

CASE NO : 2

DATE: 5/7/25

NAME: Nitha V.V. AGE: 42 SEX: F

ADDRESS: Adimuditharagi Varapuzha, Eranakulam, Kerala

OCCUPATION: Unemployed INCOME:

IP.NO. 12475 WARD NO. 4 BED NO. 7 DOA. 1-7-25 DOD. 9-7-25

PRESENTING COMPLAINTS:

1. Abdominal distension
 2. Facial puffiness
 3. Generalized itching
 4. Bilateral leg swelling
- } x 2 weeks
x 10 days.

HISTORY OF PRESENT ILLNESS: Patient was apparently normal 2 weeks back until she noticed a gradual increase in abdominal girth over the last 2 weeks, which started as tightening of clothing around the waist. It was insidious in onset, progressive. There is no h/o abdominal pain, vomiting, hematemesis, melena. She has been experiencing generalized pruritus for the past 2 weeks described as persistent, more severe at night, not associated with rashes or dryness. She has also noticed mild facial puffiness persistent early in the morning and gradually subsided as the day progressed. She also noticed swelling over both feet which gradually progressed to the mid-shin level. It was pitting in nature and prominent towards evening. No h/o redness, warmth, pain or trauma.

PAST HISTORY AND TREATMENT: T₂DM x 20 years (on OHA and insulin)
(INCLUDING ALLERGIES) #/o breathless ness (MMRC 4 II) x 2 months ago

#/o frothy urine occasionally

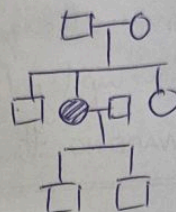
FAMILY HISTORY:
Mother is diabetic

OCCUPATIONAL HISTORY:

Housewife

SOCIO ECONOMIC STATUS:

Lower socio economic group.



GENERAL EXAMINATION

BUILD OF PATIENT: Moderately built and nourished.

GENERAL CONDITION OF PATIENT: Conscious, cooperative and oriented.

PALLOR: (+) **CYANOSIS:** (-) **CLUBBING:** (-)
ICTERUS: (-) **DEPENDENT OEDEMA:** (+) **LYMPH NODES:** (-)
THYROID: (-) **PERIPHERAL PULSES:** All felt equally **SKIN:** NI
NAILS: N/C **HEIGHT:** **WEIGHT:**

VITAL SIGNS

TEMPERATURE: Afebrile **PULSE:** 84/min **BP:** 120/70 mmHg
RESPIRATORY RATE: 18/min

RESPIRATORY SYSTEM

INSPECTION: Upper chest: No hyperinflation
No crepitations
PALPATION: Tactile fremitus: No
Vocal fremitus: No
PERCUSSION: Equally resonant
Tidal percussion: No dullness
AUSCULTATION: Normal breath sounds
No wheezes
No crackles

CARDIOVASCULAR SYSTEM

INSPECTION: Jugular venous pressure: No elevation
No cyanosis
PALPATION: Apex beat: No heaving
No thrills
PERCUSSION: No costovertebral angle tenderness
AUSCULTATION:

SYSTEM EXAMINATION

RESPIRATORY SYSTEM

INSPECTION: Upper respiratory tract - Nil; Trachea appears to be central. No hyperinflation. No drooping of shoulder.
No pectus excavatum/carinatus.

PALPATION: Trachea central.
No crowding of ribs
Vocal fremitus - equal on both sides

PERCUSSION: No palpable ribs.
Equally resonant on all lung fields.
Tidal percussion - 5th → 8th ribs on respiration

AUSCULTATION:
MVBs
Vocal resonance - equally resonant bilaterally

CARDIOVASCULAR SYSTEM

INSPECTION: Shape of chest wall - Nil. No precordial bulge.
No scars/dilated veins.
JVP - not elevated.

PALPATION: No visible pulsations.
Apex beat - 5th ICS $\frac{1}{2}$ inch medial to midline
No thrills/parasternal heave

PERCUSSION: No palpable pulsations.
No cardiomegaly
(R) heart border - (R) sternal border
(L) heart border - apex.

AUSCULTATION:
Mitral
Tricuspid
Aortic
Pulmonary
S1 S2 heard
- No murmurs

GASTRO-INTESTINAL SYSTEM

INSPECTION: Oral hygiene - good.

Lips, buccal mucosa, gums - N1

Tongue, teeth, tonsils - N1

Palate, posterior, pharyngeal wall - N1

Abdomen distended
- flanks full

All quadrants
were equally

PALPATION:

Liver palpable - 5cm from R costal margin. Soft, smooth
regular surface, sharp border, non-tender.

Spleen - just palpable below C costal margin.

PERCUSSION:

Liver dullness R 5th ICS to the MCL

Liver span = 15cm

Shifting dullness +

Transthoracic space - dull

AUSCULTATION:

Normal bowel sounds heard (2-3/min)

No hepatic/renal bruit

CENTRAL NERVOUS SYSTEM

Right handed
Studied till 8th Standard.

HIGHER FUNCTIONS: Cerebral appearance and behaviour - N1

Oriented to time, place and person.

Cooperative

Memory

Intelligence

Speech

Normal

No delusions/hallucinations.

CARNIAL NERVES:

All cranial nerves within normal limits.

Sense of smell - N1

Visual acuity, visual field, colour vision - N1

No ptosis, nystagmus

No giddiness, vertigo

Tongue, SCM, trapezius - N1

MOTOR SYSTEM:

	(R)	(L)
Bulk	NI	NI
Tone	NI	NI
Power	5/5	5/5
Reflexes	+	+

SENSORY SYSTEM:

	(R)	(L)
Posterior column sensation	}	}
Somatic sensation		
Cortical sensation		

CEREBELLAR SIGNS:

No cerebellar signs

MENINGEAL SIGNS:

No signs of meningeal irritation.

SKULL AND SPINE:

Normal

GAIT:

Normal

GENITO URINARY SYSTEM

Within normal limits

LOCOMOTOR SYSTEM

Within normal limits.

PROVISIONAL DIAGNOSIS

Acute decompensated liver disease,
with portal hypertension, most probably
MAFLD, complicated with type II DM.

INVESTIGATIONS

1. BLOOD ROUTINE

HB 9.9 TC 7400 DC P 72 L 19 E 1 B

ESR RBC PCV PLATELET COUNT 8.17L

RETICULOCYTE COUNT BLOOD GROUP & Rh

COAGULATION PROFILE

BLEEDING TIME CLOTTING TIME PROTHROMBIN TIME INR

PERIPHERAL SMEAR

BONE MARROW PICTURE

2. URINE ROUTINE PG ALBUMIN SUGAR
ACETONE BILE SALTS BILE PIGMENTS
UROBILINOGEN DEPOSIT

3. STOOL ROUTINE

OVA/CYST PARASITE OCCULT MUCUS

4. SPUTUM AFB 1..... 2..... 3.....

5. BLOOD SUGAR PROFILE FBS PPBS RBS 720 HBAIC 10.9

6. LIVER FUNCTION TEST S.BILIRUBIN: DIRECT 0.7 INDIRECT 0.7

SGOT 90 SGPT 73 ALKALINE PHOSPHATASE 1019

SERUM PROTEINS ALBUMIN GLOBULIN A/G RATIO

2.5 : 3.5

7. RENAL F

8. THYROID

9. LIPID PR

TOTAL CHOL

10. ENZYME

CPK CP

TB ANTIBOD

11. CULTUR

BLOOD

12. ECG

13. ECHOC

14. TREAD

15. X-RAYS

16. USG/DC

17. CT/MRI

18. PROCE

FNAC/BIOP

CSF

PLEURAL F

19. OTHER

7. RENAL FUNCTION TEST BLOOD UREA 25 BLOOD CREATININE 0.4

8. THYROID FUNCTION TEST T3 T4 TSH 7.54

9. LIPID PROFILE

TOTAL CHOLESTEROL TRIGLYCERIDES HDL LDL VLDL

10. ENZYMES AND IMMUNOLOGICAL STUDIES

CPK CPK-MB TROPONIN DENGUE IgM LEPTO TRIDOT

TB ANTIBODIES WIDAL HBsAG HIV VDRL

11. CULTURE REPORTS

BLOOD URINE PUS SPUTUM

12. ECG

13. ECHOCARDIOGRAM

14. TREAD MILL TEST

15. X-RAYS

16. USG/DOPPLER Abdomen - hepatosplenomegaly (+).
Features of cirrhosis. Mild to moderate ascites.
Gall bladder - mild edematous.

17. CT/MRI lumbosacral spine.
- old anterior wedge compression - no significant change

18. PROCEDURES

FNAC/BIOPSY

CSF

PLEURAL FLUID/ASCITIC FLUID

19. OTHERS CT brain - Tiny ischemic changes in small vessels (Cerebellar)

TREATMENT

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
1/7/25	BP - 150/100 mm Hg PR - 104/1' Generalized edema (+) Nephrotic range proteinuria	1. Inj Lasix 40mg Ev Q8H 2. CRBS Q8H 3. Inj HAI 16-16-12 4. Inj NPH 16-0-12 5. T. Albendazole 400mg Hb 6. T. Fe + FA 7. Inj Taxim 1g iv Q4H 8. Syb Lactulose 15ml 1-1-1 9. T. Telmesartan 40mg 1-0-0
2/7/25	BP - 120/70 mm Hg PR - 84/1' RBS - 179 Patient oriented No fresh complaints	1. T Lasix 40 1-1-1 2. T Aldactone 2-2-2 3. CRBS - Q8H 4. Inj HAI 16-16-12 5. Inj NPH 16-0-12 6. T Fe + FA 7. T. Mycogest 8. T NAC 600 2-2-2 9. T Moxifloxacin 10. T. CPM 4mg 1-0-1 "
3/7/25	BP - 140/90 mm Hg PR - 86/1' CRBS - 192 mg/dL	

TREATMENT(CONTD.)

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
4/25	BP - 180/100 mm Hg PR - 64/1'	Continue ① → ⑩ + 11. T Refaamine 40mg 1-1-1 12. T Dulcolax 2 tabs HS
5/25	Patient oriented. BP - 140/100 mm Hg PR - 96/1'	"
6/25	Patient better Intermittent micturition vitals stable CRBS - 200mg/dl	① → ⑫ + 13. T Lorazepam 1mg HS 14. T Telmisartan 40mg 1-0-1
7/25	BP - 160/110 mm Hg PR - 80/1' No fresh complaints	1. T Casin 40mg 1-1-1 2. T Aldosterone 40mg d-2x 3. CRBS - Q&H 4. Inj HAI 20-20-16 5. Inj NPH 20-0-16.
8/25	BP - 120/80 mm Hg PR - 76/1'	6. T Fe + FA 7. T Phenytoin 250mg 8. T Telmisartan 40mg 1-0-1
9/25	BP - 130/80 mm Hg PR - 74/1' To chest clear no new OPD.	9. T UDCA 10. T NAC 600 1-1-1 11. T Lorazepam 1mg HS

CONDITION AT TIME OF DISCHARGE

Clinically better. Vitals stable
No aches

Planned for outpatient follow up.
No active interventions.

TREATMENT ADVICE ON DISCHARGE

1. T. Lasix 40mg 1-1-1
2. T. Aldactone 40 2-2-2
3. Lign. HAI 20 - 20-16
4. Lign. NPH 20-0-16.
5. T. Fef TA
6. T. Thyronorm 25ug
7. T. Telmisartan. 40mg 1-0-1

8. T. UDCA

9. T. NAC 600 1-1-1

10. T. Losartan
1mg qd

⇒ Review after 2 weeks
in OPD.

REVIEW FINDINGS

IF DIED :

DATE

TIME

IMMEDIATE CAUSE OF DEATH

CASE NO : 3

DATE: 18-6-25

NAME: Muhammad Ahsan AGE: 64 SEX: M

ADDRESS: Kalas

OCCUPATION: Not working INCOME:

IP.NO. WARD NO. BED NO. DOA 17-6-25 DOD 20-6-25

PRESENTING COMPLAINTS:

1. Left sided weakness and numbness of upper limb and lower limb x 2 days
2. Slurring of speech x 2 days

HISTORY OF PRESENT ILLNESS: Patient was apparently normal 2 days back and then she developed acute onset of numbness of left side of head and both left limbs, while she was bathing. He had no issues in combing hair / getting dressed his chopsticks used to slip away from his foot. Then she went to get Fennel on the way he developed weakness of left side. Afterwards there was slurring of speech and he is unable to walk properly. He then asked for help and was brought to the hospital. He was found to have hyperglycemia and was given treatment. There was no deviation of angle of mouth, no loss of consciousness and no altered sensorium. Now all these symptoms have improved.

No lfo fever, seizures

No lfo neck pain / neck stiffness

No lfo vomiting, dysphagia

No lfo tremor

No lfo inability to feel full bladder

PAST HISTORY AND TREATMENT: No h/o similar illness in the past

(INCLUDING ALLERGIES) H/o T₂DM x 15 years (on OHA & insulin)

Previous h/o hypoglycemic episodes.

FAMILY HISTORY: H/o CAD x 5 years ago (on aspirin, atorvastatin, Amlo)

OCCUPATIONAL HISTORY: Worked in a factory. Not working currently.

SOCIO ECONOMIC STATUS:

Lower socio economic status.

GENERAL EXAMINATION

BUILD OF PATIENT: Moderately built and nourished.

GENERAL CONDITION OF PATIENT: Conscious, oriented and walking without any support.

PALLOR: ⊖

CYANOSIS: ⊖

CLUBBING: ⊖

ICTERUS: ⊖

DEPENDENT OEDEMA: ⊖

LYMPH NODES: ⊖

THYROID: ⊖

PERIPHERAL PULSES: All felt equally bilaterally

SKIN: Normal

NAILS: Normal

HEIGHT:

WEIGHT:

VITAL SIGNS

TEMPERATURE:

Afebrile

PULSE:

72/min

BP: 160/88 mm Hg

RESPIRATORY RATE: 18/min

SYSTEM EXAMINATION

RESPIRATORY SYSTEM

INSPECTION: No deviation of nasaleptum; No polyps, discharge
Oral hygiene - good. No deviation of uvula
No arching of palate. No drooping of shoulders / hallowing
No thyrotoxicosis

PALPATION: Trachea - central; vocal fremitus - equal both sides.
chest expansion (4cm) - equal on both sides.
No tenderness / local rise in temperature.

PERCUSSION:

Tidal percussion on (R) 5th $\rightarrow$ 5th ICS.

AUSCULTATION: NVB's heard.

Vocal resonance - equal on both sides
No added sounds.

CARDIOVASCULAR SYSTEM

INSPECTION: Shape of chest and precordium - N.I.
JVP not elevated. Apex beat - not visible
No scars, dilated veins, No visible pulsations

PALPATION: Trachea - central, JVP - not elevated.
Apex beat - (L) 5th ICS $\frac{1}{2}$ inch medial to MCL.
No left parasternal heave, no thrills.

PERCUSSION:

(R) heart border $\rightarrow$ (R) sternal border

(L) heart border $\rightarrow$ apex.

Upper border of liver - (R) 5th ICS.

AUSCULTATION:

Mitral
Tricuspid
Pulmonary
Aortic

S₁, S₂ heard
Normal

No murmurs

GASTRO-INTESTINAL SYSTEM

INSPECTION: Oral hygiene - good. Abdomen - distended
Unguis - central, oriented. No scars, dilated veins
Skin over abdomen - Nl . Perianal area, external
genitals - Nl

PALPATION: Abdomen - soft, non tender. No local tenderness.
Liver, spleen, kidneys - not palpable

PERCUSSION:

No fluid thrill

No shifting dullness

AUSCULTATION:

Normal bowel sounds heard.

No hepatic bruit

No renal bruit.

CENTRAL NERVOUS SYSTEM

Right handed.
Studied till 5th Standard.

HIGHER FUNCTIONS: Conscious and attentive
Oriented to time, place and person.

Intelligence } Nl
Memory }
Reasoning }

No delusion and hallucinations

Emotional lability - Nl .

CARNIAL NERVES:

II - visual acuity R L
 $\frac{2}{60}$ $\frac{3}{60}$

III, IV, VI - gaze evoked nystagmus

VII - Nasolabial fold -
absent on L side

VI - Nystagmus.

No ptosis

No wasting / atrophy
of tongue.

No nasal regurgitation

MOTOR S

SENSOR

CEREBE

MENINGE

SKULL A

GAIT:

GENITO U

LOCOMO

PROVISIO

with
local
branch
in.

	(R)	(L)
MOTOR SYSTEM:		
Bulk -	Nil	Nil
Tone -	Nil	Nil
Power -	5/5	5/5
Reflexes -	Nil	Exaggerated DTRs.

	(R)	(L)
SENSORY SYSTEM:		
Somatic sensation	Nil	Nil
Posterior column sensation -	Joint sense impaired on (L) U	
Cortical sensation	Nil	Nil

CEREBELLAR SIGNS:

No signs of cerebellar dysfunction.

MENINGEAL SIGNS:

No signs of meningeal irritation.

SKULL AND SPINE:

Normal

GAIT:

Normal

GENITO URINARY SYSTEM

Within normal limits

LOCOMOTOR SYSTEM Within normal limits

PROVISIONAL DIAGNOSIS

Acute cerebrovascular accident with (L) sided hemiparesis and UMN dysarthria; localized in the internal capsule, lenticulostriate branch of MCA, (R) ischemic stroke probably thrombotic in origin; complicated with DM and HTN.

INVESTIGATIONS

1. BLOOD ROUTINE

HB 12.5 TC 9930 DC

ESR RBC PCV

RETICULOCYTE COUNT

COAGULATION PROFILE

BLEEDING TIME CLOTTING TIME PROTHROMBIN TIME INR

PERIPHERAL SMEAR

BONE MARROW PICTURE

2. URINE ROUTINE PG ALBUMIN SUGAR
ACETONE BILE SALTS BILE PIGMENTS
UROBILINOGEN DEPOSIT

3. STOOL ROUTINE

OVA/CYST PARASITE OCCULT MUCUS

4. SPUTUM AFB 1..... 2..... 3.....

5. BLOOD SUGAR PROFILE FBS PPBS RBS 91 HBAIC 7.9

6. LIVER FUNCTION TEST S.BILIRUBIN: DIRECT 0.2 INDIRECT 0.1

SGOT 24 SGPT 24 ALKALINE PHOSPHATASE

SERUM PROTEINS ALBUMIN GLOBULIN A/G RATIO

7. RENAL FU

8. THYROID

9. LIPID PRO

TOTAL CHOLE

10. ENZYMES

CPK CPK

TB ANTIBODI

11. CULTURE

BLOOD

12. ECG

13. ECHOCA

14. TREAD M

15. X-RAYS

16. USG/DOP

17. CT/MRI

18. PROCED

FNAC/BIOPS

CSF

PLEURAL FL

19. OTHERS

7. RENAL FUNCTION TEST BLOOD UREA BLOOD CREATININE 1.1

8. THYROID FUNCTION TEST T3 T4 TSH 2.013

9. LIPID PROFILE

TOTAL CHOLESTEROL TRIGLYCERIDES HDL LDL VLDL

10. ENZYMES AND IMMUNOLOGICAL STUDIES

CPK CPK-MB TROPONIN DENGUE IgM LEPTO TRIDOT

TB ANTIBODIES WIDAL HBsAG HIV VDRL

11. CULTURE REPORTS

BLOOD URINE PUS SPUTUM

12. ECG

13. ECHOCARDIOGRAM

14. TREAD MILL TEST

15. X-RAYS

16. USG/DOPPLER

17. CT/MRI No CT evidence of acute infarct / hemorrhage
Brain B/L periventricular and deep white matter hypodensities
— chronic small vessel ischemic changes.

18. PROCEDURES C/c lacunar infarct involving left frontal
periventricular white matter.
Atherosclerotic vascular wall calcification involving the
bilateral carotids and supra aortic segments of
1st

FNAC/BIOPSY

CSF

PLEURAL FLUID/ASCITIC FLUID

19. OTHERS

TREATMENT

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
17/6/25	spo weakness of $\odot$ ear remitted slurring of speech $\oplus$ vitals: BP 134/70 mm Hg GCS: 15/15 SpO₂ - 100% CRBS - 66.	1. Check CRBS 2. Bed rest 3. Neuro consultation 4. T Aspirin 150 OD 5. T Clopidogrel 75 QD 6. T Atorva 40 HJ 7. T B Complex OD 8. Hypoglycemia awareness 9. CRBS Q 4H 10. T Amlo 5mg OD 11. Lmj 5%. Dextrose N/Gst
18/6/25	Patient conscious, alert, obeying commands, gait. BP - 110/80 mm Hg CRBS - 222 mg/dl CNS - moving all 4 limbs Power N/L bilaterally No neck stiffness, cerebellar signs. CVS - S₁S₂ + RS - B/E AET, clear.	1. Neuro consultation 2. Cardio consultation 3. Condition of patient explained to bystander

TREATMENT(CONTD.)

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
19/6/25	Pt clinically stable. BP: 160/80 mm Hg PR - 72/1' No fresh complaints. o numbness of @ rhomboid CNS - moving all 4 limbs B/L plantar flexion. H/o burning of nose both eyes.	1. T Aspirin 15mg 0-1-0. 2. T Clopidet 75mg 0-1-0. 3. T Atorva 40mg HS 4. T Amlo 5mg 1-0-1 5. CRBS - Q8H 6. Inj HA 4-4-4 sk 7. If CRBS > 200mg/dl 7. Ophthalmic consultation.
20/6/25	BP - 150/78 mm Hg PR - 74/1' CRBS - 216. Plan discharge	1. T Aspirin 15mg 1-0-1 2. T Clopidet 75mg 0-1-0 3. T Atorva 40mg HS 4. T Papa 10mg OD 5. T Vildem (50/500) 1-0-1 6. Inj HA (130/70) 8-0-8 7. T Amlo 5mg 1-0-1

CONDITION AT TIME OF DISCHARGE

Clinically better.
Vitals stable

Moving all four limbs.
Power normal bilaterally

TREATMENT ADVICE ON DISCHARGE

1. T Aspirin 150mg 0-1-0
2. T Clopidogrel 75mg 0-1-0
3. T Atorvastatin 10mg HS
4. T Dapsone 10mg HS
5. T Vitamin (50/500) 1-0-1
6. Inj AM (130/70) 8-0-8
7. T Amlodipine 1-0-1

Review in OPD
with FBS, PPBS

REVIEW FINDINGS

IF DIED :

DATE

TIME

IMMEDIATE CAUSE OF DEATH

Palp
leaves
legs
fine
dur
th
D
re
of

CASE NO : 4

DATE: 14-6-25

NAME: Sajeevan AGE: 54 SEX: M

ADDRESS: Chanthakkulam

OCCUPATION: Supermarket worker INCOME:

IP.NO. 3828 WARD NO. D BED NO. 29 DOA. 13-6-25 DOD. 15-6-25

PRESENTING COMPLAINTS:

1. Swelling of legs
 2. Abdominal pain and distension
- } x 4 days

HISTORY OF PRESENT ILLNESS:

Patient is a known case of valvular heart disease since 2 years. Now he is presented with complaints of swelling over legs which was present since 2 years but got aggravated since 4 days. It is present throughout the day, increased during evening time. No aggravating / relieving factors. He also complains of abdominal pain all over the abdomen. There was no radiation of pain. No aggravating or relieving factors. It was associated with abdominal distension, unable to consume food due to feeling of fullness. H/o associated fatigue. H/o breathlessness (Grade IV). No h/o chest pain, syncope, hemoptysis.

PAST HISTORY AND TREATMENT: *40 valvular heart disease since 2 years. 40 breathlessness 2 years. (grade to 4/6)*
(INCLUDING ALLERGIES)

FAMILY HISTORY:

No relevant family history.

OCCUPATIONAL HISTORY:

Sales manager in a supermarket.

SOCIO ECONOMIC STATUS:

GENERAL EXAMINATION

BUILD OF PATIENT: *Moderately built and nourished.*

GENERAL CONDITION OF PATIENT: *Conscious, oriented, alert, sitting on bed.*

PALLOR: $\ominus$

CYANOSIS: $\ominus$

CLUBBING: $\ominus$

ICTERUS: $\oplus$

DEPENDENT OEDEMA: $\oplus$

LYMPH NODES:

Pitting, grade IV

$\ominus$

THYROID: *Nil*

PERIPHERAL PULSES: *All feet*

SKIN: *Nil*

NAILS: *Nil*

HEIGHT: *170 cm*

WEIGHT: *64 kg*

VITAL SIGNS

TEMPERATURE: 38°C **PULSE:** *62 bpm*

BP: *110/60 mmHg*
Right arm supine position

RESPIRATORY RATE: *18 bpm, normal rhythm*
Abdomen no tenderness

RESPIRATORY

INSPECTION

dental drip.
No rales/
PALPATION:

Trachea
Chest
PERCUSSION:
Rare
Lower

AUSCULTATION:
Normal
Normal

CARDIOVASCULAR

INSPECTION
JVP elevated
over chest

PALPATION
Apex beat
thoracic

PERCUSSION
Normal

AUSCULTATION
areas
Normal

SYSTEM EXAMINATION

RESPIRATORY SYSTEM

INSPECTION: No deviation of nasal septum, no nasal congestion, polyps, dental caries present. No creling of palate, no postnasal drip. Trachea appears central. Symmetrical chest movements. No supra/infra clavicular hollowing. No kyphoscoliosis.

PALPATION: No tenderness, local rise in Temperature.

Trachea - central.

Chest expansion - Normal. VF - normal.

PERCUSSION:

Resonant on all corresponding areas of lung fields.

Lower dullness @ 5th ICS. → 1st ICS on tidal percussion

AUSCULTATION:

Wheezes heard on all areas.

Bilateral basal crepitations (+)

VR - Nil bilaterally.

CARDIOVASCULAR SYSTEM

INSPECTION: Shape of chest and precordium - Nil. No precordial bulge. JVP elevated. Apex beat visible below nipple. Dilated veins over chest. Epigastric, 2nd ICS, repesternal pulsations present. No car, swellings.

PALPATION:

JVP elevated. (4cm)

Apex beat - @ 5th ICS 1/2 inch lateral to MCC.

Hyperdynamic heaving apex. Palpable pulsations over pulmonary area.

PERCUSSION:

No dulls of left parasternal heave

@ heart border corresponds to @ sternal border.

AUSCULTATION: S₁ heard in mitral, tricuspid, aortic, pulmonary areas. Soft S₂ heard.

An ejection systolic murmur heard in pulmonary area.

Pansystolic murmur heard at apex.

GASTRO-INTESTINAL SYSTEM

INSPECTION: Dental caries present. Gums, tongue, pharynx - NI
Abdomen distended. Umbilicus central and everted
Stomach full
Stomach over abdomen - none. Hair over abdomen - NI

PALPATION: No tenderness or local rise in temperature.

Liver span = 15 cm.

PERCUSSION:

Spleen, kidney - not palpable.
Shifting dullness - present.
Fluid thrill - present.

AUSCULTATION:

Normal bowel sounds heard - 5/1

CENTRAL NERVOUS SYSTEM

Right handed

Education - 10th standard.

HIGHER FUNCTIONS:

General appearance and behaviour - NI

Conscious

Oriented to time place and person

Attention

Memory

Speech

Intelligence

} NI

No delusions / hallucinations

Cranial Nerves:

All cranial nerves within normal limits.

MOTOR SYSTEM

SENSORY SYSTEM

CEREBELLAR

MENINGEAL

SKULL AND SPINE

GAIT:

GENITO URINARY

LOCOMOTOR

PROVISIONAL

probably
and possibly
for the
acute

MOTOR SYSTEM: Bulk (R) (L)
 Tone NI NI
 Power - UL 5/5 5/5
 - LL 5/5
 - Thumb - NI

Superficial and deep tendon reflexes - NI

SENSORY SYSTEM: (R) (L)
 Somatic Sensations } NI NI
 Posterior Column sensations }
 Cortical Sensations }

CEREBELLAR SIGNS:
 Cerebellar signs absent

MENINGEAL SIGNS:
 No signs of meningeal irritation.

SKULL AND SPINE:
 Normal

GAIT:
 Normal

GENITO URINARY SYSTEM

Within normal limits

LOCOMOTOR SYSTEM Within normal limits

PROVISIONAL DIAGNOSIS

Acquired valvular heart disease of probable rheumatic etiology with pulmonary hypertension and pulmonary edema with evidence of biventricular failure in acute decompensated state without signs of acute rheumatic fever and infective endocarditis.

INVESTIGATIONS

1. BLOOD ROUTINE

HB 12 g/dl TC 7310 DC P 80.7 L 8.5 E 11
 ESR RBC PCV PLATELET COUNT 2.05L

RETICULOCYTE COUNT

BLOOD GROUP & Rh

COAGULATION PROFILE

BLEEDING TIME CLOTTING TIME PROTHROMBIN TIME 24.5

PERIPHERAL SMEAR

BONE MARROW PICTURE

2. URINE ROUTINE

PG ALBUMIN SUGAR
 ACETONE BILE SALTS BILE PIGMENTS
 UROBILINOGEN DEPOSIT

3. STOOL ROUTINE

OVA/CYST PARASITE OCCULT MUCUS

4. SPUTUM AFB 1. 2. 3.

5. BLOOD SUGAR PROFILE FBS PPBS RBS HBAIC
 146 59
 6. LIVER FUNCTION TEST S.BILIRUBIN: DIRECT INDIRECT

SGOT SGPT ALKALINE PHOSPHATASE 69
 33 15
 SERUM PROTEINS ALBUMIN GLOBULIN A/G RATIO
 6.5 2.5/2 1.3:1

7. RENAL FUNCTION TEST

8. THYROID FUNCTION TEST

9. LIPID PROFILE

TOTAL CHOLESTEROL

10. ENZYMES AND IMMUNO

CPK CPK-MB TRO 0.0
 TB ANTIBODIES WIDAL

11. CULTURE REPORTS

BLOOD URI

12. ECG

AF present

13. ECHOCARDIOGRAM =>

14. TREAD MILL TEST

15. X-RAYS

16. USG/DOPPLER

17. CT/MRI

18. PROCEDURES

FNAC/BIOPSY

CSF

PLEURAL FLUID/ASCITIC F

19. OTHERS

7. RENAL FUNCTION TEST

BLOOD UREA 53

BLOOD CREATININE 1.2

8. THYROID FUNCTION TEST

T3

T4

TSH 3.778

9. LIPID PROFILE

TOTAL CHOLESTEROL

TRIGLYCERIDES

HDL

LDL

VLDL

10. ENZYMES AND IMMUNOLOGICAL STUDIES

CPK

CPK-MB

TROPONIN

DENGUE IgM

LEPTO TRIDOT

0.016 → 0.024

TB ANTIBODIES

WIDAL

HBsAG

HIV

VDRL

11. CULTURE REPORTS

BLOOD

URINE

PUS

SPUTUM

12. ECG

AF present

13. ECHOCARDIOGRAM ⇒

14. TREAD MILL TEST

15. X-RAYS

16. USG/DOPPLER

17. CT/MRI

18. PROCEDURES

FNAC/BIOPSY

CSF

PLEURAL FLUID/ASCITIC FLUID

19. OTHERS

RA, RV, LA dilated. Concentric LCH
No RCOMA. Good LV function (EF 60%)
Moderate to severe TR. Severe PAH
Moderate MR. Moderate AR.
No clot/vegetations. RV dysfunction present.
This is pericardial effusion present.

TREATMENT

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
13/6/25	Patient conscious, alert BP - 110/70 mm Hg S ₁ S ₂ (+) MS murmur (not clear) Systolic (+)	1. Inj Lasix 40mg iv QSH 2. T Aldactone 25mg 1-0-0 3. Inj Pantop 40mg iv op 4. T Aspirin 75mg 0-1-0 5. T Atorva 70mg 0-0-1 6. CRBS QSH 7. T Auroa 500mg 1-0-1 8. T Renova 100 9. Syp. Potchlor TDS - Trop I repeat - Echo - Cardiac consultation
14/6/25	Patient conscious, oriented BP - 100/80 mm Hg Pulse - 120/ ¹ S ₃ (+) - LHF failure increased.	1. Inj Lasix 40mg iv QSH 2. T Aldactone 25mg 1-0-0 3. Inj Pantop 40mg iv op 4. T Aspirin 75mg 0-1-0 5. T Atorva 70mg 0-0-1 6. CRBS QSH 7. T Auroa 500mg 1-0-1 8. T Renova 100 9. Syp potchlor TDS - Low salt diet

TREATMENT(CONTD)

DATE	PROGRESS
15/6/25	Patient conscious, alert BP - 110/70 mm Hg S₁S₂ (+) MS murmur (not clear) Systolic (+)

TREATMENT(CONTD.)

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
15/6/25	Patient conscious, oriented S₃ (+) K⁺ - 2.2 (low) AF (+) No basal creps. Pedal edema increased.	1. Lmj Lasix 40 iv q 8h 2. T Aldactone 25mg 1-1-0 3. Lmj Pantop 40 iv OD 4. CRBS q 8h 5. T Aurox 500mg 1-0-1 6. T Renova 1000 7. Fyp Potchlor 1 top TDS 8. Lmj Lasix 60mg iv stat 9. T Rivaroxaban 15mg OD 10. T Canicelol 3.125mg 1-0-1 - Shift to ICU - Cardiac consultation urgent 11. Lmj Amiodarone 10mg Now iv over 20 min. - Anticoagulation - Seizure state explained to bystander - Check PT/INR, aPTT - Repeat Troponin - Arterial tap.

CONDITION AT TIME OF DISCHARGE

symptomatically better
Hemodynamically stable
Discharged on patient's demand.

TREATMENT ADVICE ON DISCHARGE

1. T Lasix 40mg 1-0-0
2. T Metoprolol 25 1-1-0
3. T Pantop 40 mg OD
4. T Azelox 500 1-0-1
5. T Reasav 1 OD
6. Symp Patchlor 5ml TDS
7. T Rivaroxaban 15 BD
8. T Carvedilol 3.125 1-0-1

REVIEW FINDINGS

IF DIED:

DATE

TIME

IMMEDIATE CAUSE OF DEATH

DATE: ...

NAME: ...

ADDRESS: ...

OCCUPATION: ...

IP.NO. 2

PRESENTING COMPLAINT: ...

HISTORY

Patient
of sudden
with chill
on that
immediate
found to
the sudden
which
to aggravate
she also
non-prog
Associated
No h

CASE NO : 5

DATE:

NAME: Moly

AGE: 68

SEX: F

ADDRESS: Fathochi, Emakulu

OCCUPATION: Housewife

INCOME:

IP.NO. 227589

WARD NO. 4

BED NO. 16

DOA 20/6/25

DOD 27/6/25

PRESENTING COMPLAINTS:

Fever
Loss of consciousness } x 5 days
Cough
Breathlessness } x 4 days

HISTORY OF PRESENT ILLNESS:

Patient is a known case of CKD, and now presented with complaints of sudden onset of fever since 5 days. It was high grade fever with chills, intermittent, got subsided on taking medication. On that day, in the afternoon, she was found lying unconscious. Immediately she was taken to Civil emakulu and was found to have hypoglycemia and was treated. At night, she suddenly developed breathlessness, associated with wheeze which was gradually progressive. No h/o orthopnea, PND. No aggravating / relieving factors. No diurnal variation. She also complained of cough, sudden in onset, intermittent, non-progressive. No aggravating / relieving factors. Associated chest discomfort, there was no sputum production. No h/o hemoptysis / chest pain.

PAST HISTORY AND TREATMENT: H/o T₂DM 15 years, on insulin
(INCLUDING ALLERGIES) H/o hypertension } on medication
H/o CVD - 3 years }
No h/o similar illness, TB, pneumonia

FAMILY HISTORY:

No relevant family history.

OCCUPATIONAL HISTORY:

SOCIO ECONOMIC STATUS:

GENERAL EXAMINATION

BUILD OF PATIENT: Moderately built and nourished.

GENERAL CONDITION OF PATIENT:

Conscious, oriented, cooperative

PALLOR: ⊕

CYANOSIS: ⊖

CLUBBING: ⊖

ICTERUS: ⊖

DEPENDENT OEDEMA: ⊖

LYMPH NODES: ⊖

THYROID: Normal

PERIPHERAL PULSES: Felt equally on both sides

SKIN: Normal

NAILS: Normal

HEIGHT: 156 cm

WEIGHT: 60 kg

VITAL SIGNS

TEMPERATURE: 38°C PULSE: 80/1'

BP: 122/54 mmHg

RESPIRATORY RATE: 22/1'

Normal rhythm

There are no abnormal sounds

Right arm superior position.

SYSTEM EXAMINATION

RESPIRATORY SYSTEM

INSPECTION: Shape of chest - All. Position of trachea - central. No deviation of nasal septum, oral cavity - All, uvula not deviated, no arching of palate, no post nasal drip. No thyrocardiac, supraclavicular / infraclavicular hollowing.

PALPATION: No local rise in temperature / tenderness. Trachea - central, chest movement - bilaterally symmetrical. Vocal fremitus - (R) infraclavicular, inframammary - increased.

PERCUSSION: Chest expansion - 3cm. Dull at (R) infraclavicular and inframammary area. All other areas - resonant.

AUSCULTATION: Bronchial breath sounds heard. Crepitations (+) Vocal resonance increased. Wheezes heard on right side in right infraclavicular area.

CARDIOVASCULAR SYSTEM

INSPECTION: No precordial bulge. No cyanosis / dilated veins. JVP not elevated. Apex beat - not visible. No visible pulsations.

PALPATION: No tenderness, local rise in temperature. Apex beat - palpable in the left 5th ICS $\frac{1}{2}$ inch medial to midline. No thrills / parasternal heave. No palpable heart sounds.

PERCUSSION: Lower dullness at 5th RICS. On total percussion, shift to 5th ICS. (R) heart base - (R) sternal border. (L) heart border - apex.

AUSCULTATION:

Mitral	} S ₂ heard	No murmurs / added sounds.
Tricuspid		
Aortic		
Pulmonary		

(L) heart base - apex.

GASTRO-INTESTINAL SYSTEM

INSPECTION: Oral cavity - All; Shape of abdomen - All
Umbilicus - central, inversed.
No scars / dilated veins.
Stomach over abdomen - All.

PALPATION:
No local rise in temperature. No tenderness
Liver, kidney, spleen - not palpable.

PERCUSSION:
Tympanic
No shifting dullness / fluid thrill.

AUSCULTATION:
Normal bowel sounds heard.
3/mo
No hepatic / renal bruit.

CENTRAL NERVOUS SYSTEM

Right handed.
Education - 10th.

HIGHER FUNCTIONS:

General appearance and behaviour - All
Level of consciousness - conscious.
Oriented in time, place and person.
Attends, memory, speech, intelligence - All
No delusions, hallucinations, illusions.

CRANIAL NERVES:

All cranial nerves within normal limits.

MOTOR S

SENSORY

CEREBEL

MENINGE

SKULL AN

GAIT:

GENITO U

LOCOMOT

PROVISION

probab
with

MOTOR SYSTEM: Bulk, Tone ... ② NI ... ① NI
 Power - VL } 5/5
 LL }
 trunk }
 Superficial and deep } NI
 tendon reflexes } NI

SENSORY SYSTEM:
 Somatic sensation } NI
 Posterior column sensation } NI
 Cortical sensation }

CEREBELLAR SIGNS:
 No cerebellar signs.

MENINGEAL SIGNS:
 No signs of meningeal irritation

SKULL AND SPINE:
 Normal

GAIT:
 Normal

GENITO URINARY SYSTEM

Within normal limits

LOCOMOTOR SYSTEM Within normal limits

PROVISIONAL DIAGNOSIS

lower respiratory tract infection,
 probably pneumonia, bronchopneumonia, viral etiology,
 with right side consolidation, complicated with
 diabetes, hypertension, etc.

INVESTIGATIONS

1. BLOOD ROUTINE

HB 7.1 TC 82,990 DC P L E
ESR RBC PCV PLATELET COUNT 6.18 L

RETICULOCYTE COUNT

BLOOD GROUP & Rh

COAGULATION PROFILE

BLEEDING TIME CLOTTING TIME PROTHROMBIN TIME

22.4

PERIPHERAL SMEAR

BONE MARROW PICTURE

2. URINE ROUTINE

PG

ALBUMIN

SUGAR

ACETONE

BILE SALTS

BILE PIGMENTS

UROBILINOGEN

DEPOSIT

3. STOOL ROUTINE

OVA/CYST

PARASITE

OCCULT

MUCUS

4. SPUTUM AFB

1. 2. 3.

5. BLOOD SUGAR PROFILE

FBS

PPBS

RBS

HBAIC

39

5.5

6. LIVER FUNCTION TEST

S.BILIRUBIN: DIRECT 0.3

INDIRECT

SGOT 16 SGPT 10

ALKALINE PHOSPHATASE 88

SERUM PROTEINS 5.9

ALBUMIN 2.5

GLOBULIN 3.8

A/G RATIO

0.8:1

7. RENAL FUNCTION

8. THYROID FUNCTION

9. LIPID PROFILE

TOTAL CHOLESTEROL

10. ENZYMES AND

CPK CPK-MB

TB ANTIBODIES

11. CULTURE REPORT

BLOOD

12. ECG

13. ECHOCARDIOGRAPHY

14. TREAD MILL TEST

15. X-RAYS

16. USG/DOPPLER

17. CT/MRI

18. PROCEDURES

FNAC/BIOPSY

CSF

PLEURAL FLUID/ASCS

19. OTHERS

7. RENAL FUNCTION TEST

BLOOD UREA 120 BLOOD CREATININE 3.5

8. THYROID FUNCTION TEST

T3 T4 TSH 245

9. LIPID PROFILE

TOTAL CHOLESTEROL TRIGLYCERIDES HDL LDL VLDL

10. ENZYMES AND IMMUNOLOGICAL STUDIES

CPK CPK-MB TROPONIN DENGUE IgM LEPTO TRIDOT

TB ANTIBODIES WIDAL HBsAG HIV VDRL

11. CULTURE REPORTS

BLOOD URINE PUS SPUTUM

12. ECG

13. ECHOCARDIOGRAM

14. TREAD MILL TEST

15. X-RAYS

16. USG/DOPPLER

17. CT/MRI

18. PROCEDURES

FNAC/BIOPSY

CSF

PLEURAL FLUID/ASCITIC FLUID

19. OTHERS

CRP- 47.9
Hb 78.5
E+ -5
Urea and - 7.7

TREATMENT

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
23/6	No fever spikes SpO₂ - 97% Asymptomatic CRBS - 132 BP - 136/90 mmHg PR - 70/1' Chest - BBS(+) Crep(+) Ronchi(+)	1. Lnj Pykte 2 2. 250g IV QSH 2. Lnj levoflox 750mg in 30 3. CRBS - QSH 4. Lnj HA 20/70 20-6 5. Lnj Pantop 40mg OD 6. T Amle 5mg 1-0-1/2 7. Lnj TPO 4000 U q/c 8. T Febuacotet 40mg OD 9. T NAC 600mg 1-0-1 & 2nd 10. Nebu Asthalin } QSH Budecort } Pneumot } QSH 11. T Calcium 500mg 1-0-1 12. T Acido x 500mg 1-1-1 13. T Nephrocaine 1-0-1 14. Lt one T daily - Blood transfusion (PRBC) - Physiotherapy
24/6	CRBS - 85mg/dl Ⓡ bronchopneumonia Recurrent hypoglycemia	① → ①r

TREAT

DATE

25/6

26/6

TREATMENT(CONTD.)

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
25/6	BP - 136/90 mm Hg PR - 70/ CRBS - 208 Blood transfusion started Patient stable	1. Inj Doptaz 2.25g IV & FH 2. T Levoflox 500mg OD 3. Inj HM (3570) 10-0-6-1/2 4. Inj Pantop 40mg IV OD 5. T Amlo 5mg 1-0-1 6. Inj EPO 4000 U SC 2/3 7. T Febuxostat 40mg OD 8. T Calcium 1-0-1 9. T Aceclox 500mg 1-1-1 10. T Nephrocare OD
26/6	Patient stable BP - 150/90 mm Hg PR - 80/ CRBS - 200	① → ⑩

CONDITION AT TIME OF DISCHARGE

Patient stable, chest clear

TREATMENT ADVICE ON DISCHARGE

1. T Amlo 5mg 1-0-1
2. T Febuxostat 40mg OD
3. T Calcein 500mg 1-0-1
4. T Acedox 500mg 1-1-1
5. T Nephrosone 1-0-1
6. T Furazolidone sulphate 200mg OD
7. T Folic acid 5mg OD

REVIEW FINDINGS

IF DIED :

DATE

TIME

IMMEDIATE CAUSE OF DEATH

Pa
weat
that
He
after
limb
from
his
it
ultra
impe
No
de
chro

CASE NO : 6

DATE: 25-6-25

NAME: Abraham

AGE: 72Y SEX: Male

ADDRESS: Attenuadi, Enabulam

OCCUPATION: Rubber shop

INCOME:

IP.NO. 227299 WARD NO. A BED NO. 6 DOA. 25-6-25 DOD. 30-6-25

PRESENTING COMPLAINTS:

1. Weakness of left upper limb
 2. Weakness of left lower limb
 3. Deviation of angle of mouth to right
 4. Slurring of speech
- } x 5 days
} x 4 days

HISTORY OF PRESENT ILLNESS:

Patient was apparently well 5 days back, he presented with of weakness of left limbs. He noticed it after waking up from sleep. that he wasn't able to lift up his hand and comb his hair. He was also not able to lift his shop's shutter and in the afternoon he felt weakness of left lower limb. He fell down while climbing the stairs. After that his chappals used to slip away from his left leg. On the next day, his son noted that his mouth was deviated to right side and drooling of saliva from left corner of mouth. His speech was slurred, no reduction of uric acid output. There is no difficulty of eye closure. No left sensory impairment. No left any cranial nerve involvement. No left diurnal variation of weakness. No left headache, vomiting, dizziness. No rigors, no bladder symptoms. No left chest pain, palpitation. No left loss of consciousness or fever, night sweats,

PAST HISTORY AND TREATMENT: H/o hypertension x 5 years.
Under medication.

(INCLUDING ALLERGIES) H/o hypothyroidism x 2 years.
No h/o DM, TB, asthma, or any surgery.

FAMILY HISTORY:

H/o hypertension in father and mother.

OCCUPATIONAL HISTORY:

SOCIO ECONOMIC STATUS:

GENERAL EXAMINATION

BUILD OF PATIENT: Moderately built and nourished.

GENERAL CONDITION OF PATIENT: Patient, conscious, cooperative
alert

PALLOR: No

CYANOSIS: No

CLUBBING: No

ICTERUS: No

DEPENDENT OEDEMA: No

LYMPH NODES: No

THYROID: Normal

PERIPHERAL PULSES: equal on
both sides

SKIN: Normal

NAILS: Normal

HEIGHT: 156 cm

WEIGHT: 64 kg

VITAL SIGNS

TEMPERATURE:

37.6 °C

PULSE: 82 / min

BP: 130 / 100 mmHg

(R) arm supine position

RESPIRATORY RATE: Abdomino thoracic.

SYSTEM EXAMINATION

RESPIRATORY SYSTEM

INSPECTION: No deviation of nasal septum, no congestion, polyps.
Oral cavity - Nil. Trachea - central. No drooping of shoulder.
Chest movements - symmetrical. No supraclavicular/
infraclavicular hollowing.

PALPATION:

Trachea - central. Chest expansion - Normal. (4cm)
Vocal fremitus - equally heard bilaterally. No pleural rub/
palpable crechi.

PERCUSSION:

Tidal percussion - Shift from 8th → 5th RICS on inspiration
Traube's space - tympanic.

AUSCULTATION:

RVRS heard on all lung fields.
No added sounds.
Vocal resonance - normal in all lung fields.

CARDIOVASCULAR SYSTEM

INSPECTION: Shape of chest and precordium - Nil
JVP not elevated.

Apex beat - visible below nipple.
No epigastnic pulsation. No scars/dilated veins.

PALPATION:

No local rise in temperature or tenderness.
Apex beat - (R) 5th ICS $\frac{1}{2}$ inch medial to MCL.
Position of trachea - central. JVP not elevated.

PERCUSSION:

(R) heart border - (R) sternal border

(L) heart border - apex

Upper border of liver - (R) 5th ICS is the MCL

AUSCULTATION:

Mitral	}	S ₁ S ₂ heard Normal	No murmurs/ added sounds.
Toruspod			
Pulmonary			
Aortic			

GASTRO-INTESTINAL SYSTEM

INSPECTION: Mucous, teeth, tongue, palate, uvula - Normal
Shape of abdomen - All

Umbilicus - Central, inverted. No scars/dilated veins

PALPATION: No tenderness/ Local rise in temperature

No hepatomegaly

No splenomegaly

PERCUSSION:

No fluid thrill

No shifting dullness

AUSCULTATION:

Normal bowel sounds heard. (2-3/min)

No hepatic/renal bruit.

CENTRAL NERVOUS SYSTEM

(R) hemid.

Spelled till its standard.

HIGHER FUNCTIONS:

Patient conscious, oriented to time, place and person.
General appearance and behaviour - All

Memory, intelligence - All.

Speech - Mixed

No delusions, hallucinations.

CARNIAL NERVES:

- | | (R) | (L) | | (R) | (L) | |
|-----------------------------|---------------|------|---|--------|--------|-----------|
| 1. Olfactory | + | + | 7. Nasolabial fold | NI | absent | 11. Wrist |
| 2. Optic (visual acuity) | 6/60 | 6/60 | 8. Oculobuccal | NI | weak | 12. Norm |
| 3, 4, 6. Vision | normal limits | | 9. Buccinator | NI | weak | 12. Limit |
| 5. Sensation over face | NI | | 10. Taste over ant 2 nd . | Intact | | |
| Mind | NI | | 11. No vertigo, nystagmus | | | |
| Corneal conjunctival reflex | Intact | | 12. No nasal spray, epiphora | | | |
| | | | 13. No dysphagia, no deviation of uvula | | | |

	UL		LL	
	(P)	(L)	(P)	(L)
Bulk	20	20	29	29
Tone	All spastic		All spastic	
MOTOR SYSTEM: Power	5/5	0/5	5/5	0/5

Superficial reflexes - Normal

Deep tendon reflexes -

Exaggerated on (L) side
Extensor on (L) side.

SENSORY SYSTEM:

Somato sensitive } intact.
Posterior Column sensitive }
Cerebral sensitive }

CEREBELLAR SIGNS:

No cerebellar signs.

MENINGEAL SIGNS:

No sign of meningeal irritation.

SKULL AND SPINE:

Normal

GAIT:

Normal

GENITO URINARY SYSTEM

Normal

LOCOMOTOR SYSTEM

Normal

PROVISIONAL DIAGNOSIS

Acute CVA, with left hemiplegia,
left right UMN facial palsy and UMN dysarthria.
Right internal capsule lesion, ischemic stroke probably
thrombotic in origin affecting cerebral cortex branch of
MCA complicated with HTN and hypothyroidism.

INVESTIGATIONS

1. BLOOD ROUTINE

HB 12.6 TC 6316 DC P 68 L 29 E B
 ESR 41 RBC PCV PLATELET COUNT 3076
 RETICULOCYTE COUNT BLOOD GROUP & Rh
 COAGULATION PROFILE
 BLEEDING TIME CLOTTING TIME PROTHROMBIN TIME INR
 PERIPHERAL SMEAR 18-1 1.15

BONE MARROW PICTURE

2. URINE ROUTINE PG ALBUMIN SUGAR
 ACETONE BILE SALTS BILE PIGMENTS
 UROBILINOGEN DEPOSIT

3. STOOL ROUTINE

OVA/CYST PARASITE OCCULT MUCUS

4. SPUTUM AFB 1..... 2..... 3.....

5. BLOOD SUGAR PROFILE FBS PPBS RBS HBAIC

6. LIVER FUNCTION TEST S.BILIRUBIN: DIRECT 6.3 INDIRECT 0.6

SGOT 35 SGPT 23 ALKALINE PHOSPHATASE 80
 SERUM PROTEINS ALBUMIN 4.5 GLOBULIN A/G RATIO

7. RENAL FUNCTION

8. THYROID FUNCTION

9. LIPID PROFILE

TOTAL CHOLESTEROL

10. ENZYMES AND MARKERS

CPK CPK-MB

TB ANTIBODIES

11. CULTURE REACTION
BLOOD

12. ECG

13. ECHOCARDIOGRAPHY

14. TREAD MILL TEST

15. X-RAYS

16. USG/DOPPLER

17. CT/MRI CT

18. PROCEDURES

FNAC/BIOPSY

CSF

PLEURAL FLUID/ASPIRATE

19. OTHERS

7. RENAL FUNCTION TEST

BLOOD UREA
3.5

BLOOD CREATININE
(mg/dl)

8. THYROID FUNCTION TEST

T3

T4

TSH

6.58

9. LIPID PROFILE

TOTAL CHOLESTEROL

TRIGLYCERIDES

HDL

LDL

VLDL

10. ENZYMES AND IMMUNOLOGICAL STUDIES

CPK

CPK-MB

TROPONIN

DENGUE IgM

LEPTO TRIDOT

TB ANTIBODIES

WIDAL

HBsAG

HIV

VDRL

11. CULTURE REPORTS

BLOOD

URINE

PUS

SPUTUM

12. ECG

13. ECHOCARDIOGRAM

LvH. No RWMA
Good LV systolic function (EF = 60%)
Stage I LVDD
Mild MR, No PAH
No pericardial effusion.

14. TREAD MILL TEST

15. X-RAYS

16. USG/DOPPLER

17. CT/MRI CT Brain

Acute infarct @ capsule ganglionic
region extending @ coronal section,
frontal, parietal, temporal, central,
subcortical regions.

18. PROCEDURES

FNAC/BIOPSY

CSF

PLEURAL FLUID/ASCITIC FLUID

19. OTHERS

TREATMENT

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
25/6/25	Patient conscious, oriented Obeys commands Ⓛ UL - 0/5 LL - 0/5 Plantar - extensors BP - 138/98 PR 98/ SpO₂ - 100% Plan - all routine invest. Neuro, cardio, Diet consult.	1. Inj Mannitol 100mg Q4H 2. T Aspirin 75mg 0-1-0 3. T Atorva - 40mg 0-0 4. T Pantop 40mg OD 5. T Amlo 5mg 1-0-0 6. Inj Theamine 100ml in Q4H 7. Syt Lactulose 15ml HS 8. Inj Ceftriaxone 1g iv Q4H 9. RT feeds
26/6/25	Patient conscious, oriented No progression of weakness RT pulled out BP - 150/90 mm Hg PR - 88/ FT₃, FT₄, RFT CT head - (R) MCA involvement <u>Advice</u> - 4RT brain + MCA - dual antiplatelets - Statins - Mannitol 100ml stat - Physiotherapy	Repeat ① → ⑤ 9. T Thyroxine 25mg 1-0-0 10. Pooties change Q2H

TREATMENT(CONTD.)

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
27/6/25	No progress in weakness BP - 156/92 mm Hg PR - 88/1'	Repeat ① → ⑩ 11. T Metoprolol 12.5mg BD
28/6/25	Patient conscious oriented Chest clear. Patient receiving orally BP - 126/60 mm Hg PR - 72/1'	1. T Aspirin 75mg 0-1-0 2. T Atorvastatin 40mg 0-0-1 3. T Pantoprazole 40mg BD 4. T Amlodipine 5mg 1-0-0 5. T Theophylline 100mg 1-1-1 6. Symplicase 15mg TDS 7. Inj Cefotaxime 1g iv q8h 8. T Thyroxine 25mg 1-0-0 9. T Metoprolol 12.5mg BD
29/6/25	Patient asymptomatic. No worsening of symptoms. Oral intake (+) BP - 146/80 mm Hg PR - 82/1'	Repeat ① → ⑨

CONDITION AT TIME OF DISCHARGE

Patient is asymptomatic.
No worsening of weakness
Oral intake (+).

TREATMENT ADVICE ON DISCHARGE 30-6-20

1. Daily physiotherapy
2. T Aspirin 75mg 0-1-0
3. T Clopidogrel 75mg 0-0-1
4. T Paracetamol 40mg OD
5. T Amlo 5mg 1-0-0
6. T Diamine 100mg TDS
7. T Thyroxine 25 mg OD
8. T Lisinopril 10mg BD

REVIEW FINDINGS

IF DIED:

DATE

TIME

IMMEDIATE CAUSE OF DEATH

DATE:

NAME

ADDR

OCCU

IP.NO

PRES

HIST

Pa
with
wh
Ca
poin
Th

CASE NO: 7

DATE: 1-7-25

NAME: Mary AGE: 55y SEX: Female

ADDRESS: Aitbarbuly

OCCUPATION: N/A INCOME:

IP.NO. WARD NO. 4 BED NO. 10 DOA: 1-7-25 DOD: 7-7-25

PRESENTING COMPLAINTS:

Chestpain x 1 day

HISTORY OF PRESENT ILLNESS:

Patient was apparently normal 1 day back, now presented with c/o intermittent chestpains for past 2 weeks which exacerbated to sudden onset central chestpains lasting more than 30 mins. It was a constricting type of pain radiating to left arm, associated with sweating. There were no aggravating / relieving factors.

No h/o breathlessness on lying, on exertion.

No h/o fever, cough, palpitation.

No h/o nausea, vomiting.

No h/o abdominal distension, pedal edema.

PAST HISTORY AND TREATMENT: H/O DM 10 years (on metformin)
H/O HTN 8 years (on medication)
(INCLUDING ALLERGIES) No h/o TB, asthma, drug allergy, drug

FAMILY HISTORY:

No h/o MI, CAD in family

OCCUPATIONAL HISTORY:

N/A

SOCIO ECONOMIC STATUS:

Lower middle SES

GENERAL EXAMINATION

BUILD OF PATIENT: Moderately built and nourished.

GENERAL CONDITION OF PATIENT:

PALLOR: (+) CYANOSIS: (-) CLUBBING: (-)

ICTERUS: (-) DEPENDENT OEDEMA: (-) LYMPH NODES: (-)

THYROID: Normal PERIPHERAL PULSES: Equally felt bilaterally SKIN: all

NAILS: Normal HEIGHT: 165cm WEIGHT: 63kg

VITAL SIGNS

TEMPERATURE: Afebrile PULSE: 86'

RESPIRATORY RATE: 22'

BP: 140/90 mmHg

RESPIRATORY

INSPECTION

Oral cavity

No h/o

PALPATION

No h/o

PERCUSSION

AUSCULTATION

CARDIOVASCULAR

INSPECTION

PALPATION

PERCUSSION

AUSCULTATION

SYSTEM EXAMINATION

RESPIRATORY SYSTEM

INSPECTION: No deviation of nasal septum, no nasal congestion, polyps
Oral cavity - NI, no deviation of uvula, no arching of palate.
No tonsillar enlargement. Chest movements - NI.
Trachea - central.

PALPATION:

No local rise in temperature or tenderness.
Chest expansion - sym

PERCUSSION:

Vocal fremitus - equally felt bilaterally
Tidal percussion - 5th → 8th Ribs
Traube's space - tympanic

AUSCULTATION:

NRBS heard on all lung fields.
No added sounds.
Vocal resonance - equally heard bilaterally

CARDIOVASCULAR SYSTEM

INSPECTION: Shape of chest and precordium - NI
JVP - not elevated.

PALPATION: Apex beat - visible below nipple
No scars, dilated veins, or abnormal pulsations
No epigastrium or intercostal pulsations.

No thrills, parasternal heave.
No palpable heart sounds.

PERCUSSION:

Ⓟ heart border - Ⓟ Atrial border
Ⓛ heart border - apex
liver dulls - Ⓟ 5th ICS.

AUSCULTATION:

1st ICS } S1 S2
2nd ICS } (Normal)
Pulmonary }
Aortic }

No added sounds
No murmurs.

GASTRO-INTESTINAL SYSTEM

INSPECTION: Mucos, teeth, tongue, palate, pharynx - All

Shape of abdomen - All
umbilicus - central, inverted
No scars, dilated veins,

PALPATION: No local rise in temperature, tenderness
No organomegaly

PERCUSSION: No fluid thrill.
No shifting dullness

AUSCULTATION: Normal bowel sounds heard.
No hepatic/renal bruit

CENTRAL NERVOUS SYSTEM

① handed
Education - 12th Standard.

HIGHER FUNCTIONS:

General appearance and behaviour - All
Conscious, oriented to time, place and person.

Memory }
Intelligence } Normal
Speech }

No delusions / hallucinations.

CARNIAL NERVES:

All cranial nerves are within normal limits.

	②	①
MOTOR SYSTEM:	NC	NC
Bulk	NC	NC
Tone	NC	NC
Power	5/5	4/5

Superficial and deep tendon reflexes - Nil.

SENSORY SYSTEM:

Somatosensory
Posterior Column sensation } NC
Cortical sensation

CEREBELLAR SIGNS:

No cerebellar signs

MENINGEAL SIGNS:

No signs of meningeal irritation

SKULL AND SPINE:

Normal

GAIT:

Normal

GENITO URINARY SYSTEM

Normal

LOCOMOTOR SYSTEM

Normal

PROVISIONAL DIAGNOSIS

Acute Coronary Syndrome, most probably NSTEMI,
sinus rhythm, No signs of rheumatic fever,
infective endocarditis - Complicated with DM, HTN.

INVESTIGATIONS

1. BLOOD ROUTINE

HB 7.9 TC 7960 DC P L E

ESR RBC PCV PLATELET COUNT

RETICULOCYTE COUNT BLOOD GROUP & Rh

COAGULATION PROFILE

BLEEDING TIME CLOTTING TIME PROTHROMBIN TIME

12.3

INR 1.1

PERIPHERAL SMEAR

No megaloblastic normochromic anemia

APTT - 10.5

BONE MARROW PICTURE

2. URINE ROUTINE

PG

ALBUMIN

SUGAR

ACETONE

BILE SALTS

BILE PIGMENTS

UROBILINOGEN

DEPOSIT

3. STOOL ROUTINE

OVA/CYST

PARASITE

OCCULT

MUCUS

4. SPUTUM AFB

1.

2.

3.

5. BLOOD SUGAR PROFILE

FBS

PPBS

RBS

HBA1C

204

6.7

6. LIVER FUNCTION TEST

S.BILIRUBIN: DIRECT

0.2

INDIRECT

0.1

SGOT

SGPT

26

17

ALKALINE PHOSPHATASE

13

SERUM PROTEINS

ALBUMIN

GLOBULIN

AVG RATIO

1.1:1

7. RENAL FUNCTION TEST

BLOOD UREA

BLOOD CREATININE

8. THYROID FUNCTION TEST

T3

T4

TSH

9. LIPID PROFILE

TOTAL CHOLESTEROL

TRIGLYCERIDES

HDL

LDL

VLDL

10. ENZYMES AND IMMUNOLOGICAL STUDIES

CPK

CPK-MB

TROPONIN I

DENGUE IgM

LEPTO TRIDOT

TB ANTIBODIES

WIDAL

HBsAG

HIV

VDRL

11. CULTURE REPORTS

BLOOD

URINE

PUS

SPUTUM

12. ECG

T wave Amplitude in V_2, V_3 .

13. ECHOCARDIOGRAM

14. TREAD MILL TEST

15. X-RAYS

✓ 16. USG/DOPPLER Abdomen -

Grade I renal parenchymal change
Ⓟ renal calculi.

17. CT/MRI Normal

18. PROCEDURES

FNAC/BIOPSY

CSF

PLEURAL FLUID/ASCITIC FLUID

19. OTHERS

S. Femur 12.3.

TREATMENT

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
1/7/25	Patient conscious, oriented. BP - 130/80 mm Hg PR - 80/ CRBS - 116 Routine blood investigations Anemic work up.	1. Inj Heparin 5000 U i.v. Q4H 2. CRBS Q4H 3. Inj HA 4. Inj Metolac 500 mg 1-0-1 5. T Clozoni 2mg 1-0-0 6. T Nicardipine 10mg 1-0-1 7. T Aspirin 75mg 0-1-0 8. T Clopidogrel 75mg 0-1-0 9. T Atorvastatin 40mg 0-0-1 10. T Subitrate 10mg 1-0-1 11. T Pantoprazole 40mg 1-0-1 12. T Acetaminophen 40mg 1-1-1 13. T Fe + FA 1 OD 14. T Albendazole 400mg qd
2/7/25	Patient conscious, oriented. No chest pain Stable, anemic	Repeat ① → ⑭
3/7/25	Patient conscious, oriented. BP 150/90 mm Hg PR 80/ CRBS - 167 Plan - 10 PRBC + transfusion	1. Inj Heparin 5000 U Q4H 2. T Aspirin 75mg 0-1-0 3. T Clopidogrel 75mg 0-1-0 4. T Atorvastatin 40mg 0-0-1 5. T Metolac 25mg 1-0-1 6. T Pantoprazole 40mg 1-0-0 7. T Isosorbide 1/2-0-1/2 8. T Dapsone 10mg 1-0-0 9. T Nicardipine 10mg 1-0-1

TREATMENT

DATE

4/7/25

5/7/25

6/7/25

TREATMENT(CONTD.)

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
4/7/25	Patient conscious, oriented. BP - 130/90 mm Hg PR - 94/1' Patient stable	Repeat ① → ⑨
5/7/25	Patient conscious, oriented. BP - 130/90 mm Hg PR - 90/1' Day 5 hepatitis.	Repeat ① → ⑧ 9. Lay Casox 40mg ^{iv} stat 10. Lay heparin 100mg ^{iv} stat 11. Avail 1amp 1-0-0 sos
6/7/25	Patient conscious, oriented. BP - 170/90 mm Hg PR - 88/1' Patient stable	Repeat ① → ⑧

CONDITION AT TIME OF DISCHARGE

Patient asymptomatic
Stable

TREATMENT ADVICE ON DISCHARGE

1. T Aspirin 75mg 0-0
2. T Clopidogrel 75mg 0-1-0
3. T Atorvastatin 40mg 0-0-1
4. T Metoprolol 25mg 1-0-1
5. T Nifedipine 10mg 1-0-1
6. T Dapa 10mg 1-0-0
7. T Bisoprolol 2.5-0-1/2
8. T Pantoprazole 40mg 1-0-0

Review after 2 weeks
in OPD with

FBC / PPBS / Hb / S. Fumarate

REVIEW FINDINGS

IF DIED :

DATE

TIME

IMMEDIATE CAUSE OF DEATH

DATE:

NAME

ADDRESS

OCCUPATION

IP.NO. 2

PRESENTING COMPLAINTS

HISTORY

bael, the
fiver, a
taking m
which
Spun
consistently
chest pain
chest po

CASE NO : 8

DATE: 17-7-25

NAME: C. Chinnabhi

AGE: 70

SEX: M

ADDRESS: Enabalam

OCCUPATION: Nil

INCOME:

IP.NO. 228385

WARD NO. B

BED NO. 10

DOA 15/7/25 DOD 19/7/25

PRESENTING COMPLAINTS:

Fever } x 1 week
Cough }
Chest pain x 1 day

HISTORY OF PRESENT ILLNESS:

Patient was apparently normal 1 week back, then he developed acute onset low grade intermittent fever, which aggravated during night time, relieved on taking medication. It was associated with productive cough, which aggravated during night, during lying down position. Sputum was yellowish in colour, moderate onset, mucopurulent consistency and not blood stained. She also complains of chest pain since one day. It was insidious in onset, central chest pain, no radiation.

No aggravating / relieving factors.
No h/o breathlessness, palpitations, wheezing.

No h/o orthopnea, PND, edema.

No h/o loss of appetite, weight loss, night sweats.

No h/o bluish discoloration of skin

No h/o abdominal discomfort, vomiting, diarrhoea.

PAST HISTORY AND TREATMENT: H/o HTN, DM - detected 2 months back - not on medication
(INCLUDING ALLERGIES) H/o TB - 3 years ago; Treatment completed
No h/o asthma, CAD, thyroid disorder

FAMILY HISTORY:

No significant family history

OCCUPATIONAL HISTORY:

SOCIO ECONOMIC STATUS:

Low socioeconomic class.

GENERAL EXAMINATION

BUILD OF PATIENT: Moderately built and nourished.

GENERAL CONDITION OF PATIENT:

PALLOR: No

CYANOSIS: No

CLUBBING: ⊕

Grade I

ICTERUS: No

DEPENDENT OEDEMA: 0/4

LYMPH NODES:

No enlargement

THYROID: Normal

PERIPHERAL PULSES:

SKIN: Normal

NAILS: No onychomycosis

HEIGHT: 170cm

WEIGHT: 62kg

VITAL SIGNS

TEMPERATURE:

Afebrile

PULSE: 70/min

BP: 130/80mmHg

RESPIRATORY RATE:

22/min

SYSTEM EXAMINATION

RESPIRATORY SYSTEM

INSPECTION: No deviation of nasal septum, no nasal congestion;
Trachea appears central.
Prominence of chest wall - reduced.

PALPATION: No abnormal pulsations or engorged veins.
No local rise in temperature/tenderness.
No deviation of trachea. Vocal fremitus - increased on left side.

PERCUSSION: Chest wall - symmetrical
Chest expansion - 1.5cm
Dullness in (L) infraaxillary & infraclavicular area.

AUSCULTATION: Vocal resonance increased in left infraclavicular and infraaxillary area.
Fine basal crepitations on left side.

CARDIOVASCULAR SYSTEM

INSPECTION: Shape of chest - All
No precordial bulge

PALPATION: Apex beat - not visible
No distended veins, scars, abnormal pulsations.
No local rise of temperature/tenderness. Position of trachea - central.
JVP - not elevated. No parasternal heave.
No thrill

PERCUSSION: No palpable heart sounds.
(R) heart border - corresponds to (R) sternal border
(L) heart border - corresponds to apex.

AUSCULTATION: Liver dullness - present at (R) 5th ICS.

Mitral	}	S ₁ , S ₂ heard normally No added sounds.
Tricuspid		
Pulmonary		
Aortic		

GASTRO-INTESTINAL SYSTEM

INSPECTION: Mucous, teeth, tongue - Normal.
Shape of abdomen - All
Umbilicus - central, inverted.
No renal/dilated veins.

PALPATION: No local rise of temperature, tenderness.
No hepatosplenomegaly.

PERCUSSION: No fluid thrill.
No shifting dullness.

AUSCULTATION: Normal bowel sounds heard.
No hepatic/renal bruit.

CENTRAL NERVOUS SYSTEM

② handedness
Education - 10th Std.

HIGHER FUNCTIONS:

General appearance and behaviour - All
Conscious, orientation time, place and person.

Memory } All
Intelligence }
Speech }

No delusions/hallucinations.

CARNIAL NERVES:

All cranial nerves intact

MOTOR SYSTEM:

Bulk
Tone
Power - UL
LL

Ⓐ
NI
5/5

Ⓑ
NI
5/5

SENSORY SYSTEM:

Superficial and
deep tendon reflexes

NI NI

Somatic sensations
Posterior column sensations
Cerebral sensations

} Intact Intact

CEREBELLAR SIGNS:

No cerebellar signs.

MENINGEAL SIGNS:

No signs of meningeal irritation

SKULL AND SPINE:

Normal

GAIT:

Normal

GENITO URINARY SYSTEM

Within normal limits

LOCOMOTOR SYSTEM

Within normal limits

PROVISIONAL DIAGNOSIS

probably pneumonia - left lower lobe - no signs of pleural effusion, not in respiratory failure, complicated with type II DM, HTN, and wide risk factors - smoking, old age, low SES, CURB score-2. lower respiratory tract infections - most

INVESTIGATIONS

1. BLOOD ROUTINE

HB 12.1 TC 12370 DC P L E

ESR RBC PCV PLATELET COUNT 1.28L

RETICULOCYTE COUNT

BLOOD GROUP & Rh

COAGULATION PROFILE

BLEEDING TIME CLOTTING TIME PROTHROMBIN TIME

PERIPHERAL SMEAR

BONE MARROW PICTURE

2. URINE ROUTINE

PG

ALBUMIN

SUGAR

ACETONE

BILE SALTS

BILE PIGMENTS

UROBILINOGEN

DEPOSIT

3. STOOL ROUTINE

OVA/CYST

PARASITE

OCCULT

MUCUS

4. SPUTUM AFB 1..... 2..... 3.....

5. BLOOD SUGAR PROFILE FBS PPBS RBS HBAIC

6. LIVER FUNCTION TEST S.BILIRUBIN: DIRECT 0.4 INDIRECT

SGOT

SGPT

ALKALINE PHOSPHATASE

SERUM PROTEINS

ALBUMIN

GLOBULIN

A/G RATIO

7. RENAL FU

8. THYROID I

9. LIPID PRO

TOTAL CHOLE

10. ENZYMES

CPK CPK

TB ANTIBODI

11. CULTURE

BLOOD

12. ECG

13. ECHOCA

14. TREAD I

15. X-RAYS

16. USG/DC

17. CT/MRI

18. PROCE

FNAC/BIOF

CSF

PLEURAL I

19. OTHER

7. RENAL FUNCTION TEST

BLOOD UREA
9.2

BLOOD CREATININE
2.7

8. THYROID FUNCTION TEST

T3

T4

TSH 0.5836

9. LIPID PROFILE

TOTAL CHOLESTEROL

TRIGLYCERIDES

HDL

LDL

VLDL

10. ENZYMES AND IMMUNOLOGICAL STUDIES

CPK

CPK-MB

TROPONIN
0.118

DENGUE IgM

LEPTO TRIDOT

TB ANTIBODIES

WIDAL

HBsAG

HIV

VDRL

11. CULTURE REPORTS

BLOOD

URINE

PUS

SPUTUM

Normal
pharyngeal flora

12. ECG

13. ECHOCARDIOGRAM

14. TREAD MILL TEST

15. X-RAYS PA Chest X-ray - opacities in left lower lobe

16. USG/DOPPLER Abdomen - both kidneys hyperechoic & corticomedullary distinction maintained.

17. CT/MRI

Ⓟ kidney - 8.4 x 3.7 cm

Ⓛ kidney - 9.4 x 4 cm

18. PROCEDURES

HRET - few nodules seen in Ⓛ upper lobe

FNAC/BIOPSY

CSF

PLEURAL FLUID/ASCITIC FLUID

19. OTHERS

TREATMENT

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
16/7/25	Patient conscious. O/E - chest - creps (+) BP - 110/80 mm Hg PR - 82/1' Plan - All baseline investigation. Repeat Trop I Sputum, cardiac consultation.	1. Lmj Ceftriaxone 1g to 100 ml N/C BD 2. Lmj Paracetamol 400mg IV Q6H 3. Lmj HA 100 mg IV Q6H 4. Lmj Demiphylline 100mg IV Q6H 5. Nebulizer Salbutamol + Budesonide Q6H. 6. T NAC 600mg 1-1-1 7. T Azithromycin 500 mg 1-0-0. 8. T Ozeltamivir 75mg 1-0-0
17/7/25	Patient - Stable BP - 120/80 mm Hg PR - 80/1' cough (+)	Repeat ① → ②

TREATMENT (CONT)

DATE	PROGRESS
18/7/25	Patient BP - PR - Che Tap
19/7/25	Plan

TREATMENT(CONTD.)

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
18/7/25	Patient conscious, oriented BP - 120/70 mm Hg PR - T8/1 Chest - no creps Taper steroids.	1. Inj Ceftriaxone 1g iv BD 1st 100ml NS BD. 2. T Pantop 40mg 1-0-0 3. Inj Dexamethasone 100mg iv Q8H. 4. Inj Hydrocort 50mg iv BD. 5. T NAC 600mg 1-1-1 6. T Azithromycin 500mg 1-0-0. 7. Cap Oseltamivir 75mg 1-0-1 8. Syz C/E 10ml BD
19/7/25	Patient stable Chest - clear Plan - discharge today.	Repeat ① → ⑧ 9. Tab nimesulide 1-0-1 10. T Acidex 1-0-1 11. T Febuxostat 50mg 1-0-0.

CONDITION AT TIME OF DISCHARGE

Patient asymptomatic
Hemodynamically stable

TREATMENT ADVICE ON DISCHARGE

1. T Ceftriaxone 20mg 1-0-1
2. T Paracetamol 40mg 1-0-6
3. T Theophylline 100mg 1-1-1 x 5 days
4. T NAC 600mg 1-0-0
5. Sp C/E 10ml B6
6. T rifampin 1-0-1
7. T Aciclovir 1-0-1
8. T Febuxostat 1-0-1

Review after 2 wks
at nephro op.
and medicine

REVIEW FINDINGS

IF DIED:

DATE

TIME

IMMEDIATE CAUSE OF DEATH

DATE:

NAME:

ADDRESS:

OCCUPATION:

IP.NO.:

PRESENTING COMPLAINT:

HISTORY OF PRESENT ILLNESS:

Patient
of age
in present
illness
16 days
it was
in hospital

CASE NO : 9

DATE: 10-6-25

NAME: Suresh Kumar AGE: 56 SEX: M

ADDRESS: Neimangalam

OCCUPATION: Farmer INCOME:

IP NO. 227024 WARD NO. B BED NO. 10 DOA 9-6-25 DOD 13-6-25

PRESENTING COMPLAINTS:

Abdominal distension } x 16 days.
Breathlessness

HISTORY OF PRESENT ILLNESS:

Patient was asymptomatic 16 days back. Then he complained of abdominal distension. It was insidious onset, gradual in progression. Associated with constipation, decreased urine output. He also complains of breathlessness for 16 days. It was insidious in onset, gradual in progression. It was aggravated when lying supine and relieved on lying on sides.

No h/o abdominal pain

No h/o vomiting

No h/o hemoptysis

No h/o weakness of limbs

No h/o fever, cough.

No h/o PND.

No h/o chest pain, palpitations.

PAST HISTORY AND TREATMENT: $\#0$ CAD x 2 years
(INCLUDING ALLERGIES) $\#0$ CLD x 2 years

FAMILY HISTORY:

No relevant family history

OCCUPATIONAL HISTORY:

SOCIO ECONOMIC STATUS:

GENERAL EXAMINATION

BUILD OF PATIENT: Moderately built and nourished.

GENERAL CONDITION OF PATIENT: Patient conscious, co-operative and alert

PALLOR: $\oplus$

CYANOSIS: $\ominus$

CLUBBING: $\ominus$

ICTERUS: $\ominus$

DEPENDENT OEDEMA: $\oplus$

LYMPH NODES: $\ominus$

THYROID: Nil

PERIPHERAL PULSES: All peripheral pulses felt equally

SKIN: Tumb-bleeding spots

NAILS:

HEIGHT:

WEIGHT:

VITAL SIGNS

TEMPERATURE: Afebrile

PULSE: 70/1'

RESPIRATORY RATE: 26/1'

BP: 110/60 mmHg

SYSTEM EXAMINATION

RESPIRATORY SYSTEM

INSPECTION: No deviation of nasal septum, no nasal congestion, polyps, discharge. Oral cavity - Nil. No postnasal drip.
Trachea - central. Chest movements - symmetrical.

PALPATION: No enlarged veins, sinuses, nodules.

No local rise of temperature / tenderness. Trachea - central.
Chest movements - Nil, expansile - sym. AP diameter: 9 cm

PERCUSSION: VF: Nil Transverse diameter: 27 cm.

Tidal percussion - Shift from 8th → 8th lcs.

AUSCULTATION:

WDS heard on all lung fields.
No added sounds.

VR - Nil on all lung fields.

CARDIOVASCULAR SYSTEM

INSPECTION: Shape of chest and precordium - Nil. JVP - not elevated.
Apex beat - visible below nipple. Position of trachea - central.
No scars, dilated veins, swelling. No abnormal pulsations.

PALPATION: No local rise of temperature, tenderness.
Trachea - central. Apex beat palpable is the 5th ICS 1/2 inch medial to mid. No parasternal heave.

PERCUSSION: No palpable heart sounds.
① heart border - ② sternal border
③ heart border - apex.

AUSCULTATION:

Mitral } S₁ S₂ heard No murmurs / added sounds.
Tricuspid }
Pulmonary }
Aortic }

GASTRO-INTESTINAL SYSTEM

INSPECTION: Oral cavity - NL. Tongue, gums, palate,
pharynx - NL. Shape of abdomen - distended.
Umbilicus - central & everted.

PALPATION: No dilated veins, epigastric pulsation.
No local rise in temperature/tenderness.

PERCUSSION:

Fluct (+)
Shifting dullness (+)

AUSCULTATION:

Normal bowel sounds heard.
No hepatic / renal bruit.

CENTRAL NERVOUS SYSTEM

Right handed.

Educated - 8th standard.

HIGHER FUNCTIONS: General appearance and behaviour - NL

Oriented in time, place and person.

Cooperative

Memory

Intelligence } NL.

Speech

No delusion / hallucination.

CARNIAL NERVES:

All cranial nerves are within
normal limits.

MOTOR SYSTEM:

	Ⓡ	Ⓛ
Bulb	}	All
Tone		
Power	5/5	5/5

SENSORY SYSTEM:

Superficial and deep tendon reflexes - All

Somatic sensation	}	Normal
Posterior column sensation		
Cortical sensation		

CEREBELLAR SIGNS:

No cerebellar signs.

MENINGEAL SIGNS:

No signs of meningeal irritation.

SKULL AND SPINE:

Normal

GAIT:

Normal

GENITO URINARY SYSTEM

Normal

LOCOMOTOR SYSTEM

Normal

PROVISIONAL DIAGNOSIS

Chronic liver disease in decompensated state complicated with diabetes mellitus and hypertension.

INVESTIGATIONS

1. BLOOD ROUTINE

HB 8.9 TC DC P L 204 E 3.2
 ESR RBC PCV PLATELET COUNT 81000
 BLOOD GROUP & Rh
 RETICULOCYTE COUNT
 COAGULATION PROFILE
 BLEEDING TIME CLOTting TIME PROTHROMBIN TIME
 PERIPHERAL SMEAR

BONE MARROW PICTURE

2. URINE ROUTINE

PG ALBUMIN SUGAR
 ACETONE BILE SALTS BILE PIGMENTS
 UROBILINOGEN DEPOSIT

3. STOOL ROUTINE

OVA/CYST PARASITE OCCULT MUCUS

4. SPUTUM AFB 1..... 2..... 3.....

5. BLOOD SUGAR PROFILE FBS PPBS RBS 97 HBAIC 5.6

6. LIVER FUNCTION TEST S.BILIRUBIN: DIRECT 0.1 INDIRECT

SGOT 33 SGPT 24 ALKALINE PHOSPHATASE 69
 SERUM PROTEINS 6 ALBUMIN 2.5 GLOBULIN 3.5 A/G RATIO 0.7:1

7. RENAL FUNCTION TEST BLOOD UREA 54 BLOOD CREATININE 1.5

8. THYROID FUNCTION TEST T3 T4 TSH 150.

9. LIPID PROFILE

TOTAL CHOLESTEROL TRIGLYCERIDES HDL LDL VLDL

10. ENZYMES AND IMMUNOLOGICAL STUDIES

CPK CPK-MB TROPONIN DENGUE IgM LEPTO TRIDOT

TB ANTIBODIES WIDAL HBsAG HIV VDRL

11. CULTURE REPORTS

BLOOD URINE PUS SPUTUM

12. ECG

13. ECHOCARDIOGRAM

14. TREAD MILL TEST

15. X-RAYS

16. USG/DOPPLER

17. CT/MRI

18. PROCEDURES

FNAC/BIOPSY

CSF

PLEURAL FLUID/ASCITIC FLUID

19. OTHERS

TREATMENT

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
9/6/25	Patient conscious, oriented. BP- 140/80 mm Hg PR- 76/1' Chest - Breath sounds ↓ as ② c/o contipation.	1. Lnj Cefotaxim 1g q 8h 2. T Rifampine 600 mg 1-1 3. Syp Lactulose 15ml tid 4. Bowel wash 80 5. Lnj Pantog 40mg Bid 6. T Acetosa 500mg 1-1 7. T Thyronorm 15 1-0-1 8. Lnj vt 15 ampuke 9. Egg white 2-0-2 10. T Cardivas 3-1-25 1-0-1 11. T Aspirin 150mg 0-1-0 12. T Metor 50 1-0-1 13. T Lasex 40mg 1-1-1 14. T Ampicillin 500 1-1-1
10/6/25	Patient conscious, oriented. BP- 178/110 mm Hg PR- 80/1'	Repeat ① → ①*

TREATMENT(CONTD.)

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
11/6/25	Patient conscious, oriented. BP - 110/80 mm Hg PR - 82 bpm	Repeat ① → ①r
12/6/25	Patient conscious, oriented. BP - 130/90 mm Hg PR - 76 bpm Chest clear.	Repeat ① → ①r
13/6/25	Patient conscious, oriented. BP - 100/60 mm Hg PR - 84 bpm	- Fusidic ointment for LA. - Mephaheal ointment for LA

CONDITION AT TIME OF DISCHARGE

Patient stable
~~as~~

TREATMENT ADVICE ON DISCHARGE

1. T Defacurmine 550mg 1-1-1
2. T Aurorese 500 mg 1-1-1
3. T Thyronorm 150 1-0-1
4. High-protein diet.
5. Fluid restriction.
6. T Aspirin 75mg 1-0-0

Review after
2 weeks.

REVIEW FINDINGS

IF DIED :

DATE

TIME

IMMEDIATE CAUSE OF DEATH

CASE NO : 10.

DATE:

NAME: Nesha AGE: 49 SEX: F

ADDRESS: Ematulam

OCCUPATION: Cleaning staff INCOME:

IP.NO. 4946 WARD NO. E BED NO. DOA. 7-7-25 DOD. 8-7-25

PRESENTING COMPLAINTS:

1. Weakness of Ⓒ VL and UL
 2. Slurring of speech.
 3. Deviation of angle of mouth to Ⓒ side
- } α 2 days.

HISTORY OF PRESENT ILLNESS:

Patient was apparently normal 2 days back. At evening around 7 PM, when she woke up from sleep, she developed weakness of Ⓒ VL and UL and she was unable to get up from bed by her own. She walked with support initially, by dragging her legs. She was unable to wear shoes. Then she went to nearby hospital by around 7:30 PM. Then she developed weakness of left VL. Her husband noticed slurring of speech. Speech was not legible as before. She was obeying commands. Also noted deviation of angle of mouth towards Ⓒ side. No h/o seizure, fever, chest pain, palpitations, headache, vomiting. No h/o loss of temperature, pain, sensation, altered smell, difficulty in vision, diplopia, ptosis. No h/o abnormal sensation over face, no h/o dribbling of saliva, difficulty in chewing food, No h/o dysphagia, urinary incontinence, loss of consciousness.

PAST HISTORY AND TREATMENT: H/o HTN 15 years.
(INCLUDING ALLERGIES) No h/o DM, thyroid disorder, heart.
Asitic tap was done 5 years back. renal dis.

FAMILY HISTORY:

OCCUPATIONAL HISTORY:

SOCIO ECONOMIC STATUS:

GENERAL EXAMINATION

BUILD OF PATIENT: Moderately built and nourished.

GENERAL CONDITION OF PATIENT: Patient conscious, oriented.

PALLOR: ⊖

CYANOSIS: ⊖

CLUBBING: ⊖

ICTERUS: ⊖

DEPENDENT OEDEMA: ⊖

LYMPH NODES: ⊖

THYROID: Nil

PERIPHERAL PULSES: Full

SKIN: Nil

NAILS: Nil

equally bilaterally

HEIGHT:

WEIGHT:

VITAL SIGNS

TEMPERATURE: Afebrile

PULSE: 76/min

BP: 160/80 mmHg

RESPIRATORY RATE: 16/min

SYSTEM EXAMINATION

RESPIRATORY SYSTEM

INSPECTION: Deviated nasal septum, No nasal congestion, discharge.
Uvula, tonsils, pharynx - All. Trachea - appears to be central.
Chest movements - symmetrical. No supraclavicular hollowing.

PALPATION: No local rise in temperature/tenderness.
Trachea - central. Apex beat - not palpable. Chest expansion - sym.
VF - All. No creaking of ribs. No abnormal pulsations.

PERCUSSION:
Pecol percussion - Shift from R 5th $\rightarrow$ 5th L 5 as inspiration.
Resonant on corresponding areas of lung fields.

AUSCULTATION:
Air entry bilaterally equal.
Normal vesicular breath sounds heard
Wheezes (+)

CARDIOVASCULAR SYSTEM

INSPECTION: Trachea - central. Shape of chest and precordium - All.
Apex beat - not visible. JVP - not elevated.
No dilated veins, scars. No abnormal pulsations.

PALPATION: Trachea - central. Apex beat - not palpable.
No parasternal heave, thrill, palpable heart sound.
No 2nd/3rd pulsations.

PERCUSSION:
(R) heart border - (R) 5th L 5
(L) heart border - apex.
Upper border of liver - (R) 5th L 5.

AUSCULTATION:

Left	}	S ₁ S ₂ heard, normal	(No murmurs) added sound.
Tricuspid			
Aortic			
Pulmonary			

GASTRO-INTESTINAL SYSTEM

INSPECTION: Oral cavity - NI
Tongue, gums, palate, uvula, pharynx - NI
Shape of abdomen - NI. Umbilicus - central, level

PALPATION: No dilated veins, scars, pulsations.
No local rise in temp. No other pulsation.
No tenderness.

PERCUSSION:
Shifting dullness } -ve
Fluid thrill }

AUSCULTATION:

NI bowel sounds heard
No pleuritic / renal bruit

CENTRAL NERVOUS SYSTEM

(R) handed
Educator - 10th standard.

HIGHER FUNCTIONS:

General appearance and behaviour - NI

Conscious

Oriented to time, place and person

Memory

Intelligence } NI

Speech } slurring

No delusion / hallucinations.

CARNIAL NERVES:

I Sens. of smell - NI

II visual acuity, visual field
colour vision - NI

III, IV, VI No ptosis, myotonia
Eyeball movement - NI
Pupillary reflexes - NI

V Sensation on face - NI
Gaw jerk - absent
Reflexes - +

VII Angle of mouth - Right deviated

Nasolabial fold - Absent on left side

Taste - NI.

VIII No nasal regurgitation, deviation of uvula,
dysphagia
No dysarthria (+) ⇒ IX X

No
gradeness,
myotonia
valves

XI, SCM, Trapezius - NI

XII Tongue - NI

MOTOR SYSTEM: Bulk

	UL		LL		
	3a	3b	45	45	
Tone	NI	NI	NI	NI	Cspastic
Power	NI	2/5	NI	3/5	Hypertonic

DTRs are exaggerated on left side

Superficial reflexes - NI

SENSORY SYSTEM:

Somatic sensation
Posterior Column sensation } NI
Cortical sensation

CEREBELLAR SIGNS:

No cerebellar signs

MENINGEAL SIGNS:

No signs of meningeal irritation

SKULL AND SPINE:

NI

GAIT:

Not assessed

GENITO URINARY SYSTEM

Normal

LOCOMOTOR SYSTEM

Normal

PROVISIONAL DIAGNOSIS

Acute onset cerebrovascular Accident, with left hemiparesis, left arm facial palsy and urinary dysaesthesia. Right internal capsule lesion. Ischemic stroke, probably thrombotic in origin, affecting lenticulostriate branch of MCA with systemic hypertension and hypothyroidism.

INVESTIGATIONS

1. BLOOD ROUTINE

HB 13.2 TC

ESR 16 RBC

DC

PCV

P

L

35.1

E 12.3

PLATELET COUNT

352

BLOOD GROUP & Rh

RETICULOCYTE COUNT

COAGULATION PROFILE

BLEEDING TIME

CLOTTING TIME

PROTHROMBIN TIME

18.3

aPTT - 27.3

PERIPHERAL SMEAR

BONE MARROW PICTURE

2. URINE ROUTINE

PG

ALBUMIN

SUGAR

ACETONE

BILE SALTS

BILE PIGMENTS

UROBILINOGEN

DEPOSIT

3. STOOL ROUTINE

OVA/CYST

PARASITE

OCCULT

MUCUS

4. SPUTUM AFB

1.....

2.....

3.....

5. BLOOD SUGAR PROFILE

FBS

PPBS

RBS

HBA1C

6. LIVER FUNCTION TEST

S.BILIRUBIN: DIRECT 0.1

INDIRECT

SGOT

17

SGPT

13

ALKALINE PHOSPHATASE

55

SERUM PROTEINS

7.9

ALBUMIN

4.1

GLOBULIN

3.9

A/G RATIO

1.1:1

7. RENA

8. THYF

9. LIPID

TOTAL C

10. ENZ

CPK

TB ANTI

11. CUL

BLOOD

12. ECG

13. ECH

14. TRE

15. X-R

16. US

17. CT

18. PR

FNAC/

CSF

PLEUF

19. OT

7. RENAL FUNCTION TEST

BLOOD UREA 13

BLOOD CREATININE 0.5

8. THYROID FUNCTION TEST

T3

T4

TSH

1.06T

9. LIPID PROFILE

TOTAL CHOLESTEROL

TRIGLYCERIDES

HDL

LDL

VLDL

10. ENZYMES AND IMMUNOLOGICAL STUDIES

CPK

CPK-MB

TROPONIN

DENGUE IgM

LEPTO TRIDOT

TB ANTIBODIES

WIDAL

HBsAG

HIV

VDRL

11. CULTURE REPORTS

BLOOD

URINE

PUS

SPUTUM

12. ECG

13. ECHOCARDIOGRAM

14. TREAD MILL TEST

15. X-RAYS

16. USG/DOPPLER

17. CT/MRI

18. PROCEDURES

FNAC/BIOPSY

CSF

PLEURAL FLUID/ASCITIC FLUID

19. OTHERS

TREATMENT

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
7/7/15	Patient conscious, oriented. BP- 140/100 mm Hg PR- 72 bpm RR- 20/1'	1. BP monitoring 2. T Aspirin 75mg 0-1-0 3. T Clopidet 75mg 0-1-0 4. T Atorva 40mg 0-0-0 5. T Pantop 40mg 1-0-0 6. RT feed 200ml Q2H 7. T vit, B, C 1-0-1 8. T Teloni 40mg 1/2-0-0 9. T Desiphrilene 100mg 1-1-1 10. Neb budesonide & arthro Physiotherapy

TREATMENT(CONTD.)

DATE	PROGRESS OF PATIENTS	DOCTOR'S ORDERS
8/7/25	Patient conscious, oriented. PR - 82 bpm BP - 140/80 mm Hg RR - 16/1' Consult - Cardio, Nemo PMR c/o pain over $\odot$ leg Plan for discharge	1. BP monitoring 2. T Asparin 75mg 0-1-0 3. T Clopidet 75mg 0-1-0. 4. T Atorva 40mg 0-0-1 5. T Pantop 40mg 1-0-0 6. RT feed 200ml Q2H 7. T vit BC 1-0-1 8. T Tehni 4mg $\frac{1}{2}$-0-0 9. T Desiplylone 10mg 1-1-1 10. Nebu Budecort Akthalo 1-1- 11. T Euvatalp ran 10mg 1-0-0 12. Serflo natacept 250m 1-0-1

CONDITION AT TIME OF DISCHARGE

Patient stable

TREATMENT ADVICE ON DISCHARGE

1. T Aspirin 75mg b-i-o
2. T Clopidet 75mg o-i-o
3. T Atorva 40mg o-o-1
4. T Pantop 40mg o-o-1
5. T Telmi 40mg q-o-o
6. T Dextrophen 15mg 1-1-1
7. MDI Asthalin 2puffs BD x 5 days

Review in medium
OPD after 2 weeks

REVIEW FINDINGS

IF DIED :

DATE

TIME

IMMEDIATE CAUSE OF DEATH