DISCHARGE SUMMARY

DEPARTMENT OF CARDIOLOGY

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| HospitalID : | **2307901 / 369193** | PATIENT NAME: | **Utkarsh Angio** |
| AGE : | 44 Years | ADMITTED ON: | 26-05-2021 |
| SEX : | MALE | Date of Discharge | 09/Aug/2021 |
| BED NO : | C-M-02 | UNIT HEAD: | Dr.MANJAPPA M (Cardiology) MBBS,MD,DM |
| ADDRESS : | M L HUNDI TN PURA TQ MYSURU | Date of Birth: | 15-07-1999 |
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**DIAGNOSIS :**

ACUTE ON CHRONIC PULMONARY THROMBOEMBOLISM (SUBMASSIVE)

SEVERE PULMONARY HYPERTENSION

NORMAL BIVENTRICULAR FUNCTION, LVEF-68%

TYPE 2 DIABETES MELLITUS

HYPERTENSION

**HISTORY :**

Patient name Mr. Somu, 50 years, male, k/c/o DM, presented with c/o breathlessness on exertion- sudden onset, NYHA class II-III since 4 days, associated with one episode of giddiness and syncope 2 days back. On presentation, patient had hypoxia and high BP reading. RAT & RT PCR for Covid-19 were negative. ECG showed sinus rhythm, T wave inversion in II III aVF, V2-V6. He was initially admitted to ward under general medicine department for further evaluation.

**COURSE IN THE HOSPITAL :**

MRI Brain done in view of accelerated hypertension and giddiness at presentation, showed no evidence of acute infarcts/haemorrhage. 2D ECHO showed Dilated RA & RV, Mild TR, No RWMA, Normal LV systolic function, EF 68%, Severe pulmonary hypertension, RVSP 55mmHg. D Dimer was elevated. CT-pulmonary angiogram showed features suggestive of acute pulmonary embolism in RPA & LPA extending into upper and lower lobe segmental arteries, reduced calibre of right lower lobe segmental arteries with partial occlusion and calcified thrombuslikely chronic thromboembolism, few patchy areas of ground glass opacities in medial segment of right middle lobe-infective etiology. Patient was transferred to cardiology department for further management. He was treated with heparin, insulin, antiplatelets, statin, antihypertensives, proton pump inhibitors and other supportive medications. Patient improved symptomatically. He was started on oral anticogulants. Further ward stay was uneventful. Detailed report of investigations enclosed. He was discharged with stable condition with following advice.

**CONDITION AT DISCHARGE:** **STABLE**

**ADVISE AT DISCHARGE:** LOW SALT LOW FAT & DIABETIC DIET

TAB. RIVAXON/EXAFIB 15MG Once Daily - Night X CONTINUE CAP. ECOSPRIN-AV 20MG Once Daily - Noon X CONTINUE TAB. MINILACTONE 25MG 0-1-0 X CONTINUE TAB. GLIMISAVE MV 2.2MG 1-0-1 X CONTINUE (BEFORE FOOD) TAB. HOMOCHECK 10MG Twice Daily - Morning and Night X CONTINUE TAB. PANTOCID 40MG 1-0-0 X 14 DAYS (BEFORE FOOD)

**\*DON'T STOP ANY MEDICATION WITHOUT CONSULTING DOCTOR**

**Contact in Emergency**

1.Diarrhoea, Nausea,Vomiting

2.Constipation,Fever

**IN CASE OF EMERGENCY/URGENCY PLEASE CALL 0821-2335000 OR VISIT EMERGENCY SERVICES AT GROUND FLOOR OF HOSPITAL WHICH IS OPEN 24X7X365. DIAL OUR EMERGENCY AMBULANCE HELPLINE NUMBER TO SEEK MEDICAL HELP: 14455 (24/7)**

Review with **Dr. Manjappa M, MD, DM** in Cardiology OPD on Tuesday / Friday after 1 week. For appointment please contact **0821-2335261.**

**Prepared by : Dr. Poornima K S Verified by : Dr. Manjappa M**

**Discharged Date & Time : Discharged By :**

**Dr. Manjappa M., MD, DM**

**Assistant Professor**

**Interventional Cardiologist**

**KMC No. - 50878**

Dr.MANJAPPA M (Cardiology)