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MEDICA Superspecialty Hospital
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KOLKATA

Discharge Summary

IP No.	: 37981	UHID	: MSHK.675568
Patient Name	: Mr. ANIRUDDHA RAY	Age/Sex	: 39 Year(s) /Male
Admission DateTime	: 01/05/2021 04:27 AM	Discharge Date Time	: 15-07-2021
Doctor Name	: Dr. A.Roy/A.Bera/A.Bose/R.Shukla (CRITICAL CARE)		
Bed No/Ward	: 3rd floor ICU 1		
Company	: Hospital Schedule (Nov 2019)		
Patient address	: SUMANGAL VILLA, FLAT 4B FLOOR 4TH , 43/5 PURBA SINTHEE ROAD, DUMDUM, S SOUTH 24		

Chief Complaints:
Fever, cough since 22/04/2021. COVID-19 positive on - 24.04.2021.
Shortness of breath since 28/04/2021 . Desaturation at home on 1st May.

History Of Present Illness:
He complained of fever and cough since 22nd April. He tested positive for COVID - 19 on 24th April and started having shortness of breath since 28 th April . He presented to ER at MSHK on 1st May 2021 after having desaturated at home.

Final Diagnosis:
Post severe COVID pneumonia
Bilateral extensive lung fibrosis
Urinary tract infection
Leukopenia - (Neutropenia)
LV dysfunction - Now resolved (LVEF: 55%)
Pressure sore
Anxiety necrosis
Minimal acute subarachnoid haemorrhage in left frontal lobe.(CT Brain- 27/06/2021)

Clinical Examination/Findings:
In ER -
On admission :
BP - 130/90 mm of Hg, HR - 100/min, RR - 28/min, Temperature - 97.6° F
GCS: - 15/15. SpO2: 85% on 10 liters O2. CBG: 265 mg/dl.
At the time of discharge :
BP - 114/76 mm of Hg, HR - 95/min, SPO2 - 100% on 2 liter O2 NC, RR - 25-30/min, Temperature - 98.6° F.
CBG: 111 mg/dl.

Course of Treatment including Referrals:
Mr.Aniruddha Ray, complained of fever with cough since 22nd April. He tested positive for Covid-19 on 24th April and started having shortness of breath since 28th April. He presented to MSHK at the ER on 1st May after having desaturated at home. His CT scan Thorax showed a CTSI of 20/25. He was admitted in the critical care unit and started on 10-15lits oxygen support via NRBM. All necessary investigations were sent

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CIN : U45200WB2007PTC112554

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for and treatment started as per ICMR and State guidelines (antibiotics/steroids/remdesivir/anti-coagulations/nebulisations/prone positioning/physiotherapy/supportive care). His IL-6 done on 03-05-21 was 184pg/ml. He was put on HFNO with titrated support. Antibiotics were escalated and all cultures and infective markers were sent for. B/L lower limb doppler was done on 10-05-21 which didn't show any evidence of DVT. Echocardiography showed EF=55% and grade I Diastolic dysfunction. He remained tachypneic and on high support of oxygen (HFNO +NRBM) and steroid dose was increased and antifungal added. Antifibrotic medicines (perfinex/nintedanib) started. Awake proning continued as feasible. He developed dyselectrolytemia for which necessary correction was given.D-Dimer values continued to rise and B/L venous doppler of lower limbs repeated on 23rd May also showed no evidence of DVT. Repeat Covid RT PCR on 24th May was Positive. HFNO support gradually reduced and CT Chest repeated on 27th May showed only partial resolution of previous findings. Procalcitonin levels became normal and de-escalation of antibiotics and other treatment done. On 28th May he was shifted to the Covid HDU. HFNO support continued. Expert opinion of pulmonologist taken and advice followed. Eventually he was put off HFNO support and was maintaining saturation only on NRBM. Covid CB-NAAT sent on 4th June came negative and he was shifted to non covid HDU on 6th June on 10lits O2/min via NRBM. D-Dimer levels shot up manifolds on 6th May and CTPA done the same day revealed CTSI = 25/25 and no evidence of PE. Repeat venous bilateral doppler showed no evidence of DVT. He eventually developed severe anxiety neurosis/ depressive disorder and psychology counselling done. CMV PCR came positive and Beta D Glucan raised on 14th June. Echocardiography repeated and cardiology opinion taken. He was shifted to ICU on 15th June in view of worsening dyspnea and desaturation and put back on HFNO support. Pulmonologist's opinion taken and advice followed. Chest Xray showed extensive bilateral lung fibrosis. He gradually became stable and was shifted to HDU on 4-6lits O2 via nasal canula on 19th June. Suddenly on 23rd June early morning , he became very restless and was having bradycardia and desaturation. He was shifted to the ICU andf was intubated and put on mechanical ventilatory support. HD line and arterial line were inserted. ABG showed severe respiratory acidosis. ECCO2R started on 24th May in view of persistent hypercapnea. He developed urinary tract infection. He was started on NORAD support and procalcitonin levels were raised. Pan cultures were sent and treatment again escalated. He developed exposure keratitis in his right eye for which ophthalmologist opinion taken and advice followed. He had an episode of bradycardia on 25th morning for which he was managed accordingly. Adrenaline infusion started. ECCO2R stopped at 3pm on 26th June due to improvement in ABG .Medical Board was done on 26th June and the critical condition and poor prognosis of the patient was well explained to the relatives in details. Repeat ECHO done which showed LV dysfunction (EF = 25-30%); dilated LV cavity and generalised wall hypokinesia.Cardiology opinion for taken for bradycardia and deteriorating heart function. Opinion of Clinical Microbiologist taken and advice followed. CTPA and CT Brain done on 27th June which showed

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extensive B/L fibrosis and cystic/varicose bronchiectasis (sequaele of covid) ; B/L minimal pleural effusion; features of pulmonary edema and minimal SAH (acute) in left frontal lobe. Hyperkalemia was medically managed. Dobutamine infusion started in view of refractory hypotension inspite of high dose inotrope-vasopressor support. In view of difficult weaning he was planned for early surgical tracheostomy but it could not be done due to high NORAD support and relative being unwilling for the same. Eventually after a successful Spontaneous Awakening Trial he was extubated from the mechanical ventilatory support on 2nd July. Repeat ECHO on 3rd July showed improvement in his heart function with EF = 55% and no RWMA. Regular consultation done by psychologist for his anxiety. On 5th July, he started to get fever spikes and Increasing Procalcitonin and WBC levels with increased pus cells in urine R/E indicated likely secondary infection for which Pan C/S were sent for. Antibiotics were altered accordingly and repeat CT thorax was done. B/L lower limb venous doppler done in view of high D-dimer levels, showed no signs of DVT. He remained persistently tachypneic, tachycardiac, febrile and continued to require high oxygen support. Swab for H1N1 PCR was sent and Tamiflu started. Blood C/S sent from HD Line and Peripheral line sites on 9th July. He developed sudden drop in hemoglobin with no active bleeding. Stool for OBT checked- negative. He developed Leucopenia (with neutopenia and monocytosis). Opinion of hematologist taken and advice followed. HD line removed on 12th July and treatment optimised (Clexane/solumedrol/meropenem/colistin/fosfomycin/tamiflu/nebs).Aggressive Chest and Limb Physiotherapy done and he was made to sit out of bed on chair as feasible. Medical Board done on 12th July and patient's condition well explained to the relatives in details.
Pulmonologist amnd ophthalmologist advice taken and opinion followed.
Currently, he is feeding orally , passing adequate urine, sitting out of bed on chair, maintaining saturation with minimum oxygen support,intermittently tachypneic, having intermittent cough, is anxious and off all antibiotics. His nebulisations and other supportive medications have been optimised and he is being discharged under home care with domiciliary oxygen support.

Medications given (During course of stay):
Inj Pan - 40
Inj Tazact - 4.5 gm
Inj Doxy - 100 mg
Inj Solumedrol - 40 mg
Inj Clexane - 60 mg
Tab Fabiflu - 1800 mg then tab fabiflu - 800 mg
Tab Celin - 500 mg

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