**DISCHARGE AGAINST MEDICAL ADVICE**

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| **UHID No : KH1000634780** |  | |
| **Name: Mrs Kajal Laxman Krishnani** | **Age : 60 years** | **Sex : Female** |
| **Date of Admission : 21/01/2023** | **Date of DAMA: 24/01/2023** | |
| **Treating Doctor : Dr. Sunil Pai** |  | |

**Other Consultants**

Dr Manoj jain (General Surgeon)

**Problem List**

Ileostomy Bag Bleed

Sepsis with Septic Shock with Coagulopathy

Acute Kidney Injury

**Past History**

Diabetes Mellitus

Hypertension

Hyperthyroidism

Ca Right Ovary with Metastasis s/p TAH+BSO, Post ileostomy done

**Presenting Complaints:** Patient came with c/o bleeding from ileostomy bag. Also had c/o fever with chills since 2 days.

**COURSE IN HOSPITAL** **:**

Patient was admitted to ICU with above mentioned complaints. Patient’s vitals on admission were: BP-90/60 P/O2-112/100% on RA, RR-18/m, T-98 F. Patient was transfused 2 units PRBC on 21/1/23. Patient was started on IV antibiotics with Inj Meropenem 1GM IV BD,Inj Vitamin K 10mg STAT was given and IVF with 1/2NS + 2amp NaHCo3 was started in view of metabolic acidosis. Inotropic support with Norad was started in view of hypotension. Lasix infusion in view of Acute kidney injury. Patient was transfused another 3PP unit PRBC and 4 units FFP on 22/1/23.

Reference to Dr Manoj jain was given and his advice followed.

Urine C/S was sent and report awaited.

Lasix infusion was stopped and switched to Inj Lasix 20mg 1-0-1. Inotropes requirement decreased and urine output was adequate.

As per relatives request they wish to go DAMA , will need to trace culture sensitivity reports .

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Patient discharged with lt ijv triple lumen catheter inserted on 21/01/23 and foleys catheter in situ ..

**ONGOING TREATMENT**

1. Inj Meropenem 1GM 1-0-1 started on 21/01/23 .
2. Inj Somzo 40mg 1-0-1
3. Inj Vit K 10mg OD
4. Inj Lasix 20mg 1-0-1
5. Tab Neomercazole 2.5mg 1-0-0
6. Tab Pregabid-NT 75/10mg 0-0-1
7. Tab Optineuron 1-0-0
8. Hhfudic Cream for L/A 1-1-1
9. Lulifin Cream for L/A 1-1-1
10. T-Bact Ointment for L/A 1-0-1
11. Tab Trajenta 5mg 1-0-0
12. Tab Paracetamol 500mg SOS
13. Tab Buscopan 10mg 1-0-1
14. IVF – ½ NS + 2amp NaHCo3
15. Inj Lasix infusion
16. Inj Norad @ BP

**Dr. SUNIL PAI**

**CRITICAL CARE MEDICINE CONSULTANT**

**Kokilaben Dhirubhai Ambani Hospital**

**Andheri ( West )**

**Mumbai**

|  |  |
| --- | --- |
| **Treating Doctor : Dr Vatsal Kothari** |  |

**Other Consultants**

Dr Tanu Singhal (ID Specialist)

Dr. Mohit Bhatt (Consultant Neurology)

**Problem List**

Aspiration Pneumonitis with Sepsis

Metabolic/Septic Encephalopathy

Accelerated Hypertension

**Past History**

Diabetes Mellitus

Systemic Hypertension.

Hypothyroidism.

Progressive Supranuclear Palsy. (Stopped medications on self since 6 months)

**Presenting Complaints**:

Patient came with c/o fever since 1-2 days with progressive drowsiness and reduced oral intake since 2 days.

**COURSE IN HOSPITAL**:

Patient was admitted to ICU in view of above complaints. Patient relatives (son and daughter) gave history of stopping all his old medications and routine consultation with Neurologist since last 6 months. His previous medications included- thyroid supplementation, oral hypoglycemic, oral anti- hypertensive medications and anti- parkinsonian medicines.

Vitals on admission were: HR-92/min, SPO2-94% on RA, BP-160/100mmHG, RR-17/min T-97.8 degree F, and HGT-190 mg/dl. GCS was 10/15.

The initial labs revealed leukocytosis (TLC > 20000) and CRP of 149. The blood and urine cultures were sent and the patient was started on broad spectrum IV antibiotic (Piperacillin- Tazobactum). The patient was continued with supportive treatment with IV fluids, IV Analgesics, Nebulization with Duolin/Budecort and IV Multivitamins. After initial stabilization the patient was shifted to ICU. The relatives were counselled and explained about the condition of the patient and further plan of management.

The working diagnosis was acute febrile illness. The flu panel was sent which was negative.

The Peripheral Smear for Malaria Parasite/Rapid Malaria Antigen was negative

The Dengue workup (Dengue IgM/IgG/NS1 antigen) was negative as well.

The patient became hypoxic and started requiring supplemental oxygen through nasal prongs. The patient’s blood pressure was high and hence was started on IV NTG infusion. The patient’s cough reflex was poor and airway protection was suboptimal. The patient had difficulty in swallowing and was clinically aspirating. Ryle’s tube insertion was advised to ensure safe enteral feeding and for giving medications. The relatives (DAUGHTER-SEEMA VARMA) were counselled and explained about the need of the Ryle’s tube insertion however the relatives were unwilling for the same. The neurology opinion was taken from Dr. Mohit Bhat who agreed with the plan of Ryle’s tube insertion. The relatives were again explained about the need of Ryle’s tube insertion; the relatives remained undecided.

The reference was given to Dr. Tanu Singhal (Infection Disease specialist) in view of aspiration pneumonitis. The ongoing antibiotic management was to be continued.

CT Chest/Abdomen done showed multiple nodules in right middle lobe and right lower lobe with multiple patchy consolidations suggestive of infective etiology. Areas of ground glass opacities were also seen in right and left upper lobes. Prostatomegaly and minimal perivesicular fat stranding also seen.

The 2D Echo done showed LVEF-55% with no RWMA with mild PH seen.

The patient continued to remain drowsy. The airway protection was suboptimal and the patient was clinically aspirating. The swallow assessment was done to objectively determine the safety in initiation of the oral feeds. The assessment showed delay in swallow initiation. Post swallow assessment there was a strong recommendation to keep the patient nil by mouth and to look for alternate means of nutrition and medications.

The relatives were again counselled and explained about the need of Ryle’s tube insertion. The relatives again refused for the Ryle’s tube insertion.

IV Labetalol and NTG infusion continued as oral anti-hypertensives could not be given due to swallow dysfunction.

Potassium correction was given with 1/2NS+10meq KCL

On 06/08/2023 Relatives agreed for insertion of Ryle’s tube. RT was inserted and planned for starting oral antihypertensives and feeds.

Presently the patient is oxygenating well on room air. The patient remains hypertensive requiring IV NTG and labetolol infusions. The patient is drowsy. The airway protection remains suboptimal.

The patient needs further ICU stay and further critical care monitoring and management. The relatives have been explained about the same. The relatives want to take discharge against medical advice. The relatives have been explained that this can cause deleterious effects on the clinical condition of the patient. The relatives have been explained about the possibility of life threatening complications arising from the uncontrolled blood pressure and aspiration pneumonitis. It has been explained to them that the patient needs to complete the course of IV antibiotics.

All the queries of the relatives have been answered. The relatives want to take discharge against medical advice; hence discharging the patient.

**ONGOING TREATMENT**

1. Inj Piptaz 4.5GM IV 1-1-1
2. Inj Pan 40mg IV 1-0-0
3. Inj Optineuron 1amp IV OD
4. Inj Paracetamol 1GM IV SOS
5. Inj Thiamine 500mg in 100ml NS OD
6. Tab Thyronorm 50mcg 2-0-0
7. Candid M/P 1-0-1
8. Duolin Neb 1-1-1
9. Budecort Neb 1-0-1
10. IVF with NS @ 80ml/hr.
11. Inj Labetalol @ BP IV infusion
12. Inj NTG@BP IV infusion

**Patient is discharged against medical advice.**

**Dr. VATSAL KOTHARI**

**DIRECTOR**

**CRITICAL CARE MEDICINE DEPARTMENT**

**Kokilaben Dhirubhai Ambani Hospital**

**Andheri ( West )**

**Mumbai**

**This is a Provisional summary. Kindly collect the final corrected version of Discharge against medical advice summary latter.**

**DAMA SUMMARY**

|  |  |  |
| --- | --- | --- |
| **UHID No: KH1000827061** |  | |
| **Name : Mrs. Trusha Hiten Gandhi** | **Age : 39 Years** | **Sex :Female** |
| **Date of Admission : 13/05/2023** | **Date of Discharge:** **18/05/2023** | |
|  | **Treating Doctor: Dr. SOURABH PHADTARE** | |

**OTHER CONSULTANT:**

**Dr. Sandeep Govle (Consultant Oncology)**

**Dr. Vidhi Shah (Consultant Oncosurgery)**

**Dr. Akshat Kayal ( Consultant Neurosurgery)**

**DIAGNOSIS;**

**Multiple Metastatic lesion in brain with midlinbe shift**

**K/C/O Carcinoma Of Right Breast.**

**Past history**

K/C/O Carcinoma of right breast diagnosed in July 2022

Underwent Right MRM +SLNB+ chemoport insertion on 25/07/2022

Received 4 cycles EC+dose dense Paclitaxel, was on Tab Tamoxifen 20 mg OD, last dose 15/11/2022.

**Presenting Complaints**

Headache with nausea since 4-5 days.

Altered sensorium since 1day

Drowsiness with decreased responsiveness ,restlessness so patient shifted to Life Line Hospital (PNH) where CT brain +MRI diffusion done on 12/05/2023:-multiple varying sized hererogenous enchancing mass lesion with adjacent edema in fronto-temporo-parietal region, likely metastasis. Patient received antiepileptics, steroids, Inj. Mannitol Neurosurgery team advised surgery, referred to KDAH for further management.

**Course in hospital:**

Patient brought with above mentioned complaints by relatives in Kokilaben Dhirubhai Ambani Hospital on admission in A&E . Patient was drowsy GCS—8/15 E1V1M5 with pupil-2.5 mm sluggish reactive, pulse-55/minute, BP-140/70 mmHg, SPO2-98%, HGT-168 mg/dl. Patient received in inj. Mannitol and shifted to icu. Patent intubated I/V/O of low GCS and central line and arterial line inserted, blood gasses shows-severe metabolic acidosis with lactic acidosis so correction started. Patient kept on ventilator and sedated and paralysed. MRI Brain was done s/o multiple parenchymal SOL in bilateral cerebral hemisphere, mild uncal herniation.

Patient was referred to Dr Akshat Kayal ( Consultant Neurosurgery) advice PET CT and to refer to Dr Sandeep Goyle after PET CT. PET scan was done on 16/05/2023 suggest 6\*2.3cm sized cystic collection in right mammary region/axilla. Multiple metabolically active rim enhancing lesions in cerebral parenchyma involving bilateral frontal lobes, left occipito-parietal and left cerebellum measures 2.6\*2.3cm. No evidence of metabolically active disease elsewhere within the body. Reference was given to Dr Sumeet Basu ( Radiation Oncology) for WBRT as advised by Dr Goyle and continued on Inj Mannitol, Inj Levipil, Inj Dexa. Advice Whole brain RT by Dr Sumeet Basu. Patients relatives had been explained about the scan reports, and the need of urgent WBRT, also the side effects of the same like increasing cerebral odema post RT, and the need of urgent surgery in case of worsening cerebral odema.

Patient was gradually weaned off from ventilator and extubated on 16/05/2023. Swallow assessment was done and started oral feeds. Patient was reviewed by Dr Akshat Kayal, the plan of decompressive craniotomy sos if needed has been discussed with the relatives. Relatives wish to take discharge home.

On 18/05/2023 patient was reviewed by Dr Goyle, relatives has been counselled about RT. Relatives wish to take WBRT outside. Advice OPD review with Dr Goyle 3-4 days post completion of WBRT for systemic therapy. Also advice to continue Tab Levipil 500 mg BID and Tab Dexa 4 mg TDS for 5 days then 4 mg BID till OPD review also to stop Inj Mannitol. Advice DAMA.

**Treatment in hospital:**

Inj Supacef 1.5 gm 1-0-1

Inj Levipil 500 mg 1-1-1

Inj Pan 40 mg 1-0-1

Inj Emset 4 mg 1-1-1-1

Inj Mannitol 50cc 1-0-1

Syp Cremaffin 15 ml 0-0-1

Coconut water 100 ml 1-0-1

**DR.SOURABH PHADTARE**

**CONSULTANT CRITICAL CARE**

**KDAH**

**DAMA SUMMARY**

|  |  |  |
| --- | --- | --- |
| **NAME: Mr. Syed Mumtaz Ali** | **Date of Admission : 13/02/2023** | |
| **UHID :KH1000232323** | **Age : 84 yrs.** | **Sex : Male** |
| **Date of Discharge : 15/02/23** | **Treating Consultant: Dr. Amit Raodeo** | |

**Diagnosis**

Acute Coronary Syndrome – NSTEMI with Cardiogenic Shock

Pulmonary edema

Type 2 respiratory failure

Community acquired pneumonia

Atrial Fibrillation

**Past History**

Carcinoma Prostate

Hypertension

**Reason for admission**

Rhintis and dry cough

Progressive exertional dyspnea

**Course in Hospital:**

The patient was brought to the emergency department with worsening of the above mentioned complaints on 13/02/2023.He was a known case of Carcinoma Prostate and Hypertension and was on radiotherapy, last fraction on 06/02/2023.

On arrival BP was 180/80, HR 170bpm atrial fibrillation, respiratory rate was 30/min and Spo2 was 82% on room air, he was kept on NRBM 15L O2/Min. Pitting pedal edema was present and the patient was drowsy. Chest X-ray showed pulmonary edema and left lower zone consolidation. ABG showed severe respiratory acidosis and type 2 respiratory failure and drowsiness gradually increased. Stat dose of magnesium sulfate, diuretics, hydrocortisone and first dose of Inj Clexane, Inj Piptaz and Levoflox were given.Inj Noradrenaline infusion was started in view of hyotension. He was started on NIV since there was no improvement with NRBM and was shifted to ICU for further management.

In the ICU patient was gasping and sensorium significantly declined, and the patient was intubated and started on mechanical ventilation. HsTrop I was 1204 and NT pro, screening 2D Echo showed reduced EF and posterior wall hypokinesia. Dr Sunil Wani advised cardiology intervention after hemodynamic stabilization, dual antiplatelets and statin were started. A fluid restriction of 1.2-1.5 L was followed. Electrolyte imbalances were corrected .Inspite of aggressive management S.creatinine, serum transaminases and serum sodium started rising, inotrope requirement increased and patient was started on Inj Vasopressin, phenylephrine and adrenaline for persisting hypotension.

On 15/02/2023 Inotrope and FiO2 requirement further increased with decreased urine output, and the relatives were explained regarding the current critical condition and guarded prognosis. The need for Intra-aortic Balloon Pump was explained. However relatives wish to discharge the patient against medical advice. The risks and possible mishaps during discharge and transfer has been explained to the relatives. The patient is being discharged against medical advice as per the relatives’ wish.

**Treatment during hospitalization**

Inj Monocef 1gm IV 1-0-1

Inj Pantop 40mg IV 1-0-1

Inj Lasix 10mg IV 1-1-1

Inj Noradrenaline IV infusion according to BP

Inj Adrenaline IV infusion according to BP

Inj Frenin IV infusion according to BP

Inj Vasopressin IV infusion according to BP

Tab Azee 500mg 1-0-0

Tab Ecospirin 75mg 0-1-0

Tab Clopidogrel 75mg 0-1-0

Tab Atovastatin 80mg 0-0-1

Syp Kesol 5ml 1-1-1

Syp Cremaffin 30ml 0-0-1

**KDAH**

**Date: 15/02/2023**

**Dr Amit Raodeo**

**Consultant Intensivist**

**DISCHARGE SUMMERY**

|  |  |  |
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| **UHID No : KH1000825832** |  | |
| **NAME: Mr. Avantikumar Shah** | **AGE : 87Years** | **SEX : Male** |
| **Date of admission : 01/03/2023** | **Date of discharge:** | |
| **Treating Doctor : Dr Khushboo Kataria** |  | |

**Other Consultants**

Dr. Amol Ghalme ( Consultant Plastic Surgeon)

Dr. Niranjan Kulkarni ( Consultant Nephrologist)

Dr. Tushar Raut( Consultant Neurologist)

Dr Venkat D Nagarajan (Consultant Cardiologist & Eletrophysiologist)

Dr Prashant Nair ( Consultant Cardiologist)

**DIAGNOSIS**

Acute Congestive Heart Failure( LVEF- 30%)

Atrial Fibrillation with Fast Ventricular Rate/ Ventricular Tachycardia

Acute Kidney Injury

Lower Respiratory Tract Infection

**PAST HISTRY**

Hypertension

Hypothyroidism

Chronic Obstructive Pulmonary Disease

Ischemic Heart Disease(S/P CABG-2023) with Congestive Cardiac Failure

H/O -LV Apical Clot (july 2022)

-Left Popliteal Deep Venous Thrombosis(july 2022) on tab. Eliquis 2.5mg

-Right Lower Limb Cellulitis(july 2022)

S/P Left TKR

**PRESENTING COMPLAINTS:**

Dyspnea on excertion since 3 days

Coughing since 3 days

Breathlessness since 3days

Decreased urine output since 3 days

**COURSE IN HOSPITAL:**

The patient came with above mentioned complaints in kokilaben dhirubhai ambani hospital. On admission in A&E -pulse-122/minute,SpO2-97% on room air, BP-134/70mmHg, HGT-145mg/dl. On O/E RS- B/L crepts+ inj. Lasix 40mg iv stat f/b infusion started and inj. Cardarone 75mg iv stat given i/v/o tachycardia and shifted to icu for further management.

On 02/03/2023 Dr. Prasant Nair (Consultant Cardiologist) i/v/o of AF with FVR, LVEF- 30% he adviced- continue inj. cardarone infusion and added tab. Mexohar50mg, nebulization duolin, budecort and thyroid profile. At evening BP dropped so noradrenaline infusion started and blood gasses shows- severe metabolic acidosis with lactic acidosis so sodabicorbonate infusion with iv fluid NS started for hydration.

Patient lactate was in increasing trend (12.7), SGOT & SGPT increased secondary to congestive hepatitis.- Nephrology reference was taken he advised for NAC infusion. So NAC Infusion and cardarone infusion was stopped in view of deranged Liver profile. Patient was tachypneic and tachycardic and in acidotic breathing , planned for intubation (sos). As per relative request, negative directive for intubation(DNI) was taken.

So patient kept on NIV intermittently i/v/o tachypnea.

On 03/03/2023 Dr. Niranjan Kulkarni( Consultant Nephrologist) refrence taken i/v/o AKI creatine -2.08mg/dl, decreased urine out put and metabolic acidosis he adviced- USG KUB, fluid restriction, ABG 8th hourly, tab. Eytanix 5mg bid, maintain MAP >70mmhg, avoid nephrotoxic drugs. 2DECHO done- Lvef -30%, Rwma, severe PH, severe LV dysfuntion.

On 4/3/23 Nasal prongs with intermittent NIV trilas continued , Lasix tapered and stopped .

On 5/3/23 added inj. fragmin in view of DVT prophylaxis.

ON 8/3/23 Patient had loose motion, same day inj frragmin was withhold in view of excoriation over buttock area and managed accordingly.

On 12/3/23 . s morning ECG showed complex tachycardia (? VT), given cardarone and catetherised .Dr. Prasant nair sir review reference taken 🡪 advice noted.

But patient was still in tachycardia (?VT) Discussed with Dr Nair sir advised intravenous Betaloc ,but still Rhythm remains persistently same so patient was Cardioverted with 100joules, under short seation. . patient reverted to sinus rhythm.

On 13/3/23 dr tushar raut sir reference was taken in view of increased drowsiness 🡪 advised to stop t. synaptol and added t modalert and brain imaging (sos) and secured Ryels tube.

On 14/03/2023 dr. amol ghalme refrence is taken i/v/o- Bed sore hae adviced- Mepilex, dusting powder apply on bed sore and 2nd hourly change position, use air bed.

On 15/3/23 inj fragmi was added and rt feed continued .

On 16/3/23 patient again had sudden episode of hypotension (70/40 mm hg) with v- tachycardia , patient was immediately startred with ionotrope support and discussed with Dr nair sir and cardioverted with 150 joules.--> reverted to sinus. Dr Nair sir review was taken 🡪 advice noted.

On 17/3/23 Dr Venkat D Nagarajan sir reference was taken in view of arrhythmia and advice 🡪 noted

Slowly tapered Nor adrenaline dose and stopped and optimization of oral antihypertensive done.

On 20/3/23 central line was removed and ECG- was showing normal sinus rhythm, had episode of hypotension 🡪 managed by IV Fluid bolus and foleys catether was inserted and secured.

Now patient is in stable condition with hemodynamically stable ,hence plan for discharged.and now patient is being discharged in stable condition

**TREATMENT GIVEN DURING ADMISSION**

Inj. Piptaz 2.25gm iv 1-1-1

Inj. Hydrocortisone 100mg iv 1-0-0

Inj. Lasix iv 4ml/hour infusion

Inj. Pantop 40mg iv 1-0-0

Inj. Sodabicorbionate iv 15ml/hour infusion

Inj. NAC iv infusion 1ml/hour

Inj. Noradrenaline iv infusion according to BP

Inj. Fragmin 2500 units s/c alternate day

Inj. Potassium chloride 40meq+ 50ml NS iv slowly over 4hour

Inj. Magnesium sulphate 2gm + NS100ml iv slowly

Inj. Xylocard iv infusion according to HR

Tab Urcosol 300mg PO 1-0-1

Tab. Eltroxin 25mcg po 1-0-0

Tab. Met XL 25mg po 1-0-0

Tab. Veltam Plus 0.5MG PO 0-0-1

Tab. Urotone 25mg PO 1-1-1

Tab. Angiospan TR 2.5mg PO 1-1-0

Tab. Atorvas 20mg PO 0-0-1

Tab. Synaptol 50mg PO 1-0-1

Tab. Shelcal 5000mg PO 1-0-0

Tab. Febuxostat 40mg PO 1-0-1

Tab. Mexohar 50mg PO 1-0-1

Tab. Dytor 10mg PO 1-0-0

Tab. Silodol –D 8/0.5 PO 0-0-1

Syrup. Kesol 10ml PO 1-1-1

ECONORM Sachests PO 1-1-1

DUOLIN NEB INH 1-1-1

BUDECORT NEB INH 1-0-1

**ON GOING TREATMENT :-**

**Tab pantop 40mg rt 1-0-1**

Tab. Eltroxin 25mcg po 1-0-0

Tab. Met XL 25mg po 1-0-0

Tab. Veltam Plus 0.5MG PO 0-0-1

Tab. Urotone 25mg PO 1-1-1

Tab. Angiospan TR 2.5mg PO 1-1-0

Tab. Atorvas 20mg PO 0-0-1

Tab. Synaptol 50mg PO 1-0-1

Tab. Shelcal 5000mg PO 1-0-0

Tab. Febuxostat 40mg PO 1-0-1

Tab. Mexohar 50mg PO 1-0-1

Tab. Dytor 10mg PO 1-0-0

Tab. Silodol –D 8/0.5 PO 0-0-1

Tab mucomix 650mg rt 1-0-1

Review with SGOT/PT in 7days in opd

**Dr Khushboo Kataria**

**Consultant Critical Care Medicine**

**Kokilaben Dhirubhai Ambani Hospital**

**DISCHARGE**

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| --- | --- | --- |
| **UHID No : KH1000267163** |  | |
| **Name: Mrs Hirabai Rakhmaji Salve** | **Age : 86 Years** | **Sex : Female** |
| **Date of Admission : 01/01/2023** | **Date of Discharge: 16/01/2023** | |
| **Treating Doctor : Dr Sourabh Phadtare** |  | |

**Other Consultants**

Dr Sanjiv Badhwar (ENT Consultant)

**DIAGNOSIS**

Tracheostomy Tube Blockage

**Past History**

Hypertension

Right MCA Stroke s/p Thrombolysis and Mechanical Thrombectomy

Chronic Kidney Disease

**PRESENTING COMPLAINTS:**

Patient came with c/o respiratory distress since 30 mins and developed mucous plug in TT tube which was blocked. There was difficulty in passing suction catheter,spo2 was decreased and increased secretions and breathlessness. Hence shifted to KDAH.

**COURSE IN HOSPITAL:**

Patient with above mentioned complaints came to KDAH and was admitted in ICU. After passing suction catheter, mucous plug obstruction was felt, suctioning of blocked TT tube was done following which dysnoea resolved. In ICU, TT tube was changed with No 7 TT tube. After reinsertion spo2-99%,P-58/m,BP-144/80,there were fine crepts in both lungs,yellowish and thick secretions were seen. Secretions from ET were send for Culture and Sensitivity. Post procedure patient was hemodynamically stable. Gentle Chest and Limb PT was also started.

Patient’s condition was stable and hence discharged to home.

**TREATMENT GIVEN IN HOSPITAL:**

**TREATMENT ON DISCHARGE:**

**Dr Sourabh Phadtare**

**ICU Consultant**

**Kokilaben Dhirubhai Ambani Hospital**

**DISCHARGE**

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| --- | --- | --- |
| **UHID No : KH1000002401** |  | |
| **Name: Mr Jaywant Odhavji Chavda** | **Age : 74 Years** | **Sex : Male** |
| **Date of Admission : 25/04/2023** | **Date of Discharge: 30/04/2023** | |
| **Treating Doctor : Dr Sourabh Phadtare** |  | |

**Other Consultants**

Dr Tushar Raut (Neurologist)

**DIAGNOSIS**

Lower Respiratory Tract Infection/Bilateral lower lobe pneumonia

**Past History**

Hypertension

Asthma/Obstructive Airway Disease

Facio-scapular-humeral muscular dystrophy

**PRESENTING COMPLAINTS:**

Patient came with c/o fever, cough with expectoration, breathlessness since 2 days.

**COURSE IN HOSPITAL:**

Patient with above mentioned complaints came to KDAH and was admitted in ICU. Patient was started on IV antibiotics, IV fluids, Nebulizations, IV steroids and required intermittent NIV ventilation for raised pCo2. IV antibiotics was started with Inj Monocef 1GM BD and Inj Azee 500mg OD. Chest X Ray done showed bilateral lower lung infiltrates

HRCT Chest done showed bilateral lower lobe consolidations s/o pneumonia.

2D Echo done showed LVEF-55% with No RWMA and severe PH

Blood C/S and Urine C/S – Showed no growth

Patient was switched from intermittent NIV to intermittent Home BiPap for 4 hours daytime and 6 hours overnight.

Neurology Reference was given to Dr Tushar Raut and his advice followed to start Cap Quogress OD and physiotherapy exercises.

Patient was given 5 days course of IV antibiotics and IV steroids was gradually tapered and stopped. Patient’s condition was stable and hence discharged to home.

**TREATMENT GIVEN IN HOSPITAL:**

1. Inj Monocef 1GM IV 1-0-1
2. Inj Azee 500mg IV 1-0-0
3. Inj Pan 40mg IV 1-0-0
4. Neb Duolin INH 1-1-1
5. Neb Budecort INH 1-0-1
6. Inj Hydrocort 50mg IV 1-0-1
7. Inj Thiamine 100mg IV 1-0-0
8. Inj Optineuron 1amp IV OD
9. Inj Lasix 20mg IV SOS
10. Cap Quogress 1cap PO 1-0-0

**TREATMENT ON DISCHARGE:**

**Dr Sourabh Phadtare**

**ICU Consultant**

**Kokilaben Dhirubhai Ambani Hospital**

**DISCHARGE SUMMARY**

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| --- | --- | --- |
| **Name : Mrs Manisha gohil** | **Age : 46 years** | **Sex : Female** |
| **Date of Admission :13/03/2023** | **Date of Discharge :** | |
| **UHID : KH1000776075** | **Treating Doctor : Dr.Sourabh Phadtare** | |

**Other Consultants involved:**

Dr Dattatray (Consultant Gastroenterologist)

Dr R. Shekhar (Consultant Vascular Surgeon)

Dr Aparna (Consultant Psychiatrist)

Dr Dheeraj Kapoor (Consultant Endocrinologist)

Dr Sunil Wani (Consultant Cardiologist)

Dr Sameer Tulpule (Consultant Hematologist)

Dr Amol Ghalme (Consultant Plastic Surgeon)

Dr Sunil Singh (Consultant Rheumatologist)

Dr Gordhan (Consultant Interventional Radiologist)

Dr Abhishek Srivastav (Consultant Rehabilitation)

**Diagnosis:**

Bilateral lower limb cellulitis – status post left leg below knee amputation + right lower limb debridement

Bicytopenia

Coagulopathy

DIC

Hypoalbuminemia

DAT +

Dyselectrolytemia

**Past History**

Diabetes mellitus

Hypothyroidism

Anxiety disorder

Bilateral cellulitis (multiple times)- prolonged stay

UTI

Severe Dehydration

? Nutritional deficiency

? Autoimmune disease

**Course in hospital**

Patient came with chief complaints of

Breathlessness since 2 days

Orthopnea since 2 days

Bilateral lower limb cellulitis with pain since 2 days

Bleeding for bed sore since 2days

Decreased appetite since 2 months

Bed bound since 2018 🡪 body has become stiff (unable to move hand and legs since 10 days)

Bilateral lower limb cellulitis since 2 months

**Treatment given during stay :**

Inj Poly B 7.5LU 1-0-1

Inj Elores 3gm 1-0-1

Inj Meropenem 1gm 1-1-1

Inj Targocid 200mg 1-0-0

Inj Clindamycin 600mg 1-1-1

Inj Tigecycline 100mg 🡪 50mg 1-0-1

Inj Optineuron 1amp 1-0-0

Inj Hydrocort 100mg 1-1-1

Inj Thiamine 500mg 1-0-1

Inj Vit C 500 mg 1-1-1

Inj Celcel 1amp 1-0-0

Inj NAC infusion

Inj Pan40 mg 1-0-1

Inj Human Albumin 20% 1-0-0

Inj HAI acc HGT 1-1-1

Inj Lantus 6U at 10pm

Inj Milrinone infusion

Inj Noradrenaline infusion acc to BP

Inj Vasopressin infusion acc to BP

Inj Lasix infusin

Tab Clindamycin 600mg 1-1-1

Tab Folvite 5mg 1-0-1

Tab Ivabrad 7.5mg 1-0-1

Tab Thyronorm 25mcg 1-0-0

Tab Ursocol 300mg 1-1-1

Tab Rifagut 550mg 1-0-1

Cap Redotil 100mg 1-1-1

Tab Lasilactone 20/50mg 1-0-0

Tab Asprito 2mg ½ -0-½

Tab Modalert 100mg ½-½-0

Tab Melatonin 3mg SOS

Tab Immodium 2mg 0-1-0

Cap VSL3 1-0-1

Syp Sparacid 10mg 1-1-1-1

Syp Kesol 10mg 1-1-1

AddPhos sachet 1-1-1

Econorm sachet 1-1-1

Venusia Max Lotion 1-1-1

IV Fluids

**Medications on discharge**

**Dr. Sourabh Phadtare**

**Consultant Intensivist**

**Critical Care Medicine**

**Kokilaben Dhirubhai Ambani Hospital**

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **PATIENT’S NAME**: Mrs Kanta Devi Paliwal | **UHID No** : KH1000005843 | |
| **DATE OF ADMISSION** : 26/04/2023 | **AGE**: 78 years | **SEX** : Female |
| **DATE OF DISCHARGE** : | **TREATING DOCTOR** : Dr Sourabh Phadtare | |

**OTHER CONSULTANTS**

Dr. Sharad sheth (Consultant Nephrologist)

Dr. Gaurav Mehta (Consultant Gastroenterologist)

**DIAGNOSIS:**

Pulmonary Edema/ Fluid Overload

Urosepsis

**OTHER COMORBITIES:**

Ischemic Heart Disease

Triple Vessel Disease S/P CABG

Chronic Kidney Disease

Hypertension

Diabetes Mellitus

Ca Stomach

H/O recent admission Aspiration Pneumonia with LRTI with Bilateral pleural effusion,Septic Shock with Acute Gastroenteritis,Atrial Fibrillation,Bilateral Parietal Occipital infarct with Right Hemiplegia (Posterior Circulation Stroke),Acute Kidney Injury on Chronic Kidney Disease,Ischemic Cardiomyopathy

**CHIEF COMPLAINTS:**

Breathlessness since todays morning at 3:30pm and increased since last 2hours

H/o patient on home ventilator with nebulization and h/o extra 500ml fluid given in last 2days.

H/O recent admission Aspiration Pneumonia with LRTI with Bilateral pleural effusion,Septic Shock with Acute Gastroenteritis,Atrial Fibrillation,Bilateral Parietal Occipital infarct with Right Hemiplegia (Posterior Circulation Stroke),Acute Kidney Injury on Chronic Kidney Disease,Ischemic Cardiomyopathy

**COURSE AT HOSPITAL:**

Patient with above complaints brought to KDAH.

On arrival, HR 87 beats per min ; BP -150/80 mm Hg; Spo2 100% Room Air; RR 28 pm, HGT-247mg/dl, GCS-9/15

RS crepts ++

CNS: drowsy moving all 4 limbs

Inj. Lasix 20mg iv stat given and in EPOC- metabolic acidosis, labs on admission- Na-128, K-5.06, Hb-8gm/dl, WBC-19000, Urea-273, creat-3.69mg/dl patient was shifted to icu for further management.

0n 26/04/2023 Dr. Sharad Sheth ( Consultant Nephrologist) reference is given i/v/o raised creatinine, metabolic acidosis- he advised urine routine& microscopy, fluid restriction 1.3- 1.5litre/day, RRT sos, IVF½ NS with soda bicarbonate infusion.

On 27/04/2023 Dr. Gaurav Mehta ( Consultant Gastroenterologist) given refrence i/v/o stool occult blood positive- he adviced Cap. Redotril 100mg sos, inj. Metrogyl 500mg iv tid, continue peg feed.

TT changed on 27/04/2023 – i/v/o TT block

**TREATMENT DURING HOSPITAL STAY:**

**TREATMENT AT THE TIME OF DISCHARGE:**

**Dr. Sourabh Phadtare**

Consultant

Critical Care Department

Kokilaben Dhirubhai Ambani Hospital

**DISCHARGE SUMMERY**

|  |  |  |
| --- | --- | --- |
| **UHID No : KH1000881570** |  | |
| **Name: Mrs Shobhana Shashikant Patyane** | **Age : 75 Years** | **Sex : Female** |
| **Date of Admission : 22/06/2023** | **Date of Discharge: 27/06/2023** | |
| **Treating Doctor : Dr Sourabh Phadtare** |  | |

**Other Consultants**

Dr Praveen Kahale (Consultant Cardiologist)

Dr Ismail Attar (Consultant Urologist)

Dr Gaurav Mehta (Consultant Gastroenterologist)

Dr Abhijit Pawar (Consultant Orthopedic)

**DIAGNOSIS**

Acute Coronary Syndrome

Acute Left Ventricular Failure

Acute Kidney Injury

Lower Respiratory Tract Infection

Atrial Fibrillation with Fast Ventricular Rate

**Past History**

Hypertension

Diabetes Mellitus

Bronchial Asthma

? Dyslipidemia

? Hyperthyroidism

H/o Renal Stone Surgery

B/L Total Knee Replacement surgery

L3-4, L4-5 Spondylolisthesis with Stenosis( s/p MIS-TLIF done on 17/06/2023 and discharged on 18/06/2023 under Dr. Abhijit Pawar)

H/o Preop PFT – mild restrictive ventilator defect with no past bronchodilator reversibility and narmal diffusion. D-dimer-1112.38, Fibrinogen-461,Creatine- normal, 2D-ECHO- EF-60%

**PRESENTING COMPLAINTS:**

Now patient came with c/o shortness of breath , palpitation, chest pain on/off , decreased urine output, constipation since 2 to 3 days so admitted in LH. Hiranandani Hospital and diagnosed- Acute Coronary Syndrome with Acute LVF, AKI, LRTI, anemia HB-7.5mg/dl received 1 blood transfusion and patient taken DAMA and shifted kdah for further treatmennt. Out side labs- d-dimer-6400, proBNP-8310, trop-i-4020, creatinine-1.7mg/dl.

**COURSE IN HOSPITAL:**

Patient brought to kdah with above complaints on admission in A&E

Vitals- Pulse-103,Bp-140/70,SpO2-91% on RA,HGT-102mg/dl. O/E- R/S- b/l crepts+, Extremities- b/l mild pitting edema. ECG- shows ST inversion on in v3-6, avf. All labs sended and inj. Lasix 20mg bolus f/b infusion, inj. Piptaz4.5mg start given and shifted to ICU. Patient was kept on nasal prong 2litre/minute Spo2- 99%. Hrct chest and abdomen done on 22/02/2023- suggestive of airway disease and lobulated margin of both kidney with minimal right perinephric fat standing. Lab-Creatinine-1.88mg/dl,k-5.11,Hb-9.1gm/dl,WBC-16910,CRO-35.30,NtproBNP-8984, Trop-I-4475.

On 23/05/2023 patient had AF with FVR- Heart Rate-170-180/minute so inj. Mgso4 2gm iv, inj. Cordarone150mg iv slowly received and reverted back to sinus rythum. 2d echo done- LVEF-55%, NO RWMA, mild PH.

Dr. Abhijit Pawar reference given i/v/o post operative MIS- TLIF- he advice dressing and dressing done.

Dr. Praveen Kahale reference is given i/v/o raised troponin-I, ecg changes and atrial fibrillation with fvr- he advised tab. ecosprin 75mg, LMWH(fragmin 5000iu od.

0n 24/06/2023 Hb-10.2gm/dl and stool occult blood – positive so Dr, Gaurav Mehta reference given- he advised- daily CBC, Tab. Pan40mg bid, w/f GI bleed, EGD/ Colonoscopy sos.

Dr. Ismail Attar reference is given i/v/o acute urinary retension- he advised tab. silodal 8mg od, tab. urotone35mg bid, avoid constipation, continue catheterization.

At present patient is hemodynamically stable pulse-86/minute, Bp- 120/80mmhg, SPO2-97% on room air. Hence been discharged

Advised- to fallow up in OPD after 10days with CBC, BUN, CREATINE, ELETROLYTES.

**TREATMENT GIVEN IN HOSPITAL:**

1. Inj Piptaz 4.5gm IV 1-0-1
2. Inj Lasix IV infusion
3. Inj Optineuran 1ampIV 1-0-0
4. Inj Thaimine 100mg IV 1-0-0
5. Inj Pantop 40mg IV 1-0-1
6. Inj Emeset 4mg IV sos
7. Inj Encicarb 1gm IV 1-0-0
8. Inj Cordarone 150mg IV stat
9. Inj. Fragmin 5000iu S/C 0-0-1
10. Inj. Magnisium Sulphate 2gm IV stat slowly
11. Tab. Ivabrad 2.5 mg po 1-0-1
12. Tab. Ecosprin 75mg po 0-1-0
13. Tab. Clopitab 75mg po 0-1-0
14. Tab. Febuxostat 40mg po 1-0-0
15. Tab. Telma 40mg 1-0-1 according to BP
16. Tab. Deriphylline 150mg 1-0-1
17. Tab .Arkamine 0.1mg PO 1-1-1 according to BP
18. Duolin nebulization INH 1-0-1
19. Budecort nebulization INH 1-0-1
20. Syrup. Cremaffin 15ml po 1-0-1
21. Zytee gel LA 1-1-1

**TREATMENT ON DISCHARGE:**

1. Tab. Pan 40mg po 1-0-1
2. Tab. Ivabrad 2.5mg 1-0-1
3. Tab. Febuxostat 40mg po 1-0-0
4. Tab. Optineuron tab po 1-0-0
5. Tab. Silodal 8mg po 0-0-1
6. Tab. Urotone25mg po 1-0-1
7. Tab. Folvite 5mg po 1-0-1
8. Tab. Lasix 20mg po 1-0-0
9. Tab. Vitamin-c tab po 1-0-1 for 10days
10. Tab. Thiamine 100mg po 1-0-0 for 10days
11. Tab. Emiset 4mg po sos
12. Zytee gel local apply per oral 1-1-1 for ulcers

**Dr Sourabh Phadtare**

**Consultant Critical Care Medicine**

**Kokilaben Dhirubhai Ambani Hospital**

**Andheri West**

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **UHID No** : KH1000072784 |  | |
| **Name :** Mr. KAMALAKAR POTDAR**PI_VIP** | **Age :** 83 Years | **Sex :** Male |
| **Date of Admission :** 14/04/2023 | **Date of Discharge :** | |
| **Treating Doctor:** Dr. KHUSHBOO KATARIA | | |

**OTHER CONSULTANT** :

Dr. ABHAY KUMAR (Consultant Neurosurgeon)

**DIAGNOSIS:**

1. ASPIRATION PNEUMONIA WITH VOLUME OVERLOAD
2. ACUTE GASTROENTERITIS

**PAST HISTORY:**

1. HYPERTENSION
2. TYPE 2 DIABETES MELLITUS
3. CHRONIC KIDNEY DISEASE
4. INTRAVENTRICULAR HEMORRHAGE (LEFT THALAMIC BLEED)

**COURSE IN HOSPITAL:**

Patient was on the way to KDAH for a routine follow up CT scan of brain. He had complaints of

1.)Slight drowsiness since 1 hour

2.)Breathlessness since 15 minutes.

Hence patient was brought to A & E. On arrival vitals were as follows – BP:120/80 mm Hg, Pulse rate-118/min, Respiratory rate 38/min, Temperature 99.5 Fahrenheit, SpO2 -100%. EPOCH results were ph-7.49, pCO2-7.49, HCO3-23.1, Na-145, Potassium – 3.0, Creatinine-3.31 and lactate 2.46. Patient was started on Non invasive ventilation. Patient was administered diuretics, nebulization, intravenous steroids with antibiotics and shifted to ICU. Chest x ray was done s/o Bilateral hilar shadows and fluid overload.

A CT Brain plain was done which was s/o progressive interim reduction in size and density of left thalamic hematoma as well as reduction in the density of intraventricular haemorrhage which was gradually resolving. No significant midline shift. No significant hydrocephalus. Minimal prominence of the ventricles is likely ex vacuo and related to brain parenchymal atrophy. Except for chronic ischemic changes, the rest of the brain parenchyma including the right cerebral hemisphere, right sided deep gray nuclei, brainstem and cerebellum are normal.

Dr. Abhaya Kumar’s opinion was sought in view of this scan and he adviced nil active intervention.Swallow assessment done on 15/4 was s/o oropharyngeal dysphagia and therefore RT feeds continued . Patient is conscious , following commands .

On 15/04/2023 patient had 5 episodes of loose stools and started developing mild to moderate abdominal pain and hence stool routine and C. diff were sent.Antibioitcs was changed to Monocef and Metrogyl . C Diff is negative .He has loose stools and also has dyselectrolemia . Relatives have been explained about need for hospitalisation .However , they wish to take patient after understanding consequences of same including risk of further deterioration . Therefore patient is being given discharge against medical advice .

**CONDITION AT DISCHARGE:**

At present patient is hemodynamically stable, stable sugars, good urine output. Foleys catheter in place.

**TREATMENT GIVEN AT HOSPITAL:**

INJ PAN 40 MG IV 1-0-0

INJ OPTINEURON 1 AMP IV 1-0-0

DUOLIN NEB 1 RESP INH 1-1-1

BUDECORT NEB 1 RESP INH 1-0-1

INJ HYDROCORT 50 MG IV 1-0-1

TAB MINIPRESS XL 5 MG RT 1-0-1

TAB APRESOL 25 MG RT 1-1-1

TAB NICARDIA-R 20 MG RT 1-1-1-1

TAB MOXOVAS 0.3 MG RT 1-0-1

TAB SILODAL 8 MG RT 0-0-1

TAB ROSEDAY-F 10 MG RT 0-0-1

INJ MONOCEF 1 GM IV 1-0-1

TAB POTRATE 10 MG RT 1-1-1

TAB UROTONE RT 1-1-1

ECONORM SACHET 1-1-1-1

INJ METROGYL 100 MG IV 1-1-1

**TREATMENT ON DISCHARGE:**

TAB MINIPRESS XL 5 MG 1-0-1

TAB APRESOL 25 MG RT 1-1-1

TAB NICARDIA-R 20 MG RT 1-1-1-1

TAB MOXOVAS 0.3 MG RT 1-0-1

TAB SILODAL 8 MG RT 0-0-1

TAB ROSEDAY-F 10 MG RT 0-0-1

TAB UROTONE RT 1-1-1

**Dr. KHUSHBOO KATARIA**

**Consultant**

**Critical Care Medicine**

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| UHID No : KH1000801558 |  | |
| Name: Mrs Rohini Surve | Age : 76 years | Sex :Female |
| Date of Admission : 24/02/2022 | Date of Discharge: 05/03/2022 | |
| Treating Doctor: Dr.VATSAL KOTHARI |  | |

**Attending Consultants –**

DR.Tushar Raut Consultant- Neurologyhttp://em.kdahit.com/HIS/eCommon/images/activeArrow.gif

Dr.Gordhan Sangani Consultant- Interventional Rahttp://em.kdahit.com/HIS/eCommon/images/activeArrow.gifdiology

Dr. Prashant Nair (Consultant Cardiology)

Dr.Rajendra Sonawane Consultant- General Surgery

Dr.Tanu Singhal Consultant Infectious Disease http://em.kdahit.com/HIS/eCommon/images/activeArrow.gif

**Issues:**

Gastric perforation with right subdriaphragmatic collection

Stress cardiomyopathy

**Past Medical history**

Hypertension

Autosomal dominant spinocerebellar ataxia since 10 years

The patient was bedridden since 2 years ,was able to walk with support only .The patient had abdominal pain since 7 days ,was ,admiited to Life line hospital on 17/02/2022.USG abdomen was done which was s/o Right subdiaphragmatic and liver collection ,Right sided pleural effusion .CECT chest ,abdomen ,Pelvis was done which was s/o small focal mucosal defect noted within pylorus of the stomach measuring 7mm thin defect below inferior surface of the left lobe of the liver s/o perforation .Mild to moderate perihepatic fluid,pleural effusion with subsegmental collapse mild subacute edema in right hypochondriac region,Repeat CT scan s/o increase in the collection from the previous scan .The patient was transferred to KDAH for further management

**Course on hospitalization:**

Patient shifted to A & E with above mentioned history and complaints .On admission BP 160/10omm Hg ,HR 104/min SP02 98% on O2 4Lit/min ..Right IJV in situ+ ,Foleys catheter in situ +,On Abdomen examination generalized tenderness over abdomen +.abdomen distention +,On Respiratory system examination B/L wheeze + The patient was intubated i/v/o respiratory distressin A& E .Shifted to ICU for further management .

Routine investigations and cultures were sent. On admission serum sodium was raised 150, serum potassium low 3.0, phosphorus decreased 1.1 ,Hb 10.2 g/dl ,WBC raised 13300. Chest xray s/o Right basal consolidation. I/V/O hypotension inotropic support with Noradrenaline started. Antibiotics started .

Trop I was raised 911.2 Cardiology opinion with Dr. Prashant Nair was taken and advice followed. 2Decho was done which was s/o LVEF 20%to 25%, hypoknesia of apex ,mid and apical segment present , features s/o stress cardiomyopathy. General surgery opinion with Dr.Sonawane was taken and advice followed. Dr.Gordhan Sangani reference was taken and pigtail insertion was done.

The patient had B/L upper limb restricted movement, orthopedic opinion was advised but the relative (son) refused for the same. Dr.Tanu Singhal( infectious disease )opinion was taken and advice followed.

CT Abdomen and pelvis was done prior to pigtail removal which was s/o right subdiaphragmatic collection with pigtail catheter in situ. Right mild to moderate pleural effusion, anterolisthesis of L5 over S1 with B/L paralysis .Review with Dr.Sonawane was taken - advised conservative management. Blood c/s ,Urine c/s ,CSF Fluid c/s showed no growth.

Neurology opinion was taken with Dr. Tushar Raut, advised starting T. Quogress, T. Ginkocer Ferric and to consider trial of levodopa.

Gradually inotropic support was tapered and stopped. Pigtail cather removed eventually. Tracheostomy was performed on 01/03/22 uneventfully. Subsequently, the patient was progressively weaned off the ventilator over a 36-hour period. Initially, she demonstrated suboptimal respiratory effort. As of 04/03/2022, she has tolerated an extended T-piece trial. She is also tolerating plain water through the Ryle’s tube. Nutritional needs are currently being met by TPN. The patient is scheduled for a swallow assessment on 04/03/22 as well as a monitored trial of more substantial feeds and review by Dr. Nair and Dr. Sonawane.

**Treatment during hospitalization :**

Inj. Meropenem 1gm i.v 1-1-1

Inj.Tigecycline 100mg 1-0-0

Inj.Fluconazole 400mg i.v 1-0-0

Inj.somzo 40mg i.v 1-0-0

Inj.Optineuron i.v 1AMP 1-0-0

Inj.Noradrenaline IV @BP

Inj.Clexane 40mg s/c 0-0-1

Inj.MVI 1Amp 1-0-0

Inj.Lasix 10mgIV 1-0-1

Tab.Canisure 500mg 1-0-1

Tab Flavedon MR 1 tab 1-0-1

TPN @ 50ml/hr

**Signature:**

Dr. VATSAL KOTHARI

Consultant Critical Care Medicine

KDAH

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **Name: Mrs. GEETA DESAI** |  | |
| **UHID: KH1000818301** | **Age : 72 Year** | **Sex : FEMALE** |
| **Date of Admission: 28/05/2022** | **Date of Discharge :** | |
| **Treating Doctor : Dr.Vatsal Kothari** |  | |

**Diagnosis:**

Subarachnoid Haemorrhage Grade IV – Right MCA pre bifurcation saccular aneurysm , balloon assisted coiling done.

**Past History:**

History of Space occupying lesion in Right frontoparietal area of brain– operated 40 years back

**Other Consultants:**

Dr.Tushar Raut (Consultant Neurologist)

Dr. Manish Shrivastava (Consultant inteventiontional neuroradiologist)

Dr Abhay Kumar ( Neurosurgeon)

Dr.Sandeep Wasnik (Consultant Orthopedic surgeon)

Dr Shaunak Ajinkya ( Psychiatrist)

Dr. Aparna Ramkrishanan ( Psychiatrist ).

**Chief Complains:**

Severe Headache and 2-3 episodes of vomiting since 30/11/2021

**Course:**

85 year old female patient had complaint of headache and vomiting since 30/11/2021 evening then presented to Sterling hospital where she was diagnosed with Grade 4 subarachnoid hemorrhage with cerebral edema on CT brain.MRI brain was suggestive of Right MCA – M1 saccular aneurysm with mild hydrocephalus.

Patient was shifted to KDAH for further management.Patient presented to A&E in KDAH on 01/12/2021 with BP – 194/88 mm of Hg with GCS 13/15 E3M6V4 was admitted under Dr.Vatsal Kothari.Patient was started on Inj.Labetalol infusion and taken up for urgent DSA.

Patient had a difficult intubation in the Cath lab due to grade 3 larynx. DSA was suggestive of Right pre MCA bifurcation saccular aneurysm for which balloon assisted coiling was done.Sheath was removed post coiling.Patient was then shifted to ICU post procedure while sedated on Fentanyl and Midazolam.

Patient was started on Inj.Mannitol,Inj.Levipil,Tab.Nimodipine post procedure.

CT Angio + brain and neck(02/12/2021) – Acute grade 4 SAH involving bilateral convexity sulci,basal cisterns,sylvian fissures and MCA cisterns with asymmetric involvement on the right and intraventricular extension to both the lateral.3rd and 4th ventricles.Mild ventricular dilatation with transependymal CSF migration.No midline shift or uncal herniation.No large acute territorial infarct.

Post right distal M1 aneurysm coiling with good contrast opacification of right MCA,cortical and sylvian branches.No critical stenosis seen in intra cranial vessels of circle of Willis or extracranial vessels of the neck.

Patient was seen by Dr.Tushar Raut post procedure who noted the history and advised to continue Levipil,Mannitol,Nimodipine and to avoid hypotension.

On 2nd dec Sedation and paralysis was stopped at 6am in morning ,patient remained drowsy till late afternoon , Patient was seen by Dr.Vatsal Kothari who advised CT brain + Angio to rule out early vasospasm and hydrocephalus in view of drowsiness. Ct Report was not showing any vasospasm. Mild ventricular dilatation which was stable as compared to CT done on 30 th Nov. Patient was again sedated as she was not fit for exubation ivo drowsiness

On 3rd Dec sedation was again stopped early in the morning ivo extubation.

Patient was seen by Dr.Abhay Kumar who noted the history and after examining the patient advised to maintain CVP -10 , increasing Nimodipine to 4th hourly.

Patient was awake alert following commands ,Patient was extubated and then started on oxygen 4L/min via face mask.Patient had bronchospasm for which she was started on Neb.Duolin 1-1-1-1.

Patient had left upper limb monoparesis along with facial devation to right.

On CT Angio brain + neck (04/12/2021) – No significant vasospasm is seen in major intracranial arteries.Distal right M1 MCA aneurysm is excluded from circulation.

2d echo (04/12/2021) - LVEF -60%,no RWMA,mild LVH,IVC dilated ,non collapsing,moderate pulmonary hypertension,good LV and RV systolic function.

Patient was reviewed by Dr.Tushar Raut who advised to add Tab.Oleanz 5 mg ½-1/2-1 ivo restlessness. And to add Tab.Breviracetam 50 mg 1-0-1 and to hold Levipil. ivo drowsiness.

Patient had an episode of fever for which she was started on Inj.Piptaz on 04/12/2021. ivo Microaspirations.

Patient was drowsy but arousable with irrelevant talks and restlessness and left hemiparesis with GCS -14/15.Patient was reviewed by Dr,Tushar Raut who advised Tab.Asprito 2 mg ½ if

Pseudomonas Aeruginosa ,Streptococcus Pneumoniae was detected on ET culture.

Patient was reviewed by Dr.Tushar Raut who advised to gradually taper Mannitol and to avoid Levipil, continue Breviracetam.

On 9th Dec patient was more drowsy ,arousable andfollowing commands .CT Angio brain and neck (09/12/2021) – Previously seen subarachnoid hemorrhage along bilateral convexities show significant interval resolution.Intraventricular extension is seen in the form of mild hemorrhage in the dependent portions of both lateral ventricles.Mild hydrocephalus and transependymal CSF migration is stable.No significant mass effect or midline shift is seen. Right distal M1 aneurysm coiling is seen excluding the aneurysm from the anterior circulation.Rest of the major intracerebral arteries are normal in course and caliber.

Patient had a fever spike on 09/12/2021, Foleys catheter are was changed and urine for routine and culture ,blood culture were sent.Antibiotic was upgraded to Meropenem.

EEG (10/12/2021) – Normal background rhythm (asymmetric,better over left hemisphere),continous slowing of right hemisphere,breach rhythm over right centro parietal region.No unequivocal evidence of IEDs or subclinical seizures.

Urine routine (11/12/2021) – occult blood +,WBC 6-8/hpf,RBC 10-12/hpf,lecucocyte esterase +

Paired blood culture,CV tip culture and urine culture sent on 10/12/2021 showed no growth.

Patient was advised swallow assessment and swallow therapy by Dr.Vatsal Kothari.On swallow assessment mild oropharyngeal dysphagia was present so patient was advised RT feeds

Patient had right shoulder pain so he was referred to Dr.Sandeep Wasnik who advised X ray shoulder AP view,Tab.PCM 650 mg 1-1-1,ice pack application,Volitra APS spray for local application,shoulder arm pouch.

Patient was referred to Dr.Shaunak Ajinkya in view of persistent disorientation,restlessness.Patient was seen by Dr..Shaunak Ajinkya who noted the history of the patient and diagnosed her with psychosis secondary to medical condtion and advised to start the patient on Tab.Oleanz 2.5 mg 0-1-0,Tab.Meloset 3 mg 0-0-1,Tab.Optineuron 1-0-1.

Over the period of time in icu patient gradually improved, power in all 4 limbs improved but patient remains intermittently disoriented and restless . Over the period of time dysphagia also improved without aspiration and patient was started on oral diet.

Patient was reviewed by Dr.Manish Shrivastava who advised to taper Nimodipine and stop .

Patient was seen by Dr.Aparna Ramakrishnan who increased dose of oleanz to ½ -1-1 and sos. And to continue optineurone and Meloset.

**Treatment during stay:**

**Procedure : DSA with balloon assisted coiling of right MCA aneurysm**

Inj.Mannitol 100 ml iv 1-1-1

Inj.Levipil 500 mg iv 1-1-1

Inj.Pantop 40 mg iv 1-0-1

Inj.Paracetamol 1 gm iv 1-1-1

Tab.Nimodipine 1-1-1-1-1-1

Inj.Optineuron 1 amp iv 1-0-0

Neb.Duolin 1-1-1-1

Tab.Breviracetam 50 mg 1-0-1

Tab.Oleanz 5 mg ½-1/2-1/2

Inj.Piptaz 4.5 gm iv 1-1-1

Inj.Dexa 4 mg iv

Inj.Clexane 40 mg OD

Inj.Meropenem 1 gm iv 1-1-1

Tab.Asprito 2 mg ½ SOS

Volitra APS

IV fluids .

**Treatment Discharge at discharge:**

**Tab.PCM 650 mg SOS for pain ( Given for right shoulder musculoskeletal pain )**

**Tab. Nimodipine 60 mg 1-1-1 for 3 days then**

**1-0-1 for next 3 days then**

**1-0-0 for next 3 days then Stop tab Nimodipine.**

**Tab.Breviracetam 50 mg 1-0-1**

**Tab.Optineuron 1 tab 1-0-1**

**Tab.Pantop 40 mg 1-0-1**

**Tab.Meloset 3 mg 0-0-1**

**Volitra aps gel for Local application on shoulder**

**Tab.Oleanz 2.5 mg ½ -1-1 and 1 tab sos if agitation or violent behavior. Watch for sedation and withhold the subsequent dose accordingly if patient is drowsy.**

**Follow up:**

**After 1 week with Dr Vatsal Kothari with CBC/CRP/RFT/LFT/FBS.**

**Review with Dr.Sandeep Wasnik in OPD after 2 weeks after taking prior appointment.**

**Dr. Vatsal Kothari**

**Director and HOD**

**Critical Care Medicine**

**DISCHARGE AGAINST MEDICAL ADVICE**

|  |  |  |
| --- | --- | --- |
| **UHID No : KH1000634780** |  | |
| **Name: Mrs Kajal Laxman Krishnani** | **Age : 60 years** | **Sex : Female** |
| **Date of Admission : 21/01/2023** | **Date of DAMA: 24/01/2023** | |
| **Treating Doctor : Dr. Sunil Pai** |  | |

**Other Consultants**

Dr Manoj jain (General Surgeon)

**Problem List**

Ileostomy Bag Bleed

Sepsis with Septic Shock with Coagulopathy

Acute Kidney Injury

**Past History**

Diabetes Mellitus

Hypertension

Hyperthyroidism

Ca Right Ovary with Metastasis s/p TAH+BSO, Post ileostomy done

**Presenting Complaints:** Patient came with c/o bleeding from ileostomy bag. Also had c/o fever with chills since 2 days.

**COURSE IN HOSPITAL** **:**

Patient was admitted to ICU with above mentioned complaints. Patient’s vitals on admission were: BP-90/60 P/O2-112/100% on RA, RR-18/m, T-98 F. Patient was transfused 2 units PRBC on 21/1/23. Patient was started on IV antibiotics with Inj Meropenem 1GM IV BD,Inj Vitamin K 10mg STAT was given and IVF with 1/2NS + 2amp NaHCo3 was started in view of metabolic acidosis. Inotropic support with Norad was started in view of hypotension. Lasix infusion in view of Acute kidney injury. Patient was transfused another 3PP unit PRBC and 4 units FFP on 22/1/23.

Reference to Dr Manoj jain was given and his advice followed.

Urine C/S was sent and report awaited.

Lasix infusion was stopped and switched to Inj Lasix 20mg 1-0-1. Inotropes requirement decreased and urine output was adequate.

As per relatives request they wish to go DAMA , will need to trace culture sensitivity reports .

P

Patient discharged with lt ijv triple lumen catheter inserted on 21/01/23 and foleys catheter in situ ..

**ONGOING TREATMENT**

1. Inj Meropenem 1GM 1-0-1 started on 21/01/23 .
2. Inj Somzo 40mg 1-0-1
3. Inj Vit K 10mg OD
4. Inj Lasix 20mg 1-0-1
5. Tab Neomercazole 2.5mg 1-0-0
6. Tab Pregabid-NT 75/10mg 0-0-1
7. Tab Optineuron 1-0-0
8. Hhfudic Cream for L/A 1-1-1
9. Lulifin Cream for L/A 1-1-1
10. T-Bact Ointment for L/A 1-0-1
11. Tab Trajenta 5mg 1-0-0
12. Tab Paracetamol 500mg SOS
13. Tab Buscopan 10mg 1-0-1
14. IVF – ½ NS + 2amp NaHCo3
15. Inj Lasix infusion
16. Inj Norad @ BP

**Dr. SUNIL PAI**

**CRITICAL CARE MEDICINE CONSULTANT**

**Kokilaben Dhirubhai Ambani Hospital**

**Andheri ( West )**

**Mumbai**

|  |  |
| --- | --- |
| **Treating Doctor : Dr Vatsal Kothari** |  |

**Other Consultants**

Dr Tanu Singhal (ID Specialist)

Dr. Mohit Bhatt (Consultant Neurology)

**Problem List**

Aspiration Pneumonitis with Sepsis

Metabolic/Septic Encephalopathy

Accelerated Hypertension

**Past History**

Diabetes Mellitus

Systemic Hypertension.

Hypothyroidism.

Progressive Supranuclear Palsy. (Stopped medications on self since 6 months)

**Presenting Complaints**:

Patient came with c/o fever since 1-2 days with progressive drowsiness and reduced oral intake since 2 days.

**COURSE IN HOSPITAL**:

Patient was admitted to ICU in view of above complaints. Patient relatives (son and daughter) gave history of stopping all his old medications and routine consultation with Neurologist since last 6 months. His previous medications included- thyroid supplementation, oral hypoglycemic, oral anti- hypertensive medications and anti- parkinsonian medicines.

Vitals on admission were: HR-92/min, SPO2-94% on RA, BP-160/100mmHG, RR-17/min T-97.8 degree F, and HGT-190 mg/dl. GCS was 10/15.

The initial labs revealed leukocytosis (TLC > 20000) and CRP of 149. The blood and urine cultures were sent and the patient was started on broad spectrum IV antibiotic (Piperacillin- Tazobactum). The patient was continued with supportive treatment with IV fluids, IV Analgesics, Nebulization with Duolin/Budecort and IV Multivitamins. After initial stabilization the patient was shifted to ICU. The relatives were counselled and explained about the condition of the patient and further plan of management.

The working diagnosis was acute febrile illness. The flu panel was sent which was negative.

The Peripheral Smear for Malaria Parasite/Rapid Malaria Antigen was negative

The Dengue workup (Dengue IgM/IgG/NS1 antigen) was negative as well.

The patient became hypoxic and started requiring supplemental oxygen through nasal prongs. The patient’s blood pressure was high and hence was started on IV NTG infusion. The patient’s cough reflex was poor and airway protection was suboptimal. The patient had difficulty in swallowing and was clinically aspirating. Ryle’s tube insertion was advised to ensure safe enteral feeding and for giving medications. The relatives (DAUGHTER-SEEMA VARMA) were counselled and explained about the need of the Ryle’s tube insertion however the relatives were unwilling for the same. The neurology opinion was taken from Dr. Mohit Bhat who agreed with the plan of Ryle’s tube insertion. The relatives were again explained about the need of Ryle’s tube insertion; the relatives remained undecided.

The reference was given to Dr. Tanu Singhal (Infection Disease specialist) in view of aspiration pneumonitis. The ongoing antibiotic management was to be continued.

CT Chest/Abdomen done showed multiple nodules in right middle lobe and right lower lobe with multiple patchy consolidations suggestive of infective etiology. Areas of ground glass opacities were also seen in right and left upper lobes. Prostatomegaly and minimal perivesicular fat stranding also seen.

The 2D Echo done showed LVEF-55% with no RWMA with mild PH seen.

The patient continued to remain drowsy. The airway protection was suboptimal and the patient was clinically aspirating. The swallow assessment was done to objectively determine the safety in initiation of the oral feeds. The assessment showed delay in swallow initiation. Post swallow assessment there was a strong recommendation to keep the patient nil by mouth and to look for alternate means of nutrition and medications.

The relatives were again counselled and explained about the need of Ryle’s tube insertion. The relatives again refused for the Ryle’s tube insertion.

IV Labetalol and NTG infusion continued as oral anti-hypertensives could not be given due to swallow dysfunction.

Potassium correction was given with 1/2NS+10meq KCL

On 06/08/2023 Relatives agreed for insertion of Ryle’s tube. RT was inserted and planned for starting oral antihypertensives and feeds.

Presently the patient is oxygenating well on room air. The patient remains hypertensive requiring IV NTG and labetolol infusions. The patient is drowsy. The airway protection remains suboptimal.

The patient needs further ICU stay and further critical care monitoring and management. The relatives have been explained about the same. The relatives want to take discharge against medical advice. The relatives have been explained that this can cause deleterious effects on the clinical condition of the patient. The relatives have been explained about the possibility of life threatening complications arising from the uncontrolled blood pressure and aspiration pneumonitis. It has been explained to them that the patient needs to complete the course of IV antibiotics.

All the queries of the relatives have been answered. The relatives want to take discharge against medical advice; hence discharging the patient.

**ONGOING TREATMENT**

1. Inj Piptaz 4.5GM IV 1-1-1
2. Inj Pan 40mg IV 1-0-0
3. Inj Optineuron 1amp IV OD
4. Inj Paracetamol 1GM IV SOS
5. Inj Thiamine 500mg in 100ml NS OD
6. Tab Thyronorm 50mcg 2-0-0
7. Candid M/P 1-0-1
8. Duolin Neb 1-1-1
9. Budecort Neb 1-0-1
10. IVF with NS @ 80ml/hr.
11. Inj Labetalol @ BP IV infusion
12. Inj NTG@BP IV infusion

**Patient is discharged against medical advice.**

**Dr. VATSAL KOTHARI**

**DIRECTOR**

**CRITICAL CARE MEDICINE DEPARTMENT**

**Kokilaben Dhirubhai Ambani Hospital**

**Andheri ( West )**

**Mumbai**

**This is a Provisional summary. Kindly collect the final corrected version of Discharge against medical advice summary latter.**

**DAMA SUMMARY**

|  |  |  |
| --- | --- | --- |
| **UHID No: KH1000827061** |  | |
| **Name : Mrs. Trusha Hiten Gandhi** | **Age : 39 Years** | **Sex :Female** |
| **Date of Admission : 13/05/2023** | **Date of Discharge:** **18/05/2023** | |
|  | **Treating Doctor: Dr. SOURABH PHADTARE** | |

**OTHER CONSULTANT:**

**Dr. Sandeep Govle (Consultant Oncology)**

**Dr. Vidhi Shah (Consultant Oncosurgery)**

**Dr. Akshat Kayal ( Consultant Neurosurgery)**

**DIAGNOSIS;**

**Multiple Metastatic lesion in brain with midlinbe shift**

**K/C/O Carcinoma Of Right Breast.**

**Past history**

K/C/O Carcinoma of right breast diagnosed in July 2022

Underwent Right MRM +SLNB+ chemoport insertion on 25/07/2022

Received 4 cycles EC+dose dense Paclitaxel, was on Tab Tamoxifen 20 mg OD, last dose 15/11/2022.

**Presenting Complaints**

Headache with nausea since 4-5 days.

Altered sensorium since 1day

Drowsiness with decreased responsiveness ,restlessness so patient shifted to Life Line Hospital (PNH) where CT brain +MRI diffusion done on 12/05/2023:-multiple varying sized hererogenous enchancing mass lesion with adjacent edema in fronto-temporo-parietal region, likely metastasis. Patient received antiepileptics, steroids, Inj. Mannitol Neurosurgery team advised surgery, referred to KDAH for further management.

**Course in hospital:**

Patient brought with above mentioned complaints by relatives in Kokilaben Dhirubhai Ambani Hospital on admission in A&E . Patient was drowsy GCS—8/15 E1V1M5 with pupil-2.5 mm sluggish reactive, pulse-55/minute, BP-140/70 mmHg, SPO2-98%, HGT-168 mg/dl. Patient received in inj. Mannitol and shifted to icu. Patent intubated I/V/O of low GCS and central line and arterial line inserted, blood gasses shows-severe metabolic acidosis with lactic acidosis so correction started. Patient kept on ventilator and sedated and paralysed. MRI Brain was done s/o multiple parenchymal SOL in bilateral cerebral hemisphere, mild uncal herniation.

Patient was referred to Dr Akshat Kayal ( Consultant Neurosurgery) advice PET CT and to refer to Dr Sandeep Goyle after PET CT. PET scan was done on 16/05/2023 suggest 6\*2.3cm sized cystic collection in right mammary region/axilla. Multiple metabolically active rim enhancing lesions in cerebral parenchyma involving bilateral frontal lobes, left occipito-parietal and left cerebellum measures 2.6\*2.3cm. No evidence of metabolically active disease elsewhere within the body. Reference was given to Dr Sumeet Basu ( Radiation Oncology) for WBRT as advised by Dr Goyle and continued on Inj Mannitol, Inj Levipil, Inj Dexa. Advice Whole brain RT by Dr Sumeet Basu. Patients relatives had been explained about the scan reports, and the need of urgent WBRT, also the side effects of the same like increasing cerebral odema post RT, and the need of urgent surgery in case of worsening cerebral odema.

Patient was gradually weaned off from ventilator and extubated on 16/05/2023. Swallow assessment was done and started oral feeds. Patient was reviewed by Dr Akshat Kayal, the plan of decompressive craniotomy sos if needed has been discussed with the relatives. Relatives wish to take discharge home.

On 18/05/2023 patient was reviewed by Dr Goyle, relatives has been counselled about RT. Relatives wish to take WBRT outside. Advice OPD review with Dr Goyle 3-4 days post completion of WBRT for systemic therapy. Also advice to continue Tab Levipil 500 mg BID and Tab Dexa 4 mg TDS for 5 days then 4 mg BID till OPD review also to stop Inj Mannitol. Advice DAMA.

**Treatment in hospital:**

Inj Supacef 1.5 gm 1-0-1

Inj Levipil 500 mg 1-1-1

Inj Pan 40 mg 1-0-1

Inj Emset 4 mg 1-1-1-1

Inj Mannitol 50cc 1-0-1

Syp Cremaffin 15 ml 0-0-1

Coconut water 100 ml 1-0-1

**DR.SOURABH PHADTARE**

**CONSULTANT CRITICAL CARE**

**KDAH**

**DAMA SUMMARY**

|  |  |  |
| --- | --- | --- |
| **NAME: Mr. Syed Mumtaz Ali** | **Date of Admission : 13/02/2023** | |
| **UHID :KH1000232323** | **Age : 84 yrs.** | **Sex : Male** |
| **Date of Discharge : 15/02/23** | **Treating Consultant: Dr. Amit Raodeo** | |

**Diagnosis**

Acute Coronary Syndrome – NSTEMI with Cardiogenic Shock

Pulmonary edema

Type 2 respiratory failure

Community acquired pneumonia

Atrial Fibrillation

**Past History**

Carcinoma Prostate

Hypertension

**Reason for admission**

Rhintis and dry cough

Progressive exertional dyspnea

**Course in Hospital:**

The patient was brought to the emergency department with worsening of the above mentioned complaints on 13/02/2023.He was a known case of Carcinoma Prostate and Hypertension and was on radiotherapy, last fraction on 06/02/2023.

On arrival BP was 180/80, HR 170bpm atrial fibrillation, respiratory rate was 30/min and Spo2 was 82% on room air, he was kept on NRBM 15L O2/Min. Pitting pedal edema was present and the patient was drowsy. Chest X-ray showed pulmonary edema and left lower zone consolidation. ABG showed severe respiratory acidosis and type 2 respiratory failure and drowsiness gradually increased. Stat dose of magnesium sulfate, diuretics, hydrocortisone and first dose of Inj Clexane, Inj Piptaz and Levoflox were given.Inj Noradrenaline infusion was started in view of hyotension. He was started on NIV since there was no improvement with NRBM and was shifted to ICU for further management.

In the ICU patient was gasping and sensorium significantly declined, and the patient was intubated and started on mechanical ventilation. HsTrop I was 1204 and NT pro, screening 2D Echo showed reduced EF and posterior wall hypokinesia. Dr Sunil Wani advised cardiology intervention after hemodynamic stabilization, dual antiplatelets and statin were started. A fluid restriction of 1.2-1.5 L was followed. Electrolyte imbalances were corrected .Inspite of aggressive management S.creatinine, serum transaminases and serum sodium started rising, inotrope requirement increased and patient was started on Inj Vasopressin, phenylephrine and adrenaline for persisting hypotension.

On 15/02/2023 Inotrope and FiO2 requirement further increased with decreased urine output, and the relatives were explained regarding the current critical condition and guarded prognosis. The need for Intra-aortic Balloon Pump was explained. However relatives wish to discharge the patient against medical advice. The risks and possible mishaps during discharge and transfer has been explained to the relatives. The patient is being discharged against medical advice as per the relatives’ wish.

**Treatment during hospitalization**

Inj Monocef 1gm IV 1-0-1

Inj Pantop 40mg IV 1-0-1

Inj Lasix 10mg IV 1-1-1

Inj Noradrenaline IV infusion according to BP

Inj Adrenaline IV infusion according to BP

Inj Frenin IV infusion according to BP

Inj Vasopressin IV infusion according to BP

Tab Azee 500mg 1-0-0

Tab Ecospirin 75mg 0-1-0

Tab Clopidogrel 75mg 0-1-0

Tab Atovastatin 80mg 0-0-1

Syp Kesol 5ml 1-1-1

Syp Cremaffin 30ml 0-0-1

**KDAH**

**Date: 15/02/2023**

**Dr Amit Raodeo**

**Consultant Intensivist**

**DISCHARGE SUMMERY**

|  |  |  |
| --- | --- | --- |
| **UHID No : KH1000825832** |  | |
| **NAME: Mr. Avantikumar Shah** | **AGE : 87Years** | **SEX : Male** |
| **Date of admission : 01/03/2023** | **Date of discharge:** | |
| **Treating Doctor : Dr Khushboo Kataria** |  | |

**Other Consultants**

Dr. Amol Ghalme ( Consultant Plastic Surgeon)

Dr. Niranjan Kulkarni ( Consultant Nephrologist)

Dr. Tushar Raut( Consultant Neurologist)

Dr Venkat D Nagarajan (Consultant Cardiologist & Eletrophysiologist)

Dr Prashant Nair ( Consultant Cardiologist)

**DIAGNOSIS**

Acute Congestive Heart Failure( LVEF- 30%)

Atrial Fibrillation with Fast Ventricular Rate/ Ventricular Tachycardia

Acute Kidney Injury

Lower Respiratory Tract Infection

**PAST HISTRY**

Hypertension

Hypothyroidism

Chronic Obstructive Pulmonary Disease

Ischemic Heart Disease(S/P CABG-2023) with Congestive Cardiac Failure

H/O -LV Apical Clot (july 2022)

-Left Popliteal Deep Venous Thrombosis(july 2022) on tab. Eliquis 2.5mg

-Right Lower Limb Cellulitis(july 2022)

S/P Left TKR

**PRESENTING COMPLAINTS:**

Dyspnea on excertion since 3 days

Coughing since 3 days

Breathlessness since 3days

Decreased urine output since 3 days

**COURSE IN HOSPITAL:**

The patient came with above mentioned complaints in kokilaben dhirubhai ambani hospital. On admission in A&E -pulse-122/minute,SpO2-97% on room air, BP-134/70mmHg, HGT-145mg/dl. On O/E RS- B/L crepts+ inj. Lasix 40mg iv stat f/b infusion started and inj. Cardarone 75mg iv stat given i/v/o tachycardia and shifted to icu for further management.

On 02/03/2023 Dr. Prasant Nair (Consultant Cardiologist) i/v/o of AF with FVR, LVEF- 30% he adviced- continue inj. cardarone infusion and added tab. Mexohar50mg, nebulization duolin, budecort and thyroid profile. At evening BP dropped so noradrenaline infusion started and blood gasses shows- severe metabolic acidosis with lactic acidosis so sodabicorbonate infusion with iv fluid NS started for hydration.

Patient lactate was in increasing trend (12.7), SGOT & SGPT increased secondary to congestive hepatitis.- Nephrology reference was taken he advised for NAC infusion. So NAC Infusion and cardarone infusion was stopped in view of deranged Liver profile. Patient was tachypneic and tachycardic and in acidotic breathing , planned for intubation (sos). As per relative request, negative directive for intubation(DNI) was taken.

So patient kept on NIV intermittently i/v/o tachypnea.

On 03/03/2023 Dr. Niranjan Kulkarni( Consultant Nephrologist) refrence taken i/v/o AKI creatine -2.08mg/dl, decreased urine out put and metabolic acidosis he adviced- USG KUB, fluid restriction, ABG 8th hourly, tab. Eytanix 5mg bid, maintain MAP >70mmhg, avoid nephrotoxic drugs. 2DECHO done- Lvef -30%, Rwma, severe PH, severe LV dysfuntion.

On 4/3/23 Nasal prongs with intermittent NIV trilas continued , Lasix tapered and stopped .

On 5/3/23 added inj. fragmin in view of DVT prophylaxis.

ON 8/3/23 Patient had loose motion, same day inj frragmin was withhold in view of excoriation over buttock area and managed accordingly.

On 12/3/23 . s morning ECG showed complex tachycardia (? VT), given cardarone and catetherised .Dr. Prasant nair sir review reference taken 🡪 advice noted.

But patient was still in tachycardia (?VT) Discussed with Dr Nair sir advised intravenous Betaloc ,but still Rhythm remains persistently same so patient was Cardioverted with 100joules, under short seation. . patient reverted to sinus rhythm.

On 13/3/23 dr tushar raut sir reference was taken in view of increased drowsiness 🡪 advised to stop t. synaptol and added t modalert and brain imaging (sos) and secured Ryels tube.

On 14/03/2023 dr. amol ghalme refrence is taken i/v/o- Bed sore hae adviced- Mepilex, dusting powder apply on bed sore and 2nd hourly change position, use air bed.

On 15/3/23 inj fragmi was added and rt feed continued .

On 16/3/23 patient again had sudden episode of hypotension (70/40 mm hg) with v- tachycardia , patient was immediately startred with ionotrope support and discussed with Dr nair sir and cardioverted with 150 joules.--> reverted to sinus. Dr Nair sir review was taken 🡪 advice noted.

On 17/3/23 Dr Venkat D Nagarajan sir reference was taken in view of arrhythmia and advice 🡪 noted

Slowly tapered Nor adrenaline dose and stopped and optimization of oral antihypertensive done.

On 20/3/23 central line was removed and ECG- was showing normal sinus rhythm, had episode of hypotension 🡪 managed by IV Fluid bolus and foleys catether was inserted and secured.

Now patient is in stable condition with hemodynamically stable ,hence plan for discharged.and now patient is being discharged in stable condition

**TREATMENT GIVEN DURING ADMISSION**

Inj. Piptaz 2.25gm iv 1-1-1

Inj. Hydrocortisone 100mg iv 1-0-0

Inj. Lasix iv 4ml/hour infusion

Inj. Pantop 40mg iv 1-0-0

Inj. Sodabicorbionate iv 15ml/hour infusion

Inj. NAC iv infusion 1ml/hour

Inj. Noradrenaline iv infusion according to BP

Inj. Fragmin 2500 units s/c alternate day

Inj. Potassium chloride 40meq+ 50ml NS iv slowly over 4hour

Inj. Magnesium sulphate 2gm + NS100ml iv slowly

Inj. Xylocard iv infusion according to HR

Tab Urcosol 300mg PO 1-0-1

Tab. Eltroxin 25mcg po 1-0-0

Tab. Met XL 25mg po 1-0-0

Tab. Veltam Plus 0.5MG PO 0-0-1

Tab. Urotone 25mg PO 1-1-1

Tab. Angiospan TR 2.5mg PO 1-1-0

Tab. Atorvas 20mg PO 0-0-1

Tab. Synaptol 50mg PO 1-0-1

Tab. Shelcal 5000mg PO 1-0-0

Tab. Febuxostat 40mg PO 1-0-1

Tab. Mexohar 50mg PO 1-0-1

Tab. Dytor 10mg PO 1-0-0

Tab. Silodol –D 8/0.5 PO 0-0-1

Syrup. Kesol 10ml PO 1-1-1

ECONORM Sachests PO 1-1-1

DUOLIN NEB INH 1-1-1

BUDECORT NEB INH 1-0-1

**ON GOING TREATMENT :-**

**Tab pantop 40mg rt 1-0-1**

Tab. Eltroxin 25mcg po 1-0-0

Tab. Met XL 25mg po 1-0-0

Tab. Veltam Plus 0.5MG PO 0-0-1

Tab. Urotone 25mg PO 1-1-1

Tab. Angiospan TR 2.5mg PO 1-1-0

Tab. Atorvas 20mg PO 0-0-1

Tab. Synaptol 50mg PO 1-0-1

Tab. Shelcal 5000mg PO 1-0-0

Tab. Febuxostat 40mg PO 1-0-1

Tab. Mexohar 50mg PO 1-0-1

Tab. Dytor 10mg PO 1-0-0

Tab. Silodol –D 8/0.5 PO 0-0-1

Tab mucomix 650mg rt 1-0-1

Review with SGOT/PT in 7days in opd

**Dr Khushboo Kataria**

**Consultant Critical Care Medicine**

**Kokilaben Dhirubhai Ambani Hospital**

**DISCHARGE**

|  |  |  |
| --- | --- | --- |
| **UHID No : KH1000267163** |  | |
| **Name: Mrs Hirabai Rakhmaji Salve** | **Age : 86 Years** | **Sex : Female** |
| **Date of Admission : 01/01/2023** | **Date of Discharge: 16/01/2023** | |
| **Treating Doctor : Dr Sourabh Phadtare** |  | |

**Other Consultants**

Dr Sanjiv Badhwar (ENT Consultant)

**DIAGNOSIS**

Tracheostomy Tube Blockage

**Past History**

Hypertension

Right MCA Stroke s/p Thrombolysis and Mechanical Thrombectomy

Chronic Kidney Disease

**PRESENTING COMPLAINTS:**

Patient came with c/o respiratory distress since 30 mins and developed mucous plug in TT tube which was blocked. There was difficulty in passing suction catheter,spo2 was decreased and increased secretions and breathlessness. Hence shifted to KDAH.

**COURSE IN HOSPITAL:**

Patient with above mentioned complaints came to KDAH and was admitted in ICU. After passing suction catheter, mucous plug obstruction was felt, suctioning of blocked TT tube was done following which dysnoea resolved. In ICU, TT tube was changed with No 7 TT tube. After reinsertion spo2-99%,P-58/m,BP-144/80,there were fine crepts in both lungs,yellowish and thick secretions were seen. Secretions from ET were send for Culture and Sensitivity. Post procedure patient was hemodynamically stable. Gentle Chest and Limb PT was also started.

Patient’s condition was stable and hence discharged to home.

**TREATMENT GIVEN IN HOSPITAL:**

**TREATMENT ON DISCHARGE:**

**Dr Sourabh Phadtare**

**ICU Consultant**

**Kokilaben Dhirubhai Ambani Hospital**

**DISCHARGE**

|  |  |  |
| --- | --- | --- |
| **UHID No : KH1000002401** |  | |
| **Name: Mr Jaywant Odhavji Chavda** | **Age : 74 Years** | **Sex : Male** |
| **Date of Admission : 25/04/2023** | **Date of Discharge: 30/04/2023** | |
| **Treating Doctor : Dr Sourabh Phadtare** |  | |

**Other Consultants**

Dr Tushar Raut (Neurologist)

**DIAGNOSIS**

Lower Respiratory Tract Infection/Bilateral lower lobe pneumonia

**Past History**

Hypertension

Asthma/Obstructive Airway Disease

Facio-scapular-humeral muscular dystrophy

**PRESENTING COMPLAINTS:**

Patient came with c/o fever, cough with expectoration, breathlessness since 2 days.

**COURSE IN HOSPITAL:**

Patient with above mentioned complaints came to KDAH and was admitted in ICU. Patient was started on IV antibiotics, IV fluids, Nebulizations, IV steroids and required intermittent NIV ventilation for raised pCo2. IV antibiotics was started with Inj Monocef 1GM BD and Inj Azee 500mg OD. Chest X Ray done showed bilateral lower lung infiltrates

HRCT Chest done showed bilateral lower lobe consolidations s/o pneumonia.

2D Echo done showed LVEF-55% with No RWMA and severe PH

Blood C/S and Urine C/S – Showed no growth

Patient was switched from intermittent NIV to intermittent Home BiPap for 4 hours daytime and 6 hours overnight.

Neurology Reference was given to Dr Tushar Raut and his advice followed to start Cap Quogress OD and physiotherapy exercises.

Patient was given 5 days course of IV antibiotics and IV steroids was gradually tapered and stopped. Patient’s condition was stable and hence discharged to home.

**TREATMENT GIVEN IN HOSPITAL:**

1. Inj Monocef 1GM IV 1-0-1
2. Inj Azee 500mg IV 1-0-0
3. Inj Pan 40mg IV 1-0-0
4. Neb Duolin INH 1-1-1
5. Neb Budecort INH 1-0-1
6. Inj Hydrocort 50mg IV 1-0-1
7. Inj Thiamine 100mg IV 1-0-0
8. Inj Optineuron 1amp IV OD
9. Inj Lasix 20mg IV SOS
10. Cap Quogress 1cap PO 1-0-0

**TREATMENT ON DISCHARGE:**

**Dr Sourabh Phadtare**

**ICU Consultant**

**Kokilaben Dhirubhai Ambani Hospital**

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **Name : Mrs Manisha gohil** | **Age : 46 years** | **Sex : Female** |
| **Date of Admission :13/03/2023** | **Date of Discharge :** | |
| **UHID : KH1000776075** | **Treating Doctor : Dr.Sourabh Phadtare** | |

**Other Consultants involved:**

Dr Dattatray (Consultant Gastroenterologist)

Dr R. Shekhar (Consultant Vascular Surgeon)

Dr Aparna (Consultant Psychiatrist)

Dr Dheeraj Kapoor (Consultant Endocrinologist)

Dr Sunil Wani (Consultant Cardiologist)

Dr Sameer Tulpule (Consultant Hematologist)

Dr Amol Ghalme (Consultant Plastic Surgeon)

Dr Sunil Singh (Consultant Rheumatologist)

Dr Gordhan (Consultant Interventional Radiologist)

Dr Abhishek Srivastav (Consultant Rehabilitation)

**Diagnosis:**

Bilateral lower limb cellulitis – status post left leg below knee amputation + right lower limb debridement

Bicytopenia

Coagulopathy

DIC

Hypoalbuminemia

DAT +

Dyselectrolytemia

**Past History**

Diabetes mellitus

Hypothyroidism

Anxiety disorder

Bilateral cellulitis (multiple times)- prolonged stay

UTI

Severe Dehydration

? Nutritional deficiency

? Autoimmune disease

**Course in hospital**

Patient came with chief complaints of

Breathlessness since 2 days

Orthopnea since 2 days

Bilateral lower limb cellulitis with pain since 2 days

Bleeding for bed sore since 2days

Decreased appetite since 2 months

Bed bound since 2018 🡪 body has become stiff (unable to move hand and legs since 10 days)

Bilateral lower limb cellulitis since 2 months

**Treatment given during stay :**

Inj Poly B 7.5LU 1-0-1

Inj Elores 3gm 1-0-1

Inj Meropenem 1gm 1-1-1

Inj Targocid 200mg 1-0-0

Inj Clindamycin 600mg 1-1-1

Inj Tigecycline 100mg 🡪 50mg 1-0-1

Inj Optineuron 1amp 1-0-0

Inj Hydrocort 100mg 1-1-1

Inj Thiamine 500mg 1-0-1

Inj Vit C 500 mg 1-1-1

Inj Celcel 1amp 1-0-0

Inj NAC infusion

Inj Pan40 mg 1-0-1

Inj Human Albumin 20% 1-0-0

Inj HAI acc HGT 1-1-1

Inj Lantus 6U at 10pm

Inj Milrinone infusion

Inj Noradrenaline infusion acc to BP

Inj Vasopressin infusion acc to BP

Inj Lasix infusin

Tab Clindamycin 600mg 1-1-1

Tab Folvite 5mg 1-0-1

Tab Ivabrad 7.5mg 1-0-1

Tab Thyronorm 25mcg 1-0-0

Tab Ursocol 300mg 1-1-1

Tab Rifagut 550mg 1-0-1

Cap Redotil 100mg 1-1-1

Tab Lasilactone 20/50mg 1-0-0

Tab Asprito 2mg ½ -0-½

Tab Modalert 100mg ½-½-0

Tab Melatonin 3mg SOS

Tab Immodium 2mg 0-1-0

Cap VSL3 1-0-1

Syp Sparacid 10mg 1-1-1-1

Syp Kesol 10mg 1-1-1

AddPhos sachet 1-1-1

Econorm sachet 1-1-1

Venusia Max Lotion 1-1-1

IV Fluids

**Medications on discharge**

**Dr. Sourabh Phadtare**

**Consultant Intensivist**

**Critical Care Medicine**

**Kokilaben Dhirubhai Ambani Hospital**

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **PATIENT’S NAME**: Mrs Kanta Devi Paliwal | **UHID No** : KH1000005843 | |
| **DATE OF ADMISSION** : 26/04/2023 | **AGE**: 78 years | **SEX** : Female |
| **DATE OF DISCHARGE** : | **TREATING DOCTOR** : Dr Sourabh Phadtare | |

**OTHER CONSULTANTS**

Dr. Sharad sheth (Consultant Nephrologist)

Dr. Gaurav Mehta (Consultant Gastroenterologist)

**DIAGNOSIS:**

Pulmonary Edema/ Fluid Overload

Urosepsis

**OTHER COMORBITIES:**

Ischemic Heart Disease

Triple Vessel Disease S/P CABG

Chronic Kidney Disease

Hypertension

Diabetes Mellitus

Ca Stomach

H/O recent admission Aspiration Pneumonia with LRTI with Bilateral pleural effusion,Septic Shock with Acute Gastroenteritis,Atrial Fibrillation,Bilateral Parietal Occipital infarct with Right Hemiplegia (Posterior Circulation Stroke),Acute Kidney Injury on Chronic Kidney Disease,Ischemic Cardiomyopathy

**CHIEF COMPLAINTS:**

Breathlessness since todays morning at 3:30pm and increased since last 2hours

H/o patient on home ventilator with nebulization and h/o extra 500ml fluid given in last 2days.

H/O recent admission Aspiration Pneumonia with LRTI with Bilateral pleural effusion,Septic Shock with Acute Gastroenteritis,Atrial Fibrillation,Bilateral Parietal Occipital infarct with Right Hemiplegia (Posterior Circulation Stroke),Acute Kidney Injury on Chronic Kidney Disease,Ischemic Cardiomyopathy

**COURSE AT HOSPITAL:**

Patient with above complaints brought to KDAH.

On arrival, HR 87 beats per min ; BP -150/80 mm Hg; Spo2 100% Room Air; RR 28 pm, HGT-247mg/dl, GCS-9/15

RS crepts ++

CNS: drowsy moving all 4 limbs

Inj. Lasix 20mg iv stat given and in EPOC- metabolic acidosis, labs on admission- Na-128, K-5.06, Hb-8gm/dl, WBC-19000, Urea-273, creat-3.69mg/dl patient was shifted to icu for further management.

0n 26/04/2023 Dr. Sharad Sheth ( Consultant Nephrologist) reference is given i/v/o raised creatinine, metabolic acidosis- he advised urine routine& microscopy, fluid restriction 1.3- 1.5litre/day, RRT sos, IVF½ NS with soda bicarbonate infusion.

On 27/04/2023 Dr. Gaurav Mehta ( Consultant Gastroenterologist) given refrence i/v/o stool occult blood positive- he adviced Cap. Redotril 100mg sos, inj. Metrogyl 500mg iv tid, continue peg feed.

TT changed on 27/04/2023 – i/v/o TT block

**TREATMENT DURING HOSPITAL STAY:**

**TREATMENT AT THE TIME OF DISCHARGE:**

**Dr. Sourabh Phadtare**

Consultant

Critical Care Department

Kokilaben Dhirubhai Ambani Hospital

**DISCHARGE SUMMERY**

|  |  |  |
| --- | --- | --- |
| **UHID No : KH1000881570** |  | |
| **Name: Mrs Shobhana Shashikant Patyane** | **Age : 75 Years** | **Sex : Female** |
| **Date of Admission : 22/06/2023** | **Date of Discharge: 27/06/2023** | |
| **Treating Doctor : Dr Sourabh Phadtare** |  | |

**Other Consultants**

Dr Praveen Kahale (Consultant Cardiologist)

Dr Ismail Attar (Consultant Urologist)

Dr Gaurav Mehta (Consultant Gastroenterologist)

Dr Abhijit Pawar (Consultant Orthopedic)

**DIAGNOSIS**

Acute Coronary Syndrome

Acute Left Ventricular Failure

Acute Kidney Injury

Lower Respiratory Tract Infection

Atrial Fibrillation with Fast Ventricular Rate

**Past History**

Hypertension

Diabetes Mellitus

Bronchial Asthma

? Dyslipidemia

? Hyperthyroidism

H/o Renal Stone Surgery

B/L Total Knee Replacement surgery

L3-4, L4-5 Spondylolisthesis with Stenosis( s/p MIS-TLIF done on 17/06/2023 and discharged on 18/06/2023 under Dr. Abhijit Pawar)

H/o Preop PFT – mild restrictive ventilator defect with no past bronchodilator reversibility and narmal diffusion. D-dimer-1112.38, Fibrinogen-461,Creatine- normal, 2D-ECHO- EF-60%

**PRESENTING COMPLAINTS:**

Now patient came with c/o shortness of breath , palpitation, chest pain on/off , decreased urine output, constipation since 2 to 3 days so admitted in LH. Hiranandani Hospital and diagnosed- Acute Coronary Syndrome with Acute LVF, AKI, LRTI, anemia HB-7.5mg/dl received 1 blood transfusion and patient taken DAMA and shifted kdah for further treatmennt. Out side labs- d-dimer-6400, proBNP-8310, trop-i-4020, creatinine-1.7mg/dl.

**COURSE IN HOSPITAL:**

Patient brought to kdah with above complaints on admission in A&E

Vitals- Pulse-103,Bp-140/70,SpO2-91% on RA,HGT-102mg/dl. O/E- R/S- b/l crepts+, Extremities- b/l mild pitting edema. ECG- shows ST inversion on in v3-6, avf. All labs sended and inj. Lasix 20mg bolus f/b infusion, inj. Piptaz4.5mg start given and shifted to ICU. Patient was kept on nasal prong 2litre/minute Spo2- 99%. Hrct chest and abdomen done on 22/02/2023- suggestive of airway disease and lobulated margin of both kidney with minimal right perinephric fat standing. Lab-Creatinine-1.88mg/dl,k-5.11,Hb-9.1gm/dl,WBC-16910,CRO-35.30,NtproBNP-8984, Trop-I-4475.

On 23/05/2023 patient had AF with FVR- Heart Rate-170-180/minute so inj. Mgso4 2gm iv, inj. Cordarone150mg iv slowly received and reverted back to sinus rythum. 2d echo done- LVEF-55%, NO RWMA, mild PH.

Dr. Abhijit Pawar reference given i/v/o post operative MIS- TLIF- he advice dressing and dressing done.

Dr. Praveen Kahale reference is given i/v/o raised troponin-I, ecg changes and atrial fibrillation with fvr- he advised tab. ecosprin 75mg, LMWH(fragmin 5000iu od.

0n 24/06/2023 Hb-10.2gm/dl and stool occult blood – positive so Dr, Gaurav Mehta reference given- he advised- daily CBC, Tab. Pan40mg bid, w/f GI bleed, EGD/ Colonoscopy sos.

Dr. Ismail Attar reference is given i/v/o acute urinary retension- he advised tab. silodal 8mg od, tab. urotone35mg bid, avoid constipation, continue catheterization.

At present patient is hemodynamically stable pulse-86/minute, Bp- 120/80mmhg, SPO2-97% on room air. Hence been discharged

Advised- to fallow up in OPD after 10days with CBC, BUN, CREATINE, ELETROLYTES.

**TREATMENT GIVEN IN HOSPITAL:**

1. Inj Piptaz 4.5gm IV 1-0-1
2. Inj Lasix IV infusion
3. Inj Optineuran 1ampIV 1-0-0
4. Inj Thaimine 100mg IV 1-0-0
5. Inj Pantop 40mg IV 1-0-1
6. Inj Emeset 4mg IV sos
7. Inj Encicarb 1gm IV 1-0-0
8. Inj Cordarone 150mg IV stat
9. Inj. Fragmin 5000iu S/C 0-0-1
10. Inj. Magnisium Sulphate 2gm IV stat slowly
11. Tab. Ivabrad 2.5 mg po 1-0-1
12. Tab. Ecosprin 75mg po 0-1-0
13. Tab. Clopitab 75mg po 0-1-0
14. Tab. Febuxostat 40mg po 1-0-0
15. Tab. Telma 40mg 1-0-1 according to BP
16. Tab. Deriphylline 150mg 1-0-1
17. Tab .Arkamine 0.1mg PO 1-1-1 according to BP
18. Duolin nebulization INH 1-0-1
19. Budecort nebulization INH 1-0-1
20. Syrup. Cremaffin 15ml po 1-0-1
21. Zytee gel LA 1-1-1

**TREATMENT ON DISCHARGE:**

1. Tab. Pan 40mg po 1-0-1
2. Tab. Ivabrad 2.5mg 1-0-1
3. Tab. Febuxostat 40mg po 1-0-0
4. Tab. Optineuron tab po 1-0-0
5. Tab. Silodal 8mg po 0-0-1
6. Tab. Urotone25mg po 1-0-1
7. Tab. Folvite 5mg po 1-0-1
8. Tab. Lasix 20mg po 1-0-0
9. Tab. Vitamin-c tab po 1-0-1 for 10days
10. Tab. Thiamine 100mg po 1-0-0 for 10days
11. Tab. Emiset 4mg po sos
12. Zytee gel local apply per oral 1-1-1 for ulcers

**Dr Sourabh Phadtare**

**Consultant Critical Care Medicine**

**Kokilaben Dhirubhai Ambani Hospital**

**Andheri West**

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **UHID No** : KH1000072784 |  | |
| **Name :** Mr. KAMALAKAR POTDAR**PI_VIP** | **Age :** 83 Years | **Sex :** Male |
| **Date of Admission :** 14/04/2023 | **Date of Discharge :** | |
| **Treating Doctor:** Dr. KHUSHBOO KATARIA | | |

**OTHER CONSULTANT** :

Dr. ABHAY KUMAR (Consultant Neurosurgeon)

**DIAGNOSIS:**

1. ASPIRATION PNEUMONIA WITH VOLUME OVERLOAD
2. ACUTE GASTROENTERITIS

**PAST HISTORY:**

1. HYPERTENSION
2. TYPE 2 DIABETES MELLITUS
3. CHRONIC KIDNEY DISEASE
4. INTRAVENTRICULAR HEMORRHAGE (LEFT THALAMIC BLEED)

**COURSE IN HOSPITAL:**

Patient was on the way to KDAH for a routine follow up CT scan of brain. He had complaints of

1.)Slight drowsiness since 1 hour

2.)Breathlessness since 15 minutes.

Hence patient was brought to A & E. On arrival vitals were as follows – BP:120/80 mm Hg, Pulse rate-118/min, Respiratory rate 38/min, Temperature 99.5 Fahrenheit, SpO2 -100%. EPOCH results were ph-7.49, pCO2-7.49, HCO3-23.1, Na-145, Potassium – 3.0, Creatinine-3.31 and lactate 2.46. Patient was started on Non invasive ventilation. Patient was administered diuretics, nebulization, intravenous steroids with antibiotics and shifted to ICU. Chest x ray was done s/o Bilateral hilar shadows and fluid overload.

A CT Brain plain was done which was s/o progressive interim reduction in size and density of left thalamic hematoma as well as reduction in the density of intraventricular haemorrhage which was gradually resolving. No significant midline shift. No significant hydrocephalus. Minimal prominence of the ventricles is likely ex vacuo and related to brain parenchymal atrophy. Except for chronic ischemic changes, the rest of the brain parenchyma including the right cerebral hemisphere, right sided deep gray nuclei, brainstem and cerebellum are normal.

Dr. Abhaya Kumar’s opinion was sought in view of this scan and he adviced nil active intervention.Swallow assessment done on 15/4 was s/o oropharyngeal dysphagia and therefore RT feeds continued . Patient is conscious , following commands .

On 15/04/2023 patient had 5 episodes of loose stools and started developing mild to moderate abdominal pain and hence stool routine and C. diff were sent.Antibioitcs was changed to Monocef and Metrogyl . C Diff is negative .He has loose stools and also has dyselectrolemia . Relatives have been explained about need for hospitalisation .However , they wish to take patient after understanding consequences of same including risk of further deterioration . Therefore patient is being given discharge against medical advice .

**CONDITION AT DISCHARGE:**

At present patient is hemodynamically stable, stable sugars, good urine output. Foleys catheter in place.

**TREATMENT GIVEN AT HOSPITAL:**

INJ PAN 40 MG IV 1-0-0

INJ OPTINEURON 1 AMP IV 1-0-0

DUOLIN NEB 1 RESP INH 1-1-1

BUDECORT NEB 1 RESP INH 1-0-1

INJ HYDROCORT 50 MG IV 1-0-1

TAB MINIPRESS XL 5 MG RT 1-0-1

TAB APRESOL 25 MG RT 1-1-1

TAB NICARDIA-R 20 MG RT 1-1-1-1

TAB MOXOVAS 0.3 MG RT 1-0-1

TAB SILODAL 8 MG RT 0-0-1

TAB ROSEDAY-F 10 MG RT 0-0-1

INJ MONOCEF 1 GM IV 1-0-1

TAB POTRATE 10 MG RT 1-1-1

TAB UROTONE RT 1-1-1

ECONORM SACHET 1-1-1-1

INJ METROGYL 100 MG IV 1-1-1

**TREATMENT ON DISCHARGE:**

TAB MINIPRESS XL 5 MG 1-0-1

TAB APRESOL 25 MG RT 1-1-1

TAB NICARDIA-R 20 MG RT 1-1-1-1

TAB MOXOVAS 0.3 MG RT 1-0-1

TAB SILODAL 8 MG RT 0-0-1

TAB ROSEDAY-F 10 MG RT 0-0-1

TAB UROTONE RT 1-1-1

**Dr. KHUSHBOO KATARIA**

**Consultant**

**Critical Care Medicine**

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| UHID No : KH1000801558 |  | |
| Name: Mrs Rohini Surve | Age : 76 years | Sex :Female |
| Date of Admission : 24/02/2022 | Date of Discharge: 05/03/2022 | |
| Treating Doctor: Dr.VATSAL KOTHARI |  | |

**Attending Consultants –**

DR.Tushar Raut Consultant- Neurologyhttp://em.kdahit.com/HIS/eCommon/images/activeArrow.gif

Dr.Gordhan Sangani Consultant- Interventional Rahttp://em.kdahit.com/HIS/eCommon/images/activeArrow.gifdiology

Dr. Prashant Nair (Consultant Cardiology)

Dr.Rajendra Sonawane Consultant- General Surgery

Dr.Tanu Singhal Consultant Infectious Disease http://em.kdahit.com/HIS/eCommon/images/activeArrow.gif

**Issues:**

Gastric perforation with right subdriaphragmatic collection

Stress cardiomyopathy

**Past Medical history**

Hypertension

Autosomal dominant spinocerebellar ataxia since 10 years

The patient was bedridden since 2 years ,was able to walk with support only .The patient had abdominal pain since 7 days ,was ,admiited to Life line hospital on 17/02/2022.USG abdomen was done which was s/o Right subdiaphragmatic and liver collection ,Right sided pleural effusion .CECT chest ,abdomen ,Pelvis was done which was s/o small focal mucosal defect noted within pylorus of the stomach measuring 7mm thin defect below inferior surface of the left lobe of the liver s/o perforation .Mild to moderate perihepatic fluid,pleural effusion with subsegmental collapse mild subacute edema in right hypochondriac region,Repeat CT scan s/o increase in the collection from the previous scan .The patient was transferred to KDAH for further management

**Course on hospitalization:**

Patient shifted to A & E with above mentioned history and complaints .On admission BP 160/10omm Hg ,HR 104/min SP02 98% on O2 4Lit/min ..Right IJV in situ+ ,Foleys catheter in situ +,On Abdomen examination generalized tenderness over abdomen +.abdomen distention +,On Respiratory system examination B/L wheeze + The patient was intubated i/v/o respiratory distressin A& E .Shifted to ICU for further management .

Routine investigations and cultures were sent. On admission serum sodium was raised 150, serum potassium low 3.0, phosphorus decreased 1.1 ,Hb 10.2 g/dl ,WBC raised 13300. Chest xray s/o Right basal consolidation. I/V/O hypotension inotropic support with Noradrenaline started. Antibiotics started .

Trop I was raised 911.2 Cardiology opinion with Dr. Prashant Nair was taken and advice followed. 2Decho was done which was s/o LVEF 20%to 25%, hypoknesia of apex ,mid and apical segment present , features s/o stress cardiomyopathy. General surgery opinion with Dr.Sonawane was taken and advice followed. Dr.Gordhan Sangani reference was taken and pigtail insertion was done.

The patient had B/L upper limb restricted movement, orthopedic opinion was advised but the relative (son) refused for the same. Dr.Tanu Singhal( infectious disease )opinion was taken and advice followed.

CT Abdomen and pelvis was done prior to pigtail removal which was s/o right subdiaphragmatic collection with pigtail catheter in situ. Right mild to moderate pleural effusion, anterolisthesis of L5 over S1 with B/L paralysis .Review with Dr.Sonawane was taken - advised conservative management. Blood c/s ,Urine c/s ,CSF Fluid c/s showed no growth.

Neurology opinion was taken with Dr. Tushar Raut, advised starting T. Quogress, T. Ginkocer Ferric and to consider trial of levodopa.

Gradually inotropic support was tapered and stopped. Pigtail cather removed eventually. Tracheostomy was performed on 01/03/22 uneventfully. Subsequently, the patient was progressively weaned off the ventilator over a 36-hour period. Initially, she demonstrated suboptimal respiratory effort. As of 04/03/2022, she has tolerated an extended T-piece trial. She is also tolerating plain water through the Ryle’s tube. Nutritional needs are currently being met by TPN. The patient is scheduled for a swallow assessment on 04/03/22 as well as a monitored trial of more substantial feeds and review by Dr. Nair and Dr. Sonawane.

**Treatment during hospitalization :**

Inj. Meropenem 1gm i.v 1-1-1

Inj.Tigecycline 100mg 1-0-0

Inj.Fluconazole 400mg i.v 1-0-0

Inj.somzo 40mg i.v 1-0-0

Inj.Optineuron i.v 1AMP 1-0-0

Inj.Noradrenaline IV @BP

Inj.Clexane 40mg s/c 0-0-1

Inj.MVI 1Amp 1-0-0

Inj.Lasix 10mgIV 1-0-1

Tab.Canisure 500mg 1-0-1

Tab Flavedon MR 1 tab 1-0-1

TPN @ 50ml/hr

**Signature:**

Dr. VATSAL KOTHARI

Consultant Critical Care Medicine

KDAH

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **Name: Mrs. GEETA DESAI** |  | |
| **UHID: KH1000818301** | **Age : 72 Year** | **Sex : FEMALE** |
| **Date of Admission: 28/05/2022** | **Date of Discharge :** | |
| **Treating Doctor : Dr.Vatsal Kothari** |  | |

**Diagnosis:**

Subarachnoid Haemorrhage Grade IV – Right MCA pre bifurcation saccular aneurysm , balloon assisted coiling done.

**Past History:**

History of Space occupying lesion in Right frontoparietal area of brain– operated 40 years back

**Other Consultants:**

Dr.Tushar Raut (Consultant Neurologist)

Dr. Manish Shrivastava (Consultant inteventiontional neuroradiologist)

Dr Abhay Kumar ( Neurosurgeon)

Dr.Sandeep Wasnik (Consultant Orthopedic surgeon)

Dr Shaunak Ajinkya ( Psychiatrist)

Dr. Aparna Ramkrishanan ( Psychiatrist ).

**Chief Complains:**

Severe Headache and 2-3 episodes of vomiting since 30/11/2021

**Course:**

85 year old female patient had complaint of headache and vomiting since 30/11/2021 evening then presented to Sterling hospital where she was diagnosed with Grade 4 subarachnoid hemorrhage with cerebral edema on CT brain.MRI brain was suggestive of Right MCA – M1 saccular aneurysm with mild hydrocephalus.

Patient was shifted to KDAH for further management.Patient presented to A&E in KDAH on 01/12/2021 with BP – 194/88 mm of Hg with GCS 13/15 E3M6V4 was admitted under Dr.Vatsal Kothari.Patient was started on Inj.Labetalol infusion and taken up for urgent DSA.

Patient had a difficult intubation in the Cath lab due to grade 3 larynx. DSA was suggestive of Right pre MCA bifurcation saccular aneurysm for which balloon assisted coiling was done.Sheath was removed post coiling.Patient was then shifted to ICU post procedure while sedated on Fentanyl and Midazolam.

Patient was started on Inj.Mannitol,Inj.Levipil,Tab.Nimodipine post procedure.

CT Angio + brain and neck(02/12/2021) – Acute grade 4 SAH involving bilateral convexity sulci,basal cisterns,sylvian fissures and MCA cisterns with asymmetric involvement on the right and intraventricular extension to both the lateral.3rd and 4th ventricles.Mild ventricular dilatation with transependymal CSF migration.No midline shift or uncal herniation.No large acute territorial infarct.

Post right distal M1 aneurysm coiling with good contrast opacification of right MCA,cortical and sylvian branches.No critical stenosis seen in intra cranial vessels of circle of Willis or extracranial vessels of the neck.

Patient was seen by Dr.Tushar Raut post procedure who noted the history and advised to continue Levipil,Mannitol,Nimodipine and to avoid hypotension.

On 2nd dec Sedation and paralysis was stopped at 6am in morning ,patient remained drowsy till late afternoon , Patient was seen by Dr.Vatsal Kothari who advised CT brain + Angio to rule out early vasospasm and hydrocephalus in view of drowsiness. Ct Report was not showing any vasospasm. Mild ventricular dilatation which was stable as compared to CT done on 30 th Nov. Patient was again sedated as she was not fit for exubation ivo drowsiness

On 3rd Dec sedation was again stopped early in the morning ivo extubation.

Patient was seen by Dr.Abhay Kumar who noted the history and after examining the patient advised to maintain CVP -10 , increasing Nimodipine to 4th hourly.

Patient was awake alert following commands ,Patient was extubated and then started on oxygen 4L/min via face mask.Patient had bronchospasm for which she was started on Neb.Duolin 1-1-1-1.

Patient had left upper limb monoparesis along with facial devation to right.

On CT Angio brain + neck (04/12/2021) – No significant vasospasm is seen in major intracranial arteries.Distal right M1 MCA aneurysm is excluded from circulation.

2d echo (04/12/2021) - LVEF -60%,no RWMA,mild LVH,IVC dilated ,non collapsing,moderate pulmonary hypertension,good LV and RV systolic function.

Patient was reviewed by Dr.Tushar Raut who advised to add Tab.Oleanz 5 mg ½-1/2-1 ivo restlessness. And to add Tab.Breviracetam 50 mg 1-0-1 and to hold Levipil. ivo drowsiness.

Patient had an episode of fever for which she was started on Inj.Piptaz on 04/12/2021. ivo Microaspirations.

Patient was drowsy but arousable with irrelevant talks and restlessness and left hemiparesis with GCS -14/15.Patient was reviewed by Dr,Tushar Raut who advised Tab.Asprito 2 mg ½ if

Pseudomonas Aeruginosa ,Streptococcus Pneumoniae was detected on ET culture.

Patient was reviewed by Dr.Tushar Raut who advised to gradually taper Mannitol and to avoid Levipil, continue Breviracetam.

On 9th Dec patient was more drowsy ,arousable andfollowing commands .CT Angio brain and neck (09/12/2021) – Previously seen subarachnoid hemorrhage along bilateral convexities show significant interval resolution.Intraventricular extension is seen in the form of mild hemorrhage in the dependent portions of both lateral ventricles.Mild hydrocephalus and transependymal CSF migration is stable.No significant mass effect or midline shift is seen. Right distal M1 aneurysm coiling is seen excluding the aneurysm from the anterior circulation.Rest of the major intracerebral arteries are normal in course and caliber.

Patient had a fever spike on 09/12/2021, Foleys catheter are was changed and urine for routine and culture ,blood culture were sent.Antibiotic was upgraded to Meropenem.

EEG (10/12/2021) – Normal background rhythm (asymmetric,better over left hemisphere),continous slowing of right hemisphere,breach rhythm over right centro parietal region.No unequivocal evidence of IEDs or subclinical seizures.

Urine routine (11/12/2021) – occult blood +,WBC 6-8/hpf,RBC 10-12/hpf,lecucocyte esterase +

Paired blood culture,CV tip culture and urine culture sent on 10/12/2021 showed no growth.

Patient was advised swallow assessment and swallow therapy by Dr.Vatsal Kothari.On swallow assessment mild oropharyngeal dysphagia was present so patient was advised RT feeds

Patient had right shoulder pain so he was referred to Dr.Sandeep Wasnik who advised X ray shoulder AP view,Tab.PCM 650 mg 1-1-1,ice pack application,Volitra APS spray for local application,shoulder arm pouch.

Patient was referred to Dr.Shaunak Ajinkya in view of persistent disorientation,restlessness.Patient was seen by Dr..Shaunak Ajinkya who noted the history of the patient and diagnosed her with psychosis secondary to medical condtion and advised to start the patient on Tab.Oleanz 2.5 mg 0-1-0,Tab.Meloset 3 mg 0-0-1,Tab.Optineuron 1-0-1.

Over the period of time in icu patient gradually improved, power in all 4 limbs improved but patient remains intermittently disoriented and restless . Over the period of time dysphagia also improved without aspiration and patient was started on oral diet.

Patient was reviewed by Dr.Manish Shrivastava who advised to taper Nimodipine and stop .

Patient was seen by Dr.Aparna Ramakrishnan who increased dose of oleanz to ½ -1-1 and sos. And to continue optineurone and Meloset.

**Treatment during stay:**

**Procedure : DSA with balloon assisted coiling of right MCA aneurysm**

Inj.Mannitol 100 ml iv 1-1-1

Inj.Levipil 500 mg iv 1-1-1

Inj.Pantop 40 mg iv 1-0-1

Inj.Paracetamol 1 gm iv 1-1-1

Tab.Nimodipine 1-1-1-1-1-1

Inj.Optineuron 1 amp iv 1-0-0

Neb.Duolin 1-1-1-1

Tab.Breviracetam 50 mg 1-0-1

Tab.Oleanz 5 mg ½-1/2-1/2

Inj.Piptaz 4.5 gm iv 1-1-1

Inj.Dexa 4 mg iv

Inj.Clexane 40 mg OD

Inj.Meropenem 1 gm iv 1-1-1

Tab.Asprito 2 mg ½ SOS

Volitra APS

IV fluids .

**Treatment Discharge at discharge:**

**Tab.PCM 650 mg SOS for pain ( Given for right shoulder musculoskeletal pain )**

**Tab. Nimodipine 60 mg 1-1-1 for 3 days then**

**1-0-1 for next 3 days then**

**1-0-0 for next 3 days then Stop tab Nimodipine.**

**Tab.Breviracetam 50 mg 1-0-1**

**Tab.Optineuron 1 tab 1-0-1**

**Tab.Pantop 40 mg 1-0-1**

**Tab.Meloset 3 mg 0-0-1**

**Volitra aps gel for Local application on shoulder**

**Tab.Oleanz 2.5 mg ½ -1-1 and 1 tab sos if agitation or violent behavior. Watch for sedation and withhold the subsequent dose accordingly if patient is drowsy.**

**Follow up:**

**After 1 week with Dr Vatsal Kothari with CBC/CRP/RFT/LFT/FBS.**

**Review with Dr.Sandeep Wasnik in OPD after 2 weeks after taking prior appointment.**

**Dr. Vatsal Kothari**

**Director and HOD**

**Critical Care Medicine**

**DISCHARGE AGAINST MEDICAL ADVICE**

|  |  |  |
| --- | --- | --- |
| **Name: Mr. Shiw Pujan Sharma** |  | |
| **UHID: KH1000167026** | **Age : 91 years** | **Sex : MALE** |
| **Date of Admission: 27/09/2021** | **Date of Discharge : 05/10/2021** | |
| **Treating Doctor : Dr. Sourabh Phadtare** |  | |

**DIAGNOSIS:**

Hypertensive failure

Moderate mitral regurgitation

Left ventricular dysfunction with Low EF – 35%

Volume overload

Bilateral pleural effusion – Rt>Lt

Hyponatremia

Aspiration pneumonia

Mild prostatomegaly

Diastolic dysfunction grade 3

**Other Consultants who attended the case:**

* Dr. Santosh S Waigankar ( Consultant Urologic oncology)
* Dr. Sunil Wani ( Consultant Cardiologist)

**Past History:**

1. Hypertension
2. Benign prostatic hyperplasia
3. Hypothyroidism
4. Permanent pacemaker ­ivo complete heart block
5. Osteoarthritis
6. Lumbar Canal stenosis
7. Right knee replacement
8. Hernia Surgery
9. B/L cataract surgery

**Chief Complaints:**

91 years old, male patient admitted with complaints of :

Breathlessness x 1 hour

**Course in Hospital:**

Patient Mr. Shiw Sharma, 91 years male, presented to A&E on 27/09/2021, with complaints of breathlessness x 1 hour.

Vitals -

T-96.8 F,P – 120/min, irregular, RR – 38/min ,SpO2 – 55% on room air ,HGT -191 mg/dL, BP – 180/90 mm of Hg

On examination –

CVS – Tachycardia, irregular , S1S2 normal

Resp – B/L crepts and wheeze present

P/A – Soft,non tender

CNS – Patient drowsy but arousable , intermittently obeying commands

Head and neck – Puffiness of face

Extremities – Bilateral pitting pedal edema

On screening echo – Moderate to poor contractility, Left ventricular dysfunction, Global LV hypokinesia, moderate mitral regurgitation

CXR was suggestive of Pulmonary oedema,Pacemaker lead in situ

Patient was started on NIV and Inj. Lasix 80 mg iv stat ,Inj. NTG infusion, Inj. Lasix infusion 10 mg/hour iv infusion, Inj. Betaloc 5 mg iv over 5 mins, Inj. Amiodarone 75 mg iv over 15 mins, Inj. Monocef 2 gm iv stat, Inj. Thiamine 100 mg iv stat,Inj.Clexane 40 mg s/c stat were given in A&E.

Patient was then admitted in ICU under Dr.Sourabh Phodtare.

Labs on admission –

Sodium 128,Potassium 5.26,Chloride 93.1,BUN 15,creatinine 0.77,urea 32.1,uric acid 4.5,PCT 0.02,CRP 0.213,SGOT 75.3,SGPT 52.8,ALP 104.5,Calcium 8.6,Phosphorous 4.7,Total protein 6.40,Albumin 3.95,Total bilirubin 0.54,Hemoglobin 10.4,WBC 12,950,Platelet 2,75,000

Patient was advised 2d echo, HRCT, reference was given to Dr.Sunil Wani.

On HRCT chest done on 28/09/2021 –

Significant tracheobronchomalacia with perihilar bronchiectatic changes and dependent areas bronchocentric nodules and consolidations with lung change-features are likely to represent aspiration.

Left ventricular pattern of gross cardiomegaly with bilateral pleural effusion and dependent ground glass opacities likely to represent volume overload.

In view of bilateral lower lobe consolidations secondary infection to be ruled out.

On 2d echo done on 28/09/2021 –

LVEF – 35%, moderate to severe MR, global LV hypokinesia. Grade 3 diastolic dysfunction, mild PH, dilated LA,LV

Patient was seen by Dr.Sunil Wani who noted the history, examined the

patient and advised to ad Tab.Vymada 5 mg ½ - 0 – ½ ,fluid restriction.

Patient was seen by Dr.Santosh who noted the history ,examined the

patient and advised USG abdomen and pelvis, Tab. Sildodal 8 mg HS,urine

routine and culture and S.PSA.

USG Abdomen and Pelvis –

Mildly altered liver echo texture with increased periportal cuffing,Mild

prostatomegaly,Left renal cortical cyst,moderate right pleural effusion.

S.PSA – 2.873

On Urine routine – protein +,occult blood +++,WBC – 6-8/hpf, RBC – 45-

50/hpf

On urine culture – no growth

Patient was reviewed by Dr.Santosh to continue catheterization till patient

is ambulatory and independent and to continue Tab.Veltam 0.4 mg HS.

Patient was given on NIV overnight and SOS in view of desaturation.

Patient was reviewed by Dr.Sunil Wani in view of chest pain who advised to

add Tab.Isolazine 1-0-1,Tab.Nikoran 5 mg 1-0-1 and Tab.Flavedon MR 35

mg 1-0-1.

Labs on 05/10/2021

Patient presently hemodynamically stable and being discharged on patients

request against medical advice.

**Treatment received in Hospital:**

1. Inj. Pan 40 mg i.v.1-0-1
2. Inj. Piptaz 4.5 gm i.v 1-1-1
3. Inj.Monocef 1 gm i.v 1-1-1
4. Inj.Thiamine 100 mg iv 1-0-0
5. Tab.Veltam 0.4 mg po 0-0-1
6. Tab.Mevac po 1-0-0
7. Tab.Metolar XL 50 mg po 1-0-1
8. Tab.Aztor 20 mg po 0-0-1
9. Tab.Ecosprin 75 mg 0-1-0
10. Tab.Urimax 0.4 mg po 1-0-1
11. Tab.Gabaneurone po 0-1-0
12. Tab.Gemcal po 0-1-0
13. Cap.Uprise D3 po twice a month (14/28)
14. Tab.Orofer XT po 0-1-0
15. Gloeye 0-1-0 once alternate eye
16. Tab.Dolo 650 mg SOS
17. Tab.Silodal 8 mg po 0-0-1
18. Tab.Thyronorm 75 mcg po 1-0-0
19. Syp.Cremaffin 20 ml po 0-0-1
20. Tab.Nikoran 5 mg po 1-0-1
21. Tab.Lasix 20 mg po 1-0-0
22. Tab.Vymada 50 mg po ½ - 0 – ½ (W/H if SBP < 140 mm of Hg)
23. Tab.Ivabrad 5 mg po 1-0-1 (W/H if HR <70/min)
24. Tab.Isolazine po 1-0-1
25. Tab.Flavedon MR 35 mg po 1-0-1
26. Inj. Optineuron 1amp iv 1-0-0
27. Syp.Kesol 10 ml 1-1-1
28. Inj.Clexane 40 mg s/c od

**Treatment on discharge** –

1. Tab. Pan 40 mg po1-0-1
2. Tab.Veltam 0.4 mg po 0-0-1
3. Tab.Mevac po 1-0-0
4. Tab.Metolar XL 50 mg po 1-0-1
5. Tab.Aztor 20 mg po 0-0-1
6. Tab.Ecosprin 75 mg 0-1-0
7. Tab.Urimax 0.4 mg po 1-0-1
8. Tab.Gabaneurone po 0-1-0
9. Tab.Gemcal po 0-1-0
10. Cap.Uprise D3 po twice a month (14/28)
11. Tab.Orofer XT po 0-1-0
12. Gloeye 0-1-0 once alternate eye
13. Tab.Dolo 650 mg SOS
14. Tab.Silodal 8 mg po 0-0-1
15. Tab.Thyronorm 75 mcg po 1-0-0
16. Syp.Cremaffin 20 ml po 0-0-1
17. Tab.Nikoran 5 mg po 1-0-1
18. Tab.Lasix 20 mg po 1-0-0
19. Tab.Vymada 50 mg po ½ - 0 – ½ (W/H if SBP < 140 mm of Hg)
20. Tab.Ivabrad 5 mg po 1-0-1 (W/H if HR <70/min)
21. Tab.Isolazine po 1-0-1
22. Tab.Flavedon MR 35 mg po 1-0-1

**Dr. Sourabh Phodtare**

**Consultant- Critical Care Medicine**

**Kokilaben Dhirubhai Ambani Hospital**

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **Name : Mrs Manisha gohil** | **Age : 46 years** | **Sex : Female** |
| **Date of Admission :13/03/2023** | **Date of Discharge :** | |
| **UHID : KH1000776075** | **Treating Doctor : Dr.Sourabh Phadtare** | |

**Other Consultants involved:**

Dr Dattatray Solanke (Consultant Gastroenterologist)

Dr R. Shekhar (Consultant Vascular Surgeon)

Dr Aparna Ramakrishnan (Consultant Psychiatrist)

Dr Dheeraj Kapoor (Consultant Endocrinologist)

Dr Sunil Wani (Consultant Cardiologist)

Dr Sameer Tulpule (Consultant Hematologist)

Dr Amol Ghalme (Consultant Plastic Surgeon)

Dr Sunil Kumar Singh (Consultant Rheumatologist)

Dr Gordhan Sanghani (Consultant Interventional Radiologist)

Dr Abhishek Srivastav (Consultant Rehabilitation)

**Diagnosis:**

Bilateral lower limb cellulitis – status post left leg below knee amputation + right lower limb debridement

Chronic Liver disease

Sepsis with septic shock

Bicytopenia

Coagulopathy

Disseminated Intravascular Coagulation

Hypoalbuminemia

DAT +

Dyselectrolytemia

**Past History**

Diabetes mellitus

Hypothyroidism

Anxiety disorder / Schizophrenia

Bilateral cellulitis (multiple times) - prolonged stay

UTI

Severe Dehydration

? Nutritional deficiency

? Autoimmune disease

**Course in hospital**

Patient came with chief complaints of worsening of lower limb cellulitis since two months, breathlessness since 2 days, orthopnea since 2 days, and bilateral lower limb cellulitis with pain since 2 days, bleeding for bed sore since 2days, and decreased appetite since 2 months. She was bed bound since 2018 body has become stiff (unable to move hand and legs since 10 days)

On arrival in hospital, she was in sinus tachycardia and her BP was 80/60.She was oxygenating well on room air. She was given the first dose antibiotics Meropenem and Dalacin and was shifted to ICU for further care.

On Examination patient was in sinus tachycardia with BP of 70/50.Low dose of Inj Noradrenaline was started. She was conscious oriented but anxious and restless. She was in severe dehydration Blood investigations showed low levels of multiple electrolytes and albumin, Hb of 5.2, marginal rise in BUN and urea with Creatinine of 0.65.She had severe bilateral lower leg cellulitis with maggot myasis. Inj Teicoplanin was added. There was a grade to pressure sore with oozing. INR was raised and coagulation profile was deranged. She was transfused with fresh frozen plasma, cryoprecipitate and multiple units of packed red cells. She was given Inj Vitamin K, IV albumin, Inj.Celcel, correction for various electrolytes and IV fluids.Tab Ivabradine was added for tachycardia.

Dr Dattatray Solanke’s reference was taken in view of malabsorption and dysphagia. He advised correction of electrolyte deficits, mobilization, and swallow evaluation. Ultrasonography of abdomen showed gross ascites, signs of chronic liver disease, early medical renal disease and splenomegaly. Autoimmune liver diseases was ruled out with serological evaluation and Tab Udiliv was started.Paracentesis was performed by Dr Gordhan Sanghani, evaluation of ascitic fluid showed no infection or malignancy.

Dr Amol Ghalme’s opinion was sought for grade 2 lumbar pressure sore. He advised conservative management with dressing and topical antibiotics and high protein diet. Dr R.Shekhar’s opinion was taken for cellulitis, as per his advice MRI of bilateral lower legs was done which showed extensive cellulitis with severe osteopenia, myositis, vesicles and air foci. She underwent left below knee amputation, and debridement of right leg and right hand on 15/03/23

In view of vague history of suspected autoimmune disorder in the past Dr Sunil Kumar Singh’s opinion was taken and autoimmune disorder workup was done which were negative for any autoimmune pathology.In view of persisitently low blood pressure, the patient was started on Inj Milrinone as IV infusion for 4 days.2D Echo showed fair left ventricular function, and ejection fraction of 55% with mild pulmonary hypertension.

In view of delusions delirium and irrelevant talks, Dr Aparna Ramakrishnan’s opinion was taken, she advised to start Tab Aripiprazole and Tab Melatonin.Urine culture showed growth

**Treatment given during stay:**

Inj Poly B 7.5LU 1-0-1

Inj Elores 3gm 1-0-1

Inj Meropenem 1gm 1-1-1

Inj Targocid 200mg 1-0-0

Inj Clindamycin 600mg 1-1-1

Inj Tigecycline 100mg 🡪 50mg 1-0-1

Inj Optineuron 1amp 1-0-0

Inj Hydrocort 100mg 1-1-1

Inj Thiamine 500mg 1-0-1

Inj Vit C 500 mg 1-1-1

Inj Celcel 1amp 1-0-0

Inj NAC infusion

Inj Pan40 mg 1-0-1

Inj Human Albumin 20% 1-0-0

Inj HAI acc HGT 1-1-1

Inj Lantus 6U at 10pm

Inj Milrinone infusion

Inj Noradrenaline infusion acc to BP

Inj Vasopressin infusion acc to BP

Inj Lasix infusin

Tab Clindamycin 600mg 1-1-1

Tab Folvite 5mg 1-0-1

Tab Ivabrad 7.5mg 1-0-1

Tab Thyronorm 25mcg 1-0-0

Tab Ursocol 300mg 1-1-1

Tab Rifagut 550mg 1-0-1

Cap Redotil 100mg 1-1-1

Tab Lasilactone 20/50mg 1-0-0

Tab Asprito 2mg ½ -0-½

Tab Modalert 100mg ½-½-0

Tab Melatonin 3mg SOS

Tab Immodium 2mg 0-1-0

Cap VSL3 1-0-1

Syp Sparacid 10mg 1-1-1-1

Syp Kesol 10mg 1-1-1

AddPhos sachet 1-1-1

Econorm sachet 1-1-1

Venusia Max Lotion 1-1-1

IV Fluids

**Medications on discharge**

**Dr. Sourabh Phadtare**

**Consultant Intensivist**

**Critical Care Medicine**

**Kokilaben Dhirubhai Ambani Hospital**

**DISCHARGE AGAINST MEDICAL ADVICE**

|  |  |  |
| --- | --- | --- |
| **UHID No : KH1000824669** |  | |
| **Name: Mrs Purvi Butala** | **Age : 48 years** | **Sex : Female** |
| **Date of Admission : 26/01/2023** | **Date of Discharge: 29/01/2023** | |
| **Treating Doctor : Dr. Sourabh Phadtare** |  | |

**Other Consultants**

Dr Sameer Tulpule ( Consultant Hematology)

Dr Sharad Seth ( Consultant Nephrology)

Dr Tanu Singhal ( Consultant Infectious Disease)

Dr Pravin Kahale ( Consultant Cardiology)

Dr Sunil Wani ( Consultant Cardiology)

**DIAGNOSIS**

1. Restricted Prosthetic Mitral Valve Movement with possibility of Thrombosis (Choked) with Cardiogenic Shock.
2. MODS (Multiple Organ Dysfunction Syndrome)
3. AKI
4. Acute Liver Injury
5. Low EF –>( 20 – 25 %)

**Past History**

K/C/O

1. Rheumatic Heart Disease with Mitral stenosis
2. Atrial Fibrillation
3. MVR + TV Repair was done with metallic valve replacement in Aug 2022

**Presenting Complaints**

Patient came with c/o

1. Breathlessness since 4 days- NYHA Grade 3
2. Nausea and vomiting since 4 days
3. Generalised weakness
4. Atrial fibrillation, went to PNH was advised to increase dose of Antiarrhythmics, but patient did not improve and worsened hence brought to KDAH A& E for further management.

**COURSE IN HOSPITAL** **:**

Patient a 48 years old female K/C/O RHD with MS (diagnosed in June 2022), patient underwent MVR-metallic valve replacement in Aug 2022. Patient remain stable after the surgery until 4 days back when she developed above mentioned complaints for which she was brought to KDAH.

On examination patient was in Atrial fibrillation (AF), BP was not recordable, Tachypneic, Spo2 not recordable, RS- bilateral crepts were audible.Neurologically she was conscious oriented. Screening echo showed Choked Mitral Valve. Provisionally diagnosed as Restricted Prosthetic Mitral Valve Movement with possibility of Thrombosis (Choked) with Cardiogenic Shock was made, Reference was given to Dr Sunil Wani, ( Consultant Cardiology), and the case was discussed with him and decision of thrombolysis was taken , Hematologist Dr Tulpule reference was taken and he advised to go ahead with Thrombolysis.

Line ( Central Line & Arterial Line) was Cannulated, Antibiotics were started Inj Meropem and Targocid.

Relatives were explained about the thrombolysis in detail and the risk of bleeding from any orifice and even Intracranial Bleed was explained the relatives agreed and gave consent for the same, patient was thrombolysed with Streptokinase and Infusion was started.

Patient was very breathless hence was kept on continuous NIV support, SOS Endotracheal Intubation & Mechanical Ventilation was explained.

Patient was started on Vasopressor Infusion, patient was shifted in ICU.

Patient had severe acidosis and Ischemic Liver Injury.

Nephrology reference was taken from Dr Sheth and he advised to start Inj Lasix infusion + Zytanix & Bicarbonate infusion started.

Inj Cordarone infusion was started in view of Atrial fibrillation as Advised by Dr Wani.

ABG showed Severe lactic acidosis. Dr Sharad Seth in view of AKI and oliguria advised RRT, Femoral Hemodialysis Catheter was Inserted and Dialysis was initiated.

Patient’s breathing improved and was taken off NIV Support.

2D echo s/o LVEF 20-25%, severe PH, global LV hypokinesia.Prosthetic mitral valve thrombosis likely. IVC dilated, peak -23/12

Serial 2 D echo did not show much improvement in the opening of mitral valve hence,Dr N Kapadia (Consultant CVTS) opinion was taken who advised Mitral Valve Replacement( Redo). Liver function further worsened.NAC infusion started after discussing with Dr Dattatry ( Consultant Gastroenterology).

Relatives were counselled daily about the extremely guarded prognosis and critical condition of the patient.

Hemodialysis was Stopped and repeat ABG was s/o Worsening Acidosis hence after discussing with Dr Sheth Dilaysis was restarted.

Patient relatives were counselled in detail about the condition and need for Mitral Valve Replacement ( Redo) relatives refused for the same after discussing with Dr Tulpule and Dr Kahale ( Cardiologist ), Dr Kapadia ,aPTT was monitored and patient was started on unfractionated Heparin infusion. SLED was continued.

Reference was given to Dr Tanu Singhal ( Consultant Infectious Disease) who advised Advice to continue Inj Meropenem and to add Inj Vancomycin.

Extremely guarded prognosis and critical condition of the patient with MODS was explained to relatives and need for her to continue care in the ICU was explained to the relatives.

However Relatives of the patient & Patient wish to take discharge hence the patient is being Discharged Against Medical Advice( DAMA). Risk in shifting the patient and mishaps that could occur during transfer including death have being explained to the patients relatives, but still they wish to discharge the patient, hence the patient is being Discharged Against Medical Advice( DAMA).

Patient on discharge is awake obeying commands, on NIV Support, On High Vasopressor support. No bleeding from any site.

**TREATMENT GIVEN IN HOSPITAL:**

Inj Meropenem 1 gm iv 1-0-1

Inj Vancomycin 1 gm iv stat f/b 1 gm BID

Inj Eraxis 100 mg 1-0-0

Inj Targocid stopped after 2 days

Inj Optineuron 1 amp OD

Inj Pantop 40 mg 1-0-1

Inj Thiamine 100 mg 1-0-0

Inj Cordarone iv infusion.Tab Zytanix 5 mg 1-0-1

Inj NAC iv infusion

Hyperkalemia correction

Hemodialysis

**Dr. Sourabh Phadtare**

**CONSULTANT CRITICAL CARE MEDICINE**

**Kokilaben Dhirubhai Ambani Hospital.**

**DISCHARGE AGAINST MEDICAL ADVICE**

|  |  |  |
| --- | --- | --- |
|  |  | |
| **Name: Mr. Gajanan Dukre** | **Age : 54 Years** | **Sex : Male** |
| **Date of Admission : 17/01/2023** | **Date of DAMA: 20/02/2023** | |
| **UHID No : KH1000858210** | **Treating Doctor : Dr Khushboo Kataria** | |

**OTHER CONSULTANTS INVOLVED**

Dr. Sandeep Wasnik (Consultant Orthopedic)

Dr. Attar Mohammad Ismail (Consultant Urologist)

Dr. Manoj Mulchandani (Consultant General Surgery)

Dr. Dattatray Solanke (Consultant Gastroenterologist)

Dr. Sharad Sheth (Consultant Nephrologist)

Dr. Gordhan Sangani (Consultant Interventional Radiologist)

Dr shaunak ajinkya (consultant - psychiatrist)

**DIAGNOSIS**

Acute on Chronic Liver Failure (ACLF)

Sepsis with Septic Shock

Acute Kidney Injury – secondary to Hepato-renal Syndrome (HRS)

Multifactorial Encephalopathy (septic, metabolic, hepatic)

Jejunal Obstruction with Mesenteric congestion

Right Knee Osteoarthritis (S/P Right Total Knee Replacement on 19/01/2023)

**Past History**

H/O Left Intertrochanteric Fracture – S/P Nailing done 12 years back

**PRESENTING COMPLAINTS:**

Right knee pain since 5 to 6 month and diagnosed as right knee osteoarthritis so patient admitted for right knee total knee replacement.

**COURSE IN HOSPITAL:**

The patient was admitted with above complaints to kdah in ward on 17/01/2023. On admission pulse-80/minute,SpO2-98% on room air, BP-130/70mmHg. On 19/01/2023 right knee total replacement done under spinal anaesthesia- by Dr. Sandeep Wasnik (consultant orthopedic).

Patient had continuous loose stools hence reference given to Dr N.R. Shetty sir and he advised antidiarrheoal medicines and iv hydration , further had episode of decrease urine output suspected to be cathteter block hence Dr Ismail sir reference was taken – catheter patency was checked which was normal and hence they advised to continue hydration. Patient was stable and was planned for discharge. On 24-1-23 patient had received 1 unit PRBC in view of low hemoglobin, and was planned for discharge

on 25-1-23 patient had abdominal distention, vomiting, and constipation. CT abdomen (plain ) was done which was suggestive of dilated jejunal loops with am maximum caliber of 4cm with transition point in distal ileum with small bowel faces sign, mesenteric congestion with swirling of mesenteric vessels in the root of mesentery and hence surgical reference was taken from Dr Manoj mulchandani sir and he advised CT-abdomen with oral contrast was advised and poor prognosis explained to relative in view of above findings , worsening lactates and renal and liver dysfunction .

Dr Dattatray sir reference was taken i/v/o CT findings and liver dysfunction and advise followed.

Dr sourabh sir reference was taken in view of irrelevant talks and bilateral lower limb swelling and worsening general condition and he advised to start hydration , iv albumin , correct dys-electrolemia and get CT with oral contrast and follow advice of gastroenterologist and surgeon after CT report

Dr sharad sheth sir reference was taken in view of episode of oliguria and acute kidney injury and need for oral contrast for CT Abdomen and he advised to continue hydration and correct hyperkalemia , iv diuretics sos . The patient was shifted in ICU in view of ? sub-acute intestinal obstruction/ paralytic ileus and decrease urine output, patient had dyselectrolytemia and hypoalbuminemia and he was deeply encephalopathic

Dr Ajnkiya sir reference taken in view of Delerium and was in withdrawl phase and adviced to start tab Librium and nicotine patch for withdrawl and treat underlying sepsis and metabolic paramaters , Patient was restrained as patient was delirium and was encephalopathic- due to hyperammonemia as patient may pull the tubes and lines

Meanwhile patient cultures was sent which did not have any positive Growth.

On 1-2-23 patient become drowsy but easily arousable so psychiatry medication was with-hold,

on 2-2-23 patient was hemodynamically stable , AKI was resolving but worsening hepatitis so periodically LFT and RFT was monitored and accordingly managed and under all aseptic precaution Ascitic tapping was done on 3-2-23 and ascitic fluid sample was sent for investigation.

Slowly patient sensorium was improving and abdominal girth was steady (approx.. : 92-94), abdomen was non-tender, bowel sounds present, but the wbc count was increasing so dose of antibiotics was escalated to meropenam and teicoplanin. Xray abdomen was done suggestive of dilated loops – Dr Manoj mulchandani sir review was taken and advice followed , can start liquid diet .and if patient was tolerating🡪 shifted to semisolid diet to full diet. . the patient was on antibiotic meropenem and teicoplanin initially which was escalated to minocycline and poly-b i/v/o worsening wbc counts and CRP.

On 7-2-23 patient was transferred to ward , patient was hemodynamically stable, conscious obeying command .Ascitic tapping was done (approximately 3000ml) under albumin cover . Guarded prognosis have been explained to the relatives in view of worsening sepsis , liver and renal dysfunction (rising bilirubin trend and creatinine levels) and recurrent ascitic fluid tapping needed .

On 9-2-23 patient as persistently drowsy , and increased fatigueability worsening renal function and hence patient was shifted to ICU, started with albumin and NAC infusion . Dr Dattatray sir review taken and started with Terlipressin infusion i/v/o HRS (hepatorenal syndrome) .

Patient was having dyselectrolytemia, hypoalbuminemia, anemia, thrombocytopenia with multifactorial encephalopathy , and BDG came to be negative and all culture sent were negative.

On 11-2-23 patient had a episode of vomiting with hypotension (Bp of 90/60 mm hg) not responded to iv fluid boluses and hence inotropes started.

on 12-2-23 Dr Dattatray sir review was taken in view of patient had 2 episode of large quantity vomiting and patient was kept NBM, Ryles tube was inserted, had hypotension so inotropes (nor- adrenaline) continued , central line was changed, and inj. Fluconazole was added and repeat BDG was sent and repeat cultures were sent.

On 13-2-23 patient was conscious, awake but irritable on continuous RT aspirate, guarded prognosis was explained to relative , and ascitic fluid tapping done . creatinine and crp was in increasing trend with deranged LFT.

On 14-2-23 therapeutic ascitic tapping was done (approximately 3100 ml)

Patient was started on kangaroo feed @30ml/hr but was not tolerated and developed ileus ,xray abdomen suggestive of dlayed stomach and proximal duodenum and so kangaroo feed was stopped and patient was kept NBM till further. Dr manoj mulchandani sir review was taken and advice was noted.

Due to persistent hypokalemia patient developed ileus and the patient was having 3-4 episodes of vomiting so aggressive potassium correction was given through central line , P/A- grossly distended with frank dullness present, patient was drowsy with altered sensorium , received 1unit PRBC in view of drop in hemoglobin. Guarded prognosis and overall poor outcomes were explained to relatives and they understood the same.

On 16-2-23 BDG came to be Positive so iv Flucon was continued.

Family counselled regarding critical condition of the patient and extremely guarded prognosis and need for prolonged hospitalization since patient is in ACLF with Septic Shock with multifactorial encephalopathy with acute kidney injury .

On 17-2-23 patient was started with RT feeds but the patient had another bout of vomiting and hence feeds stopped and patient kept NBM till further order , iv hydration continued .

The patient had worsening sepsis and inotropes restarted and hence Tab flucon was stopped and started on Inj. Eraxis . Dr Dattatray sir review was taken and adviced followed . Guarded prognosis explained to relatives

Patient relatives do not wish to continue treatment here and wish to go to PNH , so patient is being discharged against medical advice DAMA.

Relatives have been explained in the language best understood by them the risks of such a transfer which is including but not limited to worsening of clinical condition , risk to life during transfer due to sudden cardio-respiratory arrest and they have understood the same.

Current condition of patient- he is in altered sensorium , drowsy but arousable , occasional irrelevant talks , on NORAD support of 0.16 mcg/kg/min , on iv antibiotics and antifungal , iv fluids and other supportive medications . The patient is to be discharged on central line , foleys and ryles tube , nasal prongs oxygen 4 litres , on inotropic support in a cardiac ambulance.

**ON GOING TREATMENT :-**

Inj. Teicoplanin 200mg iv 1-0-0

Inj. Poly –B 7.5 lac units iv 1-0-1

Inj Meropenam 1gm iv 1-0-1

Inj Eraxis 100mg iv 1-0-0

Inj Terlipressin iv infusion @ 2ml/hr – stopped on 19th feb 2023

Inj. Pantop 40mg iv 1-0-1

Inj emset 8mg iv 1-1-1

Inj paracetamol 1gm iv sos for fever

Inj tramadol 50mg iv sos for pain

Inj perinorm 10mg iv 1-1-1

Tab urcosol 300mg RT 1-0-1

Tab Librium 30mg RT 1-0-0

Tab Optineuron 1tab RT 1-0-0

Tab Ivabrad 2.5mg RT 1-0-1

Tab benfomet plus RT 0-1-0

Tab rifagut 550mg RT 1-0-1

Tab trental 400mg RT 1-1-1

Looz enema PR 1-0-1

Pegmove powder 2scoops RT 10-1

IV Fluids DNS @40ML/HR

**Dr Khushboo Kataria  
Consultant Intensivist  
Kokilaben Dhirubhai Ambani Hospital**

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **UHID No : KH1000605871** |  | |
| **Name : Mrs Sucheta Suvarna** | **Age : 83 years** | **Sex : Female** |
| **Date of Admission :14/02/2023** | **Date of Discharge : 22/02/2023** | |
| **Date of surgery / Procedure :** | **Treating Doctor: Dr. Ruchi Shetty** | |

**Diagnosis:**

Infective Exacerbation of COPD

Past History :

K/C/O COPD, Diabetes Mellitus, Rheumatoid Arthritis.

**Other Treating Doctors**:

Dr Subhash Agal ( Gastroenterologist)

**Reason for hospitalization :**

Low grade fever since 2 days

Progressive increasing breathlessness since 1 day

Altered sensorium since 2 days.

**Hospitalization :**

Recent history of hospitalisation on 24/10/2022 for Infective exacerbation of OAD with Type 2 Respiratory Failure

**Course in hospital :**

83 years old female with k/c/o COPD , multiple hospitalisation for exacerbation, admitted with history of fever and breathlessness since 2 days with altered sensorium. Patient was hypoxic on arrival , saturation 86% on room air, tachypneic, tachycardic, ,bronchospasmic, unable to talk full sentence.GCS was 8/15. Patient was started on NIV pressure control,mode. Lab test shows PH 7.48, Pco2 41.2, Po2 140, Lact 1.12, Hco3 30.8 Hb 13.6 gm%, WBC 12.29, PLT 186, BUN 11.9, AST 45, ALT 34, Creatinine 0.73, CRP 61.44, Urea 25.5, Alb 3.74, K+ 4.04, Na+ 130, Chest Xray s/o bilateral hilar infiltrates.

Patient started on Inj Piptaz, Tab Doxophylline, Duolin and Budecort nebulisation, Respiratory Biofire sent, CT Brain was normal.ECG –LBBB.

Respiratory Biofire showed A1H3 positive.Started on Tab Tamiflu 75mg BID.

Ref was given to Dr Agal ( Gastroenterology Consultant ) ivo indigestion, and decreased oral intake. USG abdomen on 27/1/2023 s/o fatty liver , umbilical hernia., Adviced to continue PPI.

Patient responded to the treatment, NIV support decreased, Remain stable on 4 lit O2 by NP.

Sensorium improve gradually, general condition remain stable. Adviced discharge.

**Treatment During stay :**

**Inj Piptaz 4,5 gm iv 1-1-1**

**Inj Pan 40 mg iv 1-0-0**

**Tab Tamiflu 75 mg 1-0-1**

**Patient response :**

Satisfactory.

**Status on discharge:**

Haemodynamically stable.

Symptoms relieved.

**Medication on discharge :**

**Instruction on discharge :** Follow up with Dr. Ruchi Shetty in outpatient department as advised

with prior appointment. (Tuesday)

|  |  |  |
| --- | --- | --- |
| **Urgent Care Advice** | **:** | In case of emergency and to obtain urgent care, please contact Accident & Emergency at Tel. No. 30919191. |
| **Signature** | **:** | Dr. Ruchi Shetty Consultant - Critical Care Medicine. |

**SUMMARY**

|  |  |  |
| --- | --- | --- |
| **Name : Ripan Nayar** | **Age : 73 years** | **Sex : Male** |
| **Date of Admission :28/04/2022** | **Date of Discharge :** | |
| **UHID : KH1000864202** | **Treating Doctor : Dr. Sunil Pai** | |

**Other Consultants involved:**

Dr Sharad Sheth (Consultant Nephrologist)

Dr Sameer Tulpule (Consultant Hematologist)

Dr Prashant Nair (Consultant Cardiologist)

**Diagnosis:**

Pneumonia

Multiple Organ Dysfunction Syndrome

**Past History:**

Diabetes Mellitus

Parkinsonism

LV dysfunction

Post CABG-2011

Severe Aortic Stenosis-TAVR done -2011

Dual Chamber AICD-2011

Myelodysplastic Syndrome

**Chief Complaints:**

Sudden choking with sudden onset breathlessness while having liquid food at home yesterday followed by unconsciousness and unresponsiveness

**Course in hospital:**

The patient was brought to KDAH with the above mentioned complaints. On arrival to A & E, patient was pulseless and was started with CPR immediately. He received CPR for 15 minutes and revived. Meanwhile, he was intubated and started on vasopressors in view of hypotension. Patient was shifted to ICU for further management.

In the ICU, patient was kept sedated and paralysed. Central line and arterial line was secured and patient was catheterized.

HR-110bpm, irregular

BP-100/60 mm Hg on Noradrenalin @ 0.5mcg/kg/min

SpO2- 100% on PRVC (35/5/24/500)

Routine labs were sent as advised and patient was started on antibiotics.

Trop I -840.60

Abg was suggestive of metabolic acidosis.

Patient was started on sodium bicarbonate infusion.

Cardiology Ref was taken and advised cardorone infusion, AICD interrogation and 2D ECHO which was followed.

2D Echo was suggestive of : EF 15-20%; Marked Global LV hypokinesia; RWMA+; Moderate PH 62mm Hg

EEG was done which was suggestive of :Diffuse encephalopathy.

Interittent generalized low amplitude slow waves are seen in transients.

No equivocal evidence of interictal epileptiform discharges or subclinical seizures is noted.

In view of known case of myelodysplastic syndrome, Dr Sameer Tulpule ref was taken.

Platelets -13000 were noted. 1SDP transfusion was given and rest of the advise was followed.

Patient started having decreased urine output mid afternoon and nephrology ref was taken for the same. Dr Sharad Sheth Advised to start on Lasix infusion and USG (A+P) was advised.

He also advised SOS RRT if no improvement in acidosis and urine output.

Patient’s hypotension still persisted and was started on vasopressin and Frenin thereafter.

Patient had sudden desaturation later in the evening and increase in FiO2 requirement, thus urgent chest xray was done which was suggestive of increased haziness in left lung ? infective etiology. Antibiotics were stepped up and relatives were explained about the critical condition of the patient and the need of RRT SOS.

Patient’s relatives however signed DNE.

**Treatment given during stay:**

Inj Piptaz 2.25g 1-1-1

Inj Meropenem 500mg 1-1-1

Inj Hydrocort 50mg 1-1-1-1

Inj Targocid 800mg stat

Inj Pan 40mg 1-0-0

Inj Anfoe 10000 U twice a week ( Monday/ Thursday)

Inj Lasix Infusion @4ml/hr

Inj Cordarone Infusion @36mg/hr

Inj Atracurium @ 5ml/hr

Inj Fentanyl @ 5ml/hr

Inj Midazolam @5ml/hr

Inj Sodabicarb @ 10ml/hr

Inj Norad 8/50 acc to BP

Inj Vasopressin 40/40 acc to BP

Inj Frenin acc to BP

Tab Ivabrad 5mg 1-0-1

Tab Nafodil 50mg 0-0-1

Tab Syndopa Plus 125mg 1-1-1-1

Tab Aztor 10mg 0-0-1

Tab Feburic 40mg 1-0-0

Tab Zytanix 5mg 1-0-1

K bind sachet 15gm 1-1-1

**CASE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **Name: Mr Jafferali Karovalia** |  | |
| **UHID: KH1000740183** | **Age : 85 Year** | **Sex : MALE** |
| **Date of Admission: 12/02/23** |  | |
| **Treating Doctor : Dr.Vatsal Kothari** |  | |

**Other Consultants:**

Dr Gaurav Mehta (Consultant Gastrology)

Dr Tushar Raut ( Consultant Neurology)

Dr Navita Purohit (Consultant Physical Medicine and Rehabilitation)

Dr Sanjay Pandey ( Consultant Urology)

Dr Pravin Kahale ( Consultant Cardiology)

Dr Tanu Singhal ( Consultant Infectious disease specialist)

Dr Manoj Mulchandani ( Consultant General Surgery)

**Diagnosis:**

Disseminated Nocardia Infection

Moderate to Severe Encephalopathy (Sepsis related)

Lower Gastrointestinal bleed

Apthous ulcers in colon and rectum

Atrial Fibrillation with Fast ventricular rate

Multifactorial Anaemia

1. Stool occult blood positive
2. Iron deficiency anemia

Infected Penile ulcer ( Pus swab: Klebseilla pneumonia)

Drug related thrombocytopenia (? Linezolid induced)

**Past History:**

Hypertension

Hypothyroidism, Diabetes mellitus,

Ischemic heart disease: CABG was done in 2012.

Dyslipidaemia,

? Chronic Renal dysfunction (Creatinine 1.5) , Prostatomegaly,

Peripheral neuropathy

Monoclonal gammopathy – IgG Kappa gammopathy since November 2021

Trephine biopsy : Bone marrow 6% plasma cells

M Band : 260mg/dL, serum free light chain (41.1)

**Chief Complains:**

Complain of loose stools since 4 days associated with burning sensation after passing stools since 4-5 days

Associated with nausea and weakness, abdominal discomfort

Consulted local physician: took medications, had partial relief

Had blood clots, black coloured stools since 3 days

Outside investigations (28/1/23) Hb 12.5, WBC 7400, PC 269000, HbA1C 7.9%, creatinine 1.12, CRP 76, T3 2.08, T4 7.80, TSH 0.89

Chest Xray – infective consolidation in right mid zone

USG Abdomen (28/1/23): Mild hepatomegaly, Grade 1 fatty liver, Prostatomegaly (44.5)

**Course:**

85 year old male patient came to KDAH with above mentioned clinical condition.

His initial investigations showed …….. (on 12/2/23)

Dr. Vatsal Kothari reviewed the patient, noted the history and advised to stop ongoing antiplatelets (Tablet Ecosprin) in view of PR bleeding and to take surgical teams’s advise.

Patient had an episode of low grade fever on the day of admission, hence was started empirically on intravenous antibiotics ( Inj Ceftriaxone), intravenous antacids and other supportive medications.

Patient presently hemodynamically stable and symptomatically better,hence being planned for discharge.

**Treatment during stay:**

Inj.Nikoran infusion

Tab.Ecosprin (150 mg) 0-1-0 ( after lunch)

Tab.Brillinta (90 mg) 1-0-1 ( 8 am – 8 pm)

Tab.Storvas (80 mg) 0-0-1 (10 pm)

Tab.Repace (25 mg) 1-0-1 ( 8 am – 8 pm)

Tab.Metolar (25 mg) 1-0-1 ( 8 am – 8 pm)

Tab.Nikoran (10 mg) 1-0-1 ( 8 am – 8 pm)

Tab.Pantoprazole (40 mg) 1-0-1 ( Before breakfast – Before dinner)

Inj.Human actrapid insulin s/c according to HGT

IV fluids .

**Treatment at discharge:**

Tab.Ecosprin (150 mg) 0-1-0 ( after lunch)

Tab.Brillinta (90 mg) 1-0-1 ( 8 am – 8 pm)

Tab.Storvas (80 mg) 0-0-1 (10 pm) for 4 weeks (starting from 12/12/21) followed by

Tab.Storvas (40 mg) 0-0-1 (10 pm) to be continued.

Tab.Repace (25 mg) 1-0-1 ( 8 am – 8 pm)

Tab.Metolar (25 mg) 1-0-1 ( 8 am – 8 pm)

Tab.Nikoran (10 mg) 1-0-1 ( 8 am – 8 pm)

Tab.Pantoprazole (40 mg) 1-0-1 ( Before breakfast – Before dinner)

Tab.Galvus (50mg) 1-0-0 (after breakfast) ( for diabetes)

Tab.Glycomet GP2 1-0-1 (Before breakfast – Before dinner) ( as earlier)

Tab.Restyl (0.25mg ) 0-0-1 (at night for sleep) (optional)

Syp.Cremaffin (3 tsp) 0-0-1 (at night for constipation) (optional)

**Follow up:**

Follow up with Dr.Vatsal koathri after 4 weeks after taking prior appointment with reports of CBC,CRP,BUN,Creatinine,Electrolytes,FBS,PPBS

Follow up with Dr.Prashant Nair with CBC/BUN/Creatinine/Serum Electrolytes reports after 4 weeks in OPD.

**Dr. Vatsal Kothari**

**Director and HOD**

**Critical Care Medicine**

**Kokilaben Dhirubhai Ambani Hospital**

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **Name: Mr.Vicky Kale** |  | |
| **UHID: KH1000332807** | **Age : 32Year** | **Sex : MALE** |
| **Date of Admission: 01/10/2021** | **Date of Discharge : 04/10/2021** | |
| **Treating Doctor : Dr.Sourabh Phadtare** | **MLC NO : 64096**  **Malad Police Station**  **PCt Bhalu Pote(Batch no 130195) PSI :Phad** | |

**Diagnosis:**

Deliberate Self Harm

**Past History:**

Hospitalisation in the past for : ? UTI ?Weakness ,Details not available

**Other Consultants:**

Dr. Aparna Ramakrishnan ( Psychiatry )

**Chief Complains:**

H/O consumption of Tab. Melatonin, around half a bottle exact number not known as per PNH and relatives.

**Course:**

28 years old male with a history of consumption of Tab. Melatonin around half a bottle exact number not known as per PNH and relatives. He presented with complaints of drowsiness, hiccups and vomiting to Cooper hospital where he received Gastric lavage and then shifted to KDAH for further management. Patient received 50 gm charcoal stat through RT, Inj.DNS @ 100 ml/hr, Inj. Neksium 40 mg iv stat, Inj. Emeset 8 mg iv stat and NS 500 ml IV bolus in A&E. Patient was then shifted to ICU for further management.Patient was drowsy but arousable and following commands. Reference was given to Dr.Aparna Ramakrishanan in view of deliberate self harm.

Dr.Aparna noted the history of the patient, counselled the patient and advised the following – Strictly supervised medication, No sharps, drugs or objects of harm near him,1 relative with patient 24/7 observation,

Tab. Nexito 5 mg ½ - 0 - ½ after food; Tab. Zapiz 0.25 mg 0-0-1 in case of insomnia.

On urine tox screen – Amphetamine was positive MLC done (MLC No. = 64096)

Patient presently symptomatically better and hemodynamically stable, hence is being discharged

**Treatment during stay:**

Inj. Emeset 8 mg IV SOS

Inj. Neksium 10 mg IV 1-0-1

Tab. Nexito 5 mg PO ½ - 0 – ½

**Advise at Discharge:**

Tab. Nexito 5 mg PO ½ - 0 – 1 x 20 days

Tab. Zapiz 0.25 mg SOS PO in case of Insomnia

Strict abstinence from substances

Strictly supervised medication

No sharps, drugs or objects of harm near patient

1 relative to be with patient 24/7

**Follow up INSTRUCTIONS**

Follow up after one month in opd with Dr Sourabh Phadtare with CBC , Serum electrolyte ,BUN , Creatinine , LFT .

Follow up after 20 days in opd with Dr Aparna

**Dr. Sourabh Phadtare**

**Consultant Critical Care Medicine**

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **UHID No : KH1000810970** | **Treating Doctor: Dr. Sourabh Phadtare** | |
| **Name : Mr. Kumar Lulla.PI_VIP** | **Age :** 78 **Years** | **Sex : Male** |
| **Date of Admission : 20/04/2022** | **Date of Discharge : 02/05/2022** | |

**Attending Consultants:**

* Dr. Prashant Nair (Consultant Cardiology)
* Dr. Ismail Attar (Consultant Urologist)
* Dr. Manoj Mulchandani (Consultant General Surgery)
* Dr. Dattatray (Constultant Gastroenterologist)
* Dr. Niranjan Kulkarni (Consultant Nephrologist)

**Diagnosis:**

* Acute Coronary Syndrome with Reduced Ejection Fraction LVEF: 25-30%, Moderate PH, Moderate to severe MR/ Grade 2/4 TR, Dilated all chambers,
* New onset Atrial Fibrillation with controlled rate,
* Oral candidiasis (Treated),
* Moderate oropharyngeal dysphagia,
* Large right Inguinal Hernia (conservative management)

**Past History :**

* Known case of Hypertension, stopped treatment since 2 years
* History of CVA – Left sided in 1985, and Right sided in 1995 (Residual Right sided hemiparesis)
* Known case of Ischemic heart disease : CAG done details unavailable , On single antiplatelet and statin,
* History of Recurrent Urinary tract infection,
* Known case of Benign Prostatic Hyperplasia.

**Course in the hospital:**

78 year old male patient, Mr.Kumar Lulla is admitted to KDAH with above past history and presenting complains of Fever with chills and rigors since 4 to 5 days, Breathlessness since 2 to 3 days, consulted Cardiologist outside was advised zolfresh and amitryptiline. Patient took the above medications however became drowsy and stopped medicines, was advised Troponin which was 10,000 and Nt Pro BNP which was 25998. So reffered him to KDAH for further management.

On admission basic laboratory investigations were done suggestive of normal electrolytes, creatinine :1.28, CBC: Hb : 10.8 , WBC:8190, Platelet:271000, Liver function tests were normal, CRP :11.291, Urine routine was sent suggestive of 1-2 pus cells, Paired blood cultures and urine cultures were sent which were negative for any growth. Patient was started on Inj.Meropenem and Inj.Clindamycin meanwhile. Patient on oral examination was found to have oral candidiasis and was started on Fluconazole for the same.

On admission, consultation was taken from Dr.Prashant Nair (Consultant Cardiologist) advised medical management with Single antiplatelet, Statins and other supportive treatment. Patient was shifted to ICU for further monitoring. Patient had a history of Benign Prostatic hyperplasia and Right inguinoscrotal swelling, also in this admission had complains of scrotal swelling , consultation was taken for the same from Dr.Ismail Attar (Consultant Urologist) and advised foleys catheter insertion.

2 D echocardiography was done on 21.04.2022 suggestive of Left ventricular ejection fraction 25-30%, Moderate to severe MR/ Grade 2/4 TR, Dilated chambers, Grade 3 Diastolic Dysfunction, Moderate Pulmonary Hypertension. Swallow assessment was suggestive of moderate oropharyngeal dysphagia, however patient was tolerating soft diet orally.

Patient had an episode of Atrial fibrillation on 23.04.2022 ,a central line was inserted in right internal jugular vein, given iv amiodarone, consultation was taken for the same from dr. Prashant Nair who advised medical management with beta blocker and amiodarone. In view of inguinoscrotal swelling a plan of CT scan of Abdomen was made and conducted on 23.04.2022 which was suggestive of Bilateral Pleural effusions, dependent groundglass opacities and smooth septal thickening-pulmonary edema/volume overload. Failry large right inguinal herniation of omental fat, mid and disteal ileal loops,ileocecal junction,cecum and ascending colon into scrotal sac. No bowel obstruction seen.Consultation was taken from Dr.Manoj Mulchandani (Consultant general surgery) in view of Large right inguinal hernia findings on CT scan advised conservative management.

On 24.04.2022 patient had hypotension for which fluid boluses were given, metoprolol withheld, but blood pressure did not come up so inj noradrenaline was started, titrated according to target BP and urine output. Dr. Prashant Nair reviewed and added amiodarone tablet 200mg 2-2-2 for a day followed by 0-1-0. On 25.4.2022 meropenem and clindamycin was stopped .

On 26.4.2022 Inj Elores and Inj Targocid was started empirically as WBC counts was increasing. However sepsis workup was done suggestive of sepsis unlikely, so antibiotics

discontinued. Patients Creatinine increasesd from 1.21 to 2.23, probably related to hypotensive episode and prerenal AKI. Dr Niranjan kulkarnis reference was taken, Inj Laxis infusion was stopped and IV Lasix 10mg bd iv as patient needs diuretics low dose for underlying cardiac problem, , IV fluid at 30ml/hr was given, On 27.4.2022 inj. Noradrenaline was stopped. For Hypokalemia inj Kcl was given.. Patient was unable to pass stools and was complaining of abdominal pain for which Dr. Dattatray ref was taken for which he advised to give soap water enema and added laxatives and pegmove powderf.For deranged Lfts he added t.Udiliv. On 28.04.2022 Arterial line was removed. Patients abdominal pain reduced and was able to pass motion, LFts showed down trend.

On 30.04.2022, 9.40am patient had AFib with FVR for which Inj.Amiodarone 150mg iv was given.T. Cordarone was increased to 200mg Once a day. Cardiologist consulted for the same, as discharge is planned fragmin withhold and patient was switched to T. Eliquis 2.5mg 1-0-1. At Present pt was vitally stable, no AF episode in last 48 hours, Central line and foleys were removed. patient passed urine satisfactorily after removal of foleys, so patient is being dischareged.

**Treatment during hospital stay:**

* Inj. Meropenem 1 gm IV 1-1-1
* Inj. Clindamycin 600mg IV 1-0-1
* Inj.Fluconazole 100mg IV 1-0-0
* Inj.Lasix 20mg IV 1-1-1
* Inj.Somzo 40mg IV 1-0-1
* Inj.Thiamine 100mg IV OD
* Inj.Optineuron 1 Amp IV 1-0-0
* Tab.Clopilet 75mg PO 0-1-0
* Tab.Atorva 20mg PO 0-0-1
* Tab.Metolar 25mg PO 1-0-1
* Tab.Cordarone 200mg 2-2-2
* Tab.Flavedon MR 35mg PO 1-0-1
* Nebs Duolin 1-0-1
* Nebs Budecort 1-1-1
* Syp Cremaffibn 15ml 0-0-1
* Inj.Fragmin 2500 U s/c OD

**Treatment at Discharge:**

* Tab. Somzo 40 mg po 1-0-0,
* Tab. Clopilet 75 mg po 0-1-0,
* Tab. Atorva 20mg po 0-0-1,
* Tab. Pruvict 2mg po 0-1-0,
* Syp. Cremaffin 30ml po 0-0-1,
* Tab. Flavidon mr 35mg po 1-0-1,
* Tab. Febuxostat 40mg po1-0-1,
* Tab. Colospa135mg po 1-1-1,
* Syp Sparacid 10ml po 1-0-1,
* Pegmove 2 scoops with water po 1-0-1,
* Coconut water 100ml po 1-1-1,
* Tab Impur 30mg po 1-0-0,
* Tab Cordarone 200mg po 0-1-0,
* Tab Lasix 20mg po 1-0-1,
* Tab Augmentin 625 po 1-0-1 for 7 days,
* Tab. Eliquis 2.5mg po 1-0-1.

**Follow up after 7 days in OPD,**

**Labs-CBC, 12 lead ECG, RFT, LFT.**

**Signature:**

**Dr.Sourabh Phadtare**

**Consultant , Critical Care Medicine**

**Kokilaben Dhirubhai Ambani Hospital.**

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **UHID No : KH1000748738** |  | |
| **Name : Mr. Shrikant ShahPI_VIP** | **Age : 73Years** | **Sex : Male** |
| **Date of Admission : 02/04/2021** | **Date of Discharge :** | |
|  | **Treating Doctor: Dr.Sourabh Phadtare** | |

**Other Consultants Attended the Case  :**

Dr.Khushboo Kataria (Consultant Critical Care)

Dr. Sumit Singhania (Consultant - Pulmonologist)

Dr. N.Kapadia (Consultant CTVS)

Dr.Niranjan Kulkarni (Consultant Nephrology)

Dr.Prashant Nair (Consultant Cardiology)

Dr.Nisha Kaimal(Consultant Endocrinology)

Dr.Sumeet Singhania (Consultant Pulmonology)

**Diagnosis:**

Post COVID Pneumonia

Acute on Chronic CKD

**Past History :**

K/C/O Ischemic Heart Disease (S/P CABG 2014)

Diabetes Mellitus

Hypertension

**Presenting Complaints:**

Shortness of breath

Fever

**Course in hospital:**

73 Year old male patient referred from a PNH with chief complaints of shortness of breath and desatuiration. History of Recent hospitalization at PNH for Covid-19 Pneumonia (2/3/21-12/3/21). On evaluation, patient was tachycardic, SpO2 76% on room air, BP-160/60, afebrile, HGT-123mg/dl. Initial labs showed raised BNP (2030.38), CRP 18.05, Creatinine – 3.3, WBC count 21260. He was started on NIV support, Inj.Piptaz, nebulisations, diuretics, steroids and shifted to the ICU for further management. HRCT Chest showed extensive ground glass opacities and bronchocentric consolidations with intervening inter/intralobular septal thickening and fibrosis. CT severity score 24/25.

Renal USG showed bilateral medical renal disease. Reference was given to Dr.Niranjan Kulkarni- advised fluid restriction, monitoring of RFTs, T.Lanum. Patient improved clinically and was maintaining saturation on NRBM with 8 L O2. Reference was given to Dr.Nisha Kaimal , advice followed.2D ECHO was done which showed severe AR, moderate calcified AS, EF 55%. Reference was given to Dr.Prashant Nair, advised to increase diuretic dose, T.Ivabrad, T.Amlovas 5mg OD.

Patient was gradually tapered off O2 support and is currently requiring 1L via nasal prongs. Serial labs showed improvement in parameters, Creatinine and WBC count downtrending. Chest Physiotherapy and Incentive spirometry were continued. Steroids were tapered in consultation with Dr.Singhania, who also advised to arrange for O2 supplementation at home.

Reference was given to Dr.Kapadia in view of Mild mitral regurgitation advised will be reviewed with a follow up of 2D Echo. Patient is currently hemodynamically stable, requiring 1 litre o2 at present and is being discharged with advice as below.

**Treatment during stay:**

Inj.Piptaz 2.25 gm IV 1-1-1

Inj.Pan 40mg IV 1-0-0

Tab.Pirfinex 200mg 3-3-3

T.Ecosprin Gold 20mg OD

Tab.Ivabrad 5mg BD

Inj.Anfoe 6000U s/c once a week (Sunday)

Syp Cremaffin 15ml HS

T.Lanum 0-1-1

T.Lasix 40mg 1-0-0

T.Amlovas 5mg 1-0-0

Inj.Methylpred 40mg IV BD

T.Omnacort 20mg OD

T.Amlovas 5mg 1-0-0

Inj.Fragmin 2500u OD s/c

Inj.H.Actrapid 10-8-6

**Patient response: Improved**

**Status on Discharge:**

Hemodynamically stable.

**Medication on Discharge:**

Tab.Pirfinex 200mg 3-3-3

T.Ecosprin Gold 20mg OD

Tab.Ivabrad 5mg BD

Inj.Anfoe 6000U s/c once a week (Sunday)

Syp Cremaffin 15ml HS

T.Lanum 0-1-1

T.Lasix 40mg 1-0-0

T.Amlovas 5mg 1-0-0

T.Amlovas 5mg 1-0-0

Inj.Fragmin 2500u OD s/c

Inj.H.Actrapid 10-8-6

**T.Omnacort**

**Instruction to patient:**

**Follow up advice** : Follow up with Dr.Sourabh Phadtare after 2 weeks with prior appointment with CBC,RFT,LFT

Consultation with Dr.Prashant Nair as advised

Consultation with Dr.Nandkishore Kapadia as advised

Consultation with Dr.Sumeet Singhania as advised.

**Signature:**

**Dr.Sourabh Phadtare**

**Consultant Critical Care   
Kokilaben Dhirubhai Ambani Hospital**

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **PATIENT’S NAME**: Mrs. Manish Kapoor | **UHID No** : KH1000733034 | |
| **DATE OF ADMISSION** : 01/01/2021 | **AGE**: 46 years | **SEX** : Male |
| **DATE OF DISCHARGE** : 04/01/2021 | **TREATING DOCTOR** : DR. AMIT RAODEO | |

**CONSULTANTS WHO ATTENDED THE CASE :**

Dr. Gaurav Mehta (Consultant Gastroenterologist)

Dr. Aparna Ramakrishnan ( Consultant Psychiatrist)

**DIAGNOSIS:**

Alcohol Withdrawal Syndrome.

Alcoholic Liver Disease.

Schizophrenia.

**PAST HISTORY:**

Chronic Liver Disease.

Bilateral lower limb cellulitis.

Hypertension

Diabetes Mellitus

**CHIEF COMPLAINTS:**

Breathelessness since morning

Lower limb swelling since 15 days

**HISTORY OF PRESENTING ILLNESS:**

46 Year, male patient, came to A & E, with complaints of breathlessness since morning and bilateral lower limb swelling and redness since 15 days. Patient also had scrotal swelling since 1 week. He is a known case of schizophrenia since 6 years and has history of chronic alcoholism, undergoing rehabilitation for the same. On examination, patient had bilateral crepts and wheeze present, with oxygen saturation of 92% at room air, along with bilateral pitting oedema. Patient is agitated and very restless on admission. Patient had reddish discoloration of bilateral lower limb with Pitting edema. USG Abdomen and Pelvis was suggestive of Hepatomegaly with grade 1 fatty liver, uncomplicated cholelithiasis, mild ascites, bilateral medical renal disease, moderate to severe right side and minimal left sided pleural effusion. Reference was given to Dr. Aparna, Consultant Psychiatrist, advised strict Abstience from alcohol and treatment as below. Reference was taken from Dr. Gaurav Mehta (Consultant Gastroenterologist), advised to get CT Abdomen Pelvis and CT Chest done, patient is too agitated to be shifted for CT scan. Patient is advised to be discharge to rehabilitation centre.

**TREATMENT DURING HOSPITAL STAY:**

Tab. Pan 40 mg 1-0-0

Inj. Thiamine 100 mg IV 1-1-1

Syp. Duphalac 30 ml 1-1-1

Tab. Lasilactone (20/50) ½ - ½ - 0

Tab. Olanzapine 2.5 mg 1-1-1

Tab. Arip MT 5mg ½ - 0 – ½

Tab. Tofisopam 50 mg ½ - ½ - 0

Tab. Benfomet plus 0-1-0

Tab. Librium 10 mg 1-1-1

**TREATMENT ON DISCHARGE:**

Tab. Thyronorm 75mcg 1-0-0

Tab. Razel F 10 Mg 0-0-1

Tab. Pan 40 mg 1-0-0

Tab. Clopidogrel 75 mg 1-0-0

Tab. Glucomet 500 mg 1-0-0.

Tab.Telma 40mg 1-0-0

Follow up with Dr.Vatsal Kothari with prior appointment after two weeks.

**Dr. Vatsal Kothari**

Head and Consultant

Critical Care Department

Kokilaben Dhirubhai Ambani Hospital

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **PATIENT’S NAME**: Mr. SOLI DEBOO | **UHID No** : KH1000019755 | |
| **DATE OF ADMISSION** : 25/07/2023 | **AGE**: 79 years | **SEX** : Male |
| **DATE OF DISCHARGE** : 02/08/2023 | **TREATING DOCTOR** : DR. SOURABH PHADTARE | |

**CONSULTANTS WHO ATTENDED THE CASE:**

Dr sunil wani (Consultant – Cardiology)

Dr. shalmali imandar ( consultant infectious disease)

Dr Gaurav mehata (consultant gastroenterologiest )

**DIAGNOSIS:**

Shock – Septic/Cardiogenic

Severe LV dysfunction

Metabolic acidosis

Acute kidney injury

Ischemic hepatitis

**PAST HISTORY:**

* Hypertension
* Hypothyroidism
* Dyslipidemia
* History of LAD + RCA PTCA – 2002
* 2016 – LVEF 15%, LVF – hospitalized
* History of atrial fibrillation on Cordarone
* Surgery for BPH
* History of urinary tract infection in 2022 – hospitalized

**SIGNIFICANT FINDINGS:** On examination

Afebrile

Pulse rate: 148/minute

Blood pressure: not recordable

Respiratory rate: 30/minute

Peripheral capillary oxygen saturation: 68% on room air

Home glucometer testing: 121mg/dl

Systemic examination:

Cardiovascular system: S1 S2 +

Respiratory system: air entry bilaterally equal and clear

Per abdomen: soft, non-tender

Central nervous system: conscious, awake, obeys commands.

**CHIEF COMPLAINTS:**

Cough and breathlessness since 4 days

Decreased appetite and Constipation since 2 days

Unable to walk with multiple falls since 2 days

**HISTORY OF PRESENTING ILLNESS:**

79 Year, male patient, came to A & E, with above mentioned complaints from outside hospital i/v/o low blood pressure and feeble pulse, ECG was suggestive of Ventricular tachycardia treated with electrical cardioversion and sinus rhythm was achieved. Patient had low blood pressure despite fluid resuscitation and was started on inj. Noradrenaline iv infusion, along with oxygen supplementation with NRBM mask.

EPOC blood gas revealed severe metabolic with lactic acidosis. Ph 7.16/co2 19.5/hco3 7.0/lac 16.62. Was started on sodium bicarbonate infusion.

Patient was admitted under Dr. Sourabh Phadtare and started on i.v antibiotics and investigations were sent. wbc 22.37/Hemoglobin 13.3/Platelet 110/Sgot 2538.0/Sgpt 3070.0/ALP 193.0/CRP 38.7/ntProBNP 70000.0/Total bilirubin 3.72/Phosphorus 8.7/Calcium 7.3/BUN 84.6/Creatinine 3.25/Uric acid 14.2/INR 2.28/Troponin I 209.10/PCT 0.38.

Central venous catheter insertion, radial arterial line cannulation and Foley’s catheter insertion was done. Inj. Lasix infusion was started i/v/o low urine output which then gradually picked up and Lasix infusion was tapered off and stopped. Intraveouns Milrinone and Noradrenaline infusions were continued according to blood pressure.

Dengue NS-1 Antigen detection test was positive. While Dengue IgG and IgM, flu panel, leptospira detection by PCR and smear for malarial parasite were negative.

Blood culture was sent suggestive of staphylococcus epidermis which was sensitive to inj. Teicoplanin

Reference was given to Dr sunil wani who advised for Coronary angiography and CRTD insertion at later date on follow up. Also advised to start with Tab. Cordarone.

2d echo (25/7/23) s/o Severe LV dysfunction with EF – 15%, GRADE III DD, mod PH (Pasp-51 mmhg), dilated RA/LA, RWMA- akinesia of inferior-posterior wall and hypokinesia of rest of the segments.

Sonography of abdomen and pelvis was done s/o: 1. Large left renal cortical cyst. 2. Prostatomegaly. 3. Mild right pleural effusion. 4. GB distension with sludge.

Ionotropic support was gradually tapered off and stopped. Invasive lines were removed. Iv antibiotics were given accordingly. Patient had an episode of pulseless Ventricular Tachycardia on 30/7/2023 CPR was initiated and DC cardioversion was done 3 times ,patient reverted to sinus rhythm. Hypokalemia correction was given.inotropic support was given i/v/o hypotension. Opinion was taken from Dr.Sunil Wani [cardiologist] and started the patient on Tab.Mexilitine 100mg 1-1-1 ,need for CRTD and CAG was explained to relatives in detail by Dr.Wani,relatives wanted to continue medical management for now.

Supportive treatments continued and tapered off the inotropic support

Patient hemodynamically stable.

At discharge :

Patient is hemodynamically stable

No breathlessness , no Arrythmia

**TREATMENT DURING HOSPITAL STAY:**

Inj. Meropenem 1 gm i.v 1 - 0 - 1

Inj. Targocid 400 mg iv 3 doses 12 hours apart f/b 200 mg 1 - 0 – 0

Inj. Doxycycline 200 mg i.v stat f/b 100 mg i.v 1-0-1

Inj. Pantoprazole 40 mg i.v 1 - 0 – 1

Inj. Vitamin k 10 mg i.v 1-0-0 x 3 days

Inj. Vitamin c 500 mg i.v 1-0-1

Inj. Thiamine 100 mg i.v 1-0-0

Inj. Lasix 10 mg i.v 1-1-0

Inj. Hydrocort 100 mg i.v stat f/b 50 mg i.v 1-1-1-1 f/b 50 mg i.v 1-1-1 f/b 50 mg i.v 1-0-1 f/b 50 mg i.v 1-0-0

Inj. N-acetyl cysteine 8gm in 50 ml NS at 4 ml/hr x 3days f/b Tab mucomix 600 mg p.o 1-0-1

Tab. Cordarone 200 mg p.o. 1-0-1 f/b 200 mg p.o 1-0-0

Tab. Ecosprin 75 mg p.o 0-1-0

Tab. Ivabrad 2.5 mg p.o 1-0-1

Tab. Monotrate 20 mg p.o 1-1-0

Tab. Atorva 20 mg p.o 0-01

Tab. Flavedon-MR 35 mg p.o 1-0-1

Tab. Eltroxin 25 mcg p.o 1-0-0

Tab. Folvite 5 mg 1-0-1

Syp. Cremaffin 30 ml p.o 0-0-1

Cap. Silodal 8 mg p.o 0-0-1

Tab. Sevcar 800 mg p.o 1-0-0

Tab. Restyl 0.25 mg p.o 0-0-1

**TREATMENT ON DISCHARGE:**

Tab. Cordarone 200 mg p.o. 1-0-1 f/b 200 mg p.o 1-0-0 for one week

Tab codarone 100 mg 1-0-0

Tab. Ecosprin 75 mg p.o 0-1-0

Tab Pan 40 mg 1-0-1

Tab. Monotrate 20 mg p.o 1-1-0

Tab. Atorva 20 mg p.o 0-01

Tab. Flavedon-MR 35 mg p.o 1-0-1

Tab. Eltroxin 25 mcg p.o 1-0-0

Tab. Folvite 5 mg 1-0-1

Syp. Cremaffin 30 ml p.o 0-0-1

Cap. Silodal 8 mg p.o 0-0-1

Tab. Sevcar 800 mg p.o 1-0-0

Tab. Restyl 0.25 mg p.o 0-0-1

Advice on Discharge: **TO DO CBC , RFT,LFT AFTER 2 WEEKS AND FOLLOW UP WITH DR SOURABH PHADTARE IN OPD .**

**Dr. Sourabh Phadtare**

Consultant

Critical Care Department

Kokilaben Dhirubhai Ambani Hospital

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **UHID No :** KH1000626879 |  | |
| **Name :** ANIL SAXENA | **Age : 69 Years** | **Sex :** Male |
| **Date of Admission :** 31/05/2021 | **Date of Discharge : 23/06/2021** | |
|  | **Treating Doctor: DR.KIRAN SHETTY** | |

**OTHER CONSULTANTS**

Dr.Diptiman Roy (Consultant Interventional Radiology)

Dr.Ismail Attar (Consultant Urology)

Dr.Gaurav Mehta (Consultant Gastroenterology)

Drt.Tanu Singhal (Infectious Disease Specialist)

**DIAGNOSIS:**

Fluid Overload

Bacterial Pneumonia with Pleural and Pericardial effusion

**CHIEF COMPLAINS:**

fever

thick secretions

hypoxia

**PAST HISTORY:**

PSP, Parkinson’s disease

Hypothyroidism

Anemia

**COURSE IN HOSPITAL:**

The patient, Mr.Anil Saxena waqs brought to the hospital with chief complaints of fever, thick TT secretions and hypoxia (Saturation- 85%). On arrival in the A &E, his vitals were as follows: Pulse- 76/min, BP- 150/70 mm Hg, RR- 14/min, SpO2- 99% (on 3 L O2), afebrile. Tracheostomy and PEG tube in situ, Bed sores on the back and lateral thighs, pedal edema noted. Routine labs and cul;tures were sent and he was admitted to the ward for further management.

HRCT done on 1/6/2021 showed gross left sided pleural effusion with collapse/consolidation of entire left lower lobe, and findings suggestive of volume overload and aspiration.Initial labs showed Hb- 8.8, WBC 12070, Platelet count 101000.Patient was started on Inj.Elores, diuretics, other supportive medications continued. Reference was given to Dr.Diptiman – Left pleural cavity Pigtail was inserted. Pleural fluid was s/o infection- exudative, neutrophil predominant, low ADA. Chest USG was done on 5/6/2021- showed mild pleural effusion Pigtail removed on 10/6/2021.

Reference was given to Dr.Ismail Attar for change of foley’s catheter.Had a fever s[ike on 12/6/2021- Colistin nebs added, ET C/S sent. On 15/6/21 – reference was given to Dr.Gaurav Mehta in view of crampy abdominal pain 🡪 started on Tab.Colospa, Tab.Rifagut,Pentasa suppository. On 15/6/21, Lasix infusion was started in view of low Urine output and patient was shifted to the ICU for further management. Repeat HRCT Thorax was done on 14/6/21 which showed resolution in the pleural effusion and consolidation. CT Abdomen was done on 15/6/21 which showed moderate pericardial effusion was a new finding which was not present on the previous day’s CT scan, splenomegaly. Urine output began improving 🡪 Lasix tapered off. Review Chest USG showed mild right sided and moderate left sided pleural effusion, and mild pericardial effusion. Reference was given to Dr.Diptiman- fluid too minimal to tap. 2D ECHO was done on 16/6/21 which showed globally reduced EF- 30%, Moderate PH, mild pericardial effusion.

Serial WBC count showed rising trend. Patient was referred to Infectious Disease specialist Dr.Tanu Singhal – opinion Bacterial pneumoniawith bacterial pleural and pericardial effusion, advised to start on Inj.Zavicefta. On 18/6/21 patient had an episode of tachyarrhythmia- started on Cordarone bolus followed by infusion. On 21/6/2021 , CXR showed increase in the amount of left sided pleural effusion – CT guided Pigtail insertion done by Dr.Diptiman Roy- Investigations sent. Patient received blood transfusions during the hospital stay.

Presently the patient is hemodynamically steady and is being discharged. Pigtail (Left Pleural cavity) is in situ.

**TREATMENT DURING HOSPITAL STAY**

**Antibiotics:**

**Inj.Elores 1.5gm IV BD -31/5/21 to 7/06/2021**

**Tab.Ceftum 250mg BD – 10/6/21-14/6/21**

**Inj.Zavicefta 1.25gm IV TDS – 16/6/21 onwards**

Other medications:

Tab.Thyronorm 100mcg 1-0-0

Tab.Pan 40mg 1-0-0

Tab.Syndopa Plus 125mg 1-1-1-1

Tab.Syndopa CR 125 0-0-1

Tab.Urispas 1-1-1

Tab Mirago 25mg 0-1-0

Tab.Dariten 7.5mg 2-0-0

Tab.Ecosprin 75mg 0-1-0

Tab.Tonact 20mg 0-0-1

C.Gutsium 1-0-1

Tab.Colospa 135mg 1-0-1 x 5 days

Tab.Rifagut 400mg 1-0-1 x 5 days

Syp Cremaffin Plus 30ml 0-0-1

Pentasa 1 g suppository 0-0-1 for 2 weeks

Mucomix nebs 1-1-1-1

NS nebs 1-1-1-1

Inj.Lasix 10mg 1-0-0

Tab.Cordarone 100mg OD

Tab.Ultracet 50mg BD

**Advice at Discharge:**

Tab.Urispas 1-1-1

Tab Mirago 25mg 0-1-0

Tab.Dariten 7.5mg 2-0-0

Tab.Ecosprin 75mg 0-1-0

Tab.Tonact 20mg 0-0-1

C.Gutsium 1-0-1

Syp Cremaffin Plus 30ml 0-0-1

Pentasa 1 g suppository 0-0-1 for 2 weeks – till 29/6/21

Mucomix nebs 1-1-1-1

NS nebs 1-1-1-1

Inj.Lasix 10mg 1-0-0

Tab.Cordarone 100mg OD

Tab.Ultracet 50mg BD

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **UHID No : KH1000531057** |  | |
| **Name : Mr.Jayantilal J Bhanushali** | **Age : 57 Years** | **Sex : Male** |
| **Date of Admission : 20/09/2020** | **Date of Discharge :23/09/2020** | |
|  | **Treating Doctor: Dr.Sourabh Phadtare** | |

**Other Consultants Attended the Case  :**

Dr. Dattatray Solankhe (Gastroenterologist)

Dr. Jyotsna Oak (Rheumatologist)

Dr. Diptimon Roy (intervention Radiologist)

Dr. Sanjiv Badhwar (ENT)

Dr. Sameer Tulpule (Hematologist)

**Diagnosis:**

**Presenting Complaints:**

Malena with foul smelling stools since 2-3 days

Epistaxis (1 Episode)

Hematemesis multiple Episodes

Past History :

**Course in hospital:**

Mr Jayantilal J Bhanushali, a 57 year old male known case of Diabetes Mellitus, Mixed Connective Tissues Disorders(MCTD) and Raynauds:?Interstital Lung Disease.He was Admitted with complaints of Malena with foul smelling stools since 2-3 days,Epistaxis (1 Episode),Hematemesis multiple Episodes bluish discolouration of digits of upper limb and small joint pain 3 years back .He was evaluated and found to have high ANA, and was started on steroids, Folitrax and HCQ.Patient had undergone endoscopy 2years ago which was within normal limits . Presently admitted for 1 episode of Malena 3 days ago, foul smelling stools since 2-3days. Pat had 1 episode of nasal bleed and multiple episodes of hematemesis with Malena .On admission was found to have hypotension and bradycardia. Pat was investigated for the same and ENT opinion was taken and advised for  
Rheumatology opinion taken for underlying MCTD and one PRBC Transfusion done in view of low Hb

**Investigations:**

**Treatment during stay:**

**Patient response:**

Satisfactory.

**Status on Discharge:**

Hemodynamically stable.

**Treatment Advised:**

**Medication on Discharge:**

**Instruction to patient:**

**Follow up advice** : Follow up as advised in outpatient department with Dr.Vatsal Kothari

with prior appointment.

**Signature :**

**Dr. Vatsal Kothari**

**Director - Critical Care Medicine  
Kokilaben Dhirubhai Ambani Hospital**

**Date : 06-08-2020**

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **PATIENT’S NAME**: Mrs. Neeta Sushil Vadher | **UHID No** : KH1000704401 | |
| **DATE OF ADMISSION** : 19/12/2020 | **AGE**: 56 years | **SEX** : Female |
| **DATE OF DISCHARGE** : 21/12/2020 | **TREATING DOCTOR** : DR.VATSAL KOTHARI | |

**CONSULTANTS WHO ATTENDED THE CASE :**

Dr. Prashant Nair (Consultant Cardiologist)

Dr. Niren Dongre ( Consultant Ophthalmologist)

**DIAGNOSIS:**

Probable Transient Ischaemic Attack.

**PAST HISTORY:**

Hypothyroidism since 5 years.

**CHIEF COMPLAINTS:**

56 years female, known case of hypothyroidism since 5 years, newly diagnosed with Diabetes and hypertension, presented with complaints of occasional giddiness, heaviness over forehead and mild blurring of vision since 2-3 days. Patient was brought to Accident and Emergency, in view of aggravation of symptoms. On admission, patient was conscious and oriented. B.P – 150/80 mmHg, H.R – 71/ min, SpO2 – 96% at room air, Afebrile. Patient had GCS score of 15/15, moving all 4 limbs, NIHSS – 0, pupils bilaterally reactive to light (3 mm). HSTrop I – 2.1. ECG was suggestive of T wave inversion in lead II,III, AvF V4-V6. Cardiology reference was taken from Dr. Prashant Nair adviced to get 2D echo done. 2D echo suggestive of mild left ventricular hypertrophy, LVEF – 55%, PASP – 26mmHg, no RWMA. MRI Brain and Neck (plain + angiogram) was done on 19/12/2020 suggestive of no acute infarct, few foci of chronic ischaemic changes in cerebral white matter, mild luminal narrowing of right carotid bulb causing 20 to 30% luminal reduction. Opthalmology reference was taken from Dr. Niren Dongre, suggested no papilloedema or any other eye pathology. Videonystagmography was done on 21/12/2020, impression – normal study.

**TREATMENT DURING HOSPITAL STAY:**

Tab. Thyronorm 75mcg 1-0-0

Tab. Razel F 10 Mg 0-0-1

Tab. Pan 40 mg 1-0-0

Tab. Clopidogrel 75 mg 1-0-0

**TREATMENT ON DISCHARGE:**

Tab. Thyronorm 75mcg 1-0-0

Tab. Razel F 10 Mg 0-0-1

Tab. Pan 40 mg 1-0-0

Tab. Clopidogrel 75 mg 1-0-0

Tab. Glucomet 500 mg 1-0-0.

Tab.Telma 40mg 1-0-0

Follow up with Dr.Vatsal Kothari with prior appointment after two weeks.

**Dr. Vatsal Kothari**

Head and Consultant

Critical Care Department

Kokilaben Dhirubhai Ambani Hospital

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **UHID No : KH1000010962** | **Treating Doctor: Dr. Khushboo** | |
| **Name : Mrs.Naina Chugh.PI_VIP** | **Age :**  80 **Years** | **Sex : Female** |
| **Date of Admission : 29-01-2021** | **Date of Discharge : 16-02-2021** | |

**Attending Consultants:**

Dr.Manoj Mulchandani

Dr.Niranjan Kulkarni

Dr.Dattatray

**Diagnosis:**

k/c/o - Interstitial lung disease

-Old CVA

-Ca Breast (operated), left lymphedema

-Chronic Atrial fibrillation

**Chief Complaints:**

Left thigh Pain x 1 day

**Course in the hospital:**

The patient, Naina Chugh, presented with complaints of left thigh pain since 1 day. On evaluation in the A&E, Pulse 74/min, BP – 100/70mmHg, afebrile, Sats- 93% (room air), Pain score 7/10, left upper limb lymphedema, bilateral pedal edema. RS examination revealed bilateral crepitations, CNS- left hemiplegia. Potassium was found to be 6.72- correction given. She was admitted to the ICU for further management.

Initial labs showed: Hb 6.0, WBC 7550, Platelet 403000, Serum electrolytes Na 129.0, K 6.72, Cl 97.3, CRP 8.9, Procalcitonin 0.61, CREAT 1.22, BUN 29.9, Total Bilirubin 1.26, Direct – 1.01, SGOT 31, SGPT 16, ALP 160, Albumin 2.54. CT Abdomen was done which showed inter and intramuscular hematomas in the left proximal thigh and left gluteus, partially distended gall bladder, dilated CBD with multiple calculi, ascites. She was started on antibiotics (Tazact), blood transfusion, O2 and other supportive measures. She was referred to Dr.Dattatray- advised USG Abdomen + Pelvis which showed

Pleural fluid characteristics- exudative, neutrophil predominant with occasional pus cells, ADA of 29.6, LDH 707, negative for malignant cells, no organism grown on culture, Genexpert – M.tuberculosis not detected. She was continued on antibiotics in view of the same. In view of multiple loculations seen on CT Thorax, fibrinolysis was performed using Urokinase. CT Thorax was repeated on 1/2/21 which showed loculated pleural based collection, air fluid levels, consolidation with air bronchogram in the right lower lobe, mild cardiomegaly and pericardial thickening, hepatosplenomegaly.

Reference was given to Dr.Tanu Singhal - opinion – cavitating community acquired pneumonia with empyema – likely etiology streptococcus/staphylococcus/klebsiella/mycoplasma- advised to continue Augeoz and change from Levoflox to Levonadifloxacin while evaluating underlying causative organism – Mycoplasma IgM was found to be positive, Cold agglutinins detected. Antibiotics were continued – over next few days patient improved clinically- WBC counts and CRP were downtrending, fibrinolysis was repeated in view of persistence of loculated effusion. CT Thorax was repeated on 6/2/21 –significant regression in the amount of loculated pleural fluid with decreased consolidation of right lower lobe. Reference was given to Dr.Rajesh Mistry in view of residual pleural fluid who advised USG guided drainage considering VATS. Repeat USG- the fluid was minimal and non tappable, hence no intervention done. Pigtail drain was removed on 12/2/21 as there was lung expansion noted, and no drain output over last 24-48 hours. Repeat Chest Xray showed adequate ling expansion without recollection of fluid. The patient improved symptomatically, was afebrile and hemodynamically stable and is thus being discharged with advice as below.

**Treatment during stay:**

|  |  |  |  |
| --- | --- | --- | --- |
| Inj.Augeoz | 1.25gm | IV | 1-0-1 |
| Inj.Levonadifloxacin | 800mg | IV | 1-0-1 |
| Tb.Pan | 40mg | PO | 1-0-0 |
| Tb.Eltroxin | 75mcg | PO | 1-0-0 |
| Tb.Folvite | 5mg | PO | 1-0-0 |
| Tb.Metolar | 25mg | PO | 1-0-1 |
| Triptin biscuits |  | PO | 1-1-1 |
| Tb.Optineuron |  | PO | 1-0-0 |
|  |  |  |  |

**Patient response:** Improved

**Status on Discharge:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DRUGS** | **DOSE** | **ROUTE** | **FREQUENCY** |  |
| TAB. LEVONADIFLOXACIN | 1000 MG | P.O. | 1......0......1 | AFTER MEAL |
| TAB. LIMCEE | 500 MG | P.O. | 1......0......0 | AFTER MEAL |
| TAB. FOLVITE | 5 MG | P.O. | 0......1......0 | AFTER MEAL |
| TAB. PAN | 40 MG | P.O. | 1......0......0 | BEFORE MEAL |
| SYP. CREMAFFIN | 15 ML | P.O. | 0......0......1 | AFTER MEAL |
| TAB. OPTINEURON | 1 TAB | P.O. | 1......0......0 | AFTER MEAL |
| TAB. ELTROXIN | 50 MCG | P.O. | 1......0......0 | EMPTY STOMACH |
| TAB. EMSET | 4 MG | P.O. | SOS FOR VOMITING | AFTER MEAL |

**Advice on Dischargel;**

Follow up with Dr.V.M.Kothari after two weeks with CBC,RFT,LFT,CXR with prior appointment.

Follow up with Dr.Rajesh Mistry with prior appointment.

**Signature :**

**Dr.Vatsal Kothari**

**Director, Critical Care Medicine**

**Kokilaben Dhirubhai Ambani Hospital.**

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **UHID No : KH1000737807** | **Treating Doctor: Dr. Vatsal Kothari** | |
| **Name : Mrs.Fancy Raman.PI_VIP** | **Age :** 27 **Years** | **Sex : Female** |
| **Date of Admission : 31-01-2021** | **Date of Discharge : 12-02-2021** | |

**Attending Consultants:**

Dr.Rajesh Mistry (Consultant Surgery)

Dr.Diptiman Roy (Consultant Interventional Radiology)

Dr.Tanu Singhal (Infectious Disease Specialist)

Dr.Neha Pawar (Consultant Obstetrics and Gynaecology)

**Diagnosis:**

1. SEVERE COMMUNITY ACQUIRED PNEUMONIA WITH LOCULATED EXUDATIVE PLEURAL EFFUSION
2. MULTIFACTORIAL ANEMIA (BLOOD LOSS + NUTRITION)
3. HYPOTHYROIDISM

**Chief Complaints:**

Fever with cough and dyspnoea since 10 days

**Course in the hospital:**

The patient, Fancy Rani Raman, presented to a outside hospital with complaints of menorrhagia since 3 months, fever, cough and dyspnoea since 10 days- on evaluation was found to have anemia – Hb 7.7- was started on blood transfusion and shifted to KDAH in view of Severe pneumonia and loculated pleural effusion. On evaluation in the A&E, she was tachycardic (Pulse 128/min), BP – 140/90mmHg, febrile (Temperature-100.4 deg F), RS examination revealed reduced breath sounds on right lung base. HRCT Thorax done outside showed multiloculated mild to moderate Right sided pleural effusion with multiple air locules within. She was admitted to the ICU for further management.

Initial labs showed: Hb 6.3, WBC 26270, Platelet 437000, Serum electrolytes Na 137.0, K 4.36, Cl 100, CRP 41.6, Procalcitonin 0.52, CREAT 0.88, BUN 7.6, Total Bilirubin 2.39, Direct – 1.32, SGOT 28, SGPT 18, ALP 160, Albumin 3.27. She was started on antibiotics (Augeoz, Levoflox), blood transfusion, High flow O2 and other supportive measures. She was referred to Dr.Diptiman Roy- USG guided Pigtail was inserted for right sided pleural effusion. Reference was given to Gynaecologist in view of menorrhagia – advised USG Abdomen + Pelvis which showed

Pleural fluid characteristics- exudative, neutrophil predominant with occasional pus cells, ADA of 29.6, LDH 707, negative for malignant cells, no organism grown on culture, Genexpert – M.tuberculosis not detected. She was continued on antibiotics in view of the same. In view of multiple loculations seen on CT Thorax, fibrinolysis was performed using Urokinase. CT Thorax was repeated on 1/2/21 which showed loculated pleural based collection, air fluid levels, consolidation with air bronchogram in the right lower lobe, mild cardiomegaly and pericardial thickening, hepatosplenomegaly.

Reference was given to Dr.Tanu Singhal - opinion – cavitating community acquired pneumonia with empyema – likely etiology streptococcus/staphylococcus/klebsiella/mycoplasma- advised to continue Augeoz and change from Levoflox to Levonadifloxacin while evaluating underlying causative organism – Mycoplasma IgM was found to be positive, Cold agglutinins detected. Antibiotics were continued – over next few days patient improved clinically- WBC counts and CRP were downtrending, fibrinolysis was repeated in view of persistence of loculated effusion. CT Thorax was repeated on 6/2/21 –significant regression in the amount of loculated pleural fluid with decreased consolidation of right lower lobe. Reference was given to Dr.Rajesh Mistry in view of residual pleural fluid who advised USG guided drainage considering VATS. Repeat USG- the fluid was minimal and non tappable, hence no intervention done. Pigtail drain was removed on 12/2/21 as there was lung expansion noted, and no drain output over last 24-48 hours. Repeat Chest Xray showed adequate ling expansion without recollection of fluid. The patient improved symptomatically, was afebrile and hemodynamically stable and is thus being discharged with advice as below.

**Treatment during stay:**

|  |  |  |  |
| --- | --- | --- | --- |
| Inj.Augeoz | 1.25gm | IV | 1-0-1 |
| Inj.Levonadifloxacin | 800mg | IV | 1-0-1 |
| Tb.Pan | 40mg | PO | 1-0-0 |
| Tb.Eltroxin | 75mcg | PO | 1-0-0 |
| Tb.Folvite | 5mg | PO | 1-0-0 |
| Tb.Metolar | 25mg | PO | 1-0-1 |
| Triptin biscuits |  | PO | 1-1-1 |
| Tb.Optineuron |  | PO | 1-0-0 |
|  |  |  |  |

**Patient response:** Improved

**Status on Discharge:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DRUGS** | **DOSE** | **ROUTE** | **FREQUENCY** |  |
| TAB. LEVONADIFLOXACIN | 1000 MG | P.O. | 1......0......1 | AFTER MEAL |
| TAB. LIMCEE | 500 MG | P.O. | 1......0......0 | AFTER MEAL |
| TAB. FOLVITE | 5 MG | P.O. | 0......1......0 | AFTER MEAL |
| TAB. PAN | 40 MG | P.O. | 1......0......0 | BEFORE MEAL |
| SYP. CREMAFFIN | 15 ML | P.O. | 0......0......1 | AFTER MEAL |
| TAB. OPTINEURON | 1 TAB | P.O. | 1......0......0 | AFTER MEAL |
| TAB. ELTROXIN | 50 MCG | P.O. | 1......0......0 | EMPTY STOMACH |
| TAB. EMSET | 4 MG | P.O. | SOS FOR VOMITING | AFTER MEAL |

**Advice on Dischargel;**

Follow up with Dr.V.M.Kothari after two weeks with CBC,RFT,LFT,CXR with prior appointment.

Follow up with Dr.Rajesh Mistry with prior appointment.

**Signature :**

**Dr.Vatsal Kothari**

**Director, Critical Care Medicine**

**Kokilaben Dhirubhai Ambani Hospital.**

**DISCHARGE SUMMARY**

|  |  |  |
| --- | --- | --- |
| **UHID No : KH1000626879** |  | |
| **Name : Mr.Anil SsaxenaPI_VIP** | **Age : 68 Years** | **Sex : Male** |
| **Date of Admission : 03/2/2021** | **Date of Discharge :** | |
|  | **Treating Doctor: Dr.Kiran Shetty** | |

**Other Consultants Attended the Case  :**

Dr.Amol Galme ( Plastic Sugery)

Dr.Gaurav Mehta(Gastroenterologist)

Dr. Tanu Singhal (Infectious Diseaset)

Dr. Mohit Bhatt (Neurologyt)

**Diagnosis:**

**Presenting Complaints:**

Fever

Desaturation at home

Tachycardia

**Past History** :

Hypertension

IHD

Old CVA

PSP

Post Covid

LV dysfunction.

**Course in hospital:**

Patient presented to the A/E with above mentioned complaints.On arrival his PR-118/MIN, bp-130/72, SpO2-88% on room air.All routine investigations including pan cultures were sent and patient was transferred to the ICU.He was empirically started on Meropenem and Teicoplanin.

On 4/2/2021 patient received one pint PRBC i/v/o drop in Hb.CT Brain was done i/v/o of unequal pupils.Ct brain was s/o generalized parenchymal atrophy and volume loss in the mid brain , and hyperdense focus in the left globe suggestive of dislocated lens/ foreign body.

Blood culture showed E.coli, Urine culture – pseudomonas, and wound swab culture moprgannella morganei and proteus penneri.

Reference given to Dr Mohit Bhatt( Neurologist) i/v/o h/o OF psp. He advised to continue same line of tteatment. Reference given to Dr Amol Galme i/v/o bedsores who advised debridase ointment.

On 8/2/2021 patient underwent debridement of bedsore.Procedure was uneventful.

Reference was given to Dr Ismail Attar ( Urology)for SPC change.

On 10/2/2021 patient had fever spike . Hence fresh cultures were sent, antibiotic changed to Elores and central line was changed.

Reference was given to Dr Gaurav Mehta ( Gastrologist) i/v/o abdominal pain. He advised mesalazine suppository and cremaffin plus and sos sigmoidoscopy.

Urine culture showed Pseudomonas sensitive to Fosfomycin, Blood culture – no growth. Was started on Inj Fosfomycin.

Reference was given to Dr Tanu Singhal for antibiotic optimization.

On 17/2/2021 patient had an eoisode of desaturation and fever spike. Hence HRCT chest was done which was s/o volume over load and bilateral pleural effusion with collapse /consolidation.Covid swas( CBNAAT ) which was negative.

**Treatment during stay:**

**INJ MEROPENEM 1GM BD**

**INJ ELORES 3GM BD**

**ING TAROCID 400MG OD**

**INJ FOSFOMYCIN 2GM TDS F/B 2GM BD THEN STOPPED**

**INJ HYDROCORT 25 MG TDS**

**TAB PAN 40 MG OD**

**TAB OPTINEURON OD**

**TAB THYRONORM 100MCG OD**

**TAB SYNDOPA PLUS OD**

**TAB SYNDOPA CR 125 HS**

**TAB LEVERA 500 BD**

**TAB URISPAS TDS**

**TAV GUTSIUM BD**

**TAB DARITEN 2 TAB OD**

**TAB ATORVA 20MG HS**

**TAB MIRAGO 25 OD**

**MESALAZINE SUPPOSITORY 500MG AT NIGHT**

**TAB ORCIBEST 10MG TDS**

**TRANEXEMIC ACID NEB BD**

**Status on Discharge:**

Hemodynamically stable.

**Treatment Advised:**

**Medication on Discharge:**

**Instruction to patient:**

**Follow up advice** : Follow up as advised in outpatient department with Dr.Vatsal Kothari

with prior appointment.

**Signature :**

**Dr. Vatsal Kothari**

**Director - Critical Care Medicine  
Kokilaben Dhirubhai Ambani Hospital**

**Date : 06-08-2020**