

CASE 18

Name Thirappa

Age 49 yrs

Gender Male

Address Mysore

Chief Complaint loss of appetite
Vomiting] x 15 days

HPI

The patient was apparently asymptomatic 15 days ago when he developed complaints of vomiting, which was sudden in onset gradually progressive, non projectile, non bilious, occurred 10-15 mins after food intake, vomit consisted of food particles, vomiting was relieved by medicine.

Symptoms of vomiting led to loss of appetite.

There is a n/p weight loss of appetite about 2-3 kg / 15 days.

No H/o haematemesis
fever
cough { passed stool
constipation { passed black stool

Past History

Had on and off stomach pain x 2 yrs (details not told)

No H/o similar complaints in past.

No H/o major surgery.

He is a known case of diabetes mellitus x 15 yrs but is on medication from last 2-3 years only.

Personal History:

Mixed diet

Normal Bowel and Bladder.

Decreased sleep

Decreased appetite

weight loss of - 2-3 kg / 15 days

Habits → Alcohol → 20 years → 180 ml / day

stopped 5 days back

→ NO H/P smoking / tobacco

Family history:

nothing significant

examination:

The patient was conscious, cooperative, oriented to time place and person.
The patient was well built and well nourished.

VITALS: Pulse - Rate - 100 beats/min

Rhythm - Regular

Volume - { Normal
Character - {

Condition of arterial wall - Good

Radio - Radial Delay { Present

Radio - Femoral Delay

Temperature - Afebrile

SpO₂ - 96 %

Bp - 126 / 80 mm of Hg

taken in supine position on right arm.

Respiratory Rate - 16 breaths / min

General Physical Examination

Pallor
Ictereus
edema } Present

Clubbing
cyanosis
dysphagia/painy } Absent

Abdominal examination:

INSPECTION: Shape - distended

flank fullness is present.

creased umbilicus

Movement of abdomen with respiration is equal in all quadrant

multiple hyperpigment macules are present all over the trunk and back.

No visible mass, dilated veins, pulsations, peristalsis.

PALPATION: Superficial tenderness absent

No local rise in temperature

No hepatosplenomegaly

Percussion: Shifting dullness present

Find trill

Liver span -

AUSCULTATION: Bowel sounds are heard.

Respiratory system - normal vesicular breath sounds B/L, no additional findings

Cardiovascular system - S₁ and S₂ heard, no murmur

Central nervous system - no focal neurological deficit

Provisional diagnosis - Alcoholic liver disease.

CASE 2:

Name - Aruna

Age - 25 years

Sex - female

Address - Kurla

Occupation - housewife

Marital status - unmarried

Chief complaint - breathlessness x months

R/L lower limb swelling x months.

HPI's

Patient was apparently asymptomatic 1 month ago when he developed breathlessness.

① Breathlessness - insidious onset

Gradually progressive

occurs only on exertion

starts after walking 500m

relieves on taking rest

each episode lasts about 5 minutes/day

NO H/O sinus variation, positional variation, chest pain, cough or fever.

NYHA Grade II breathlessness.

② Limb swelling - insidious onset

Gradually progressive

appeared in both limbs at the same time

equal in both limbs

increases on walking

relieves on taking rest

NO H/O pain or redness

NO H/O staining

NO H/O skin changes.

Past history: no H/O similar complaints.

Personal history:
Mixed diet
Normal adequate sleep
Bowel and bladder movements are normal
no H/O any substance abuse.
no H/O any comorbidities

Examination:
The patient was conscious, cooperative and oriented to time, place and person

Family history:
nothing significant

Treatment history:
The patient present to Govt. hosp. Kastala 1 week ago for same complaints
Prescribed medication for symptoms, condition did not improve and come to K.H.

Examination:
The patient was conscious, cooperative, oriented to time place and person
Moderate built and nourished

VITALS:
① Pulse - 76 beats/min, regular, normal volume, normal character, good vessel wall condition. No radio-radial delay, no radio-femoral delay. All peripheral pulses felt.

② BP - 140/80 mm of Hg, left arm in sitting

③ RR - 35/min, Abdomino thoracic

④ Temp - Afebrile

⑤ SpO₂ - 95%,

General physical

Pallor
Icterus
cyanosis
Clubbing
lymphadenopathy } Absent

Edema - Pitting edema in BL lower limb just above medial malleolus.

CVS

- ① INSPECTION - chest wall normal, no deformities
Apex beat was visible in lower left part of chest.
no dilated veins
Trachea was central.
- ② PALPATION - Apex beat localized in 5th ICS lateral to mid clavicular line
- Parasternal Heave present in 3rd & 4th ICS
- NO thrill
- ③ AUSCULTATION - Mitral - } S₁ and S₂ heard
Tricuspid - } no murmur
Aortic - } no murmur
Pulmonary - S₁ - normal
S₂ - split

Respiratory system
Abdomen

central nervous system

} Normal.

Provisional diagnosis : Heart failure right sided

CASE 3

A 55 yr old male patient Ramdas Nayak Resident, resident of Kurla and fisherman by profession present to medicine OPD

chief complaint

weakness of left arm and left leg x 2 days

HOP I

Weakness - ~~sudden~~ 2 days ago he woke up at 4 am and noticed he is unable to move his left arm and left leg.

onset - sudden

progression - The control of his left arm and left leg is better now with treatment

There is no associated pain

NH/D trauma, slurring of speech, confusion, no vision loss, no diplopia, dysphagia, no headache

Past History

Similar complaints -

DM x 2 ~~days~~ on mediation

Family History

nothing significant.

Personal History

Mixed diet

Adequate sleep

Normal BP.

Habits - Quit alcohol 10 years back

Examination:

The patient was conscious, cooperative, oriented to time place and person

well nourished and well built

Vitals: Pulse - G2 beats/min, normal rhythm, normal volume, normal character, good arterial wall condition, no bruits, no radio-radial delay, no radio-femoral delay.

All peripheral pulses felt

Temperature - Afebrile

RR - 20/min.

SpO₂ - 99%.

PB - 100/70 mm of Hg (R) arm in sitting position

Head to toe

No loss of hair

→ frowning symmetrical

(+) side nasolabial fold ↓

(-) side of mouth deviated ↓

oral hygiene was poor, multiple dental caries present, teeth were central, tongue central.

neck - no swelling or engorged vessels

nails - had fungal infection

General

Pallor

Icteus

Cyanosis

} ABSENT

{ Clubbing
Edema
Lymphedema

CNS:

Mental status examination

Physical appearance - Good, cooperative, (R) psychomotor activity

Attention & concentration - intact

Speech - (R) fluent

Mood and affect (R)

Memory - Immediate, recent and remote intact

Thoughts - Good, no delusions

Perception - no hallucinations

Insight - (R)

Judgment - Good.

<u>Examination of cranial nerves</u>		<u>Right</u>	<u>Left</u>
I Olfactory		Normal	Normal
II Optic	CR	accommodation +	CR accommodation +
III, IV, VI Oculomotor			
Trochlear			
Absentness.			
		extra oculomotor movements normal in all directions no ptosis	
V Trigeminal		sensation +	sensation +
		naso labial fold +	Nasolabial fold -
VI Facial.		no drooling of saliva	no drooling of saliva
		-	Angle of mouth deviated to right side
VII	Brewing (N)		
VIII	Glossopharyngeal (N)		
IX	Glossopharyngeal (N)	Gag reflex +	
X	Vagus	no shivering of speech	
XI	Spinal accessory	no nasal tone int in speech.	
XII Hypoglossal		Head turn to right side + resistance +	
		central tongue no deviation	

<u>Motor system</u>	<u>Right</u>	<u>Left</u>
Attitude.	VL - normal LL - normal	VL - normal LL - flexion and external rotation
Brisk	VL] no atrophy	VL] no atrophy.
Powers.	VL] 5/5 LL]	VL - 3/5 LL - 3/5.
		weak hand grip.
<u>Hand grip</u>	(N)	

Reflexes

Biceps

right

left

Triceps

✓

right
left

right

left

knee

✓

✓

right
left

Ankle

✓

✓

right
left

Abdominal

✓

right
left

right
left

Plantar

✓

right
left

right
left

Clonus present

right
left

Brisk reflexes

right
left

Coordination: Fingere nose test.

right
left

No dysdiuknia

Heel knee test (X)

right
left

CVS: Apex beat palpable.

S₁, S₂ heart no murmur

④ pulsation

BP: Systolic 120 mm Hg diastolic 80 mm Hg

④

④

RS: Abdominothoracic breathing

B/P: vesicular breath sound from both

no additional sounds.

Abdominal: All quadrants move with respiration

umbilicus - central

no hepatosplenomegaly

Diagnosis: VMI haemorrhagic stroke of middle cerebral artery.

CASE 4:

Name - Nirmala

Age - 57

Sex - Female

Address - Davangere

Occupation - Housewife.

Chief complaints Facial puffiness x 10 days

B/L lower limb swelling x 4 days.

HPI:

The patient was apparently asymptomatic 10 days ago, when she noticed swelling of her face which was insidious in onset and non progressive. No diurnal variation. No H/O fever, abdominal distension, jaundice, blood in stool, no H/O vomiting, breathlessness, allergy.

The lower limb swelling was sudden in onset. Appeared simultaneously on B/L legs. was progressive as the day progressed and did not resolve on taking rest.

No H/O orthopnea & PND

No H/O chest pain

No H/O cough.

Past history.

25 years ago, she was diagnosed and treated from pulmonary TB.

3 years ago had B/L, gave rise to pulmonary embolism. 5 years ago was diagnosed R sided heart failure (currently on medication).

Diabetes] x 2 yrs. (On regular medications)
hypertension

Family history

Nothing significant

Personal history

Vegetarian diet

Appetite }
By S } normal
Sleep }

No Habits

General Examination

Patient was conscious, cooperative, oriented to time, place and person.

VITALS:

Pulse - 78 beats/min

Regular rhythm

Volume] normal

Character] Good artery wall conditions

Radio-Radial delay] Absent

Radio-Taminal delay] No pulsations

BP - 120/70 mm of Hg @ arm supine position

RR - 20 breaths/min

SpO₂ - 97%

Temp. - Afebrile

Pallor

Icterus

Cyanosis

Lymphadenopathy

Absent

Clubbing \oplus

Pitting edema \oplus P/F till arm above medial malleolus

Cardiopulmonary System.

22/2/2023

Inspection - (N) shape of chest
Apex beat could not be seen
No visible scars / sinus.
pericardial bulge.
adventitious pulsation

Normal heart shape

apex off

Scars / sin-

pericardial bulge

adventitious pulsation

Palpation - Apex beat could not be palpated

No palpable mueses

Parasternal heave present in apical mammary area

Normal heart

mueses

apical heave in apical mammary area

Auscultation - S₁, S₂ heard in M, I, P, A areas.

Abnormal findings - loud P₂ heard in pulmo nary area.

No mueses.

Apical heave with mueses

Respiratory system

Inspection - central trachea, no chest abnormality

(N) chest movements, thoraco-abdominal breathing

Palpation - inspection findings confirmed

vocal fremitus equal b/l

Percussion - b/l resonant

Auscultation - (N) vesicular breath sounds heard in all areas

except (I) mammary, suprascapular, Interscapular areas
where crepitations are heard (Velcro type)

CNS exam: No focal neurological deficit

Diagnosis:

V/L Restrictive lung disease, interstitial lung disease, not in respiratory failure with pulmonary arterial hypertension?

CASE 5:

Name Siddana

Age 55 yr.

Sex male

Address Davanagere

Occupation Farmer

Chief complaint

fever

cough

for 15 days. Dry cough. No sputum.

HPI: The patient was apparently asymptomatic 15 days ago when he fever was insidious in onset, intermittent in nature, not associated with chills and rigor.

→ No diurnal variation

→ No Aggravating factors

→ Relieved by taking medication

→ Patient also complains of cough since 15 days

insidious in onset
progressive in nature

No A/R factors

No diurnal variation

Cough is associated with expectoration & since the sputum was blood tinged

Thin mucoid consistency, scanty quantity, no foul smell

Cough is associated with breathlessness, left shoulder pain, flank pain and back pain

No H/O of nausea/vomiting

wt. loss

chest pain

wheezing

Allergy.

Past history.

Hypertension x 10 yrs - on regular medication

Personal history

Veg-diet Good appetite
BS - normal

Sleep ↓

No habits

Family history

This wife also had similar complaints but fully resolved on taking medication

Examination

The patient is conscious, cooperative, oriented to time, place and person.

well built and well nourished.

General

Pallor

Icterus

Cyanosis

Clubbing.

Edema

Lymphadenopathy

Present: mild tachycardia [slow] [soft] and bradycardia [fast] [loud]
Absent: mild tachycardia [fast] [soft] and bradycardia [slow] [loud]

Vitals

Pulse - 100 beats/min

- Regular rhythm

- normal volume.

Normal character [good arterial wall]

- Radio - Radial delay] ⊗ condition

- Radio - Femoral delay - All peripheral pulses feet

B.P - 120 / 80 mm of Hg - supine position, left upper limb

RR - 24 breaths/min - abdominal thoracic - breaking

Afebrile on touch

No General physical abnormality

JVP - ⊗

Respiratory system

Upper Resp. tract

Good oral hygiene

Tonsils, PNS tenderness, SNS, Post nasal drip → Aspirant, hoarseness, nasal pharynx

Lower Resp. tract

Inspection: elliptical - shape of chest

Normal - spine

NO deepening of shoulder

Central trachea

NO use of accessory muscles

Apex beat not visible

Symmetrical chest.

No scars / sinus / dilated veins.

Decreased but symmetrical chest movements

Palpation: All the postero findings are confirmed

central trachea

Apex beat - left 4th intercostal space

Symmetrical chest movements

Resonant vocal fremitus

No palpable - ronchi.

Measurements: AP diameter - 25cm

Transverse - 35cm

Chest circumference - 114cm

Chest expansion

Percussion - stony dull in outer left suprascapular region.
Auscultation - BPI vesicular breath sounds.
crepitacions in outer left infrascapular region.
normal vocal resonance.

CNS - S₁ and S₂ heard, no meninges

Abdomen - soft, non-tender, no hepatosplenomegaly

CNS - no focal neurological deficit.

Provisional
diagnosis v/p left sided lung consolidation of
infectious etiology, not in respiratory
failure, not in cor pulmonale.