Jan Sanjeevni Trust

Soch Hamari Suraksha Aapki

Jan Sanjeevni Trust Registration No: 1061/2017
Jan Sanjeevni Trust PAN No: AADTJOB16E
Jan Sanjeevni Trust Website : www.jansanjeevnitrust.org
Jan Sanjeevni Trust E-mail : contact@jansanjeevnitrust.org

PATIENT NAME	Shiv Solanki
PATIENT FATHER NAME	Dambar Singh
D.O.B. AND SEX	9-02-2013 Male
DISEASE NAME	Blood Cancer
TREATMENT HOSPITAL	AIIMS
UHID NO	105976072
DEPARTMENT NAME	Pediatric Hematology Oncology
TREATMENT COST	Four Lakh Only
PATIENT FATHER OCCUPATION	Labour
PATIENT ADDRESS	Bulandshahr Hapur

Jan Sanjeevni Trust

DEPARTMENT OF PEDIATRICS

DIVISION OF PEDIATRIC ONCOLOGY

ALL INDIA INSTITUTE OF MEDICAL SCIENCE, NEW DELHI 29

ESTIMATE CERTIFICATE

Ref.No..........

TO WHOM SO EVER IT MAY CONCERN

Date ....

This is Certify that Shri / Kum... SHIV SOLANKI .... Aged 9 YEAR Sex......

UHID 105976072 S/o./D/o.. Dambar Singh is getting treatment in Division of Oncology at Department of Pediatrics AIIMS for diagnosis HODGKIN LYMPHOMA

It is proposed to treat the patient with Chemotherapy Bone Marrow Transplantation/ Surgery/ Radiotherapy/ Others.

The approximate cost of the total treatment i. ₹........ 4,00,000/-

The approximate breakdown is given under the subheadings listed below. The cost under one subheading may exceed the projected estimate and excess would then be used from the other subheadings.

1. Chemotherapy 2,00,000
2. Antibiotics / Antifungal..........
3. Blood Component Kits and Tests.......... 1,50,000
4. Investigations..........
5. Room Charges ....
6. Post Transplant Immune Suppression ....
7. Miscellaneous Charges 50,000
8. Total 4,00,000

Note :- This certificate is issued to avail financial assistance only. The Cheque/ Demand Draft may be issued in favour of :

AIIMS RAN & HMDG A/C 40207561 85

AIIMS PATIENT TREATMENT A/C 10 745885 3

AIIMS P.M. PATIENT A/C 376714051 7

AIIMS DELHI AROGYA KOSH A/C 334 769060 9

For Account Transaction Please Contact : 011-26594746, 011-26546084

(Name & Signature of Consultant) [stamp: Dr. ... SETH, Professor, Department of Pediatrics, A.I.I.M.S., New Delhi-110029]

(Counter Signature of HOD)

डॉ. अरविंद बग्गा
Dr. Arvind Bagga
आचार्य एवं विभागाध्यक्ष/Professor & Head
बाल चिकित्सा विभाग/Department of Pediatrics
अखिल भारतीय आयुर्विज्ञान संस्थान, नई दिल्ली-29
All India Institute of Medical Sciences, New Delhi

Jan Sanjeevni Trust

अ० भा० आ० सं० अस्पताल/A.I.I.M.S. HOSPITAL
बहिरंग रोगी विभाग /Out Patient Department

अस्पताल के अन्दर धूम्रपान मना है।/SMOKING IS PROHIBITED IN HOSPITAL PREMISES

शरीरमाद्यं खलु धर्मसाधनम्

OPR-6

एकक/Unit

विभाग/Dept.

Regn. No.

नाम/Name

पता/Address

UHID: 105976072
Dept No: 20220030009354
Clinic No: 2022POC/179

कक्ष/Room

14
UNI-
POC
Queue No: F10
25/07/2022

SHIV SOLANKI
9Y 5M 18D / M(पुरुष)

Add: SONDA HABIBPUR SAUDAHAVPUR BULANDSHAHR SONDA HAPUR, UTTAR PRADESH Pin 203132 INDIA
Mob: 8278305316 Follow Up... General: 0 Reporting: 1:30 PM

निदान/Diagnosis

दिनांक/Date	उपचार/Treatment

UHID: 105976072
Dept No: 20220030009354
Clinic No: 2022POC/179

कक्ष/Room

14
UNI-
POC
Queue No: F18
22/08/2022

SHIV SOLANKI
9Y 6M 13D / M(पुरुष)

Add: SONDA HABIBPUR SAUDAHAVPUR BULANDSHAHR SONDA HAPUR, UTTAR PRADESH Pin 203132 INDIA
Mob: 8278305316 Follow Up... General: Reporting: 1:30 PM

Inv copy
Dg

TO 23.9

Jan Sanjeevni Trust

शरीरमाद्यं खलु धर्मसाधनम्

CLEAN AND GREEN AIIMS / एम्स का यही संकल्प, स्वच्छता से काया कल्प

अंगदान-जीवन का बहुमूल्य उपहार/ORGAN DONATION - A GIFT OF LIFE

O.R.B.O., AIIMS, 26588360, 26593444, www.orbo.org Helpline - 1060 (24 hrs service)

mersaspatal.mhp.gov.in

अखिल भारतीय आयुर्विज्ञान संस्थान
अंसारी नगर, नई दिल्ली-110029
ALL INDIA INSTITUTE OF MEDICAL SCIENCES
Ansari Nagar, New Delhi-110029

बी० पी० एल०/निर्धन/गरीब रोगी के लिए दवाईयों/शल्यक उपभोग्यों की मांग हेतु प्रपत्र ।
Proforma for requisition of medicines/Surgical consumables for BPL/Poor Indigent Patient

दिनांक /Date 7/6/22

नाम/Name : Shiv Solanki आयु/Age : 9 Yr लिंग/Sex Male
यू.एच.आई.डी.सं./UHID No. 105976072 सी.आर.नं./C.R. No. .... दाखिल की तिथि/Date of Admission 25/5/22
विभाग/एकक/Department/Unit : Pediatrics III वार्ड/Ward : C5 बिस्तर सं./Bed No. : 4
निदान एवं उपचार योजना/Diagnosis & Treatment Plan : Hodgkin lymphoma

उपर्युक्त उल्लेखित निर्धन एवं गरीब रोगी हेतु निम्नलिखित दवाईयों/शल्यक उपभोग्यों की आवश्यकता है । यह संस्तुति की जाती है कि रोगी को इन दवाईयों/शल्यक उपभोग्यों को अस्पताल भंडार से एक विशेष केस के रूप में जारी किया जाए ।
The following medicines/surgical consumables are required for the above mentioned poor & indigent patient. It is recommended that the patient may be issued these medicines/surgical consumables from hospital store as a special case.

क्र० सं० S.No.	दवाईयाँ/शल्यक वस्तुऐं Medicine/Surgical Items	खुराक एवं अवधि Dose & Duration	मात्रा Quantity
1	Ceftazidime Anibactum	2gm	10

बी०पी०एल० कार्ड के विवरण (प्रतिलिपि संलग्न की जाए)/Details of BPL Card (Photocopy to be enclosed):
कार्ड सं०/Card No............ वैधता: दिनांक/Validity: से From............ तक/To............

जारी करने वाला राज्य / Issued in the State of............
जारी करने वाले प्राधिकारी के वैध हस्ताक्षर Valid signature of issuing Authority: उपस्थित/अनुपस्थित Present/Absent

किसी स्थिति में यदि निर्धन/गरीब रोगी के पास वैध बी०पी०एल. कार्ड नहीं है तो उपचार करने वाला संकाय विशेष केस के रूप में अस्पताल से अपेक्षित दवाईयों/शल्यक उपभोग्यों की संस्तुति करने के लिए औचित्य के साथ विशिष्ट टिप्पणियाँ अवश्य दें ।
In case the poor/indigent patient does not have a valid BPL card, the treating faculty member must give specific remarks with justification for recommending provision of required medicines/surgical consumables from the hospital as a special case.

संकाय सदस्य की ईलाज हेतु टिप्पणियाँ /Comments of treating Faculty Member: PCH Remarks The patient is not eligible for AB-PMJAY.

Family is assessed & evaluated & is found to be poor.

डा०/Dr. S.K. Kabra
Professor, Deptt. of Pediatrics
मोहर सहित हस्ताक्षर/Signature with seal

कृपया अनुमोदन हेतु प्रभारी अधिकारी (बी०पी०एल०/निर्धन/क० स्वा० यो० रोगियों हेतु विशेष मांग) के पास प्रस्तुत है ।
Submitted to Officer I/C (Special Requisition for BPL/Poor Indigent Patients) for approval.

नोट-संस्तुति करने वाले चिकित्सक संबंधित रोगी उपचार क्षेत्र के नर्सिंग स्टाफ को निर्देश देंगे कि इस प्रकार से उपर्युक्त उल्लिखित ई.एच.एस. लाभार्थी रोगी को जारी कोई भी दवाई/शल्यक उपभोग्य संबंधित अस्पताल भण्डार को वापस किए जाएं ।
Note : Recommending physician will instruct the nursing staff of respective patient care area that any medicines/surgical consumables left unused after treatment / discharge of aforementioned EHS beneficiary are returned to respective hospital stores.

Help of medications may be provided.

Jan Sanjeevni Trust

HO CLINIC
CL. No: 2019/HO/8126
UHID: 104985045
KUNJ KUNJ 3Y7D

HO CLINIC
Queue No: F3
Room: C-510
UHID 104985045 06-06-2022

Rx

1. T 6. MP. [illegible]
2. T. MTX [illegible] /weekly
3. T. Septran-DS ½ — ½ M/W/F
4. T. Dosanil [illegible]

Dr. Manoranjan Mahapatra
Professor
Department of Hematology
A.I.I.M.S., New Delhi-110029

Jan Sanjeevni Trust

1:30 pm

HO-8126/2019

अ० भा० आ० सं० अस्पताल/A.I.I.M.S. HOSPITAL
बहिरंग रोगी विभाग /Out Patient Department
अस्पताल के अन्दर धूम्रपान मना है।/SMOKING IS PROHIBITED IN HOSPITAL PREMISES

3rd Floor, OPD Block, AIIMS

OPR-6

एकक/Unit

विभाग/Dept.

ब०रो०वि० पंजीकृत सं०/O.P.D. Regn. No.

नाम/Name	पिता/पुत्र/पत्नी/पति		आयु Age	पता/Address
HO CLINIC CL. No 2019/HO/8126 UHID 104985045 KUNJ KUNJ 3Y7D	HO CLINIC Queue No F2 Room C-510 UHID 104985045 09-05-2022			

निदान/Diagnosis Ph- Positive ALL c ~~Isolated~~ CNS relapse.

दिनांक/Date	उपचार/Treatment
(13) 2pm 9/5/2022 Switch to Dexa in maintenance a better CNS bioavailability	(1) T. Dasatinib 40 mg PO OD (2) Inj Vincristine 1 mg IV push every month (3) ~~T. Prednisolone 3.5~~ T. Dexamethasone 2 mg PO BD for 5 days every 4 weeks (4) T. 6 MP 50 mg PO OD in evening. daily (5) T. Methotrexate 12 mg PO once every week (6) TIT once every month (7) T. Septran SS 1 OD M/W/F (8) R/A 1-month c CBC LFT KFT

CLEAN AND GREEN AIIMS / स्वच्छता ...
अंगदान-जीवन का बहुमूल्य उपहार/ORGAN DONATION - A GIFT OF LIFE
O.R.B.O., AIIMS, 26588360, 26593444, www.orbo.org Helpline - 1060 (24 hrs service)

Dr. ... Assistant ... Department of ... A.I.I.M.S. ... 110029

Jan Sanjeevni Trust

Plan:

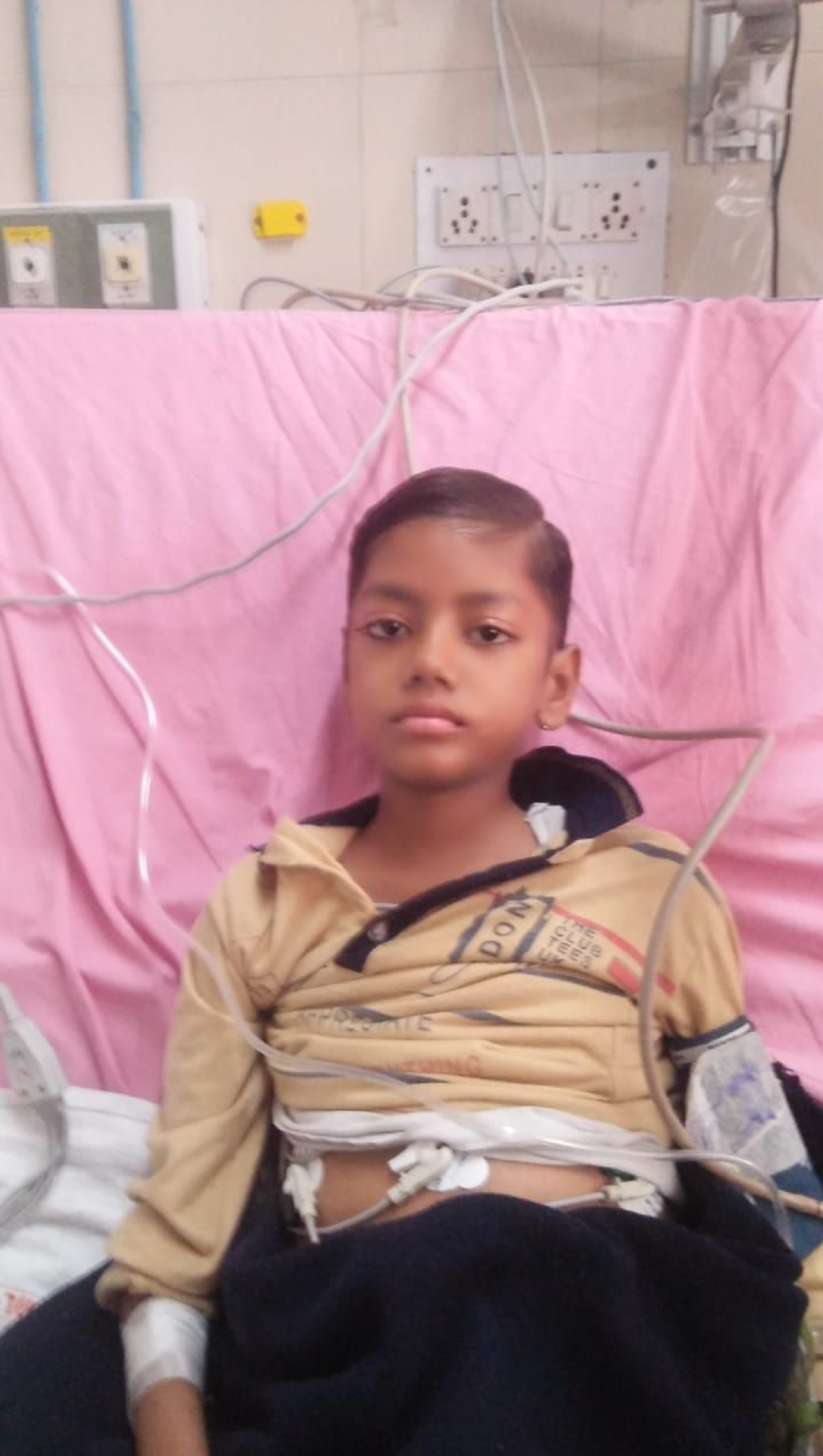
1) To give next cycle of chemo once edema settles
2) Continue oral cefixime for a total of 14 days (till 17/7/22)
3) Dating for PET-SCAN at the end of this month (to send)
4) Monitor serum Potassium – to review with reports
5) Pediatrics Unit-3 OPD visit on 9/7/22 (Room 7/10/14)
6) To taper and stop Prednisolone

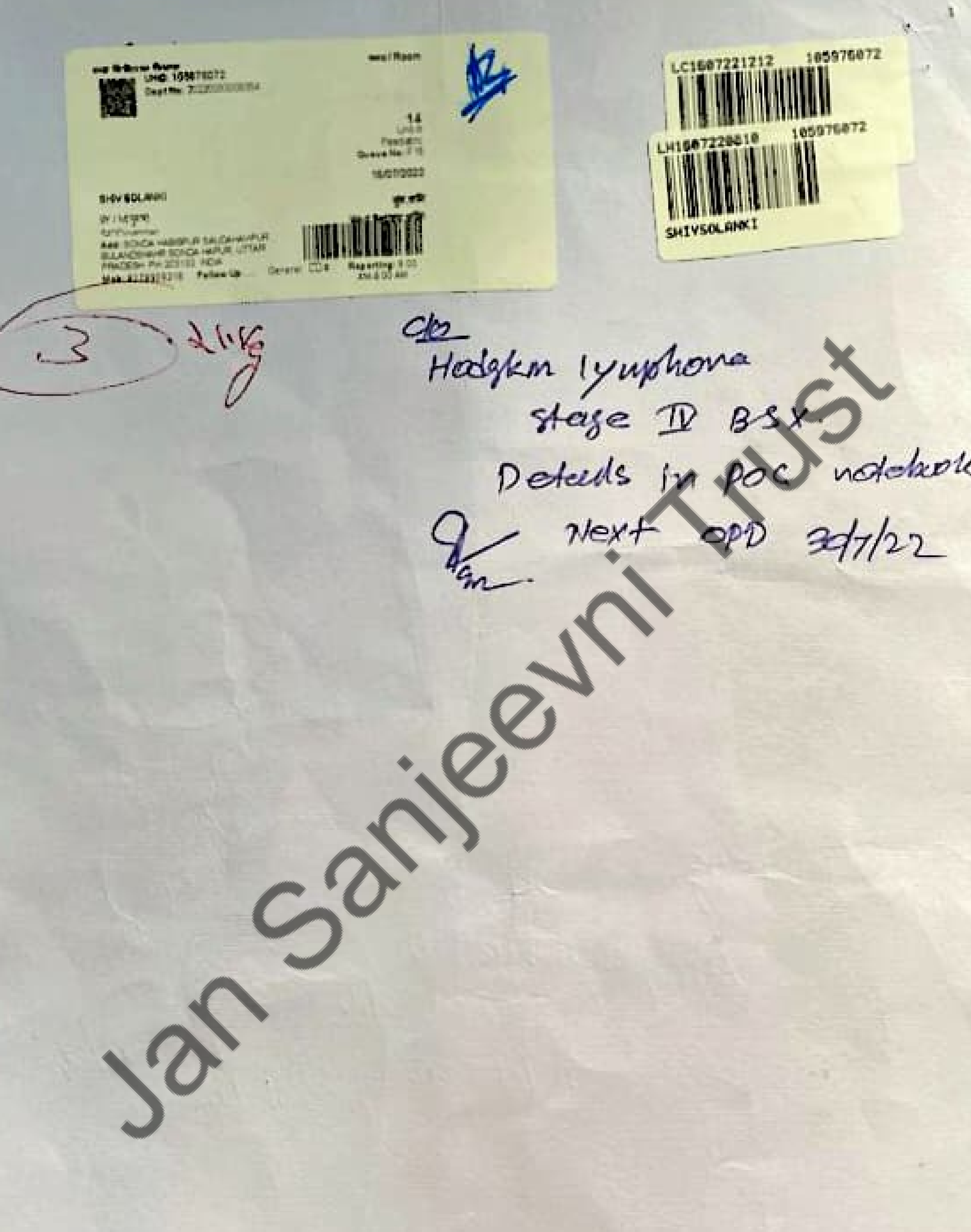
Advice at discharge

1. Syp Cefixime 5 ml PO BD (till 17/7/22) 1—1.
2. Tab Enalapril 2.5mg PO OD (1) — BP—
3. Tab Lasilactone ½ tab PO BD 1—1.
4. Tab Lanzol JR (15mg) 15mg PO OD (1) O:BF —
5. Tab Prednisolone 10mg PO OD (stress dose) (1) ×
6. To start COTRIMOXAZOLE prophylaxis. T. COTRIMOXAZOLE DS ½—0—¼ A/D.

JR	SR
Dr. Gayatri/ Dr Arjun	Dr.Asma/ Dr Sagarika

Jan Sanjeevni Trust


DON


LC1607221212 105976072
LH1607220010 105976072
SHIVSOLANKI
C/o
Hodgkin lymphoma
stage IV BSx
Details in POC notebook
Next OPD 30/7/22
Jan Sanjeevni Trust

अ० भा० आ० सं० अस्पताल/A.I.I.M.S. HOSPITAL
बहिरंग रोगी विभाग /Out Patient Department

अस्पताल के अन्दर धूम्रपान मना है।/SMOKING IS PROHIBITED IN HOSPITAL PREMISES

OPR-6

14

बहिरंग रोगी पंजीकृत सं०/O.P.D. Regn. No.

	आयु Age	पता/Address

निदान/Diagnosis

दिनांक/Date	उपचार/Treatment
5	21/7
	Selarb ... ...
	8/8/22

Jan Sanjeevni Trust

शरीरमाद्यं खलु धर्मसाधनम्

ALL INDIA INSTITUTE OF MEDICAL SCIENCES

CLEAN AND GREEN AIIMS / एक ही संकल्प, स्वच्छता से काया कल्प

अंगदान-जीवन का बहुमूल्य उपहार/ORGAN DONATION - A GIFT OF LIFE

O.R.B.O., AIIMS, 26588360, 26593444, www.orbo.org Helpline - 1060 (24 hrs service)

मेरा अस्पताल My Hospital meraaspatal.nhp.gov.in

18/7/22. Sent from ?? (Cone / nano) outside i/o/s reason of hyperuricemia (8.0)

UA 8.0

last UA 15/7/22 7.1

- possibility of ? Tumor / underlying ?/ bone / dietary contribution kept a possibility

Plan - hydrate
1.25-1.5L - ↓ uric acid drugs / causing diet compound hyperuricemia.
- re review c biochemistry [illegible] ↓

urine output

- repeat S. biochemistry on 20/7/22

formulation
- [illegible] protein
- [illegible]/ [illegible]
-

Review c S. biochemistry

[illegible]

20/7/22
On TAS ?? H/A
2x. Belladonna (bayer) side sat]
- No fresh comp.

Wt - 21kg.
MUAC - 15 cm ??
(Severe Thinness). Uric Acid - 8.0 mg/dl.
Low Purine Diet Advised
Current Intake : 980 kcal / 30 g P
Recommended Intake : 1300 kcal / 33 g
Target 1700 kcal and 50 g P.
Advice Essential ?? in 150 ml water ?? 2x.

Jan Sanjeevni Trust

(H) case vome:
reports to be seen
m.VA
↓
Dr. old may pass c
[illegible]
[illegible] 9 [illegible].
[illegible]

3/8/22

[illegible]

R NO 4 CV [illegible]] 2. S [illegible].

I see this pt.
H.Lgh lymphoma
- baseline cardiac dysfunction ⊕
- on Envas + Spironolacto + Furosemide
↓
having ↑ uric acid
↓
?) showed we change to
Envas + Beta blocker.
↓
last Echo, done today EF:
30-35%.

Jan Sanjeevni Trust

(5) Date for PET-CT [illegible]
at the end of July/start of August

(6) T. COTRIMOXAZOLE DS ½—0—½
(Septran) (800/160) (1/D)

Continue supportive care measures

(7) Continue cardioprotection
T. ENALAPRIL 2.5mg PO OD
T. LASILACTONE ½ tab BD
(FUROSEMIDE + SPIRONOLACTONE)

(8) F/U in [illegible] 3 OPD on 16/07/22 at 9am

(9) To bring photocopies of discharge summaries, to be attached in file.

[stamp: illegible]

16/7/22

- 2Y. Bladder [illegible]
- [illegible]
- No fresh [illegible]

C/O
Stage - IV BS X. Hodgkin lymphoma
⇒. on EBVD i.v.o [illegible] Baseline cardiac dysfunction (EF = 38%)
⇒. Last EF (16/6/22) = 40%.
- post EBVD. #IIa.

Jan Sanjeevani Trust

- Due for #2b.

O/E
~~[illegible]~~
pot belly. } steroid
cheek swelly. } related
(tapered & stopped).

13.7 \ 11750 / 2.18 ⓛ / 6280 — [illegible]

C/D/W Prof. R. Seth
- To give next # EBVD. f/b post 2nd response assessment.
- Interim PET dated in October, request sent for prepony.
(Please check LFT before giving)

Rx
• Pre chemo
  - Inj. Dexa 4 mg stat
  - Inj. Emeset 4 mg IV stat.
• Chemo.
  - Inj. Etoposide 125 mg 400 ml NS IV over 4 hrs
  - Inj. Bleomycin 8 cc IV slow push.
  - Inj. Vinblastin 6.5 mg IV slow push.
  - Inj. Dacarbazine 310 mg/100 ml NS IV @ 1 hr.
• Post chemo.
  - Tab Dexa 4 mg TDS. | x 3 days.
  - Tab Emeset 4 mg TDS |
  - Next visit on 30/7/22.
  2D echo by Prof. S. Seth. (form given)

[signature] 5/1/10

(7.1) 15/7/22

WBC aud: 8.0
U/Cr: 31/0.3
[illegible] : 9.9/3.6, 0.7/0.2 7
[illegible] 0.8 [illegible] : 53/86/138 [illegible] : WNL

22-20433 Deepak

अ० भा० आ० सं० अस्पताल/A.I.I.M.S. HOS[PITAL]
बहिरंग रोगी विभाग /Out Patient Depart[ment]
अस्पताल के अन्दर धूम्रपान मना है।/SMOKING IS PROHIBITED IN HOSPITAL

LB150722029 105976072
LH150722009 105976072
LC150722020 105976072
SHIVSOLANKI

एकक/Unit
विभाग/Dept.
नाम/Name

UHID: 105976072
Room 14
Unit Paediatric
SHIV SOLANKI
29/06/2022
Add: SONDA HABIBPUR SALDAHAVPUR BULANDSHAHR SONDA HAPUR UTTAR PRADESH PIN 203132 INDIA
Mob: 8279005316

निदान/Diagnosis

दिनांक/Date	उपचार/Treatment
UHID: 105976072, Room 14, Unit Paediatric, Group No: F21, SHIV SOLANKI, 09/07/2022, Add: SONDA HABIBPUR SALDAHAVPUR BULANDSHAHR SONDA HAPUR UTTAR PRADESH PIN 203132 INDIA, Mob: 8279005316	
22	20.4
	Refer patient notebook
	Adv
	1) Ped 3 OPD appointment on 16/07/022 at 9am
	Dr. ... Senior Resident

Jan Sanjeevni Trust

CLEAN AND GREEN AIIMS / एक कदम स्वच्छता की ओर
अंगदान जीवन का बहुमूल्य उपहार/ORGAN DONATION - A GIFT OF LIFE
O.R.B.O., AIIMS, 26588360, 26593444, www.orbo.org Helpline - 1060 (24 hrs service)

Hodgkin lymphoma - stage IV liver / [illegible]
bone [illegible].

- B/L cervical / [illegible] / [illegible]
omental nodules.
- 31M+

ABVD ↗
now [illegible]
EBVD
- SGTC
[illegible]
↓
[illegible] - [illegible]
?!

↑ [illegible]
- [illegible] / Ⓐ.
- SAP [illegible]
- [illegible]
[illegible]

[illegible] - [illegible]
- [illegible]
- [illegible]
- [illegible]

Jan Sanjeevni Trust

07/07/2022
e.L.3 OPD admitted from 26/6/22 - 5/7/22;
in c/o cardiogenic shock/ acute pancreatitis
septic shock

*Hypokalemia, corrected. 8/7/22 K^+ = 4.56; not on KCL supplementation

* R. lower limb swelling has subsided

* on oral course of cefixime

* On Enalapril and furosemide/ spironolactone [last LVEF during admission = 40%]

* tapering steroid (for sepsis, stress dose) [currently PREDNISOLONE 10mg OD]

* received IIa on 4/7/22; due for IIb on 13/7/22.

PRECHEMO LABS not done.

→ no active issues
P/A liver palpable 1cm BRCM
spleen tip palpable.

Adv

(1) CBC
RFT/LFT
TG/ferritin
fibrinogen
amylase, lipase
] on 15/7/22

(2) T. PREDNISOLONE 10mg ½ OD x 2d
f/b 10mg ¼ OD
↓
STOP

(3) Complete cefixime course (till 17/7/22)

(4) Baseline PET-CT review — for bulky/ non-bulky disease status

Jan Sanjeevni Trust

Brooklyn
STREET
AUTHENTIC SPORTS

Diagnostic Work UP & Risk Stratification

9/7/22

28/5/22 Abdominal lump biopsy:
infiltration by few large atypical cells with prominent eosinophilic nucleoli and moderate amount of cytoplasm in the background of polymorphous population of lymphocytes, histiocytes, plasma cells and eosinophils. These atypical cells are immunopositive for CD20, CD30, PAX-5, EBV-LMP1, EMA and negative for CD3, ALK, CD15. F/o classic HL.

Autoimmune hemolytic anemia; DCT 3+

31/5/22 BM biopsy – no e/o HL.
BMA – ↑ histiocytes; hemophagocytosis ⊕

2/6/22 FDG/Q0108/22

Metabolically active lymph nodes on both sides of diaphragm with spleen and marrow involvement, b/l pleural and pericardial effusion and ascites ← to be reconfirmed by PET-CT discussion

Stage IV_B X HL

(R) inguinal and (R) femoral lymph nodes
largest ~ 9.2 x 6.8cm lymph nodal mass (as per

Name of treatment protocol

In v/o pre-existing cardiac dysfunction – on EBVD regimen

Jan Sanjeevni Trust

Cycle No ③ IIa Date 4/7/22

Hb 10.3 TLC 4750 ANC 3330 Platelets 2.63L

LFT 19/23/111

U/Cr = 16/0.2

Others

ABVD

~~Inj Doxorubicin~~ Etoposide	~~25mg/m2~~ @ 150mg/m² IV (infusion)	125 mg	✓
Inj. Bleomycin	10 ~~mg~~ U/m2 IV	8U	✓
Inj. Vinblastine	6mg/m2 IV	5mg	✓
Inj. Dacarbazine	375mg/m2 IV	310 mg	✓
Inj Dexamethasone	0.15 mg/kg	4mg	✓

Injection Emset.

Off therapy from day 16-28

Next visit

Cycle No IIb. Date 18/7/22.

Hb 13.7 TLC 11750. ANC 6220 Platelets 2.42 ©

LFT

Others

ABVD

~~Inj Doxorubicin~~ Etoposide	~~25mg/m2 IV~~ 150mg/m² (infusion)	125mg.
Inj. Bleomycin	10 mg/m2 IV	8 U.
Inj. Vinblastine	6mg/m2 IV	5 mg.
Inj. Dacarbazine	375mg/m2 IV	310 mg.
Inj Dexamethasone	0.15 mg/kg	4 mg

Injection Emset.

Off therapy from day 16-28

Next visit

Jan Sanjeevni Trust

Patient copy

ALL INDIA INSTITUTE OF MEDICAL SCIENCES, NEW DELHI
DEPARTMENT OF PEDIATRICS

DISCHARGE Summary

Peds ED= 01126594225

Name: SHIV SOLANKI	**Age**: 9 years	**Gender:** Male	**UHID No**: 105976072
Date of **Admission: 26/06/22**	Date of **Discharge – 05/07/2022**		**Ward/Bed**: D5/13

Address: SONDA HABIBPUR, SAUDAHAVIPUR, BULANDSHAHR, HAPUR

Phone number:

Consultant In charge: Prof .SK Kabra/Prof. Rachna Seth /Dr.Kanaram Jat/Dr.J P Meena/Dr.Aditya Gupta

DIAGNOSIS: Hodgkin's lymphoma stage 4/ Autoimmune haemolytic anemia/ mild myocardial dysfunction/ acute pancreatitis

MEDICAL HISTORY

CHIEF COMPLAINTS:

Loose stools since 1 day
Fever since 1 day
Vomiting since 1 day
Pain abdomen since 1 day

HISTORY OF PRESENT ILLNESS:

K/c/o Hodgkin's lymphoma, post CBVD cycle 2 with autoimmune hemolytic anemia, was in his ususal state of health when he developed loose stools, 5-6 episodes since morning, watery in consistency, non blood stained, non bile stained. Child also had fever , documented upto 103 degree F , not associated with chills and rigors. Child had 3-4 episodes of vomiting since morning, containing partially digested food particles.

No h/o altered sensorium
No h/o seizures
No h/o fast breathing/ respiratory distress
No h/o pain during micturition
No h/o ear discharge
No h/o contact with COVID

PAST HISTORY:

Child had complaints of fever, abdominal lump and abdominal distention for which abdominal lump biopsy was done and child was diagnosed with classical hodgkin's lymphoma. Chemotherapy was initiated. In view of cardiac dysfunction child was given EBVD instead of ABVD, child has received 3 cycles (Ia on 1/6/22 , Ib on 17/06/22 and IIa on 05/07/2022). Child also had anemia for which workup was showed normochromic normocytic RBCs and positive DCT, thus child was diagnosed with AIHA and was started on prednisolone. Child also had persistent conjugated hyperbilirubinemia (? related to etoposide)

Jan Sanjeevni Trust

Cycle No ① Iᴀ Date 2/6/22.

BSA = 0.83m²

Hb 11.6 TLC 19,630 ANC 18,520 Platelets 1.08 lkh

LFT 55/47/217

TB/DB: 2/1.5

Others

Given EBVD i.v.o poor EF = 38%.

Inj. Etoposide. 150mg/m².

ABVD

~~Inj Doxorubicin~~	~~25mg/m2~~ IV ~~(infusion)~~	125 mg	
Inj. Bleomycin	10 mg/m2 IV	8 mg	
Inj. Vinblastine	6mg/m2 IV	5 mg	
Inj. Dacarbazine	375mg/m2 IV	310 mg	
Inj Dexamethasone	0.15 mg/kg		

[signature] 02/06/22.

Injection Emset.

Off therapy from day 16-28

Next visit

Cycle No ② IB Date 18/6/22

Hb 7.6 TLC 5300 ANC 3512 Platelets 1 lakh

LFT 1.6/1.34/34/23/836

Ur - 24, Creat - 0.2

Others

Etoposide @ 75mg/m²

ABVD (@ 50% Dose)

~~Inj Doxorubicin~~	~~25mg/m2 IV~~ (infusion)	58 mg	
Inj. Bleomycin	10 mg/m2 IV	8mg	
Inj. Vinblastine	6mg/m2 IV	2.5mg	(@ 3mg/m²)
Inj. Dacarbazine	375mg/m2 IV	310 mg	
Inj Dexamethasone	0.15 mg/kg	4mg	

Dr [signature]

Injection Emset. - 4mg

Off therapy from day 16-28

Next visit

Jan Sanjeevni Trust

Lymphocyte predominance	Rare	Predominance of normal appearing lymphocytes	Excellent
Nodular sclerosis	Frequent 'lacunae'	Lymphoid nodules collagen bands	Very good
Mixed cellularity	Numerous	Pleomorphic infiltrates	Good
Lymphocyte depletion	Numerous often	Paucity of lymphocytes pleomorphic fibrosis	Poor

---

RS-Reed Sternberg cell

Favorable

Localized nodal involvement (Early&Intermediate) (I/II/IIIA)
Absence of B symptoms
Absence of bulky disease

Bulky mediastinal lymphadenopathy is designated when the ratio of the maximum measurement of mediastinal lymphadenopathy to intrathoracic cavity in upright chest radiograph equals or exceeds 33%

Unfavorable

B symptoms
Bulky mediastinal/ peripheral LN
Extranodal extension of disease
Advanced stage (IIIB-IV disease)
Localized disease with unfavorable features (I/II,IIIA)are treated as advanced disease

Jan Sanjeevni Trust

TREATMENT PLAN

After staging workup all patients with early stage Hodgkin lymphoma must be stratified into favorable and unfavorable / Localized & Advanced subgroups.

SUCCESS
BEFORE YOU ARE READY
NO SPEED

(i) unexplained loss of more than 10% of body weight in 6 months before diagnosis (ii) unexplained fever with temperature above 38°C for 3 consecutive days (iii) drenching night sweats.
Pruritis alone does not qualify for B classification, nor does a short febrile illness associated with an infection.

DIAGNOSTIC EVALUATION FOR CHILDREN WITH HL (Please tick)

1. Physical examination with measurement of lymph nodes
2. Haemogram, Differential counts, peripheral smear, ESR
3. Chest X-ray P/A view- Measurement of mediastinal mass to thoracic cavity ratio
4. Liver, & Renal function tests
5. Electrolytes, serum calcium/ phosphate, serum alkaline phosphate, Uric acid, serum LDH
6. Echocardiography or MUGA scan
7. Histopathology (LN/ organ biopsy)
8. CT scan of neck, chest, abdomen & pelvis
9. Bone marrow biopsy (all children except IA/IIA)
10. Bone scan (recommended in children with bone pain raised SAP)
11. CSF examination (if indicated)
12. CT scan brain (if indicated)
13. PET (may identify more sites than conventional imaging, more accurate for residual mass)
    a. Baseline
    b. Minimum of 3 weeks post chemotherapy
    c. 8-12 weeks post irradiation
14. Surgical staging with LN sampling (selected cases)

Jan Sanjeevni Trust

HODGKIN'S DISEASE – HOSTOPATHOLOGICAL CLASSIFICATION

Histology	Pathology RS	Other	
Prognosis			

Hb ...11.6... TLC ...19,630... DLC ...N64 L3 M1.7... Platelets ...1.08 lkh... ESR ...-... LDH ...

SGOT ...55... SGPT ...47... SAP ...217... Albumin/globulin ...2.5... Serum bil ...5.9... Conj/ ...4.8

Unnconj ...

Urea ...45... Creatinine ...0.2... Uric acid ...2.2...

Others ...

ANN ARBOR STAGING CLASSIFICATION FOR HODGKIN LYMPHOMA *(Pl.tick)*

Stage	Definition
STAGE I	Involvement of single lymph node region (I) or of a single extra-lymphatic organ or site (IE) by direct extension
STAGE II	Involvement of two or more lymph node regions on the same side of the diaphragm (II) or localized involvement of an extralymphatic organ or site and one or more lymph node regions on the same side of the diaphragm(IIE)
STAGE III	Involvement of lymph node regions on both sides of the diaphragm (III), which may be accompanied by involvement of the spleen (IIIS) or by localized involvement of an extra lymphatic organ or site (IIIE) or both III (E+S). III 1. Abdominal disease limited to upper abdomen (spleen , splenic hilar nodes, celiac nodes, porta hepatis nodes) III 2. Abdominal disease includes paraaortic , mesenteric and iliac involvement with or without disease in upper abdomen
STAGE IV	Diffuse or disseminated (multifocal) involvement of one or more extra lymphatic organs or tissues with or without associated lymph node involvement

SYSTEMIC SYMPTOMS

Each stage is subdivided into A and B subcategories, B for those with defined systemic symptoms and A for those without. The B designation is given to those patients with

Jan Sanjeevni Trust

Stage - IV BSX

TREATMENT PROTOCOL FOR HODGKIN LMPHOMA

Name Shiv Shdonki **Age** 9yr **Sex** Male **POC No**...........

Stage IV
symptoms fever, abdominal distension ....yes.....**Systemic**

Poor prognostic factors (if any; refer to last page).......Hb<11
Male sex
Stage IV
WBC>13,500

Treatment
EBVD (EF = 38%) **received**

Reports at diagnosis

1. Histopathology : Date ..... No.......
Report Classical HL Please encircle LP; NS; MC; LD

2. ~~CT~~ Scan : Site WB - PET/CT Date 2/6/22
No FDG/20108/22.
Report Metabolically active LN on both side of diaphragm + spleen + BM involvement. Bilateral pleural & pericardial effusion, Ascites ⊕. Heterogeneous marrow in pelvis.

3. Bone marrow
Touch date 31/5/22 no.......
Report Hematopoietic cells of all series (M: E = 1.5 : 1). No obvious ↑ in blasts. Marrow histiocytes mildly increased, few of which show hemophagocytosis. No granuloma/ Non malignancy/ parasite
Biopsy date..................... no.......
Report No infiltration by tumor ....

4. 2D Echo EF = 38%.

Jan Sanjeevni Trust

FAMILY HISTORY: 2 nd child born out of a non consanguineous marriage with one elder sibling. History of contact with TB (paternal grandfather). History of cancer in paternal uncle who had abdominal mass and died at 20 years of age due to ? sarcoma.

IMMUNISATION History: Immunised as per schedule, No special vaccines received

DEVELOPMENTAL HISTORY: studying in 4th standard. Currently not attending school since 6 months due to illness.

EXAMINATION AT ADMISSION:

GENERAL EXAMINATION AT ADMISSION:

The child was conscious, alert,oriented Temp-Afebrile,
HR: 164/min, Peripheries: cool, PP++, CRT-2sec
RR –28/min, SpO2-100%

Pallor + , icterus +, no cyanosis/ clubbing/ lymphedema of right lower limb
Lymphadenopathy present – inguinal region,single, 1.5 cm, discrete, firm, non tender, mobile

ALIMENTARY SYSTEM:

Oral cavity: Normal

Abdomen:

Inspection- Uniform distension with dilated veins and flanks full.
Palpation- liver not palpable, spleen palpable 15cmsbelow costal margin, Right lower quadrant mass – moves with respiration, non-tender
Percussion-fluid thrill present

CNS EXAMINATION:

Higher Mental Function: Normal
Cranial nerves:Pupils- b/l RL; No nystagmus, No facial asymmetry, gag reflex present
Motor: Bulk-symmetrical; Tone -Normal
Power: normal; Deep tendon reflexes:2 ;Plantars: B/L flexor
Meningeal Signs: Neck stiffness(-ve), Kernig's (-ve); No apparent autonomic imbalance; No abnormal movement noted during examination.

RESPIRATORY EXAMINATION:

Chest expansion symmetric, mild intercostals retractions present, bilateral breath sounds equal, no added sounds

CVS EXAMINATION:

Precordium normal, S1,S2 normal, no added sounds

Jan Sanjeevni Trust

Adv

✓ 1. Emnas 2.5 ½ BD ∅ — ∅

✓ 2 Carca 3.125 ½ BD ∅ — ∅

✓ 3 Lasix 20 OD. 0.

↑ Citrus fruits

Review after 3mo to ↑ Rx

4B/c (Prof Rachna) seth madam

→ As there is Cardiac Dysfunction which will require Emnas + Carca + Lasix, despite risk of further rising uric acid

→ To start on Allopurinol for hyperuricemia and continue above medications

✓ – Tab Allopurinol (100)

1 — 1 — 1 × continue

→ Repeat KFT after 3 days

– Ped OPD on 25/7/20 (10c - Tuesday)

Jan Sanjeevni Trust

(iii) Repeat BM biopsy where ever abnormal initially and in the cases with no response or progressive disease.

PET Scan

Positive predictive value of PET has not been validated for routine clinical use. It varies by about 60% indicating that in some instances only half of the patients will experience treatment failure in future.

Single center studies have demonstrated that PET has a negative predictive value ranging from 85% to 100% which indicates that patients with a negative PET result will not suffer from a relapse in most instances

CHEMOTHERAPY SCHEDULES

ABVD

Inj Doxorubicin/ Adriamycin	25mg/m2 IV	day 1 & 15
Inj. Bleomycin	10 mg/m2 IV	day 1 and 15
Inj. Vinblastine	6mg/m2 IV	day 1 and 15
Inj. Dacarbazine	375mg/m2 IV	day 1 and 15
Inj Dexamethasone	0.15 mg/kg	day 1 and 15

Injection Emset as required.

Off therapy from day 16-28
Repeat on day 28.

Name..

Treatment details **BSA**.................

No of cycles planned ....

Protocol ....

Radiotherapy.......................................

Echo .... Date.......................... Report...

MT.................... HBS Ag... 0. .....1........ .2...

Supportive care...

....

....

....

Details of chemotherapy

Jan Sanjeevni Trust

Early stage : Favorable Localized nodal involvement (I/II/IIIA)
Absence of B symptoms
Absence of bulky disease

Chemotherapy : 2-4 cycles of ABVD ±

Involved field RT (20-30 Gys)

Early stage : Unfavorable Localized disease with unfavorable features (I/II,IIIA)are treated as advanced disease

Chemotherapy : ABVD x 4 cycles followed by

± involved field RT

Advanced Hodgkin's disease

Advanced stage (IIIB-IV disease)

Chemotherapy : ABVD 6 cycles ± radiotherapy

FOLLOW UP ASSESSMENT

Chemotherapy – ABVD 4 cycles Re- assess for response

1. CR→ give 2 more cycles to a total of 6 cycles then follow up
2. PR give 2 more cycles, evaluate and consider for
   (i) if residual disease is localized e.g. single lymph node consider involved field RT to the residual disease.
   (ii) if residual disease is more than one site or to visceral site (s) then consider high dose Chemotherapy followed by stem cell transplant.
3. No response or Progressive disease

Review histopathology and consider high dose chemotherapy followed by stem cell transplant

RE-ASSESSMENT: At the end of 3-4 cycles

(i) Detailed physical examination to look for any lymph node, liver or spleen enlargement. Any new lymph node should be taken as suspicious and do FANC or biopsy to confirm or rule out disease.

(ii) Repeat CT scan abdomeh and pelvis or other site, which ever was abnormal at initial diagnosis, to document CR.

Jan Sanjeevni Trust