

HYDROCELE

Mr.Elumalai,54 years male,Teynampet who is a Cab driver came with **chief complaints** of

Swelling in the left side of the scrotum for the past 5 years.

History of Presenting Illness

Patient was apparently normal before 5 years

He developed a swelling in the scrotal region

Insidious in onset

Slowly progressive to attain the present size

No aggravating and relieving factors

Does not reduce on lying down

No H/o pain

No H/o trauma

No H/o fever with chills and rigor

No H/o heavy weight lifting

No H/o loss of weight

No H/o loss of appetite

No H/o burning micturition

No H/o any other swelling

Past History & Personal history

Family history

Treatment history

General Examination

Vital Signs

Local examination - Inspection

Patient examined in standing position

Left sided scrotal swelling

12*10 cm , Oval in shape

Extends from pubic symphysis to bottom of the scrotum

Skin is stretched and shiny

Rugosity is lost

No dilated veins seen over the scrotum

No ulcer or discharge from the swelling

Cough impulse – negative

Penis in midline

Pubic Hair not seen

Palpation

Patient in standing position

Not warmth ,Not tender

Left sided swelling seen over the scrotum

15*13 cm ,Oval in shape

Extends from root of the scrotum to base of the scrotum

Not reducible

Able to get above the swelling

Fluctuation positive

Trans-illumination positive

Cystic in consistency

Testis not palpable –LEFT SIDE

Right side testis normal

OTHER SYSTEM EXAMINATION

Diagnosis

LEFT SIDED PRIMARY VAGINAL HYDROCELE

Specific Investigation - Ultrasound scrotum

Routine Investigation

Treatment

Jaboulay's method – eversion of sac

Lord's plication

SALIVARY GLAND SWELLING

Mr. Masthan Babu 29/M from chepauk who is a tailor came with

CHIEF COMPLAINTS

Swelling below and behind the left ear- 4 years

History of presenting illness

The patient was apparently normal 4 years back

Then he developed swelling just below and behind the left ear lobule for the past 4 years

Insidious onset, Gradually Progressive

No H/O fever , No H/O trauma

No H/O variation in size of the swelling or pain during meals

No H/O referred pain in the ear

No H/O difficulty in swallowing

No H/O sudden increase in size

No H/O pain over the swelling

No H/O difficulty in opening or closing the mouth or chewing food

No H/O deviation of angle of mouth or difficulty in closing eyelids

No H/O loss of weight, loss of appetite

Past history (recurrence M/c) / Personal history / Family history

General examination

Vital signs

Oral cavity examination

Nicotine stains present

No dental caries ,Tongue moist

Tonsils not enlarged in the left side,Uvula in midline

Local examination

INSPECTION-

A swelling is present in the region of parotid in the left side of

Size 5*3 cm, oval in shape,

Surface appears smooth

Skin over the swelling appears reddish and shiny,

Margins - well defined

No dilated veins over the swelling

Retromandibular groove – obliterated

Ear lobule – lifted

PALPATION

Not warm, not tender, Size 5 * 3 cm

Inspectory findings confirmed, Consistency-firm

Extent-superior- just below ear lobule inferiorly upto left angle of mandible

anteriorly-2 cm from tragus & posteriorly- 1 cm from mastoid process

Not fixed to skin, masseter or bone

Bimanual palpation- deep lobe is not palpable

Bidigital examination-stenson's duct palpable

FACIAL NERVE - No deviation of angle of mouth

Wrinkles present over forehead

Nasolabial fold – present

Eye closure is normal

Taste sensation – preserved

Examination of mandible- no mandibular thickening

Examination of lymph nodes- Preauricular nodes and neck nodes not palpable

Diagnosis- Pleomorphic adenoma of left parotid gland.

DD - Pleomorphic adenoma / Warthin's tumour Oncocytoma / Mucoepidermoid carcinoma(low grade)

Specific Investigations

FNAC OF LEFT PAROTID GLAND

CT Scan /MRI

Treatment - Superficial parotidectomy

DIABETIC ULCER

Mr.Subramani 58/M from Porur who is a cook came with **Chief Complaints of**

Wound in Left leg for 4 weeks

H/OPI :Patient was apparently normal before 4 weeks

Wound in medial aspect of lower half of left leg for 4 weeks

Started as a blister, burst out to become an ulcer ,insidious in onset, progressive in nature and it has attained present size

H/o yellowish discharge, scanty in amount and foul smelling.

H/o loss of sensation around ulcer

H/o limitation of movements in ankle joint

No h/o pain

No h/o trauma/ fever / burns

No h/o dilated veins

No h/o loss of weight / loss of appetite

Past History

Personal History

General examination

Vitals

Local Examination - Inspection

Site: ulcer in the medial aspect of distal half of left leg, upper limit extending 20 cm from tibial tuberosity and lower limit 4 cm from heel and it is 2 and 7 cm medial to shin of tibia of 20cm×5cm×2 cm

Irregular in shape

Margin: well defined

Edge : sloping

Floor: red granulation tissue

Discharge : scanty serous discharge

Skin hyper pigmented , scaly , edematous, loss of hair , brittle nails.

No varicose veins

PALPATION

Skin not warm, not tender

Inspectory findings of site, edge and margin are confirmed

Size 22×5×2 cm with indurated margins

Base: bone

Ulcer is not mobile & Does not bleed on touch

Dorsalis pedis and Posterior tibial artery pulsations are feeble in left leg.

Popliteal pulsations felt in left leg.

Sensation decreased in left foot.

No palpable lymph node

Other system examination

PROVISIONAL DIAGNOSIS - A case of chronic healing diabetic ulcer on the medial aspect of left leg with neuro-vascular deficit.

DD - Venous ulcer / Arterial ulcer

SPECIFIC:

Discharge C/S ,Edge biopsy

X-ray left leg and foot

BASIC:

Complete hemogram

Blood sugar, HbA1C,
lipid profile

Urine examination
for sugar and ketone

Arterial doppler

Renal function test

Fundus examination

Electrocardiogram

Chest X-ray

HbsAg , HIV-ELISA

TREATMENT

Lifestyle modification - diet plan / exercise / weight reduction

Control of blood sugar- insulin, hypoglycemics

Wound debridement, cleaning and dressing of wound

Appropriate Antibiotics Split skin graft

ADVICIE:

Foot care, MCR footwear, Screening for retinopathy, nephropathy& neuropathy

ORAL MALIGNANCY

Mr.Thirunavukarasu 43/M from Pudupet a Coolie with Chief Complaints of

Ulcer over left lateral margin of tongue for 6 months.

HISTORY OF PRESENTING ILLNESS:

Patient was apparently normal 6 months back

Developed ulcer over left lateral margin of the tongue

Insidious in onset

Started as a small ulcer opp. to 2nd molar tooth, progressed to attain the present size.

- Associated with pain for past 3 months

- Intermittent in nature

- Pricking type of pain

- Aggravated on taking foods

- No radiation of pain

No h/o difficulty in chewing

No h/o halitosis

No h/o difficulty in swallowing

No h/o discharge

No h/o difficulty in speech

No h/o loss of appetite

No h/o difficulty in opening the mouth

No h/o loss of weight

No h/o of excessive salivation

No h/o trauma

No h/o inability to protrude the tongue

No h/o recent falling of tooth

No h/o deviation of tongue

No h/o hemoptysis , pleuritic chest pain

No h/o alteration of voice

Past history / Personal history (Gutkha/Smoking) / Family history

General examination

Vital Signs

INSPECTION

Lips normal

Nicotene pigmentation on lips

No ulcers / No halitosis / No trismus

Dental formula –

2123	2123
2123	2123

Gums normal

Tongue –ulceroproliferative growth **3.5*2cm** involving middle part of left lateral aspect of tongue. Oval In shape with well defined margins and everted edges

Extent - 1 cm from tip of tongue and 1cm from midline

Floor - reddish with necrotic tissue

Mobility of tongue not restricted

Buccal mucosa normal

Floor of the mouth normal

Retromolar trigone not involved

PALPATION:

Tender

Ulcer does not bleed on touch

Inspectory findings confirmed

Base - indurated

Mandible - no thickening / irregularity

LYMPH NODE EXAMINATION: No palpable lymph nodes

OTHER SYSTEM EXAMINATION

Diagnosis - CARCINOMA TONGUE TNM STAGING – T2N0M0 (STAGE II)

INVESTIGATIONS :

Imaging – orthopantogram , CECT neck ,

MRI

Punch biopsy

VDRL

Upper gastrointestinal endoscopy

Treatment

Left Hemiglossectomy