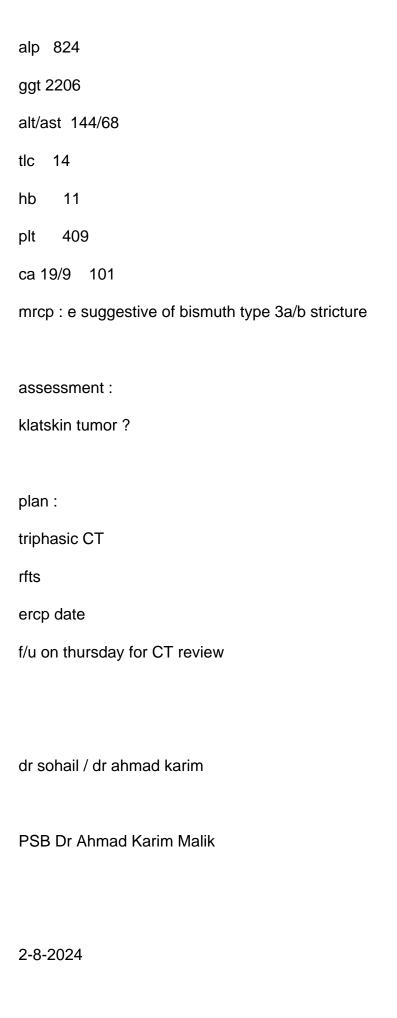
Gender: Male
Age: 70
MRN: 786333
Diagnosis: Cholangiocarcinoma
History and Physical:
29/7/24
14;30 h
first visit at PKLI
k/c/o of asthma , HTN, DM presented e history painless jaundice since 1 month , associated e
itching , weight loss & anorexia
MRCP done outside suggestive of bismuth type 3a/b stricture
A/C;
jaundice
itching
weight loss
anorexia
o/e:
jaundice, scratch marks
abd ; soft non tender
inx: 25/7/24
bil 5
OII O



MRN ;786333 Age / Gender:70 y/M

Name ;Muhammad.Asghar Ali Examined On: 02 /08/2024.

Referred By: Dr Usman Aujla Assistant: Wiliam/ Saleem/ Usman

Endoscopist: Dr Usman Aujla

Fellow: Dr Imran Syed/ Dr Osama Butt

Procedure Name:

Indications:

Nurse: Aasia Julian

Medications: General anesthesia

Report content: A consent was obtained prior to procedure. The patient was placed in the prone position. The scope was introduced in the mouth and advanced under direct vision into oesophagus, stomach and duodenum. Vital signs and oxygen saturations were monitored. Patient was deep sedative with no immediate complications. Endoscopy Report is given below.

ERCP Findings: Hanging bulky ampulla. Challenging pancreatic duct cannulation achieved. 5 Fr 7 cm PD stent was placed. CBD cannulation achieved after precut palillotomy and extended sphincterotomy. Cholangiogram revealed proximal CBD/ CHD stricture with dilated IHDs. Guide wires placed in RAHD. Brush cytology obtained from the strictured area (40 passes made) followed by stricture dilation with 10 Fr soehendra dilator. A single PBS 10Fr x 12cm placed with good drainage.

Plan:

Keep NPO for 4 hours.

Vitals monitoring as per PACU protocol.

Inj Ringer lactate 500ml iv over 4 hours.

Discharge home when vitally stable.

Tab Ciproxin 500 mg twice daily for 5 days

Dr Usman Iqbal Aujla (FRCP, UK) Consultant Gastronenterologist & Hepatologist
GI Review
DR atif
19/8/24
k/c/o of asthma , HTN, DM presented e history painless jaundice since 1 month , associated e
itching , weight loss & anorexia
MRCP done outside suggestive of bismuth type 3a/b stricture
A/C;
jaundice
itching
weight loss
anorexia
o/e:
jaundice , scratch marks

Follow up in clinic with fresh LFTs and CBC in 2 weeks

Follow brush cytology report

Family counseled about procedure details.

inx: 25/7/24 bil 5 alp 824 ggt 2206 alt/ast 144/68 tlc 14 hb 11 plt 409 ca 19/9 101 mrcp: e suggestive of bismuth type 3a/b stricture Fresh labs 18/8/24 hb 10.4 wbc 7 bili 4.37 alt 40 ast 46 alp 196 ggt 166

Ct 30/7/24

abd; soft non tender

Lobulated enhancing mass at porta hepatis almost completely encasing CHD and CBD up till before head of pancreas, inseparable from adjacent contracted gallbladder with adjacent locoregional involved enlarged lymph nodes, possible differentials include primary gallbladder malignancy or cholangiocarcinoma (sparing hilar ductal confluence). Further evaluation with CA19-9, ERCP with

tissue sampling is suggested.

Indeterminate hypodense lesion at junction of caudate with left lobe closely abutting IVC, possibility

of this being a metastatic deposit appears very less likely, this could represent a hepatic cyst with

internal debrinous / proteinaceous content.

cytology

positive for malignant cell

Ercp 2/8/24

ERCP Findings: Hanging bulky ampulla. Challenging pancreatic duct cannulation achieved. 5 Fr 7

cm PD stent was placed. CBD cannulation achieved after precut palillotomy and extended

sphincterotomy. Cholangiogram revealed proximal CBD/ CHD stricture with dilated IHDs. Guide

wires placed in RAHD. Brush cytology obtained from the strictured area (40 passes made) followed

by stricture dilation with 10 Fr soehendra dilator. A single PBS 10Fr x 12cm placed with good

drainage.

assessment:

obstructive jaundiced 2 to klatskin tumor

S/p ercp with stenting

post ercp lfts improved

Plan

Dr usman aujla

MDT

Family counseling done regarding nature of disease and possible outcome