0349/IPD/2009

DISCHARGE SUMMARY / CARD

Name : HARLALKA SUNIL Age : 56 Years Sex : M

Admission Date :21/11/2019 Discharge Date : 29/11/19
Location :13E42
Dr. NAGARAJAN GANESH Dept-GENERAL SURGERY

FINAL DIAGNOSIS:
Ca rectum, post CT-RT

Operation Title and Date:
Abdominoperineal resection with end colostomy under general anesthesia done by Dr.

CHIEF COMPLAINT AND HISTORY:
The patient presented with complaints of altered bowel habits since 6 months. On investigations, the patient was found to have occult blood positive in stools. There is no complaints of abdominal pain, vomiting, or jaundice. No complaints of weight loss or loss of appetite. The patient took treatment for altered bowel habits, but there was no improvement. Colonoscopy was done, which was suggestive of proliferative growth extending from anorectal junction to the rectosigmoid region. The patient took chemotherapy with Capecitabine and 25 cycles of radiotherapy with last cycle of radiotherapy received on 17/09/2019. The patient is now admitted for surgical management.

PERTINENT PHYSICAL FINDINGS:
On examination:
Vitally stable
P/A - Soft, nontender. No guarding or rigidity. Bowel s
P/R - Ulcerative growth noted in the anal canal exte ve the anal verge, more towards the left side.

F647

PERTINENT INVESTIGATIVE DATA:
MRI done on 30/10/2019 suggestive of eccentric mass like thickening in low rectum (was seen previously). It is now showing significant regression with reduced contrast enhancement suggestive of response to the therapy. Perineal fat stranding noted, which could represent post RT changes. Fat planes between prostate and rectum lost with fat stranding.

Rest all reports with the patient

PRE-OPERATIVE COURSE:
Preoperatively, the patient is admitted to the ward and pre-op fitness taken from Dr. A. Hegde. The patient was given bowel preparation on the night before the surgery.

After due consent, the patient is taken up for surgery.

DISCHARGE SUMMARY / CARD

Name : HARLALKA SUNIL
HH No :1726572
Admission Date :21/11/2019
Location :13E42
Dr. NAGARAJAN GANESH

Age : 56 Years Sex : M
Admission No :1430705
Discharge Date :

Dept-GENERAL SURGERY

OPERATIVE PROCEDURE AND DATE:
Abdominoperineal resection with end colostomy under general anesthesia done by Dr. G. Nagarajan on 22/11/2019.

Procedure - Written, verbal and informed consent taken. The patient in lithotomy position. General anesthesia given. Parts painted and draped. Lower midline incision taken and abdomen opened in layers.

Findings - No liver mets, peritoneal nodules, or gross ascites noted. No organomegaly. Rectal growth 2 cm from the anal verge noted. Decision taken to go ahead with the surgery.

Operative steps - Dissection began at the level of sigmoid colon mesentry and proceeded medially till left ureter and gonadal vessels identified. Dissection proceeded and inferior mesenteric artery identified and ligated. Proximal stump of the sigmoid divided by LTC 75 stapler. Mesorectal dissection started and proceeded anteriorly, laterally and posteriorly safeguarding the hypogastric nerve plexus. Adequate distal margin suitable for anastomosis, not possible. Hence, decision to go ahead with APR taken. Perineal resection begin after making an elliptical incision in the perineum. Dissection is continued till abdominal cavity is identified. Specimen is taken out and sent for histopathological analysis. Rectal drain inserted from perineal wound and perineal wound closed in layers using Vicryl No. 1 and silk No. 1 sutures. Mop and gauge count check. Hemostasis achieved. Romovac drain placed in abdominal cavity subcutaneous plane. Closure done with loop Ethilon. Skin closure with the help ethilon
2-0 and skin staplers. Stoma is brought out from left iliac fossa. End colostomy is matured and stoma bag applied. The patient tolerated the procedure well and shifted to the recovery room for further management.

POST-OPERATIVE COURSE:
Postoperatively, the patient is shifted to wards and careful monitoring of the input/output and drain charting is done. On POD 2, Ryle's tube was removed. The patient was started on 20 cc clear liquids on POD 3, which was subsequently increased to clear liquid as tolerated, normal liquids and soft diet. Stoma was functional on POD 3 (evening). The patient is now being discharged with Romovac perineal drain in situ and Foley's catheter in situ. Care of both has been explained to the patient and relatives. The patient is stable at the time of discharge.

TREATMENT GIVEN:
Inj. Supacef, Inj. Metrogyl, Inj. Perfalgan, Inj. Tramadol, Inj. Pan, Inj. Emeset, IV fluids

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Dept-GENERAL SURGERY

DISCHARGE ADVICE:
Tab Ceftum 500 mg 1-0-1 x 5 days
Tab. Dolo 650 mg 1-1-1 x 3 days and then SOS
Tab. Pan 40 mg 1-0-0 x 3 days
Syp. Grilinctus 2 tsp. SOS for cough
Tab Ultracet sos for pain
Resource protein 2 scoops with milk 1-0-1 x 1 month

To follow up with Dr. G. Nagarajan in OPD as advised with prior appointment.

In case of severe pain or discharge from operative site please report to Hinduja Hospital casualty immediately.

INFORMED CONSENT FOR SURGERY

I, Mr SUNIL HARLALKA and my relatives, have been explained the following by the doctor. I have been diagnosed with Carcinoma of rectum and have recieved CTRT for the same and now I will need a surgery in the form of Exploratory Laparotomy for Anterior Resection sos Abdomino perineal resection sos temporary/permanent stoma which will be done by Dr.Nagarajan.

We have been explained that in case there is e/o peritoneal metastasis, vascular invasion, extensive unresectable disease surgery will not be carried out.

There is possibility of bleeding,surgical site infection,sepsis,anastomotic leak. This may increase the hospital stay and expenses.

The patient may have a stoma which can be temporary/permanent. Patient has been explained about emptying the intestinal contents into the stoma bag which will be fixed to anterior abdominal wall.

Also in view of primary disease status and the nature of extensive surgery, patient may require postoperative ICU stay with sos ventilatory support. Patient might also require, sos inotropic support and blood transfusions/ higher antibiotics. This is high risk surgery and there are high chances of perioperative morbidity and mortality, sepsis.

We realize that after this surgery, some dietary and lifestyle changes may be required. Loss of sensation on some areas of abdominal wall around the incision has been explained to me. I have been explained about the risk of Bladder disturbance. Similar problem may occur in future which may require further surgical or interventional radiological intervention. There may also be a chance of recurrence of the disease in long term.

We also have been explained that the further treatment will depend upon final histopathology report in the form of chemo or radiation or secondary surgery.

All the above have been explained to me in the language I understand best, about the patient's condition, complications and the sequelae of surgery. We give informed consent for the procedure.

DATE 21-11-2019

TIME

DOCTOR'S SIGN

HH 1726572 ADM 1430705
HARLALKA
SUNIL
56 Y M 13E42
Dr NAGARAJAN GANESH