From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 05/08/2024 10:05 AM
Subject: Fwd: [EXTERNAL MAIL] nvitation for Student CPC

The next student CPC is scheduled on **Aug 5, 2024** in **CPD Hall**, AIIMS Rishikesh from **8:00 AM to 9:00 AM**.

You can also join online through the following Webex link:

Meeting link:

https://aiimsrishikesh.webex.com/aiimsrishikesh/j.php?MTID=mc2f508ebdf26716fe4f19140f93770ea

Monday, Aug 5, 2024, 8:00 AM | (UTC+05:30) Chennai, Kolkata, Mumbai, New Delhi

Meeting number:2511 623 8404

Meeting password:050824

The Clinical handout of the case to be discussed is attached herewith.

Thanks & Regards
Regional Resource Centre
Dept of Telemedicine
AIIMS Rishikesh

Student CPC

Age: 30 year/Female	**Clinician in-charge &discussant**	**Pathology discussant:**

	Dr Kavindra Singh	Dr Sanjeev Kishore
Ward: Neurosurgery	**Radiology discussant:** Dr Tripti Prajapat	**Neurosurgery discussant:** Dr Kavindra Singh
DOA: 27/05/2024	**DOS:** 06/06/2024	**DOD:** 17/06/2024

PRESENTING COMPLAINTS

- Generalized tonic clonic seizures 3-4 episodes/month for 3 months
- Occipital headache for 14 days
- Urinary and fecal incontinence for 2 days

HISTORY OF PRESENTING ILLNESS

- Seizures: 3-4 episodes/month for 3 months (GTCS lasting for 4 min with postictal confusion, frothing from mouth, last episode on 19/5/24)
- Headache: for 14 days, occipital region, dull aching, mild to moderate in intensity, associated with vomiting, relieved on medication
- Urinary/Faecal Incontinence: for 2 days
- Other Symptoms: No blurring of vision, weakness of limbs, fever, altered sensorium

PAST AND PERSONAL HISTORY

- No co-morbidities
- No addiction history
- She presented to AIIMS on 10.02.23 with complaints of dizziness and occasional headache for 1.5 months. She was diagnosed as Left insular space-occupying lesion likely low grade glioma. She underwent Left frontotemporal craniotomy and subtotal resection of lesion on 28.02.2023 at AIIMS Rishikesh. Tumour was greyish firm moderately vascular with ill-defined plane with surrounding brain parenchyma. Sub-total resection was done. Frozen section was suggestive of glial neoplasm and Biopsy was suggestive of gliosis.

EXAMINATION

- Conscious, oriented, vital signs within normal limits.
- Higher mental function- MMSE- 16/30

- Frontal lobar signs
    - Graphic Luria- normal
    - TMT a and b -abnormal
    - DST-abnormal
    - Insight -abnormal
    - Judgement -abnormal
    - Motor Luria- abnormal
    - Sequencing- abnormal
- Temporal lobar signs
    - Remote memory- normal
    - Visual memory- normal
    - New learning ability- impaired
    - Recent memory- impaired
- CN 1-12 WNL
- Motor and sensory examination was within normal limits
- No cerebellar signs

RADIOLOGICAL INVESTIGATIONS

MRI Brain films (06.02.23):

Ill-defined T2/FLAIR hyperintense, T1 hypointense intra axial lesion centered in left insula, involving adjacent front parietotemporal lobes causing their expansion. No blooming on SWI/ diffusion restriction. Post contrast images were not available in the provided films. Imaging findings s/o neoplastic etiology - diffuse infiltrative glioma.

CEMRI Brain films (19.05.2024):

There is progression of the lesion with involvement of corpus callosum and contralateral periventricular white matter. Areas of diffusion restriction with patchy enhancement and necrotic areas are present. Findings likely suggest high grade glioma.

PATHOLOGICAL INVESTIGATIONS

1st surgery (23.02.23)

- Frozen section F/S 1412/23:

    - Necrotic and cheesy grey, white soft tissue showing proliferation of glial cells in eosinophilic fibrillary background and blood vessels suggestive of **glial neoplasm**.
- HPE S-1438/23(7.3.2023):
    - Multiple glial tissue bits exhibiting **gliosis**. No mitosis, increased cellularity, vascular proliferation and atypia identified in the sections examined

2nd surgery (06.06.24)

- HPE suggestive of malignant round cell tumor
    - Vimentin and NKX 2.2 positive
    - S100 and FLI 1 positive
    - CD 99 Negative

COURSE AND MANAGEMENT

- Patient was admitted and diagnosed as a case of left frontotemporal recurrent glioma likely high-grade glioma. she underwent surgery on 6.06.24. subtotal resection was done. Post op NCCT head was suggestive of resection cavity in left frontotemporal region with hematoma. She was sedated, ventilated and managed on antiepileptics, decongestant and analgesics. She was extubated on POD 1. On POD 4, patient had drop in sensorium and was drowsy following which repeat CT head was done which was suggestive of resection cavity in left frontotemporal region with resolving hematoma with increase in mass effect due to edema.In view of poor GCS, she was intubated and ventilated and her decongestant dose was escalated. She received blood products in view of low hemoglobin. Gradually patient sensorium improved, hence she was gradually weaned off from ventilator and was extubated in next 2 days. On POD 16 she had an episode of seizure with altered sensorium. Repeat NCCT was done which was suggestive of hydrocephalus with periventricular ooze. She underwent right side medium pressure ventriculoperitoneal shunt. Her neurological status gradually improved and was discharged in satisfactory condition on POD22. At the time of discharge she was conscious oriented and following commands, febrile, accepting RT feeds and ambulating on wheelchair due to generalised weakness.

FINAL DIAGNOSIS

Left frontotemporal extra osseous intraparenchymal Ewing's sarcoma

TREATMENT PLAN

Adjuvant chemotherapy and radiotherapy.

Attachments:

File: Neurosurgery CPC.docx	Size: 24k	Content Type: application/vnd.openxmlformats-officedocument.wordprocessingml.document