
कलावती सरन बाल अस्पताल
Kalawati Saran Children's Hos

Govt. of India

# छुट्टी की पर्ची Discharge-Slip

# कलावती सरन बाल अस्पताल

# Kalawati Saran Children's Hospital

बंगला साहिब मार्ग, नई दिल्ली-110001
Bangla Sahib Marg, New Delhi-110001
दूरभाष / Tel. No. : 23344160, 23344162-65

यूनिट Unit U7 C5 सी.आर. नं. C.R. No. 15958

नाम Name : Aryansh Kumar

आयु Age : 2yr 6m लिंग Sex : Male

पता Address : village Narwara Dist Shivhar Bihar 843128

भर्ती की तारीख : Date of Addmission 15/6/23

छुट्टी की तारीख : Date of Discharge 17/6/23

निदान

Final Diagnosis : Multisystem LCH (HR), stratum II now E febrile illness

Anthropometry

Wt. at Admission 12 kg Wt. at Discharge

Height/Length Head Circumference

Nutritional Status

Immunisation

BCG

Pentga/DPT/OPV 0 1 2 3 B1 B2

Hep. B 0 1 2 3

Measles / MMR / Typhoid

LADY HARDINGE MEDICAL COLLEGE & SMT. SUCHETA KRIPLANI HOSPITAL
NEW DELHI
DEPARTMENT OF RADIODIAGNOSIS

| | | |
|---|---|---|
| NAME: Ayansh | AGE/SEX: 2y Y/M | REGISTRATION NO: 28787 |
| REFERRED BY: U2C5 | CT NO: 131/23 | DATE: 9/1/23 |
| CLINICAL DIAGNOSIS: K/C/O Mutisystemic LCH. C/O respiratory distress not responding to antibiotics. | | |

## CECT CHEST

**SUBOPTIMAL SCAN DUE TO PATIENT MOTION.** CT SCANNING OF THE CHEST WAS OBTAINED AFTER ADMINISTRATION OF INTRAVENOUS IODINATED CONTRAST. NO ADVERSE REACTIONS SEEN. STUDY REVEALS:

FINDINGS IN CHEST

- Bilateral lung fields appear normal.
- Trachea and major bronchi appear normal.
- Mediastinal vessels and cardiac chambers appear normal.
- No mediastinal lymphadenopathy seen.
- No pericardial or pleural effusion seen.
- Chest wall appear normal.
- ***In the visualised sections of the abdomen, hepatomegaly with linear hypoattenuating areas along the portal tracts ? portal triaditis. Advised USG correlation.***

IMPRESSION: **No significant abnormality in chest.**

Please correlate clinically

Consultant

Dr. Shivani
Senior Resident

# Department of Pathology

G.B. Pant Institute of Post Graduate Medical Education and Research, New Delhi - 110002 (GIPMER)

Biopsy no: T12790/22

Year: 2022

Name: AYANSH KUMAR

Age: 2

Sex: Male

Referred By: DR NUPUR

CR / OPD No: 28787

Receipt Date: 24-12-2022

Specimen Received:
T12790/22:Liver biopsy

Report:
T12790/22:Liver biopsy
Section examined show maintained lobular architecture. Six portal tracts identified show minimal chronic lymphocytic inflammation. No interface activity. Hepatocytes show mild and focally ballooning degeneration with mild zonal steatosis amount less than 10 percent. Sinusoids are dilated and infiltrated by histiocytes with groove nuclei, few ill defined granulomas are also seen.
Masson Trichrome- No fibrosis
Orcein- No copper associated protein
AFB- negative
On IHC histiocytes cells are CD68 positive in sinusoids.

Impression:
T12790/22:Liver
Feature are suggestive for histiocyte storage disorders.
Kindly evaluate for Gaucher's diseases.

Reported by:

Dr Puja Sakhuja/Dr RM(SR)

Verified by: Dr. AK

Date of Report: 09-01-2023

### 6.3 Diagnostic Evaluation During Treatment and at Follow-up

The evaluation and the respective intervals and time points during therapy can vary depending on disease severity and treatment, and are therefore specified in the Roadmaps of each therapeutic Stratum (see Appendix **A-IV**).

The long-term follow-up evaluation scheme after end of systemic treatment is specified in Stratum VII (Section 14). The evaluation scheme is based on the assumption that patients have non-active disease (NAD) at the time being included in Stratum VII. In the case of complaints, signs and/or symptoms suggesting disease reactivation a basic evaluation as described in Section 6.2 has to be performed.

### 6.4 Definition of Organ Involvement

#### 6.4.1 Risk organs

The definition of risk organs in the LCH-IV protocol is different from that of the previous study, since **lung** will **no longer** be considered **a risk organ**. The reason is the frequent association of pulmonary involvement with involvement of other risk organs, the low relative hazard ratio in a multivariate analysis, and last but not least, the very difficult and subjective evaluation of disease activity and therapy response in this organ.

A patient is considered to have risk organ involvement if at least one of the risk organs is involved. The current definition of involvement of the risk organs is presented in **Table V**.

**Table V: Definition of Risk Organ Involvement**

| | |
|---|---|
| **Hematopoietic involvement:** (with or without bone marrow involvement*) | **At least 2 of the following:**<br>• **anemia:** hemoglobin <100 g/L (<10 g/dl), infants <90 g/L (<9.0 g/dl), not due to other causes e.g. iron deficiency<br>• **leukocytopenia:** leukocytes <4,0 x$10^9$/l (4,000/µL)<br>• **thrombocytopenia:** platelets <100 x$10^9$/l (100.000/µL) |
| **Spleen involvement:** | • **enlargement** >2 cm below costal margin in the midclavicular line** |
| **Liver involvement:** | • **enlargement** >3 cm below costal margin in the midclavicular line**<br>and/or<br>• **dysfunction** (i.e. hypoproteinemia <55 g/L, hypoalbuminemia <25 g/L, not due to other causes<br>and/or<br>• **histopathological findings** of active disease |

# Department of Pediatric Cardiac Sciences
## Sir Ganga Ram Hospital


**DR. NEERAJ AGGARWAL**
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**DR. JAY R**
MD, (Peds), DM (Pediatric Card
Associate Consultant Pediatric Card
E-mail : jay.relan@gm
DMC Regn No.


Ayansh

2yrs/ Male

3/1/23
Kalwakurthy

Echo

Normal study

No MR/TR

No RPM

For BVP

Nil

A bone lesion **with contiguous soft tissue** involvement is considered

lesion.

**Table X: Clinical classification of LCH**

| Disease categories: | Definitions: |
|---|---|
| **Single System LCH (SS-LCH)** | **One organ/system involved (uni- or multifocal):**<br>• Bone unifocal (single bone) or multifocal (>1 bone)<br>• Skin<br>• Lymph node (not the draining lymph node of another LCH lesion)<br>• Lungs<br>• Central nervous system<br>• Other (e.g. thyroid, thymus) |
| **Multisystem LCH (MS-LCH)** | **Two or more organs/systems involved**<br>With or without involvement of "Risk Organs" (e.g. hematopoietic system, liver, spleen) |

### 6.7 Stratification for the First-Line Therapy

Patients with indication for systemic therapy are stratified at diagnosis into two groups:

#### 6.7.1 GROUP 1 – Multisystem LCH

- Two or more organs/systems involved, with or without involvement of "Risk Organs" (e.g. hematopoietic system, liver, or spleen)

#### 6.7.2 GROUP 2 –Single-system LCH

- isolated "CNS-risk" lesion
- multifocal bone lesions (MFB)

① Liver +/- 10cm (AST-19, Pro-4.4)
② Spleen + 9cm
③ Cytopenia (F) - ~~BM biopsy awaited~~ BM ? Not Involved
④ Skeletal Survey - ~~Not~~ (F) (Cystic Skull
⑤ Skin Biopsy - S/o LCH (IHC awaited & Resent)
⑥
(Plan to start - IC-2)



IC-I

Re-assessment - after

- No Cytopenia
- Skeletal Survey - Skull lesion slightly reduced
- Liver - 7cm
- Spleen - 6cm

# BIOCHEMISTRY SHEET

| | NA/K | UR/CR | BIL (T/D/I) | OT/PT | ALP | URIC ACID | CA+2 | IP |
|---|---|---|---|---|---|---|---|---|
| | 30/4 | 30~~8~~/0.4 | 1.85/1.18 | 118/53 | 813 | | ~~7.8~~ | 4.9 |
| | 41/4.3 | 23/0.12 | 2.95/2.02 | 122/54 | 1711 | | 4.1 | 3.7 |
| | | 37/0.08 | – | – | | 3.1 | – | 3.8 |
| | 134/4.3 | ~~9~~8/0.1 | 4.63/3.99 | 96/60 | 1355 | | – | – |
| | | – | – | – | – | – | – | – |
| 2 | 136/4.7 | 23/0.2 | 1.8/1.2 | 79/86 | 725 | | 8.10 | 3.82 |
| 2 | 135/4.5 | 13.6/0.05 | 1.41/0.65 | 73/40 | 857 | 2.3 | 9.0/4.4 | 7.77 |
| 12 | 134/4.8 | 26/0.26 | 1.5/0.96 | 62/170 | 718 | 2.0 | 8.4/4.8 | 4.6 |
| 12 | 134/4.9 | 25/0.29 | 1.02/0.8 | 40/111 | 549 | | 8.4/5.0 | 3.7 |
| 12 | 140/4.6 | 29/0.10 | 0.95/0.48 | 28/76 | 652 | 0.95 | 9.4/5 | 4.1 |
| 0/12 | | 21/0.21 | 0.9/ | 41/93 | 581 | 2.4 | 8.4 | |
| 27/12 | 129/4.2 | 21/0.30 | 0.72/0.56 | 10/51 | 406 | 2.8 | 8.1/4.7 | 3.9 |
| 29/12 | 135/4.6 | 21/0.32 | 0.7/0.4 | 15/35 | 287 | 2.4 | 8.1/5.0 | 4.2 |
| 30/12 | 132/5.0 | 21/0.22 | 0.4/0.3 | 15/18 | 368 | 2.0 | 8.5/4.7 | 4.1 |
| 31/12 | 136/4.8 | 22/0.35 | 0.44/0.35 | 21/27 | 360 | 2.0 | 8.3/5.2 | 3.9 |
| 2/1 | 134/5.0 | 13/0.1 | 0.5/0.2 | 27/44 | 447 | 2.9 | 11.1/5.0 | 2.5 |
| 2/1 | 132/4.4 | 22/0.3 | 0.6/0.3 | 29/59 | 300 | 2.4 | 9.2/4.7 | 2.8 |
| 4/1 | 136/4.3 | 17/0.2 | 0.3/0.1 | 13/24 | 310 | 3.8 | 9.7/4.0 | 4.5 |
| 6/1 | 136/4.7 | 22/0.12 | 0.4/0.18 | 30/55 | 261 | – | 8.4 | 4.1 |
| 7/1 | 138/4.4 | 28/0.10 | 0.29/0.15 | 45/121 | 265 | | 10/4.5 | 4.6 |
| 10/01 | 136/4.9 | 32/0.07 | 0.41/0.22 | 23/109 | 239 | 2.3 | –/4.6 | – |
| 11/01 | 138/4.5 | 26/0.15 | 0.45/0.23 | 21/81 | 206 | – | – | – |
| 12/1 | 134/4.0 | 35/0.15 | 0.80/0.49 | 46/99 | 259 | 7.3 | 14.7 | 6.1 |
| 13/1 | 141/4.6 | 25/0.15 | 0.68/0.47 | 15/76 | 290 | | 14.6 | 4.8 |
| 14/1/23 | 137/3.8 | 31/0.18 | 0.39/0.21 | 50 | 230 | 3.9 | 14.8 | 5.1 |
| 15/1 | 139/4.5 | 33.8/0.15 | 0.37/0.23 | 21/51 | 215 | 3.0 | 15.1 | 5.8 |
| 16/1 | 137/4.4 | 12.5/0.13 | 0.35/0.19 | 32/77 | 243 | 3.3 | 3.8 | |

Department of Nuclear Medicine and PET
All India Institute of Medical Sciences, New Delhi, India

## $^{18}$F-FDG WHOLE BODY PET-CT STUDY

| Patient Name: AYANSH KUMAR | | Age/Sex: 2Y/M |
|---|---|---|
| Study ID: FDG/23492/23 | UHID:106391315 | Date: 11.04.2023 |

**Indication: Multisystem LCH, post Vinblastine (last-18.03.2023). PET-CT for disease status.**

**Procedure:** PET-CT acquisition was done 60 minutes after injection of 10mCi $^{18}$F-FDG by intravenous route, from the level of orbits to mid-thigh. CT was done for attenuation correction and anatomical localization.

**PET-CT Findings:**

Head and Neck: *Increased tracer uptake noted in bilateral palatine tonsils with few sub-centimetric bilateral cervical lymph nodes – infective.* Visualized paranasal sinuses, skull base, pharynx, larynx and thyroid do not show any abnormality on CT.

Thorax: *Few sub-centimetric bilateral axillary lymph nodes noted with preserved fatty hilum. Few paratracheal, prevascular, AP window, subcarinal and bilateral hilar lymph nodes noted, some of them showing calcifications, with no significant tracer uptake – likely infective.* Physiological FDG uptake is seen in the myocardium. Lungs, large airways, pleura, heart, great vessels and other mediastinal structures appear normal on CT.

Abdomen-Pelvis: **Hepatomegaly noted (CC span ~11cm) with mild FDG uptake al dilated intra-hepatic biliary radicles.** *Few sub-centimetric bilateral inguinal lymph n noted with preserved fatty hilum.* Normal FDG distribution is noted in the liver, sp kidneys, gastrointestinal tract and urinary bladder. Biliary ducts, spleen, kidneys, sto adrenals, pancreas, retroperitoneum, bowel and urinary bladder appear normal on C ascites is noted.

Musculo-Skeletal System: **FDG avid lytic lesions with soft tissue component n bilateral skull and facial bones. Opacification noted of right mastoid a** Physiological FDG distribution is seen rest of the visualized axial and appendicular s

IMPRESSION:

- **Metabolically active lytic lesions in bilateral skull and facial bones with right mastoid involvement-residual disease.**
- **No previous PET-CT available for comparison.**

# Department Of Pathology
## All India Institute Of Medical Sciences
### Delhi
Tel: +91-11-26588500/26588700 Fax +91-11-26588500/26588700


| | | | |
|---|---|---|---|
| Patient Name: | Ayansh Kumari | Acc. No: | 2252872 |
| F/H Name: | Mukesh Kumar | Hosp. Reg. No: | 106391315 |
| Age/Sex: | 2 Y/Male | UHID No: | --- |
| Clinic/Dept/Unit: | Skin OPD/Unit 1 | Consultant Incharge: | Dr. N/A |
| Reg Date: | 13-12-2022 | Reporting Date: | 22-12-2022 |

## Histopathology Report

**Report Findings:**

Received two specimens .

1)Skin biopsy of chest papule shows unremarkable epidermis . At one end there is proliferation of langerhan cells abutting the epidermis with few eosinophils

Papillary dermis shows localised collection of langerhan cells histocytes.

2) Skin biopsy of back shows similar features with excess of langerhan cells These cells are positive for of CD1a, S100 and langerin

Overall features are suggestive of langerhan cell histocytosis

Reporting Incharge: Dr. Sudheer Arava

Reporting SR: Dr. Priya Jayakumar
Verify By: Dr. Priya Jayakumar

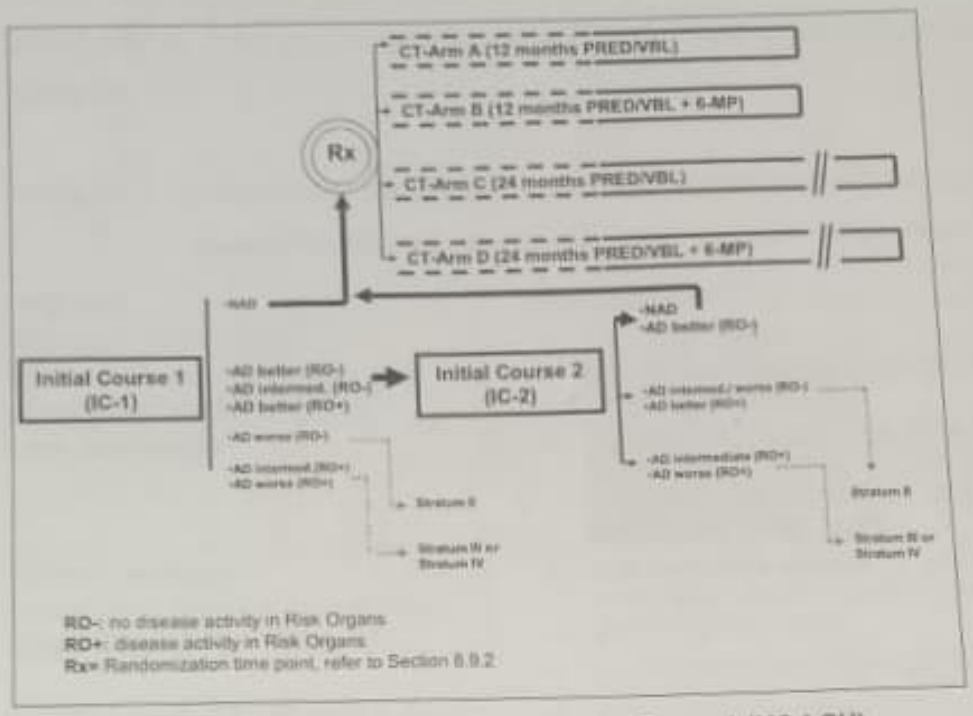



**Figure 8. Stratum I: Overall therapy plan for Group 1 (MS-LCH)**

### 8.4.1.1 Group 1: Initial Treatment

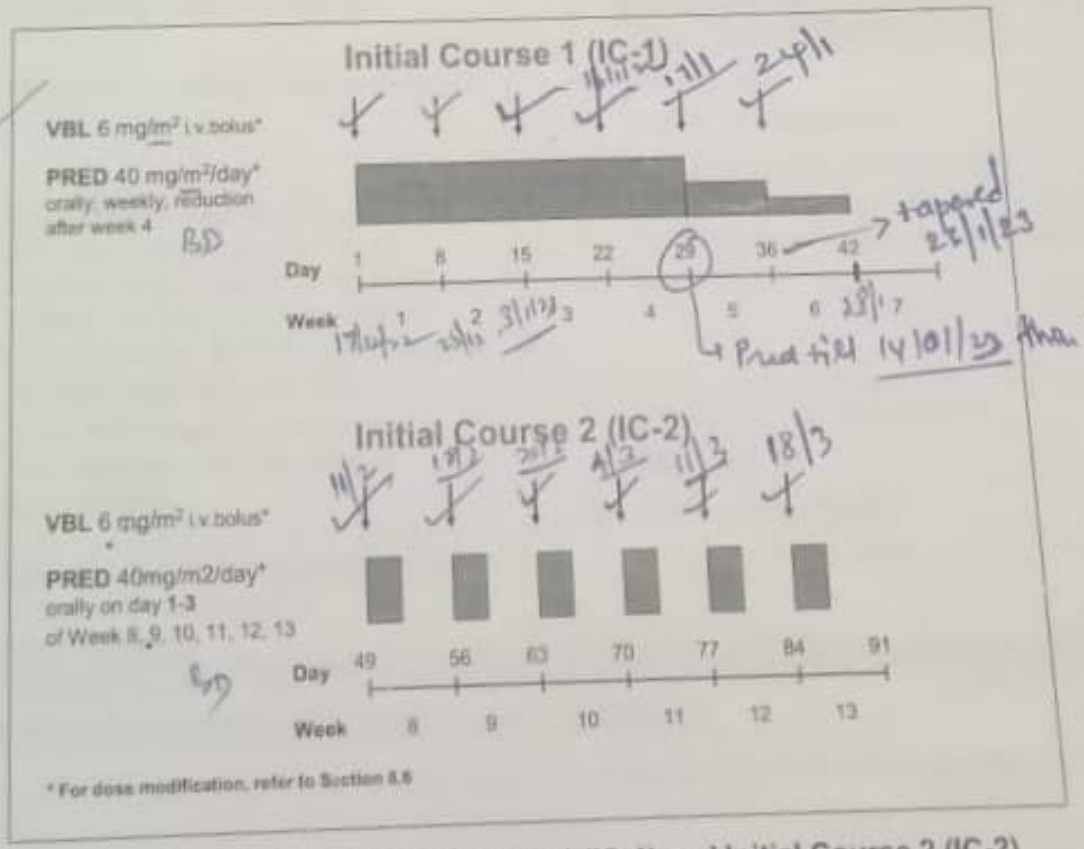
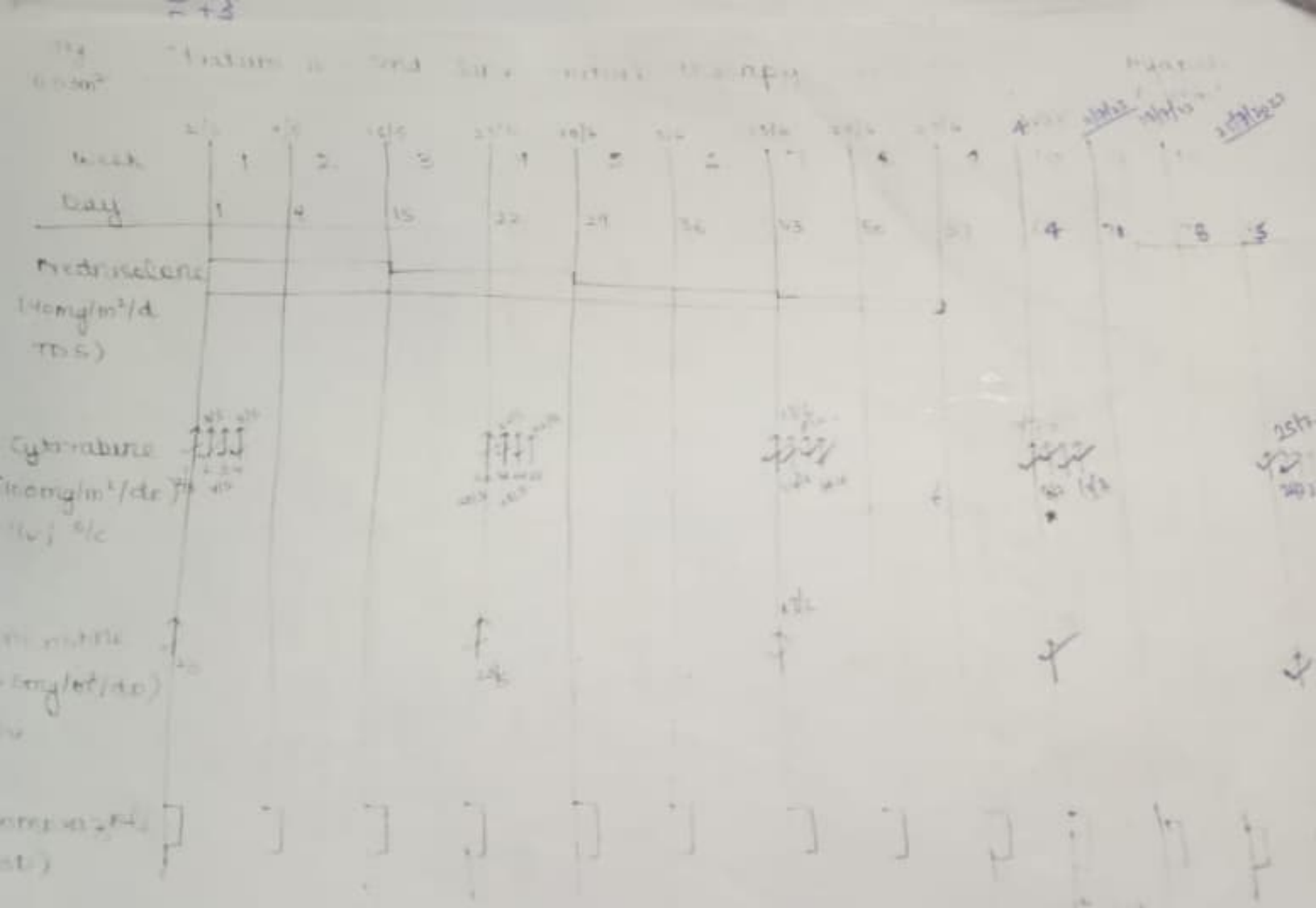



**Figure 9. Stratum I: Initial Course 1 (IC-1) and Initial Course 2 (IC-2)**




25/7/22 - S. bil → (Dirw) ↓ 1.57mg/dl
Full dose Vincristine Given
cytarabine.

KALAWATI SARAN CHILDREN'S HOSPITAL, NEW DELHI

(CONSENT FORM)

मुझे अपने बच्चे AYANSH की बिमारी LCH (multi-system)

के बारे में अपनी मातृ भाषा में समझा दिया गया है यह रोग एक प्रकार का कैंसर है मेरा बच्चा जिस कैंसर से पीड़ित है, उसके इलाज और ठीक होने की संभावना के बारे में डॉक्टरों ने बता दिया है इस बिमारी के उपचार की अवधि लगभग 2 महीने/Year है

कीमोथेरेपी उपचार का मुख्य आधार है इसके अन्य दुष्प्रभाव (side effects) हो सकते है ये दुष्प्रभाव स्थायी (permanent) या अस्थायी (temporary) हो सकते है बालों का झड़ना, भूख ज्यादा या कम लगना मुंह में छाले, मूड में बदलाव होना, चिड़चिड़ापन, पेट दर्द, कब्ज, टांगों में दर्द आदि आमतौर पर अस्थाई (temporary) रूप से देखे जाते है कीमोथेरेपी के कारण अक्सर न्युट्रोपीनिया (सफेद Cell की कमी) हो जाता है इसके कारण बुखार और संक्रमण (infection) होना आम बात है बुखार होने पर तुरंत एंटीबायोटिक (antibiotic) शुरू करना आवश्यक है कई बार संक्रमण (infection)) गंभीर और जानलेवा भी हो सकता है जरूरत पड़ने पर गंभीर समस्याओं के लिए इंटेसिव केयर यूनिट (ICU) में जाने की आवश्यकता पड़ सकती है ICU में बैड की उपलब्धि मांग और आपूर्ति पर निर्भर होती है कीमोथेरेपी कारण प्लेटलेट (platelets) की कमी हो जाती है जिसके कारण विभिन्न प्रकार की bleeding (खून बहना) हो सकती है कभी-कभी कीमोथेरेपी के कारण एलर्जिक रिएक्शन हो सकते है, जो गंभीर रूप ले सकते हैं कदाचित (rarely), दवाईयों का असर दिमाग पर हो सकता है, जैसे दौर पड़ना, नसों में नुकसान, मस्तिष्क विकृति और बुद्धि में कमी, आदि कई दवाईयों के कारण हृदय (heart) को क्षति पहुंच सकती है जिगर या आंतड़ियों को नुकसान, मधुमेह, pancreas को क्षति, हड्डियों में कमजोरी, मैटाबॉलिक बदलाव, आदि दुष्प्रभाव हो सकते हैं ये दुष्प्रभाव इलाज के दौरान या समाप्ति के बाद देखे जा सकते हैं इलाज में कई प्रकार की प्रक्रियाएं आवश्यक होती है, जैसेकि बोनमैरी जांच और इंटरथिकल (IT) कीमोथेरेपी, जिसके लिए एनसथिसिया (बेहोशी) जरूरी होता है एनसथिसिया (बेहोशी) आमतौर पर सुरक्षित होता है यदाकदा कई प्रकार की समस्याएं हो सकती है उदाहरण के तौर पर - सांस का रुकना, दिल का दौरा, निमोनिया, आदि इलाज के दौरान खून, प्लेटलेट (platelets) या पलाजमा plasma (खून का सफेद पानी) चढ़ाने की आवश्यकता पड़ सकती है कदाचित (rarely) इसके कारण एलर्जिक रिएक्शन हो सकते हैं और हिमेटाइट्स बी, सी, या HIV जैसे संक्रामक रोग भी हो सकते है कीमोथेरेपी के कारण प्रजनन (fertility) शक्ति पर दुष्प्रभाव हो सकता है इलाज के दौरान या उसके पश्चात, कैंसर के वापिस आने का जोखिम है

हम आपको आगामी उपचार के लिए शुभकामना देते है

माता के हस्ताक्षर उषा कुमारी

पिता के हस्ताक्षर मुकेश कुमार

.....

डाक्टर के हस्ताक्षर Kanchi Kakkar 17/12/22

KILKARI TRUST
Regd. No.464

# KILKARI TRUST

You Think, You Care, You give.

Mob.: 8588981217

Ref. No.: .....

Date : 26/07/2023

सेवा में,

संस्थापक महोदया
किलकारी ट्रस्ट
नई दिल्ली,

महोदया,

मैं मुकेश कुमार ~~कि~~ आयशा का पिता आपसे आवेदन करता हूँ की हमारे बच्चे के इलाज में सहायता करें। हमारे बच्चे को ब्लड कैंसर हो रखा है। दिन प्रतिदिन इसका परेशानी बढ़ते जा रहा है। कैंसर बहुत गंभीर किमारी है। इसका इलाज कल्याणी सरण बन चिकित्सालय से हो रहा है। मैं बहुत दूर से आता हूँ अपने बच्चे के इलाज के लिये।

हमारा परिवार जिवन भर आपका आभारी रहेगा। कृपया करके हमारे बच्चे पर अपना आशीर्वाद बनाये।

प्रार्थी
मुकेश कुमार

KILKARI TRUST Reg. No. 464 DELHI