Dept. of Orthopaedics
Dr. M. Madan Mohan Reddy,
MS(Ortho)., F.R.C.S(UK)., MD(France).
Consultant

Apollo HOSPITALS
TOUCHING LIVES

March 25, 2013

To Whomsoever It May Concern

This is to certify that Mr.Venkataraman, Age: 18yrs/M, UHID: 2558670, is under my care for the treatment of Chronic ACL tear Left Knee. He is admitted on 13-03-2013 and underwent Arthroscopic ACL Reconstruction with Hamstring Graft Left Knee on 15-03-2013. He is discharged on 19-03-2013. He is reviewed today and he is fit to join college on 27-03-2013.

Dr. MADAN MOHAN REDDY .M
SENIOR CONSULTANT ORTHOPAEDIC SURGEON
APOLLO HOSPITALS CHENNAI
REG. NO: 18645

Dr. Madan Mohan Reddy,
Senior consultant joint replacement Surgeon

CHRISTIAN MEDICAL COLLEGE
VELLORE - 4
NEUROSURGERY UNIT II

DISCHARGE SUMMARY

DS No. 1512/2011
Email neurosurgery2@cmcvellore.ac.in
Tel (0416) 2222102 Extn: 2767/2018
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Name : VENKATARAMAN E. **Hospital Number :**089404F
Age : 17 **Sex :** Male **Ward :** NT **Admitted On :** 01-Dec-2011
Discharged On: 14-Dec-2011

Address : S/O MR. V ELANGOVAN
NO.4, KALAINGNAR STREET, PULAVAR NAGAR
RANGAPURAM, SATHUVACHAI, VELLORE - 632009
9443009749 **Pincode :**

Diagnosis: MODERATE HEAD INJURY
RIGHT BASIFRONTAL EXTRA DURAL HAEMATOMA
LEFT POSTERIOR FOSSA EXTRADURAL HAEMATOMA

History

Seventeen year old Mr.Venkataraman was brought to the casualty half an hour following an alleged road traffic accident at 1830 hours on 01/12/2011. He was riding a two wheeler which was hit by a four wheeler. He was in an altered sensorium since the time of the incident. He was not wearing a helmet and not under the influence of alcohol at the time of the injury. There was history of oro-nasal bleed and one episode of vomiting. There was no history of seizures. There was history of injury to the right upper limb. There were no other significant past illnesses.

On Examination

Pulse 150/min, BP 110/70 mm of Hg, RR 35/min, Sat 80%
Airway was not maintained with inadequate breathing.
GCS score was 9/15 (E2 M5 V2), he was intubated in casualty. Pupils were 2 mm bilaterally and reacting to light. There was no facial paresis. There was paucity of movements in the right upper limb. There was no scalp laceration. Examination of the face showed a right periorbital ecchymosis with abrasion over the right supra-orbital region. There was active oro-nasal bleed. There was no CSF rhinorrhoea or otorrhoea. The spine examination showed no deformity.

Investigations

12-Dec-2011	P.C.V.	30.4	%
12-Dec-2011	CREATININE	1.1	mg%
12-Dec-2011	NA/K		
	SODIUM	139	m mol/L
	POTASSIUM	3.5	m mol/L
11-Dec-2011	NA/K		
	SODIUM	137	m mol/L
	POTASSIUM	4.5	m mol/L
10-Dec-2011	NA/K		
	SODIUM	135	m mol/L
	POTASSIUM	4.4	m mol/L
09-Dec-2011	PHENYTOIN ASSAY	<2.50	ug/ml
09-Dec-2011	NA/K		
	SODIUM	138	m mol/L
	POTASSIUM	4.1	m mol/L
08-Dec-2011	C/S PUS SWAB COMMON		
	SUPPLEMENTARY REPORT WILL FOLLOW IF GROWTH OCCURS		
	No growth so far		

	EOSINOPHILS	0	%
	BASOPHILS	0	%
	LYMPHOCYTES	8	%
	MONOCYTES	5	%
	NUCL RED CELLS	0.0	/100 WBC
03-Dec-2011	URINALYSIS ROUTINE	Edited	
	epi cells prt.coarse gra cast prt.		
	GLUCOSE	Negative	
	BILIRUBIN	Negative	
	KETONE	Negative	
	SPECI.GRAVITY	1.030	
	BLOOD	++	
	PH	6	
	PROTEIN	trace	
	UROBILINOGEN	Normal	
	NITRITE	Negative	
	LEUKOCYTES	Negative	
	RBC	6-8	
	WBC	10-12	
03-Dec-2011	CULTURE BLOOD		
	No Growth		
03-Dec-2011	C/S SPUTUM COMMON		
	MANY PUS CELLS, NO BACTERIA		
	Normal Flora		
03-Dec-2011	WBC TOTAL	8400	/CU MM
03-Dec-2011	WBC DIFFERENTIAL		
	NEUTROPHILS	84	%
	EOSINOPHILS	0	%
	LYMPHOCYTES	6	%
	MONOCYTES	9	%
	NUCL RED CELLS	0.0	/100 WBC
03-Dec-2011	CPK (CK)	1606	u/L
03-Dec-2011	PROCALCITONIN	2.458	
03-Dec-2011	P.C.V.	29.9	%
03-Dec-2011	NA/K		
	SODIUM	157-R	m mol/L
	POTASSIUM	4.4	m mol/L
03-Dec-2011	PLATELET COUNT	174000	CC.MM
03-Dec-2011	PT WITH INR		
	PATIENT	11.2	SECS
	NORMAL RANGE	9.5-12.7	SECS
	INR	1.02	
03-Dec-2011	APTT		
	PATIENT	24.2	SECS
	NORMAL RANGE	26.6-40.2	
03-Dec-2011	FIBRINOGEN	417.4	mg/dl
02-Dec-2011	P.C.V.	28.0	%
02-Dec-2011	P.C.V.	32.8	%
02-Dec-2011	PLATELET COUNT	269000	CC.MM
02-Dec-2011	PT WITH INR		
	PATIENT	11.0	SECS
	NORMAL RANGE	9.5-12.7	SECS
	INR	1.0	
02-Dec-2011	APTT		
	PATIENT	24.2	SECS
	NORMAL RANGE	26.6-40.2	
02-Dec-2011	NA/K		
	SODIUM	137	m mol/L
	POTASSIUM	4.6	m mol/L
02-Dec-2011	ABG - SICU		
	SAMPLE TYPE	Arterial	%
	FO2(I)	21.0	%
	T	37.0	
	pH	7.358	
	PCO2	38.0	mmHg
	PO2	71.6	mmHg
	pH(T)	7.358	
	pCO2(T)	38.0	mmHg
	pO2(T)	71.6	mmHg
	cK+	4.5	mmol/L
	cNa+	135	mmol/L
	cCa2+	1.11	mmol/L

Discussion

Seventeen year old male was brought to the casualty half an hour post-trauma with a GCS score of 9/15 [E2 M5 V2] and bilaterally equal and reacting pupils. He had paucity of movements of right upper limb. His airway was not maintained because of the profuse oro-nasal bleed, and his saturation on admission to casualty was 80% and he had to be intubated. His CT scan showed siognificant right basifrontal and a left posterior fossa extradural haematomas. He was rushed into operation theatre and underwent a left paramedian sub-occipital craniectomy and evacuation of the posterior fossa fracture haematoma followed by a right fronto-temporal craniotomy and evacuation of the extra-dural haematoma on 02/11/2011 under GA. Intra op he was found to have a mild ooze from the nose which was packed with a BIPPS pack bilaterally. His right arm was found to be swollen and had ecchymotic patches for which an ultrasound was done which showed subcutaneous haematoma and x-ray was not suggestive of any fracture. He was conservatively managed with limb elevation. Post-operatively he was sedated and ventilated for 36 hours. He was managed medically with adequate hydration, hypertonic saline, anti-oedema measures and antiepileptic. He started spiking high grade fever on the 2nd hospital day for which he was started on intravenous Cefoperazone-Sulbactam and Gentamicin after sending all cultures. He was persistently tachycardic and hypotensing for which he required vaso-pressors. He was started on a ketamine infusion with which his tachycardia subsided. He was extubated on the 2nd post-operative day following which his GCS score improved to 12/15(E3 V3 M6). 6 hours following extubation he developed profuse nasal bleed with restlessness and a probable aspiration for which he was reintubated. Post intubation his nasal bleed alo subsided. He underwent a tracheostomy under GA on 06/12/2011. Following tracheostomy he was weaned off the ventilator, and his sensorium gradually improved to 15/15. He had further episodes of fever, and E.T. aspirates grew GNB and he was treated with Tab. Levofloxacin. He was found to have bilateral sixth nerve paresis for which no definite cause could be determined, and was referred to Ophthalmology OPD for review. He was discharged with advice to review in Brain Injury Clinic after 2 weeks, or earlier in Casualty in case of worsening of headache, vomiting, seizures, fever, CSF rhinorrhoea or otorrhoea, altered sensorium or motor weakness.

CONDITION AT DISCHARGE:

Afebrile, ambulant, on normal diet and voiding normally. He had bilateral sixth cranial nerve paresis, left worse than right. His right upper limb had improved to full power and the swelling had subsided. The wound was healing well.

Recommendations

Tab. Phenytoin 200 mg thrice a day till further advice.
Tab. Levofloxacin 500mg once daily till 18-Dec-2011.
Tab. Combiflam 1 tablet thrice daily for 1 week.
Tab. Rantac 150mg twice daily for one week.
Tab. Paracetamol 1 gram for pain as and when required.
Moisol eye drops four times a day both eyes

To review in Opthalmology OPD after discharge.
To review in Brain Injury Clinic (Wednesday 10am, PMR OPD) on 28-Dec-2011.

Written By : Registrar

NEUROSURGERY UNIT II