr. RAJESH KUMAR MANI	Report Date :	09 Nov 2020
Age/Sex :	50 YRS/MALE	Referred By :	Dr. DHRUV JAIN MS,MRCS

CECT WHOLE ABDOMEN

Protocol: Serial thin axial sections in delayed were obtained in the spiral mode on a multi slice CT- scanner from the level domes of diaphragms to the pubic symphysis after administration of oral, rectal and I.V. contrast media. Thereafter coronal and sagittal reformats were done for further references.

Follow up post-op case of GIST (4th part of duodenum)

FINDINGS

- **Liver** is enlarged in size (170 mm). The tomography of liver is altered with relative hypertrophy of caudate and left lobe. The margins of liver are nodular. Intrahepatic biliary radical are not dilated. A speck of calcification is noted in left lobe.
- **Gall bladder**: No radio-dense calculus is seen. USG is the modality of choice for GB stones / polyps.

- **CBD** is normal in calibre.
- **Portal Vein** is dilated and measures 13mm.

- **Pancreas** is normal in C.T. attenuation patterns with no focal lesions or peripancreatic collections. Pancreatic duct is not dilated.
- **Spleen** is borderline enlarged measures 125 mm in CC dimension and shows normal in CT attenuation pattern.

- Few collaterals suggestive of varices are seen in at gastro-splenic ligament, splenic hilum, gastroesophageal junction and in retroperitoneum.

- Minimal stranding is seen in mesentery.

- **Both Kidneys** are normal in C.T. attenuation patterns. Corticomedullary differentiation is maintained. No evidence of hydronephrosis / calculus is noted. Renal cortical thickness and margins are normal. **Both ureters** are normal in their course and caliber.
- **Both adrenal regions** are normal. **Psoas shadows** are normal.

- **Prostate** is normal in size. **Seminal vesicles** are normal.
- **Urinary bladder** is well distended and appears to be normal.

Contrast filled stomach is well identified and appears to be normal.

Mild prominence and mucosal thickening of jejunal loops is noted ---- Jejunitis.

Health Care Imaging Centre

A3,Shivaji Road, Near H.A.S. College, (Opp. Shankar Ashram) Meerut (U.P.)
Ph: 0121-2652438, 2654546
Helpline : 9760011538

- 3 Tesla Platform MRI (1.5T)
- Multi-Slice Cardiac C.T.
- 3D & 4D Ultrasound
- Digital O.P.G.
- Digital X-Rays
- DEXA Scan (BMD)
- Digital Mammography

H.I.C. No. :	[illegible]	Reg. Date :	07 Nov 2020
Patient Name :	Mr. HARISH KUMAR MAHI	Report Date :	09 Nov 2020
Age/Sex :	50 YRS/MALE	Referred By :	Dr. SHRUV JAIN MS,MBBS

Large defect (8cm) is noted in anterior & lateral abdominal wall on left side at the level of umbilicus with herniation of fat, large bowel (sigmoid colon, descending and splenic flexure of colon) and small bowel loops (jejunal loops). Mild narrowing noted in caliber of splenic flexure of colon where it is exiting from the hernia.

Post-surgical changes noted at the level of 4th part of duodenum, however no obvious thickening noted at anastomotic site.

Few small lymphinodes with short axis diameter upto 4 mm noted in left para-aortic region of retroperitoneum and in mesentery.

No evidence of ascites or bilateral pleural effusion is seen.
Aorta and IVC are normal.

Visualized spine shows degenerative changes. No focal bony aggressive lesion is seen.
Visualized lung bases appear unremarkable.

IMPRESSION: CT. Findings reveal;

- **Post-surgical changes at the level of 4th part of duodenum, however no obvious thickening or residual / recurrent lesion at anastomotic site.**
- **Hepatomegaly altered tomography of liver with relative hypertrophy of caudate and left lobe with nodular liver margins with speck of calcification in left lobe with dilated portal vein with borderline splenomegaly with few varices in at gastro-splenic ligament, splenic hilum, gastroesophageal junction and in retroperitoneum. -----Findings are suggestive of Chronic Liver Disease with Portal Hypertension.**
- **Large defect (8cm) in anterior & lateral abdominal wall on left side at the level of umbilicus with herniation of fat, large bowel (sigmoid colon, descending and splenic flexure of colon) and small bowel loops (jejunal loops) with mild narrowing in caliber of splenic flexure of colon where it is exiting from the hernia. ----Suggestive of large Incisional Hernia.**
- **Mild prominence and mucosal thickening of jejunal loops ---- Jejunitis.**
- **Hyperdense lesion of CT attenuation 4000 HU in subcutaneous tissue of anterior abdominal wall in right hypochondrium suggestive of metallic foreign body.**

Adv Follow up / PET Scan for further evaluation