CN 4063

H-2021-0768

MGM HEALTHCARE

SURGICAL DISCHARGE SUMMARY

Patient Name	: MS SATVIKI PATIDAR	**Encounter No**	: 902504216013
Address	: PARAS PATIDAR ALWASA - 453111 MADHYA PRADESH,INDIA	**UHID**	: 9000701818
Age / Gender	: 6 Y / FEMALE	**Ward**	: PVT-A / 10 / A
Phone	: 8826533558	**Date Of Admission**	: 21/04/2025 15:45:59
BillType	: STAR HEALTH & ALLIED INSURANCE CO.LTD	**Date Of Discharge**	: 26/04/2025 09:32:08

DEPARTMENT OF NEUROSURGERY
Dr. Roopesh Kumar V R, Director and Senior Consultant
Dr. Saranyan R, Consultant
Dr. Harishchandra L.S, Consultant
Dr. Babu R, Consultant
Dr. Rajesh Menon M, Associate Consultant

NEURO-ANESTHETIST
Dr. Arulvelan- Senior Consultant
Dr. Chandrasekar- Consultant
Dr. Sujatha- Consultant
Dr. Ayshwarya- Consultant

DEPARTMENT OF PAEDIATRICS :
Dr.NISHA M GEORGE
Dr.GOPALAKRISHNAN- PICU CONSULTANT (Visiting)

DIAGNOSIS: ? OPTIC PATHWAY HYPOTHALAMIC GLIOMA WITH LEFT MESIAL TEMPORAL EXTENSION - MODIFIED DODGE TYPE 3B, H+
PROCEDURE DONE: LEFT PTERIONAL CRANIOTOMY WITH MICROSURGICAL EXCISION OF MESIAL TEMPORAL SOL on 22.04.2025

History of present illness: Ms. Satviki Patidar 6 year girl with history of seizure - first observed in Oct 2023, (Semiology - Nausea + sensation to vomit, Bad smell; Frequency- Initially 1 episode - a month, Increased frequency of seizure for the past 3 months, seizure free since SEP 2024)
Initial MRI - Jan 2024 showed Large left gangliocapsular SOL extending in to the left temporal lobe. Repeat MRI in April 2024 - Similar lesion with no gross change in size /contrast enhancement, MRS - Choline peak. F/S/O - Glioma ? Low grade. EEG done twice - Normal.
Recently there was new onset right hand dystonia with mild weakness and double vision. Follow up MRI brain with contrast with tumor protocol done on 15/2/25 showed - Persistent large and poorly marginated intra axial SOL seen involving basal ganglia, thalamus, midbrain and the medial temporal lobe on the left side. The lesion 46 x 46 x 40 mm in size. Now patient admitted for further management.

Past history:
No known co-morbidities

Birth history:
2 nd child born by - LSCS delivery
Developmental mile stone - Normal
Studying - 2 nd standard
Dominant - Right handed
Scholastic performance - Good

VITAL SIGNS
BP: 100/60 mmhg
PR: 89/min
RR: 22/min
SPO2: 98% o room air
Temp: Afebrile

Systemic Examination:
CNS:
Conscious, oriented and obeying commands
B/L PERL
Moving all 4 limbs
CVS: S1/S2 (+)
RS: B/L air entry (+)
Abdomen: Soft, not tender, BS (+)

Course in the Hospital: Ms. Satviki Patidar 6 year old female, admitted with above mentioned history and finding. Necessary investigation was done. MRI brain with contrast with tractography was done on 21/4/25 showed There is evidence of patchy nodular enhancing well defined lobulated homogenous T2 FLAIR hyperintense lesion epicentered in left capsulothalamic region of size approx 4 x 5.08 x 4.6 cm (AP X TR X CC). The lesion extends anterosuperiorly till the caudothalamic groove, medially to the massa intermedia and posteroinferiorly along left cerebral peduncle, periaquedutal region and cranial midbrain. Laterally the lesion involves the medial temporal lobe involving anterior temporal pole , amyglada and hippocampus. Anteroinferiorly it involves the left basifrontal cortex and inferiorly the hypothalamus , optic chiasm , anterior commisure, mamillary bodies, intracanalicular and cranial part of right optic nerve. Lesion causes mass effect in the form of mild midline shift to right of 1.6mm. Tractography - Lateral deviation of lef CST noted with no clear cut margins. Fibers are traversing through the lesion - Left Arcuate fasciculus – deviated posterolaterally. No evidence of any infiltration distance between tract and tumour is approx 3-4mm. Left uncinate fasiculus – lateral deviation of fibers with loss of few fibers and no clear cut resection margin. Fibers are traversing through the lesion. Left Inferior occipitofrontal fascilus - lateral deviation of fibers with no clear cut resection margin. Fibers are traversing through the lateral margin of the lesion Left inferior longituidnal fasiculus - No clear cut resection margin. Fibers are traversing through the lateral aspect of the lesion. Probabaly pediatric type low grade glioma. Doubtful leptomeningeal ehancement over brainstem extending along cervical cord.
Based on clinical presentation and radiological findings, she was planned for. Left pterional craniotomy and microsurgical excision of SOL on 22.04.2025. The need for surgery, its benefits, risks, complications and outcomes were explained in detail to the patient attenders. Necessary preoperative investigation and anesthesia clearance were obtained. After written consent for surgery, she underwe Left pterional craniotomy and microsurgical excision of SOL on 22.04.2025 under general anesthesia.

Procedure notes: LEFT PTERIONAL CRANIOTOMY WITH MICROSURGICAL EXCISION OF MESIAL TEMPORAL SOL on 22.04.2025
POSITION - Supine on pins with head turned to R side
INCISION - Left fronto-temporal
PROCEDURE -
Scalp incision deepened, musculo-cutaneous flap reflected
2 burr hole - pterional craniotomy performed
Temporal pole exposed and sphenoid ridge partly excised
Durotomy sphenoid ridge based
Sylvian fissure opened, however frontal and temporal lobes were not falling apart
Hence we proceeded with temporal pole resection
Uncus identifed - was abnormal - minimal vascularity, subpial resection was performed
Complete uncus was abnormla - resected subpially
Amygdala was also abnormal and resected in subpial fashion until perforators were seen
Hemostasis secured with bipolar, fibrillar, and spongestan
Hemostasis checked with raising systolic BP 20 above baseline and Valsalva manuvre

10F ROmovac drain placed - No suction
WOund closed in layers with 2-0 vicryl and 3-0 monocryl
Compression dressing applied

Post operatively she was extubated and shifted to post surgical ICU and was managed with IV fluids, antibiotics, analgesic, AED and other supportive medications. Post op MRI brain with contrast done on 23/4/25 showed - Compared to the previous pre-operative MRI dated 21.04.2025, the present post-op scan shows, status post left pterional craniotomy with post op scalp changes and small extra- axial hematoma along left anterior temporal convexity. Left medial temporal lobectomy with resection cavity filled with fluid and peripheral hemorrhagic residue. Major bulk of the tumor remains same except for the resected medial temporal lobe. She was doing well post operatively and was gradually mobilised out of bed. As her condition improved, she was shifted to ward on 23/4/25. Under strict aspectic precaution surgical site drain was removed on 24/4/25. She was tolerating oral diet, self voiding and ambulant independently. She continued to be clinically and hemodynamically stable. Hence being discharged with the necessary advice.

Condition on discharge:
Vitals stable
CNS:
Conscious, oriented and obeying commands
B/L PERL
Moving all 4 limbs
No new neurological deficits
CVS: S1/S2 (+)
RS: B/L air entry (+)
Abdomen: Soft, not tender, BS (+)
Surgical site wound healthy
Tolerating oral diet
Ambulant with minimal support
Self voiding

MEDICATIONS:

S NO	MEDICATION	DOSE	FREQUENCY	DURATION
1	TAB. TEGRETOL	200MG	1/2 TAB - 1/2 TAB - 1 TAB	TO CONTINUE
2	TAB. CLOBAZAM	1 TAB (5 MG)	1-0-0	TO CONTINUE
3	TAB. DEXA	2 MG	1-0-1	FOR 3 DAYS AND FOLLOWED BY
			1-0-0	FOR 3 DAYS AND STOP
4	TAB. JUNIOR LANZOL	15 MG	1-0-0	FOR 1 WEEK AND STOP
5	SYP. IBUGESIC PLUS	5 ML (5ML/100 MG)	1-0-1	FOR 3 DAYS and sos
6	SYP. CREMAFFIN PLUS	10 ML	0-0-1	IN CASE OF CONSTIPATION

DISCHARGE ADVICE:

- Normal diet
- To continue medications as per advise
- To continue physiotherapy
- Can take complete head bath with shampoo.
- Keep the wound clean and dry.
- To collect HPE report - then plan for IHC, EXOM sequencing

REVIEW:

- Review in Neurosciences OPD with prior appointment on 30.04.2025 (Wednesday, prior to flight travel back to native place)

Typed By: Ms. Selvi Preetha A (Physician Assistant)
Verified By: Dr. Harishchandra L.S (Consultant Neurosurgeon)

WHEN TO OBTAIN URGENT CONSULT :

Headache, Vomiting, fits, giddiness, drowsiness, loss of consciousness, memory disturbances, slurring of speech, blurring of vision, double vision, bleeding or discharge from ear, nose or oral cavity ,fever.
Limb Weakness, numbness, bladder or bowel problem.
Pain, swelling, discharge or breakdown at the Wound or operating site.
Increasing or persistent neck, back or any other pain.
Onset of any new symptoms or worsening of old symptoms.

IN CASE OF EMERGENCY CONTACT, NO: +91 - 44 - 4200 4200 (24*7)
FOR NEURO APPOINTMENTS PLEASE CONTACT: 7845936365

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In case of Emergency, Please contact :

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