Name: Mr.Rajendran

Sex: Male

Age: 62 years

Occupation: watchman

Socio economic status: lower middle

CHIEF COMPLAINTS

- Loss of weight and loss of appetite for 5 months
- Vomiting for 4 months

HISTORY OF PRESENTING ILLNESS

- The patient was apparently normal 5 months back after which he developed loss of weight and appetite- 5 months (6kgs)

- H/o vomiting for past 4 months, insidious onset, 1-3 episodes/day.

- Contains food particles, not bile stained,after 1-1.5hrs of consuming food, not projectile, not relieved by medications.

- H/o passage of black stools, tarry, sticky, foul smelling stools for 1 month, 1-2 episodes/day
- H/o nausea
- No H/o hematemesis

- H/o ball rolling movements present
- H/o early satiety
- No H/o difficulty in swallowing
- No H/o abdominal pain/distension/belching
- No H/o heartburn

- No H/o abdominal mass
- No H/o indigestion and epigastric discomfort
- No H/o constipation and obstipation
- No H/o fever

- No H/o suggestive of chronic gastritis
- No H/o bone pain, breathlessness, chest pain, hemoptysis
- No H/o swelling elsewhere in the body

PAST HISTORY

- No H/o similar complaints in past
- No H/o previous hospitalization/ surgery
- No H/o DM,TB, HT, asthma, epilepsy, typhoid, jaundice.
- No H/o chronic drug intake
- No H/o radiation exposure

PERSONAL HISTORY

- Consumes non vegetarian diet
- Normal bowel and bladder habits
- No addictive habits
- No H/o excessive consumption of coffee

- No H/o consumption of high salt and high calorie food
- No H/o excessive consumption of spicy foods
- No H/o excessive consumption of preserved foods
- No H/o drug/food allergy

FAMILY HISTORY

- No relevant family history.

GENERAL EXAMINATION

- Patient is conscious, oriented, moderately built and nourished,hydrated.
- Pallor present
- No icterus/ cyanosis/clubbing/pedal edema/generalised lymphadenopathy

ORAL HYGIENE

- Poor
- Dental caries present

HEAD TO FOOT EXAMINATION

- No acanthosis nigricans
- No irish nodes in the axilla
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- No seborrheic dermatitis
- No markers of liver cell failure.

VITALS

- Pulse rate;80/min, regular in rhythm, normal volume and character, no vessel wall thickening, no radioradial/ radiofemoral delay, felt in all peripheral vessels
- Blood pressure ; 110/70 mm Hg measured in right upper arm in sitting posture
- Respiratory rate: 17 per minute, abdominothoracic
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- Temperature: afebrile

EXAMINATION OF ABDOMEN

After getting consent and explaining the procedure, the patient is exposed from mid chest to mid thigh and examined under bright light in supine position

INSPECTION

- Abdomen : epigastric fullness seen, flanks free, umblicus in midline, everted, no visible nodules in periumblical region
- All quadrants move equally with respiration
- Visible gastric peristalsis seen
- No visible mass/ pulsation
- No scar, sinuses, dilated veins
- No divarication of recti, external genitalia normal
- Hernial orifices free
- Supraclavicular fossa : no visible fullness

PALPATION

- Not warm, not tender
- A single mass 5*5 cm felt in epigastric region extending 6cm below xiphisternum , 3cm above umblicus, 3cm from midline towards left side and 2cm from midline towards right side
- Surface: irregular, well defined margins, hard in consistency, not mobile, moves with respiration

- Rising test : swelling becomes less prominent
- Lateral recumbent position: becomes more prominent
- Plane of swelling: intra abdominal
- Succussion splash present
- No pulastion felt over mass
- No cough impluse
- No organomegaly
- External genitalia normal

- Left supraclavicular node – not palpable (TROISIERS SIGN negative)
- Axillary lymph nodes not palpable
- Para-aortic nodes not palpable
- Inguinal nodes not palpable

MEASUREMENTS

- Xiphisternum to umblicus-14 cm
- Umblicus to pubic symphysis-12 cm
- Spino umblical line-14cm on both sides
- Abdominal grith-74 cm

PERCUSSION: no free fluid, impaired resonance over mass

AUSCULTATION: normal bowel sounds heard, no arterial bruit/ venous hum

AUSCULTOSERAPING :impaired resonance

- PER RECTAL EXAMINATION: to be done

SYSTEMIC EXAMINATION

- RESPIRATORY SYSTEM: normal vesicular breath sounds heard and no added sounds
- CARDIOVASCULAR SYSTEM: S1 S2 heard and no murmurs
- CENTRAL NERVOUS SYSTEM: no focal neurological defect
- Spine and Cranium : Normal

DIAGNOSIS:

- Carcinoma stomach involving distal part of stomach with symptoms of gastric outlet obstruction

INVESTIGATIONS

- BASELINE:

  CBC, TC, DC, Hb%, ESR

  Urine – sugar, albumin

  Blood- sugar, urea, creatinine

  Blood grouping(A) and typing

  Chest X-ray

  ECG

  Liver function test

  Renal function test

SPECIFIC:

- USG abdomen
- Upper GI endoscopy(flexible)& biopsy
- Barium meal
- Contrast enhanced CT abdomen
- Endoscopic ultrasonography
- Diagnostic laproscopy

CT chest

Liver function test

PET scan

Tumour marker-CA724

Skeletal survey

TREATMENT :

- Lower radical (subtotal) gatrectomy with billroth II (roux-en-y) gastro jejunostomy