From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 24/03/2025 09:11 AM
Subject: Student CPC

Greetings from AIIMS, Rishikesh !!

The next student CPC is scheduled on **March 24, 2025** in **CPD Hall**, AIIMS Rishikesh from **8:00 AM to 9:00 AM** in CPD Hall, AIIMS Rishikesh,

You can also join online through the following Webex link:

Meeting link:
https://aiimsrishikesh.webex.com/aiimsrishikesh/j.php?MTID=m0fd1bcd08024b6d382e91b21ceec67eb

Monday, March 24, 2025, 8:00 AM | (UTC+05:30) Chennai, Kolkata, Mumbai, New Delhi

Meeting number: 2519 430 2067
Meeting password: 240325

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

Thanks & Regards
Regional Resource Centre
Dept of Telemedicine
AIIMS Rishikesh

CPC MEET

Department of Neurosurgery – 24.3.2025

Name: SA	**Age/Sex: 42y /M**	**Residence: Najibabad, Uttar Pradesh, India**
• **UHID: 20240163564**		
Case Presenter: **Dr Sreekanth (Academic SR)**	**Consultant in charge:** **Dr Saravanan S (Associate Professor)**	

Chief complaints:

Diminution of vision: in left eye for 1 year, in right eye for 10 months. Initially, Patient had difficulty in left eye in the form of side vision loss, which was gradual and progressive in nature, after 2 months there was side vision loss of right eye, associated with occasional headache

History of weight gain (5KG in 5 months).

Other Symptoms: No, enlargement of hands/legs, coarsening of facial features, polyuria/ polydipsia, postural dizziness/ hypotension, decreased libido, behavioural changes

Comorbidities: Hypertension since 2018, Hypothyroidism since 2024 (T. Thyroxine 100mcg OD, T Telmisartan 40mg OD)

Brief History:

Patient presented with complaints of diminution of vision on left eye for 1 year, diminution of vision on right eye since 10 months. Initially, Patient had difficulty in left eye, side vision loss which was gradual and progressive in nature, after 2 months there was side vision loss of right eye associated with occasional headache.

History of increased weight gain (5KG in 5 months).

No history of constipation.

No history of nausea/ vomiting.

No history of behavioural changes.

No significant past or family history

Examination

General Examination

- Conscious and oriented to time, place, and person; moderately built, BMI = 23.4 kg/m2
- No pallor, Icterus, clubbing, cyanosis, pedal edema, generalized lymphadenopathy.

Vitals

- HR - 74 bpm
- BP - 112/70 mm of Hg
- RR - 18/min
- SpO2 - 98% on RA
- Temp- 98.4 F

Systemic examination

- Respiratory System – B/L normal vesicular breath sounds, no added sounds
- Per abdomen - Soft, non-tender, no organomegaly, bowel sounds+
- Cardiovascular System - S1 S2 heard
- Central Nervous System -

Pupil: B/L equal ERTL

CN 2: Visual acuity : Right- 6/18-6/12

Left: 6/60- 6/36

Visual field defect: B/L temporal hemianopia

EOM – no restriction

No papilledema

Disc margins distinct

Rest CN: with in normal limits

No cerebellar signs

Power: moving all 4 limbs against gravity

Reflex: +2 in all joints

Tone: normal

Differential Diagnosis:

Pituitary adenoma

Craniopharyngioma

Sellar meningioma

Rathke's cleft cyst

Metastasis

Hypothalamic glioma

Optic nerve glioma

Superior hypophyseal artery aneurysm

Diagnostic Investigations:

MRI – Sellar- supra sellar lesion with compression of optic chiasma without hydrocephalus

Date	24.2.25	4.3.25	8.3.25
Hematology			
Hemoglobin (mg/dL)	16.4	15.9	11.1
TLC (cells per cumm)	8.80	10.18	0.84
Platelets (lakhs/cumm)	161	151	80
PT INR	13.4/1.17		
Biochemistry			
Blood Urea (mg/dL)	31	44	35
S. Creatinine (mg/dL)	1.11	0.97	0.82
S. Sodium (mmol/L)	139	141	140
S. Potassium (mmol/L)	4.4	4.3	3.5
Total Bilirubin	0.77	0.98	0.79
Direct Bilirubin	0.14	0.20	0.08
S.G.P.T. (U/L)	98	51	33
S.G.O.T. (U/L)	36	24	30
ALP (U/L)	106	103	68

S. Total Protein (g/dL)	7.1	6.6	4.6
S. Albumin (g/dL)	4.0	3.7	2.8

Management

TRANS NASAL AND TRANS SPHENOIDAL APPROACH AND DRAINAGE WITH PARTIAL REMOVAL OF CAPSULE

Summary:

42-year-old male presented with history of diminution of vision for 1 year with features of bitemporal hemianopia with hypertension for 7 years with hypothyroidism for 1 year without features of raised intracranial pressure with no history of bladder bowel involvement, no cerebellar involvement and no autonomic nervous system involvement. he was admitted to our Centre for management. After evaluation Sellar - suprasellar lesion was detected, and managed with trans nasal and trans sphenoidal approach and drainage of abscess with partial removal of capsule, post op he was managed with intravenous antibiotics for 2 weeks. No episodes of Diabetes Insipidus detected. He is currently in regular follow-up.