F-68 (A)

F / THER / 04-01-01

RAJIV GANDHI CANCER INSTITUTE
AND RESEARCH CENTRE
Sector - V, Rohini, Delhi - 110 085
Tel. : 47022222(30 Lines) 27051011-1015
Fax : 91-11-27051037

DISCHARGE SUMMARY | ***This is an important document, please bring it for future reference / follow up***

Department of Paediatric Haematology and Oncology

CR NO: *312976*	***DATE OF ADMISSION:*** *OCT 18, 2022*
IP NO: *13212*	***DATE OF DISCHARGE:*** *NOV 09, 2022*
NAME: *ISHANT CHAUDHRY*	***Ht:*** *173cm*
AGE: *17 Years*	***Wt:*** *53.6 kg*
GENDER: *MALE*	***BSA:*** *1.6 m^2*
ROOM NO: *216-A*	***BLOOD GROUP:***
REG. DATE: *30.08.22*	***CONSULTANT:*** *DR.GAURI KAPOOR/DR.SANDEEP JAIN*

Address : *RZ-629/A 27 E Sadh Nagar , Palam Colony , Delhi, India, 110045*
Tel : *9716909278*
Primary Diagnosis : *B-Cell Acute Lymphoblastic Leukemia with right sided Hydropneumothorax with Hyponatremia seizure*
Admission Diagnosis : *Supportive Care*
Operative Procedure : *Right sided VATS assisted excision of the giant bulla with decortication and wedge excision of S10 segment necrotic area with mechanical apical pleurodesis under GA on 21.10.22*
Central Line : *PICC line insertion on 02.09.22*

Brief Summary:

17 years old boy diagnosed case of B-Cell Acute Lymphoblastic Leukemia post IA (completed on 17.10.22) presented with the complaint of fever and 1 episode of generalized tonic clonic seizure. On examination conscious, oriented, febrile (101'F), PR-128/min, RR-26/min, BP-110/70mmHg, pallor++, oral cavity- normal, chest- air entry markedly decrease in right side, CVS-NAD, P/A-soft, no organomegaly, CNS- conscious, E4V5M6, pupil-RRRTL, no meningeal sign.

He was admitted for supportive care and started on broad spectrum antibiotics, antiepileptics and managed conservatively. Investigations revealed dyselectrolytemia (hyponatremia) for which sodium correction was given and antiepileptic drug continued.

His fever and respiratory distress worsened, for which his antibiotics were upgraded. Chest X-Ray revealed bilateral mild to moderate pleural effusion with bilateral patchy opacities. So CT chest was done that revealed right tension hydropneumothorax with shift of the mediastinum to contralateral side, right chest wall subcutaneous emphysema. Chest physician & Infectious disease specialist reference was taken and advice followed.

In view of effusion, his antibiotics were upgraded and diagnostic pleural tap was done on 20.10.22. Pleural fluid was sent for cytology, gram stain, KOH stain, AFB stain, bacterial culture, TB culture and Gene Xpert fungal culture that didn't reveal any growth.

In view of CT chest findings and worsening distress, thoracic surgeon reference was taken, and surgery was adviced. He was operated on 21.10.22 and right sided VATS assisted excision of the giant bulla with decortication and wedge excision of s10 necrotic segment with mechanical apical pleurodesis was perfomed under GA. HPE findings were unremarkable. Bronchoscopy under GA was done on 22.10.22 and BAL done and it didn't reveal any growth.

In view of persistently reduced air entry on right side of lung, serial chest X-Ray was done which showed right mild pneumothorax with ICD's in situ. Physiotherapy reference was taken and advice followed.

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He had breakthrough seizure on 26/10/22, which was aborted with inj midazolam and mini loading of levipil. Dose of oral levipil was subsequently increased. Serum electrolytes were normal.

Post operatively day 6, he developed high grade breakthrough fever for which antibiotics were upgraded but fever did not respond and culture didn't reveal any growth so Infectious disease specialist reference was taken. In view of breakthrough high grade fever and no growth, hospital acquired MDR infection was suspected and patient was started on empirical inj fosfomycin and inj meropenem. His fever subsided after upgrading antibiotics and clinical condition improved. He received packed cell transfusion during hospital stay.

He was started on IB cyclophosphamide chemotherapy on 07.11.22, which he tolerated uneventfully. LP was done on 08.11.22 and IT MTX (12.5mg) was administered. CSF was sent for cytology, report of which is negative for malignant cells

At present he is clinically better, afebrile for 5 days, has no respiratory distress with improved air entry. He is being discharged on 09.11.22.

Operation Notes:

Right Side VATS with Decortication on 21.10.22

- *Diagnostic thoracoscopy at previous site failed to visualize pleural cavity*
- *Utility incision was used for entering pleural cavity / thickened wall of the bulla was identified and extrapleural mobilization done all around*
- *The bulla cavity was opened and the trappled upper lobe seen followed by the middle and lower which was not seen initially*
- *The bulla was mobilized on all sides till hilum*
- *The bulla wall was traced along hilum involving diaphragm/posteriorly till azygous vein and anteriorly just below superior pulmonary vein*
- *The bulla was mobilized and the layer overlying the lung was removed along the middle and lower lobe*
- *Iatriogenic 2cm tear to diaphragm during bulla wall removal was repaired with prolene no1 interrupted*
- *Decortication of the whole lung and opening of fissure done*
- *S10 segment which was necrotic was stappled [* ***x3 nos 45 mm GST****]*
- *Intraop lung well expanded*
- *Mechanical pleurodesis done along the apical segment of chest wall*
- *Intraop minimal air leak on ventilation.*
- *Hemostasis attained*
- *2 Chest tubes placed 28fr apical and basal and connected to SINAPI drain*
- *wound closed in 2 layers, skin stapled after approximating ribs.*

Treatment given in hospital:

Supportive Care

- *Inj Magnex forte 3gm IV twice a day (18.10.22 to 25.10.22)*
- *Inj Ticocin 400mg IV twice a day x 3 doses then once a day (20.10.22 to 21.10.22)*
- *Inj Levipil 500mg IV twice a day (21.10.22)*
- *Inj Clexane 40mg s/c once a day (22.10.22 to 24.10.22)*
- *Inj Meropenem 1gm IV thrice a day (29.10.22 to 05.11.22)*
- *Inj Fosfamycin 4gm IV every 6th hrly (29.10.22 to 05.11.22)*
- *Tab Posaconazole 300mg once a day*
- *Tab Faronem 200mg twice a day (07.11.22)*

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- Inj Pantop 40mg IV once a day
- Inj Vitamin K 5mg IV stat
- Inj Rantac 150mg HS
- Tab Shelcal 1tab once a day
- Syp Levipil 7.5ml twice a day
- Syp Potklor 10ml thrice a day with ½ glass of water
- Calcirol sachet 60000IU 1 sachet once a day x 4 days
- Salsol nebulization twice a day
- NS Nebulization
- Duolin Nebulization
- Salt water mouth wash QID
- Sitz bath twice a day

Cyclophosphamide Chemotherapy

- Inj Palzen 0.25mg IV stat
- Inj Cyclophosphamide 1.5gm IV (07.11.22)
- Inj Mesna 640mg IV slow after completion of Cyclophosphamide infusion and repeat after 3 hrs and 6 hrs
- Hydration DNS
- Inj Cytarabine 12mg IV stat (09.11.22)
- Tab 6MP 2 tabs alternate with 1 tab HS from 07.11.22 onwards

Investigations:

Haematology	18.10.22	21.10.22	24.10.22	29.10.22	05.11.22	07.11.22
Hb gm%	9.6	6.8	7.0	7.7	6.9	9.7
TLC/cumm	39120	4450	3210	10810	4170	5630
DLC %	P91L06	P80L10	P53L23	P88		P66L24
Platelets/cumm	308000	145000	94000	161000	329000	363000

Biochem	18.10.22	21.10.22	23.10.22	25.10.22	01.11.22	05.11.22	09.11.22
Blood urea mg/dl			19				
S.Creatinine mg/dl			0.5				
S. Uric Acid mg/dl			2.7				
S. Sodium mEq/l	118	131	129	132	131	134	131
S. Potassium mEq/l	4.6	4.2	4.0	3.3	3.4	3.7	4.4
S. Direct Bilirubin mg/dl		0.4					
S. Total Bilirubin mg/dl		1.0					
SGPT U/L		87					
SGOT U/L		24					
S. ALK Phos. U/L		123					
S. Total Protein gm/dl		4.7					
S. Albumin gm/dl		2.7					
S. Globulin U/L		2.0					
S. Gamma GT U/L		133					
S. Ion. Calcium mmol/L	1.03						
S. Magnesium mg/dl	1.4						

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APTT/PTTK	***21.10.22***	***22.10.22***
Mean APTT	*31.3*	*31.3*
APTT/PTTK	*34.6*	*33.1*
Prothrombine Time		
Mean PT	*11.7*	*11.7*
Prothrombine Time	*14.6*	*13.3*
INR	*1.24*	*1.13*

Chest X-Ray (19.10.22): Bilateral mild to moderate pleural effusion with bilateral patchy opacities. Sclerotic bone lesions.
Blood culture (20.10.22): no growth
Low dose CT Chest (20.10.22): right tension hydropnuemothorax with shift of the mediastinum to contralateral side, right chest wall subcutaneous emphysema.
2D Echo (20.10.22): Normal (LVEF-60%)
BAL culture (21.10.22): no growth
BAL KOH Exam (21.10.22): no fungal filament seen.
Gram Stain culture (21.10.22): no organism seen
AFB Stain culture (21.10.22): no acid fast bacilli seen
S. TSH (21.10.22): 4.12uIU/ml
Anti viral markers (HCV/HIV/HbSAG) (20.10.22): non reactive
HPE from Right S6 Wedge Excision & Bulla Wall Right Side (22.10.22): no evidence of tumor
BAL Culture (22.10.22): no growth
X-Ray Chest (21.10.22): Right mild pneumothorax with ICD's in situ.
X-Ray Chest (22.10.22): Right mild pneumothorax with ICD's in situ.
X-Ray Chest (23.10.22): Right mild pneumothorax with ICD's in situ.
X-Ray Chest (24.10.22): Right mild pneumothorax with ICD's in situ.
X-Ray Chest (25.10.22): Right mild pneumothorax with ICD's in situ.
Blood culture (24.10.22): no growth
Blood culture (29.10.22): no growth
CSF Cytology (08.11.22): Negative for malignant cells

Advice on discharge:

- ***Inj Cytarabine 120mg IV slow push once a day x 3 days (10.11.22 to 12.11.22) in Day Care***
- *Tab 6MP 2 tabs alternate with 1 tab HS (1½ hrs after dinner, no milk/milk products at night)*
- *Tab Posaconazole 300mg once a day*
- *Syp Potklor (20meq/15ml) 10ml in 100ml juice thrice a day*
- *Syrup Levipil 7.5 ml twice a day*
- *Tab Septran DS 1 tab twice a day (Sat-Sun)*
- *Drink 3 liter water / day*
- *Chest Physiotherapy as adviced*
- *Salt water mouth wash QID*
- *Avoid raw / uncooked food / fresh fruits / juices*
- *Diet and hygiene as advised*
- *Sample collection time: 8am to 11am*
- *PICC LINE dressing and flushing once a week in OPD: 11am to 12pm*
- *Discharge counseling done by*

F-10A

F/RECP/01-05-06

Rajiv Gandhi Cancer Institute and Research Centre

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25 Years of excellence in Cancer Care

NABH H-2012-0138 MC-2143

C. R. NO. ..... Date 16/11

Patient's Name Ishant.

Age/Sex ..... Doctor's Name .....

PRESCRIPTION SLIP

Rx

(1) Inj Cytarabine (AraC)
120mg IV OD x 4 days.
(16/11 — 19/11)

(2) Tab 6MP 2 - 2 - 1 - 2 - 2 - 1
16/11 17/11 18/11 19/11 20/11

(3) Tab Emeset 4mg before AraC

(4) Pot Kbr — 2 times.

Re: 23/11

PLEASE TAKE PRIOR APPOINTMENT FOR NEXT VISIT