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

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
Recieved 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 temperoparietal 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 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.

Referrals / New Investigation:
oedema or mass effect. Orally started, tolerated. Headache managed with iv analgesics

...karni- Physician
... Speech therapist
... neurophysiotherapist

Surgical Treatment:
Re exploration of right temperoparietal 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

...HRLY
...F 1.5G 12HLRY
...MIKACIN 750MG OD
- IV PCM 1G 8 HRLY
- IV PANTOP 40MG OD
- IV EMESET 4MG 8 HRLY

Supplied : Lawsam-100 (15)
2/1/25

Medication on Discharge: Levera 100mg -30

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---0 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.
~~Medication on Discharge:~~
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

Supplied : Levera 1gm - 30
LMMF'S Deenanath Medical Stores Unit-04
Date :
Name : 24/12/25
Sign of P'cist :

...ow up:
...ntrast after 3 months

...al 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

rpatil