

## NEUROSURGERY DISCHARGE SUMMARY

**Patient Name:** Mr. GOPAKUMAR  
KUTTANPILLAI.

**MRD#:** 184612

**Date Of Birth:** 19/05/1952

**Sex:** Male

**Visit Code:** IP0004

**Speciality:** NEUROLOGICAL SURGERY

**Ward/Bed No** SS8C - 3818

**Consultant** Dr. DINDORKAR KAUSTUBH

**Date of Admission:** 11/02/2025

**Date of Procedure:** 12/02/2025

**Date of Discharge:** 24/02/2025

**Discharge Status:** Follow up Discharge Summary

### Final Diagnosis:

Recurrent right temporo parietal lesion- Glioblastoma, IDH-1 Negative, CNS WHO Grade 4.

### Name Of Surgery:

Re exploration of right temperoparietal craniotomy and gross total excision of tumour under GA on 12/02/2025.

### Chief Complaints / Status at admission:

Recurrent right temporo parietal anaplastic ependymoma

Admitted with left lower limb heaviness and weakness since morning

Dragging left lower limb ,headache.

Had similar transient left lower limb weakness 2-1/2 months ago

Recovered well in half hour.

Recent mri brain on Jan/25 showed increased enhancement and hyper perfusion suggest recurrence of disease.

Admitted for surgery

### Examination Finding:

General Examination:

Vital Signs:

Temperature: Afebrile

Pulse: 80/min

BP: 140/74 mm of hg

Respiratory Rate: 20/min

SpO2: 98% room air

Systemic Examination:

Rs clear

Cvs s1s2 normal

P/a soft non tender

CNS -conscious coherent

MRD No:184612

Name:Mr. GOPAKUMAR KUTTANPILLAI.

Coherent  
response  
hemiparesis grade 3/5  
left upper limb pronator drift  
Dragging left lower limb  
Ambulating with difficulty and support  
Cognition fair recent memory mild impairment delayed recall  
No bowel bladder Complaints

#### **Relevant Investigation:**

Routine pre-op work up  
CT brain contrast  
EEG  
(All reports are attached)

#### **Previous Medical / Surgical History:**

Operated right temporo parietal anaplastic ependymoma April/20

Post Craniospinal RT

Received 4 cycles of chemotherapy pcv - last June/20, had severe pancytopenia hence not received further cycles.

Was under observation regularly - stable disease

Recent mri Jan/25 showed increased enhancement and hyper perfusion suggest recurrence of disease.

Hypertension in past presently not on any medications.

#### **Course in hospital:**

72 year male patient with above-mentioned past surgical history, presenting complaints, recent mri brain on Jan/25 s/o increased enhancement and hyper perfusion suggest recurrence of disease admitted for surgery. Anti-epileptic, anti-oedemics and other supportive care measures started. All routine pre-op work up and CT brain contrast done. PAC and physicians fitness done. Discussed with patient and relatives regarding present clinical status, radiological findings, need and indication with pros and cons of surgery, risks and complications of surgery, further treatment plan as per HPR- they consented for surgery, written informed consent obtained from them. He underwent Re exploration of right temporo parietal craniotomy and gross total excision of tumour under GA on 12/02/2025.

Intra-op uneventful, post op extubated and shifted to ICU for further care and neuro observation. Pod 1. Patient haemodynamically stable, conscious oriented, dysarthria present, left motor weakness same as pre-op 3/5, apraxia worsened. CT brain contrast done on 13/02/2025 s/o No evidence of ivh.

Oedema or mass effect. Orally started, tolerated. Headache managed with iv analgesics. Anti-oedemics tapered gradually and stopped. Shifted to ward. Pod 2, no fresh complaints.

Physiotherapy for limbs strengthening exercises done, ambulation with support started. Speech therapy started. Pod 3, sensorium better, dysarthria improving, left paresis distal more than proximal.

Wound checked healthy, dressing changed. Pod 4, had sensorium worsening- awake but dull, slow to respond, had left sided worsening of power 1/5 ? post ictal-- EEG done on 16/02/2025 s/o generalized slowing-- AEDs optimized. Pod 6, Sensorium and left sided power improved, left sided power 2/5--

aggressive rehab continued. Active ambulation with support started. Foleys catheter removed, voided post catheter removal. SAPT added. He had no further neuro worsening, speech significantly improved, left sided power gradually improving. Pod 12, cranial wound sutures removed, wound healthy. HPR s/o GBM, IDH negative and mib upto 10%-- sample sent for second opinion to NIMHANS on 21/02/2025- report awaited. Discussed with patients relatives regarding disease prognosis, further plan of radiation with adjuvant chemotherapy as per HPR. Now discharging patient in stable condition on oral medications. All post op home care instructions with red flags explained to patient and relatives. Follow up in opd as advised.

#### **Referrals / New Investigation:**

Oedema or mass effect. Orally started, tolerated. Headache managed with iv analgesics.



Dr. Kaustubh Dindorkar - Physician  
Dr. Kaustubh Dindorkar - Speech therapist  
Dr. Kaustubh Dindorkar - neurophysiotherapist

### **Surgical Treatment:**

Re exploration of right temporoparietal craniotomy and gross total excision of tumour under GA on 12/02/2025 by Dr Kaustubh Dindorkar.

### **Incision:**

Previous C shaped incision

### **Operative Notes:**

The previous right temporoparietal craniotomy incision was reopened, and the scalp flap was elevated. Dura was carefully dissected and opened in a cruciate manner, exposing the underlying brain and tumor. Microscopic dissection was carried out to carefully separate the tumor from the surrounding brain tissue. The tumor was well-vascularized, and bipolar cautery was used for hemostasis. Piecemeal excision was performed, ensuring maximal safe resection. Critical neurovascular structures were preserved. Intraoperative neuronavigation and neuromonitoring were used to guide the excision. After achieving gross total resection, hemostasis was meticulously secured. The dura was closed in a watertight fashion using dural substitutes where necessary. The bone flap was repositioned and secured with plates and screws. Scalp layers were reapproximated and closed in anatomical layers. The patient was extubated in the operating room and transferred to the neurosurgical ICU for close monitoring. No immediate complications noted.

### **HPR Status:**

Right Temporo-Parietal Lobe Mass Lesion ( ? Tumor ): Excision Biopsy:

High grade Glioma with necrosis - Consistent with Glioblastoma ( IDH-1 : Negative ) : CNS WHO Grade 4

Tumor shows marked nuclear pleomorphism, mitoses, endothelial proliferation and tumor necrosis.

Molecular Information : IDH-1 : R132H- Negative ; ATRX- Retained ( Patchy )

P53 : Weak Positive ( Testing platform : IHC )

The neoplastic cells express Vimentin ( weak, subset ), Olig-2 ( strong ), GFAP ( strong ), P53 ( weak ) S-100 ( subset ), D2-40 ( strong ) and ATRX ( patchy ) and are negative for IDH-1, EMA and CD34.

Staining with P53 has marked approximately 10 to 18 % of tumor cell nuclei.

Staining with ATRX shows patchy positivity in some of the tumor cell nuclei ( ATRX - Retained ).

Some of the cells show loss of nuclear expression of ATRX.

MIB-1 ( Ki-67 ) Labeling Index is approximately 8 to 10 % ( on an average ), in the hot spots.

~~in the operating room and transferred to the neurosurgical ICU for close monitoring. No immediate~~

### **Discharge Status::**

On discharge haemodynamically stable, no further episodes of seizures, no neuro worsening, patient awake obeying, left sided paresis power 3/5, able to stand and ambulate with maximum support, accepting orally well, no bowel/bladder complaints. cranial wounds sutures removed, wound healthy. HPR s/o GBM, IDH negative and mib upto 10%-- sample sent for second opinion to NIMHANS on 21/02/2025- report awaited. Discussed with patients relatives regarding disease prognosis, further plan of radiation with adjuvant chemotherapy as per HPR. Now discharging patient in stable condition on oral medications. All post op home care instructions with red flags explained to patient and relatives. Follow up in opd as advised.

### **Medication During hospitalization:**

- IVF NS AT 80 ML/HR

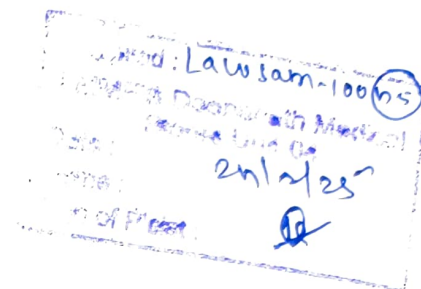
- IV LEVIPIL 500MG 12 HRLY

- IV MANNITOL 100CC 8 HRLY

8 HRLY  
1.5G 12HRLY  
KACIN 750MG OD  
IV PCM 1G 8 HRLY  
IV PANTOP 40MG OD  
IV FMESET 4MG 8 HRLY

### Medication on Discharge:

- ✓ Tab Levenue 1000mg 1-0-1 x to be continued.
- ✓ Tab Lacosam 100mg 1-1-1 x to be continued.
- ✓ Tab Strocit plus 1-0-1 x 3 months.
- ✓ Cap Palsineuron 1-1-1 x 3 months.
- ✓ Cap Absolute 3 G 0-1-1 x 2 months.
- ✓ Tab Pruvict 2mg 0-0-1 x 10 days and continue if having constipation.



### Follow-up:

F/U with Dr Kaustubh Dindorkar in neurosurgery OPD in New building 2nd floor at 11 am to 1 pm after 2 weeks.

### Special Instruction::

- 1) Report to ER /the treating doctor if you have increase in headache, seizure episode, altered sensorium, vomiting, fever, discharge from wound.
- 2) Continue home physiotherapy and speech therapy as advised, full diet and plenty of fluids orally.
- 3) Do not omit or take any medicine without the Doctors advice. Contact your Doctor for any medical emergency.
- 4) Please carry all the previous clinical documents ( Discharge summary, Investigation reports, CT-Scan/ MRI /X-Ray films) with you every time for F/U consultation visits.
- 5) Treatment will not be advised on phone / TEXT SMS /Whatsapp without examining the patient.
- 6) Continue your regular Anti Hypertensive, cardiac ,Diabetic and thyroid medications ( if any ) as per your physician.

Contact No :

Neurosurgery OPD ----- 020- 49153227-----3234/23 ( Ext. )

Emergency Room (ER) ----- 020- 40151027/1054/1065

In case of any queries, can whats app on 8390066231 between 9am to 5pm from Monday to Saturday. (Neurosurgery Helpline Number).

For appointment please call on 020-40151100 between 9.00 AM TO 4.30 PM (Sunday closed).

**Special needs:** Brain

**Neuro physiotherapy:**

Left upper and lower limb strengthening exercises and stimulation for left paresis to be continued.

**Occupational therapy:**

Hand occupational therapy

**Speech therapy:**

To continue

**Post Radiation care:**

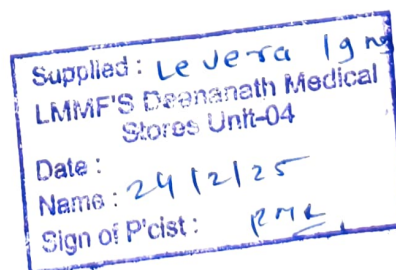
Radiation to be started as per advise.

**Chemotherapy care and follow up:**

- Adjuvant RT with concomitant TMZ

**Requirements for special Orthosis:**

Left hand and AFP splint





Follow up:  
Contrast after 3 months

Full diet, neurophysiotherapy and stimulation to be continued at home.  
Follow up after 10 days.

Reason for **Reminder**: Follow up

Reminder Date: 07/03/2025

Locality: neurosurgery OPD in New building 2nd floor

SIGNED BY: Dr. DINDORKAR KAUSTUBH

PREPARED BY: DR.PATIL RUPALI SANJAY

Patil