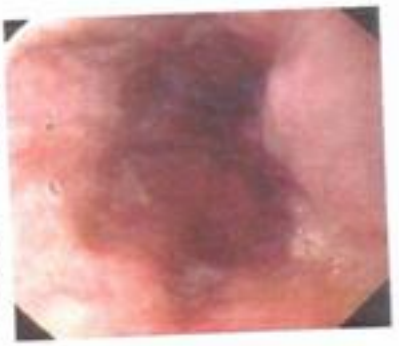
Endoscopy Report

Lakeshore
Hospital & Research Centre Ltd

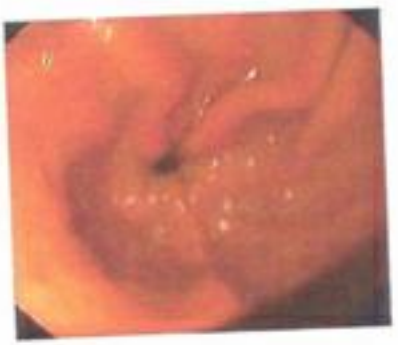
Digestive Disease Centre
Nettoor, Kochi, Kerala, India, Phone: 91-484-2701032



Patient Name	**Dr. NAFEESATHU BEEVI T V**
Hospital ID	**239268**
Age/Sex	**56/F**
Date/Time of Procedure	07/02/2013, 11:08 AM
Referring Physician	DR. PHILIP AUGUSTINE

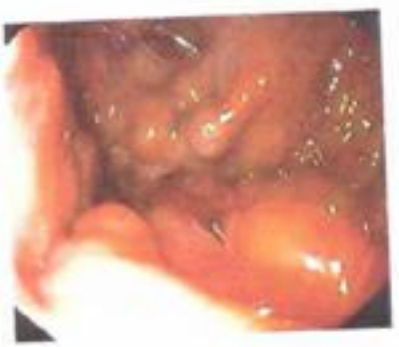
PROCEDURE PERFORMED

OGD



Instruments:	OLYMPUS GIF Q 180
Medications:	None
Extent of Exam:	second part of duodenum
Limitations:	None
Visualization:	Good **Tolerance:** Good **Complications:** None

PROCEDURE TECHNIQUE: The patient was intubated and the scope advanced under direct visualization to the second part of duodenum. The scope was subsequently removed while carefully examining the mucosa on the way out. The following findings were noted:



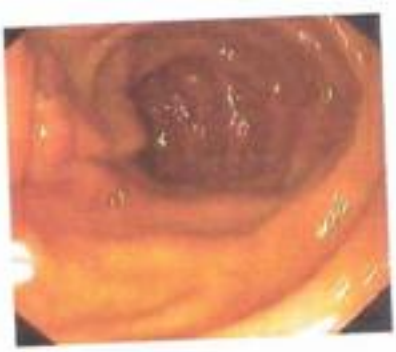
FINDINGS

Oesophagus : Grade III varices x 3 columns

Stomach : Fundus - Small to moderate sized GOV2
Severe portal gastropathy

Body and antrum - Normal

D1D2 : Normal



ENDOSCOPIC DIAGNOSIS

GRADE III OESOPHAGEAL VARICES
GASTRIC VARICES
SEVERE PORTAL GASTROPATHY

Suggest EVL, Cyanoacrylate injection

Endoscopist: **DR. PRADEEP G MATHEW, MD**
Sheeba

Endoscopy Report

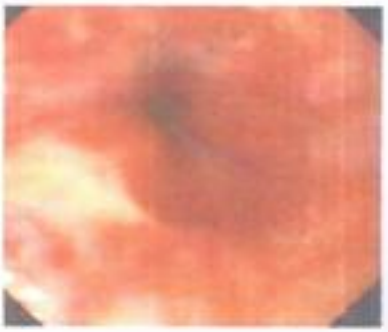
op. 9038
Ca Liver

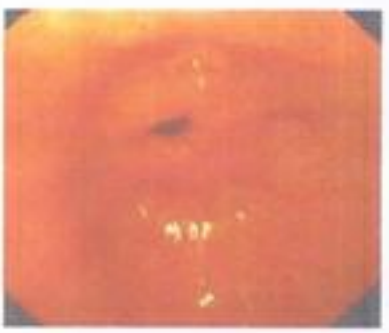
OGD

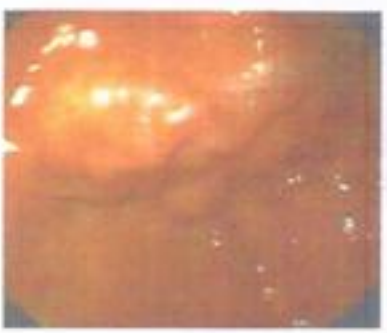
Lakeshore
Hospital & Research Centre Ltd

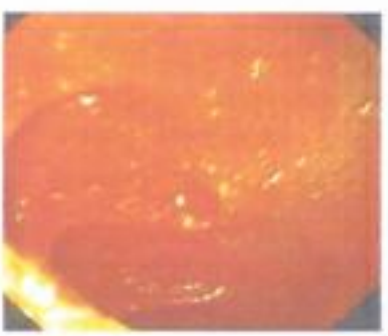
Digestive Disease Centre
Nettoor, Kochi, Kerala, India, Phone: 91-484-2701032

Patient Name	DR. NAFEESATHU BEEVI T V
Hospital ID	239268
Age/Sex	56/F
Date/Time of Procedure	22/07/2013, 09:35 AM
Referring Physician	DR.ANTONY PAUL CHETTUPUZHA









PROCEDURE PERFORMED

OGD

Instruments:	OLYMPUS GIF Q 180
Medications:	Midazolam 2 mg
Extent of Exam:	second part of duodenum
Limitations:	None
Visualization:	Good **Tolerance:** Good **Complications:** None

PROCEDURE TECHNIQUE: The patient was intubated and the scope advanced under direct visualization to the second part of duodenum. The scope was subsequently removed while carefully examining the mucosa on the way out. The following findings were noted:

FINDINGS

Scope passed down to D2

Oesophagus : Grade I varix x 2 streaks

Stomach : Small bunch of gastroesophageal varix (GOV 1)

D1 D2 : Normal

ENDOSCOPIC DIAGNOSIS

GRADE I OESOPHAGEAL VARIX
SMALL GASTROESOPHAGEAL VARIX (GOV 1)

Endoscopist: **DR. ROY J MUKKADA, MD, DNB**
Zameena

OP. 9038
Dr. Nafeesathu Beevi

AMRITA INSTITUTE OF MEDICAL SCIENCES
AND RESEARCH CENTRE
(An ISO 9001 certified Hospital)

DRAFT-COPY.

Printed Date:13/12/2012 17:00:33

ULTRASOUND ABDOMEN

Patient Name : Dr. DR. T.V. NAFEESATHU BEEVI **MRD#:** 1233224
Age : 56Y 24D **Sex:** Female
Date : 13/12/2012

LIVER :
Shows coarse echotexture with surface irregularity. No focal lesion seen. IHBR not dilated. CBD appears normal. Portal vein shows normal calibre (11 mm) and flow.

GB :
Wall appears thickened and measures 4.2 mm. No evidence of calculus.

SPLEEN :
Mildly enlarged (13.6 cm). No focal lesion seen.

PANCREAS :
Head appears normal, body and tail not visualised due to bowel gas.

KIDNEYS :
Normal in size (RK 9.3 cm, LK 9.8 cm), shape, position and echotexture. Corticomedullary differentiation is preserved.

BLADDER :
Physiologically distended. Echo free lumen. Wall thickness is normal.

UTERUS :
Appears normal.

Retroperitoneum not visualised due to bowel gas.
No free fluid is seen in abdomen.

IMPRESSION :
Features suggestive Chronic liver disease
Mild splenomegaly

Dr. LEKSHMY R.

Dr. Nafeesathi Beevi
OP. 9038

Lakeshore
Hospital & Research Centre Ltd.
Kochi, Kerala, India.

DEPARTMENT OF RADIOLOGY & IMAGING

Phone: 91-484-2772011, 2701033 E-mail: info@lakeshorehospital. com; Web: www. lakeshorehospital.com

Patient's Name	:	*Dr. Nafeesathu Beevi T V, 56 yrs, F*
Hosp. No.	:	*239268*
Date	:	*20.06.2013*
Ref. Doctor	:	*Dr. Antony Paul Chetupuzha, MD, DM.*

CT IMAGING OF UPPER ABDOMEN

Multiple serial contiguous sections have been taken from the level of domes of the diaphragm down to L4 vertebral level. Neutral contrast was given orally to opacify the stomach, and proximal small bowel.

Liver is shrunken show lobulated contour. Caudate hypertrophy noted. Coarse attenuation values noted. Numerous non enhancing rounded hypodense lesions are noted scattered in both lobes of the liver. No abnormal enhancing lesion with contrast wash out noted in that level to suggest focal mass lesion. Hepatic vasculature is normal. Hepatic parenchyma show homogenous CT attenuation values. No focal lesion present. No dilatation of intra or extra hepatic biliary system. Gall bladder show normal distension and wall thickness. Pericholedochal fluid noted. No radiopaque gall stones.

Spleen show enlargement with multiple collaterals. Head, body, tail of pancreas is normal. No focal lesion. No calcification. Pancreatic duct is not dilated. Both adrenal glands show normal size and configuration. Both kidneys show normal size, shape and position. Normal perfusion and contrast excretion noted. No dilatation of collecting system.

Aorta, inferior venacava and other visualized vascular structures show normal caliber. No retroperitoneal or mesenteric lymphadenopathy. No free fluid in the abdomen.

Neutral contrast distended stomach and small bowel loops show normal wall thickness and CT appearance. Minimal ascites noted.

All visualized lower thoracic, lumbar vertebrae show normal bony architecture and CT appearance except for degenerative changes.

***IMPRESSION** : CT scan of upper abdomen reveal:*

a) ***Shrunken liver with wavy contour coarse attenuation values. Rounded hypodense foci of variable size without enhancement is noted scattered in both lobes of liver. No abnormal enhancing or contrast wash out lesion noted in the liver to suggest mass lesion.***

b) ***Splenomegaly with collaterals.***

c) ***Normal CT appearance of gall bladder, pancreas, adrenal glands, kidneys.***

d) ***No retroperitoneal or mesenteric lymphadenopathy.***

e) ***Minimal ascites.***

DR. GEORGE JOSEPH, MD, DMRD
RADIOLOGIST

PATIENT'S NAME	: Mrs. NAFEESATHU BEEVI	Pat. ID	: 101315976	Sample Coll.	: 11/02/2013 15:56
AGE	: 56 Years / FEMALE	Reg. DATE	: 11/02/2013	Report Auth.	: 11/02/2013 17:34
REFERRED BY Dr	: S. KRISHNAKUMAR	Client Name	: NA		
IP/ OP No.	:	Hosp. Name	:		

Department Of Haemotology

COMPLETE BLOOD COUNT

INVESTIGATION		OBSERVED VALUE		UNITS	REFERENCE RANGE
Haemoglobin	:	12.9		gm%	11 - 15
Total Count	:	5400		Cells/cumm	4000 - 11000
Differential Count					
Polymorph	:	56		%	50 - 70
Lymphocytes	:	40		%	25 - 40
Eosinophils	:	4		%	0 - 6
Erythrocyte Sedimentation Rate	:	H	23	mm/hr	0 - 20
Platelet Count	:	L	1.00	Lakhs/cumm	1.5 - 4.0
Packed Cell Volume	:	37		%	36 - 47
Red Blood Cells Count	:	4.1		Millions/cumm	3.5 - 5.5
Mean Corpuscular Volume	:	90		fL	80 - 92
Mean Corpuscular Haemoglobin	:	H	33	Pg	27 - 32

NOTE : - * L= Low
* H= High

TINTU1 : 12/02/2013 05:12:03PM

PATIENT'S NAME	: Mrs. NAFEESATHU BEEVI	Pat. ID	: 101315976	Sample Coll.	: 11/02/2013 15:56
AGE	: 56 Years / FEMALE	Reg. DATE	: 11/02/2013	Report Auth.	: 11/02/2013 16:56
REFERRED BY Dr	: S. KRISHNAKUMAR	Client Name	: NA		
IP/ OP No.	:	Hosp. Name	:		

Department Of Biochemistry

PARAMETER		OBSERVED VALUE	UNITS	REFERENCE RANGE
LIVER FUNCTION TEST				
Serum Bilirubin Total	:	H 2.1	mg/dl	0.2 - 1.0
Serum Bilirubin Direct	:	H 0.5	mg/dl	Upto 0.4
Serum Protein	:	7.10	gm/dl	6.3 - 8.0
Serum Albumin	:	L 3.30	gm/dl	3.5 - 5.0
Serum Globulin	:	H 3.8	gm/dl	1.8 - 3.4
A/G Ratio	:	L 0.9		1.0 - 2.0
Serum SGOT	:	H 41.0	U/L	5 - 40
Serum SGPT	:	29.0	U/L	5 - 40
Serum Alkaline Phosphatase	:	66.0	U/L	48 - 300

Technique used : Spectrophotometry

NOTE : - * L= Low
* H= High

TINTU1 : 12/02/2013 05:12:03PM