From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 31/08/2026 11:07 AM
Subject: Student CPC

Greetings from AIIMS, Rishikesh!!

The next student CPC is scheduled on **Aug 31, 2026, in the 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=m2be415b0707cd0871ee6e640e5b9036f
Monday, Aug 31, 2026 | 8:00 AM | (UTC+05:30) Chennai, Kolkata, Mumbai, New Delhi

Meeting number: 2525 707 1750
Meeting password: 31082026

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

Thanks & Regards,
Regional Resource Centre
Dept of Telemedicine and Biomedical Informatics
AIIMS Rishikesh

CPC CLINICAL SUMMARY

Patient particulars:

UHID / CR No.	2020007240	**Department / Unit**	Obstetrics & Gynaecology
Sex	Female	**Age**	29 years
Address	Meerut , Uttar Pradesh	**Occupation**	Housewife
Date of admission	11/08/2026	**Date of surgery**	13/08/2026

Chief complaints:

1. **Post coital bleeding** for 2 months
2. **Heavy menstrual bleeding** for 2 months
3. **Pain in bilateral lumbar region** for 1 month

Summary:

29 -year-old Nulligravida, resident of Meerut , Uttar Pradesh, a homemaker, known diabetic, presented with history of Postcoital bleeding for 2 years and heavy menstrual bleeding lasting for 10-12 days soaking 5-6 pads/day associated with clots and dysmenorrhea relieved on oral medications.

H/o foul smelling discharge per vaginum , on and off blood tinged soaking her undergarments for last 2 years

H/o dyspareunia persisting for the last 2 years

Pain in bilateral lumbar region, moderate intensity ,dull aching type, resolved with medications for 1 month

Associated with easy fatigability, weakness, loss of appetite and weight loss characterised by loosening of clothes

Received 4 unit PRBC on admission to AIIMS Rishikesh in view of severe anemia and heavy menstrual bleeding .Past history of laparotomy and cystectomy outside 6 years ago.

General Examination:

- Poorly built and poorly nourished
- Pulse: 100/min, regular
- BP: 100/62 mmHg, right arm
- RR: 22/min
- SpO_2: 99% on room air
- Temp: 98.7°F
- Pallor present
- No icterus, cyanosis, clubbing, lymphadenopathy, or edema

Systemic Examination:

Cardiovascular — S1 and S2 heard; no murmur.

Respiratory — Bilateral equal air entry; left infra-axillary fine end-inspiratory crepitations.

Abdominal — a midline vertical scar noted extending from pubic symphysis to 6 cms above umbilicus healed by secondary intention. Vague firm mass felt in the right iliac and suprapubic region, no ascites, no organomegaly.

Pelvic examination -

L/E: External genitalia normal

P/S: Friable polypoidal growth distending the vaginal canal, cervix not visualised

P/V: cervical lips felt hard , a hard fungating proliferative mass with necrotic friable tissue close to posterior lip , bleeds on touch, uterine size separately not made out, right fornix a firm mass felt ,other fornices free, vaginal walls free

P/V/R : Bilateral parametrium appears involved medially not upto the level of pelvic side walls.

P/R : Rectal mucosa free, rectovaginal septum normal, pouch of douglas obliterated by a firm mass

INVESTIGATIONS:

Cervical biopsy (20.11.25) : autolysis

Cervical biopsy(15.12.25) : Endometrial polyp

Cervical HPE (27.4.26): chronic cervicitis

Adnexal mass biopsy (27.4.26): Endometriosis

USG KUB (3/4/26)

Right kidney- 8.2x8.9cm. Gross HUN. Renal pelvis-1.9cm, proximal ureter-2.1cm Left kidney- 10.8x4.7cm. Moderate HUN seen with dilatation of renal calyces without any echogenicity proximal ureter-1.2cm. Right adnexal lesion with cystic components & mural nodule noted within ~6x4 cm. Right ovary and left ovary is separately visualised. Bulky uterus IMPRESSION- Right adnexal lesion as described Right gross HDUN & contracted kidney

CEMRI Abdomen & Pelvis (4.4.26)

Ill-defined heterogeneous solid-cystic mass lesion involving the uterus and cervix, with multiple cystic areas showing diffusion restriction measuring 9.5 × 4 cm and infiltrates the posterior fornix, extending into the upper 1/3 of vagina (~3.1 × 1.2 cm).

Infiltration of the posterior lip of cervix; cervical mucosa appears unremarkable. Tumour extends superiorly along the posterior uterine wall with loss of fat planes. Posteriorly abutting L5–S1 vertebra, without cortical erosion or bone marrow edema. Extension into the mesorectal fat, with loss of fat planes.

Right adnexal involvement with loss of fat planes; right ovary bulky, measuring approximately 5.4 × 4.4 × 4.9 cm, with stromal edema. Right anterior abdominal wall muscle infiltration.

Left ovary displaced medially, measuring approximately 1.6 × 1.2 × 1.9 cm, with multiple T2-hyperintense follicles. Inferiorly, the lesion indents the urinary bladder and abuts the distal ureter, with upstream HDUN.

Multiple subcentimetric to mildly enlarged pelvic lymph nodes, including along the common and external iliac vessels; largest ~9 mm along the left external iliac vessels.

Bilateral hydroureteronephrosis, with a severely atrophic right kidney.

Hb	4.6 g/dL
TLC	0.76 $\times 10^3/\mu L$
Platelet Count	121 $\times 10^3/\mu L$
SGPT/SGOT	22 / 44 U/L
ALP	112 U/L
S. Albumin	3.6 g/dL
B. Urea/S. Creatinine	38 / 1.86 mg/dL
Na^+/K^+	139 / 3.0 mmol/L
Ca125	600 u/ML