ck
ck
NER
File No.
LCH
BUSHAIMA
78614

0|539

Abbu - Sharma. | 14yr 5m/M

PET - CT.

2CH → chemotherapy completed.

↓

Post chemo PET CT.

Dr. [illegible]

वर्धमान महावीर मेडीकल कॉलेज एवं सफदरजंग अस्पताल
VARDHMAN MAHAVIR MEDICAL COLLEGE & SAFDARJUNG HOSPITAL
नई दिल्ली / NEW DELHI–110029

DISCHARGE SUMMARY

Name of Patient : Afreema / Ahamad Age / Sex : 1ysm / M UHID : 162400

IP No. : Emergency/Department/Unit :

Date of Admission : 23/11/23 Time of Admission :

Date of Discharge : 23/11/23 Time of Discharge :

DIAGNOSIS : LCH - cycle 2

PRESENTING COMPLAINTS:

Patient come for chemotherapy.

ON EXAMINATION: [illegible]

HR = 90
RR = 24/min
CP/PP = +/+
CRT < 3sec.

INVESTIGATIONS:

8 / 4810 / 740 \ 561×10³

LFT = 0.7 / 67 / 160 / 539

Procedure (If Any)

Treatment Given / Course in the Hospital:

Inj Vinblastine 2.4 mg in 10 ml NS
slow IV push

Patient Condition on Discharge stable

Advice on Discharge
(Medication, Other Instruction)

- syr Septran (40/200) 2.5 ml PO OD
- Lorazol 1.5 mg ½ tab PO BBF
- syr Omnacortil (5/5)
  - 24/11/23 - 27/11/23 - 2ml PO BD
  - 28/11/23 - 29/11/23 - 2ml PO OD
- Sitz Bath | Betadine gargles | candid mouth paint

In case of following [illegible] contact at Phone No./Room / Hall / NEB No. ____________

Follow Up in OPD Room No. Bayyo... On Date 30/11/23 with new OPD SLIP
→ for CBC, LFT

I ____________ (Patient / Guardian) has received the discharge summary

Signature Name, Date & Time (Patient / Guardian)

Signature of PG Name, Date & Time

Signature of SR/Faculty Name, Date & Time

वर्धमान महावीर मेडिकल कॉलेज एवं सफदरजंग अस्पताल, नई दिल्ली110029-

Vardhman Mahavir Medical College & Safdarjung Hospital, New Delhi-110029

बाल रोग विभाग

Department of Paediatrics

Division of Paediatrics Haematology & Oncology

DISCHARGE SUMMARY

Name	ABBU SHAIMA	Time/Date of admission	23/08/2023; 6:17 PM
Age/Gender	1 ½ YEAR/MALE	Time/Date of discharge	28/08/2023; 6:00 PM
MRD no	13844	Hematology no	
Weight	7.5KG	BSA Blood group	0.38 M2
Attending faculty	Dr. Amitabh Singh, Dr. Sumit Mehndiratta, Dr Nidhi Chopra, Dr, Ritamoni C Baruah		
DIAGNOSIS	MULTISYSTEM LANGERHANS CELL HISTIOCYTOSIS Involved systems: hepatobiliary (periportal infiltrates, raised liver enzymes and GGT, history of hyperbilirubinemia), respiratory (respiratory distress, patchy ground glass opacities and atelectatic bands in b/l lobe), skin (lesions are biopsy positive for histiocytosis) No Bone Marrow involvement No CNS involvement.		

ANTHROPOMETRY	OBSERVED	Z SCORE
WEIGHT	7.5 KG	<3 SD
HEIGHT	72 CM	<3 SD
HEAD CIRCUMFERENCE	34 CM	<3 SD
US:LS RATIO	1.18	

PRESENTING COMPLAINT:

Abdominal distension for 4 months
Fever for 4 months
Fast breathing for 2 months

HOPI

Child was apparently alright till 4 months back when he developed fever, low grade, undocumented, not associated with chills or rigors, relieved on taking some medications. No associated joint pain, rash, abnormal body movements, local eye or ear discharge, vomiting was present.
Child also had abdominal distension, which was progressively increasing in size. Abdominal distension was associated with jaundice, onset was along with onset of abdominal distension, was gradually progressive, but resolved spontaneously within 1 month. There was no h/o constipation, abdominal pain, vomiting, or decreased oral acceptance. No medical attention was sought for the same.
Child also had h/o fast breathing for 2 months, received antibiotics i/v/o suspected pneumonia, but there was no resolution.

PAST HISTORY:

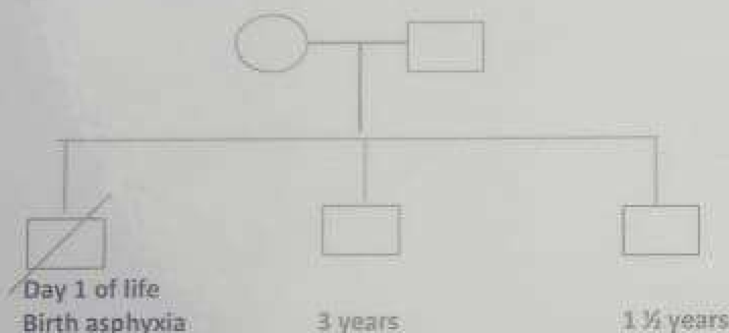
Child presented with the above complaints to SJH, and worked up. There was no resolution on antibiotic therapy. USG whole abdomen done, suggestive of altered echotexture present with dense

periportal echogenicity and focal areas of fatty infiltration. CECT abdomen and chest was done.
Chest: few patchy areas of ground glass opacities seen in the apicoposterior segment of left upper lobe. Few atelectatic bands are observed in apical segment of right upper lobe.
Abdomen: Hepatoma-splenomegaly with periportal hypodensity, likely periportal infiltrates.
Lymphadenopathy present.
Child became symptomatically better, therefore was discharged and worked up on OPD basis. Child was planned for liver biopsy and skin biopsy under the suspicion of Langerhans cell histiocytosis. Liver biopsy done on 23/08/2023 showed only fibro collagenous tissue. Skin biopsy done on 11/08/2023 was suggestive of Langerhans cell histiocytosis. (CD 1a and S 100 positive).

BIRTH HISTORY: term/LSCS i/v/o previous LSCS/ non-complicated perinatal history

IMMUNIZATION HISTORY: Immunized for Age.

FAMILY HISTORY:



No h/o contact with TB,
No h/o DM, HTN, asthma
Non consanguineous marriage
No h/o similar complaints in the family

DEVELOPMENTAL HISTORY: GROSS MOTOR: able to stand without support
FINE MOTOR: child scribbles
LANGUAGE: child can speak short meaningful sentences
SOCIAL: child can do parallel play

PHYSICAL EXAMINATION:
P-/I-/C-/C-/ E-/L-
RR: 22/min HR:102 /MIN CP/PP: +/+ CFT: < 3sec. SPO2: 99 % on RA BP: 98/64mmHg Temp: afebrile,
R/S: B/L AE+, clear CVS: S1S2+/Mo P/A: soft/NT/ liver palpable 6cm below costal margin, span is 11 cm, spleen is palpable 4 cm along axis /BS+ CNS: conscious/oriented/ GCS: 15/15

COURSE DURING HOSPITAL STAY:
Child referred to Haemat-oncology division after diagnosis of MS-LCH via skin biopsy. Child was started on empirical antibiotic Inj Piptaz/Amikacin, and chemotherapy started with Inj Vinblastine @ 6mg/m2 and daily prednisolone therapy @ 40 mg/m2. Workup for LCH was done. Child tolerated chemotherapy well, no adverse effects observed, now being discharged and kept on close follow up.

DATE	HB	TLC	ANC	PLT	T BIL	OT/PT	ALP	BUN /UREA	CREAT	NA/K	OTHERS

24/08/2023					0.8	148/108	788	11	0.1	133/4.9	s.ferritin=6.6 PT=12.1 SEC APTT=30.3 SEC INR=1.0 S ALB=3.8
26/08/2023	11.2	12740	7200	142000	0.8	119/98	589	14	0.1	135/3.8	Ca=9.7 Po4=4.5 GGT=172

INVESTIGATIONS

28/07/2023: BONE MARROW BIOPSY AND ASPIRATION: no abnormalities present.

21/07/2023: CECT abdomen and chest was done. Chest: few patchy areas of ground glass opacities seen in the apicoposterior segment of left upper lobe. Few atelectatic bands are observed in apical segment of right upper lobe.

Abdomen: Hepatoma-splenomegaly with periportal hypodensity, likely periportal infiltrates. Lymphadenopathy present.

23/08/2023: showed only fibro collagenous tissue

11/08/2023: suggestive of Langerhans cell histiocytosis. (CD 1a and S 100 positive).

28/08/2023: MRI Brain is normal

VITAMIN D3/PTH (26/08/2023) and urine for osmolarity and specific gravity (25/08/2023) sent, reports remain to be provided

Antibiotic Therapy/Chemotherapy	
INJECTION AND TABLET	DAYS
INJ. PIPTAZ	5
INJ. AMIKACIN	5
INJ. PANTOP	5
INJ VINBLASTINE	1 DOSE
SYP OMNACORTIL	5

Advice at discharge (explained to parents by doctor/nurse-

SYP OMNACORTIL 5MG/5ML 5ML PO TDS

TAB LANZOL JR 15MG ½ TAB OD BBF

TAB SEPTRAN (80/400) ½ TAB BD ON SATURDAY AND SUNDAY.

Danger signs explained. In case of fever report to ER2 and start iv antibiotics within 1 hour.

(signature)

DR. CH... SHAL BISWAS
PG Resident
Department of Paediatrics
VMMC & Safdarjung Hospital
New Delhi -110029

Follow up in pediatric hematology oncology clinic in room number 228/229, Wednesday 2PM
In case of emergency call Pediatric oncology helpline number 9354073207
Danger signs explained:
Lethargy/ persistent vomiting/fever/fast breathing/ loose stool/ seizure or any new symptom which patient perceive to be alarming

Next visit: 31/08/2023

periportal echogenicity and focal areas of fatty infiltration. CECT abdomen and chest was done.
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IMMUNIZATION HISTORY: Immunized for Age.

FAMILY HISTORY:

Day 1 of life
Birth asphyxia

3 years

1 ½ years

No h/o contact with TB,
No h/o DM, HTN, asthma
Non consanguineous marriage
No h/o similar complaints in the family

DEVELOPMENTAL HISTORY: GROSS MOTOR: able to stand without support
FINE MOTOR: child scribbles
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Vardhman Mahavir Medical College & Safdarjung Hospital, New Delhi–110029

बाल रोग विभाग

Department of Paediatrics

Division of Paediatrics Haematology & Oncology

DISCHARGE SUMMARY

Name	ABBU SHAIMA	Time/Date of admission	23/08/2023; 6:17 PM
Age/Gender	1 ½ YEAR/MALE	Time/Date of discharge	28/08/2023; 6:00 PM
MRD no	13844	Hematology no	
Weight	7.5KG	BSA Blood group	0.38 M2
Attending faculty	Dr. Amitabh Singh, Dr. Sumit Mehndiratta, Dr Nidhi Chopra, Dr, Ritamoni C Baruah		
DIAGNOSIS	MULTISYSTEM LANGERHANS CELL HISTIOCYTOSIS		
	Involved systems: hepatobiliary (periportal infiltrates, raised liver enzymes and GGT, history of hyperbilirubinemia), respiratory (respiratory distress, patchy ground glass opacities and atelectatic bands in b/l lobe), skin (lesions are biopsy positive for histiocytosis) No Bone Marrow involvement No CNS involvement.		

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PAST HISTORY:

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24/08/2023					0.8	148/108	788	11	0.1	133/4.9	s.ferritin=6.6 PT=12.1 SEC APTT=30.3 SEC INR=1.0 S ALB=3.8
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(signature)

DR. [illegible] SHAL BISWAS
PG Resident
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New Delhi -110029

Follow up in pediatric hematology oncology clinic in room number 228/229, Wednesday 2PM

In case of emergency call Pediatric oncology helpline number 9354073207

Danger signs explained:

Lethargy/ persistent vomiting/fever/fast breathing/ loose stool/ seizure or any new symptom which patient perceive to be alarming

Next visit: 31/08/2023

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VARDHMAN MAHAVIR MEDICAL COLLEGE & SAFDARJUNG HOSPITAL
नई दिल्ली / NEW DELHI–110029

DISCHARGE SUMMARY

Name of Patient : Aleeima / Ahamad Raza Age / Sex : 1y5m / M UHID : 162400

IP No. : ____ Emergency/Department/Unit : ____

Date of Admission : 23/11/23 Time of Admission : ____

Date of Discharge : 23/11/23 Time of Discharge : ____

DIAGNOSIS : LCH – cycle 2

PRESENTING COMPLAINTS:

Patient came for chemotherapy.

ON EXAMINATION: Vitally stable

HR = 90

RR = 24/min

CP/PP = +/+

CRT < 3 sec.

INVESTIGATIONS:

CBC: 8 / 4810 / 340 / 561×10³

LFT = 0.7
67 / 160 / 539

Procedure (If Any)

Name	Mst. Abbu			2Y / Male	Lab. No.	145987/OPDPB23HO
Ref-by	Dr. RAJESH				UHID	65209/UHID23HO
Manual					Bill Date	12-Jan-2024
IP/OP					Rep.Date	13-Jan-2024

Urinary bladder is normal in shape, size and distention. Bladder mucosa appears unremarkable.

Musculo-skeletal System:

No definite evidence of focal FDG uptake in skin or bone marrow lesion.

No obvious focal lytic / sclerotic lesion with abnormal FDG uptake is seen in the visualized axial and appendicular skeleton.

OPINION: PET-CECT SCAN REVEALS:

- **Diffusely increased FDG uptake is seen corresponding to bilateral palatine tonsils and bilateral cervical level II, right level III lymph nodes with no corresponding enhancing CT correlate – likely infective / inflammatory.**
- **Mild hepatomegaly with no other abnormal FDG avid lesion in the visualized region of the body.**

Please correlate clinically.

Dr. Shuvro Ghorai
MBBS, MD,DRM (Nuclear Medicine)
Consultant & Head
Department of Nuclear Medicine & PET/CT
(DMC / R / 8607)
Mob. No – 9818620044

This report is for diagnostic use only and NOT valid for medico-legal purpose. In case of any discrepancy due to machine error or typing error, please get it rectified immediately. **Typed By Medical Transcriptionist on Duty**

Yashoda Hospital & Research Centre Ltd.
III rd M, Nehru Nagar, Ghaziabad - 201001
Ph - 98109 22042, 0120-4182000

Yashoda Superspeciality Hospital & Cancer Institute
(A Unit of Vivekanand Nursing Home Pvt. Ltd.)
B 1 & 2, Sec - 23, Sanjay Nagar, Ghaziabad - 201002
Ph - 98107 09038, 0120-4612000

Yashoda Hospital & Cancer Institute
HC - 1, Sec - 15, Vasundhara, Ghaziabad - 201
Ph - 98107 05772, 0120-4466000

info@yashodahealthcare.com www.yashodahealthcare.com

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Ref-by	Dr. RAJESH				UHID	65209/UHID23HO
Manual					Bill Date	12-Jan-2024
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Brain:

No focal abnormally 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.*

Head & Neck:

Diffusely increased FDG uptake is seen corresponding to bilateral palatine tonsils (SUV max – 9.5) and bilateral cervical level II, right level III lymph nodes with no corresponding enhancing CT correlate – likely benign.

Minimal mucosal thickening in bilateral maxillary sinus noted.

Mild diffuse FDG uptake in the vocal cord region (SUV max – 4.0) noted –likely physiological.

No significant bilateral supraclavicular lymphadenopathy with increased FDG uptake is seen.

No focal lesion with abnormal FDG uptake is seen involving nasopharynx, oropharynx, hypopharynx or larynx.

The thyroid gland is sharply demarcated and shows homogeneous pattern on CT scan. No abnormal FDG uptake is seen in the thyroid.

Bilateral carotid arteries and jugular veins are well opacified and appear normal.

Thorax & Mediastinum:

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

Ground glass opacities noted in bilateral lungs field.

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Ref-by	Dr. RAJESH				UHID	65209/UHID23HO
Manual					Bill Date	12-Jan-2024
IP/OP					Rep.Date	13-Jan-2024

PATIENT ID:24/01/152
WHOLE BODY (18F-FDG) PET-CECT SCAN

CLINICAL HISTORY: Patient is a case of LCH.

INDICATION: PET-CECT scan is being done for further evaluation.

ACQUISITION PROTOCOL:

Scanner: GE Discovery™ IQ Gen 2 PET-CT	**Radio-isotope:** ^{18}F – FDG; 60 minutes uptake period
Study Mode: PET-3D with Ultra-HD (OSEM / QClear Image Reconstruction) mode & CT - Auto mA mode	**Extent of Study:** Brain and Skull base to mid-thigh
Semiquantitative analysis of FDG uptake: SUV value corrected for dose administered and patient lean body mass (gm/ml* SUV lbm)	**Special acquisition:** HRCT Chest (With Breathholding instructions)
Blood glucose level: 91 mg/dl	**Intervention:** None
Serum creatinine level: 0.66 mg/dl	**Contrast:** I/V Contrast (Non - ionic) and oral plain water (Negative Contrast)
Height: 73 cm	**Weight:** 9 Kg

OBSERVATIONS: Study Image Quality: Satisfactory. The overall biodistribution of FDG is within normal physiological limits.

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Bilateral pulmonary parenchymas otherwise do not show any obvious focal lesion with abnormal FDG uptake.

No significant mediastinal / hilar lymphadenopathy with increased FDG uptake are noted.

There is no evidence of pleural effusion / thickening on either side.

Abdomen & Pelvis:

The liver is mildly enlarged in size 11.7 cm with mild hypoattenuation pattern. The intra hepatic biliary radicals are not dilated. The portal vein is normal. No focal lesion with abnormal contrast enhancement and / or increased FDG uptake is seen involving hepatic 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, attenuation and physiological cortical FDG uptake. No evidence of calculus or hydronephrosis is noted.

The stomach, small bowel and large bowel loops appear normal in calibre and fold pattern with no evidence of focal lesion / abnormal FDG uptake.

There is no evidence of significant abdomino-pelvic lymphadenopathy with abnormal FDG uptake.

No free peritoneal fluid is seen.

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