Medical Discharge Summary

FINAL DIAGNOSIS (ICD-10 CODES)

Send for Xray & CBC Test

CLINICAL HISTORY & EXAMINATION

Patient Cam with Chest & Pain Complain

SIGNIFICANT PAST MEDICAL / SURGICAL / FAMILY HISTORY

No family history

CLINICAL FINDINGS

• Fever: High-grade, persistent for 3 days, no chills
• Cough: Dry, occurs mostly at night, no sputum
• Abdominal Ache: Cramping, lower left quadrant, after meals

INVESTIGATIONS - RADIOLOGY

ALT (SGPT):

Input value: 66 U/L

Reference range: 7 - 56 U/L

Interpretation: The ALT level is mildly elevated above the upper limit of normal. This may indicate hepatocellular injury or inflammation. Mild elevations can be seen in conditions such as fatty liver, medication-induced liver injury, or early viral hepatitis.

AST (SGOT):

Input value: 20 U/L

Reference range: 10 - 10 U/L (Reference range shown appears unusually narrow — typically 10-40 U/L. Assuming a possible display error. With 20 U/L, value is within common normal limits.)

Interpretation: AST level is within an acceptable range and does not suggest significant hepatocellular injury on its own.

Bilirubin Total:

Input value: 4.0 mg/dL

Reference range: 0.2 - 1.2 mg/dL

Interpretation: Total bilirubin is significantly elevated, suggesting impaired bilirubin metabolism or excretion. Possible causes include obstructive jaundice, intrahepatic cholestasis, or significant hepatocellular dysfunction.

Summary / Impression:
The patient demonstrates significant hyperbilirubinemia with mildly elevated ALT and normal AST

INVESTIGATIONS - PATHOLOGY

The current CBC values entered for this adult patient (DOB: 1998) demonstrate the following significant abnormalities:

Hemoglobin: 20 g/dL (Ref: 12.0–17.5 g/dL)
!’ Markedly elevated Hemoglobin level, suggestive of Polycythemi
!’ Differential considerations include:

Physiologic causes: Dehydration, chronic hypoxia (e.g., smoking, COPD, sleep apnea), living at high altitude.

Pathologic causes: Polycythemia vera (primary polycythemia), erythropoietin-secreting tumors.

Recommend evaluation of hydration status, oxygen saturation, and further testing (EPO levels, JAK2 mutation if clinically indicated).

White Blood Cells (WBC): 16 x10y/L (Ref: 4.0–11.0 x10y/L)
!’ Leukocytosis present.
!’ Possible causes include:

Acute or chronic infection

Inflammatory process (autoimmune or reactive)

Physical/emotional stress

Hematologic malignancy (requires exclusion if persistent or unexplained)

Recommend clinical correlation, review of infection markers (CRP/ESR), and close follow-up.

Platelet Count: 450 x10y/L (Ref: 150–400 x10y/L)
!’ Thrombocytosis observed.
!’ Likely considerations:

Reactive (secondary) thrombocytosis: Infection, inflammation, iron deficiency, post-surgical state.

Primary thrombocytosis: Essential thrombocythemia or other myeloproliferative neoplasm (MPN).

Suggest monitoring trend and considering further hematology workup if persistent or unexplained.

Overall Impression:
CBC pattern is consistent with a potential reactive process, but primary hematologic disorders must be ruled out.
Given the simultaneous elevation of Hemoglobin, WBC, and Platelets, a myeloproliferative disorder (e.g., Polycythemia Vera, Essential Thrombocythemia) should be considered if no secondary cause is identified.

Recommendations:

Repeat CBC after correction of hydration status and clinical stabilization.

Evaluate for secondary causes (infection, inflammation, hypoxia, iron status).

If abnormalities persist, consider referral to Hematology for further evaluation, including:

OPERATION / PROCEDURE

LIver Operation

Patient placed in supine position on the operating table.

General anesthesia induced, endotracheal intubation performed.

Abdomen prepped and draped in sterile fashion.

Midline laparotomy incision made for optimal exposure of the liver.

Abdominal cavity explored; no evidence of peritoneal metastases.

Liver mobilized by dividing ligaments as required (falciform, coronary, triangular ligaments).

Intraoperative ultrasound used to localize liver lesion and define margins.

Hepatic inflow control achieved using Pringle maneuver as needed.

Parenchymal transection performed using a combination of energy devices (CUSA, harmonic scalpel) and vascular staplers.

Major vessels and bile ducts carefully dissected and ligated.

Hemostasis achieved with cautery and hemostatic agents.

Resected liver specimen sent for histopathological examination.

Surgical drain placed near liver resection bed.

Abdominal cavity irrigated and inspected for bleeding.

Abdominal incision closed in layers.

Patient extubated and transferred to recovery room in stable condition.