-------the discharge sheet for mr shivanand jee starts here-------

PATIENT NAME: Mr. Shivanand Jee

ADMISSION NO: IP2303120

AGE/GENDER: 55 Years/Male

UMR NO: UMR13277

ADMISSION DATE: 24-Mar-2023

Discharge DATE: 26-Mar-2023

CONSULTANT: Dr.PRIYANSHU DIXIT

REFERRED BY: Dr.DR PRIYANSHU DIXIT

DEPARTMENT: ORTHOPAEDICS

WARD: 4 TRIPLE SHARING/407/3

PATIENT ADDRESS: Chattarpur
Chhatarpur , MADHYA PRADESH
8959106506

DIAGNOSIS:
Bimalleolar # Lt. Ankle with Obesity & HTN.

ICD CODE
M84.471A, R03.0, E66,

CHIEF COMPLAINTS:
Trauma on 23.03.2023 at around 8.00 PM due to a fall at home.
Primary t/t elsewhere.
C/o- Pain & Swelling- Lt. ankle since the trauma.

CLINICAL EXAMINATION:
Local: Oedema, Tenderness & Deformity- Lt. ankle.
General: HR- 80/min, BP- 130/80 mmHg, RR- 20/min, SpO2- 80%, Temp.- 98º F.
RS - B/L Clear. -CVS - S1 S2+.
PA - Soft. -CNS - Conscious.

INVESTIGATION:

HB- 11.3, TLC- 8100, ESR- 34, Platelets- 1.52, BSR- 92, Creatinine- 0.9, B.Urea- 27, Total Bilirubin- 0.56, SGPT- 49, SGOT- 27, Total Protein- 6.6, Alkaline Phosphatase- 251, PT Test- 13.9, INR- 1.1, HBsAg- Negative, HIV- Negative, B.Group-"B" +VE,

PROCEDURE:
- Open reduction fibula plating with tension band wiring medial malleolus Lt. done under SA by Dr.P.Dixit on 24/03/2023.

IMPLANT:
1/3rd Tubular Plate, K-wire-2, Tension band wire-1 (SS Orthomax)

TREATMENT GIVEN:
Inj. Cetriax S 1.5gm, Inj. Lines 1amp, Inj. Tramazac 100mg, Inj. Histac 1amp, Inj. Dicefin AQ, Inj.Phenargan, Inj. Rubuphin,

COURSE IN HOSPITAL:
Mr. Shivanand Jee, 55y/M, presented with pain & swelling left ankle due to a fall at home on 23/03/2023 at around 8.00 PM. Seen by an Orthopedic surgeon, x-rays show a bimalleolar fracture left ankle and advised surgery. Blood investigations were done, which were normal. After medical fitness & pre-anesthetic checkup, the patient was planned for the procedure. Open reduction fibula plating with tension band wiring medial malleolus left done under spinal anesthesia on 24/03/2023. The postoperative period was uneventful. The patient is being discharged in stable condition.

SPECIAL INSTRUCTION:
Bed Rest.
Elevation and Toes exercises.
Keep the limb in wide abduction.
Static quadriceps exercises.
Back Care with terogood powder.
-Regular consultation with a physician for HTN & Regular BP Check-up.

TREATMENT ON DISCHARGE:
Tab Cefrotux 250mg 1 BD (Twice a day) x 10 days
Cap Lines 500mg 1 TDS (Thrice a day) x 10 days
Tab Sporlac 1 BD (Twice a day) x 10 days
Tab Panda DSR 1 OD (Once a day) x 10 days
Tab Calastan 1 HS (Once a day at night) x 30 days
Tab Limcee 1 BD (Twice a day) x 30 days
Tab Convidex Forte 1 BD (Twice a day) x 15 days
Tab Modvita Forte 1 OD (Once a day) x 15 days
Tab Troyfenac SP 1 BD (Twice a day) x 5 days
Tab Zinase XT 1 TDS (Thrice a day) x 5 days
Tab Ketotru S/L SOS (for severe pain)

Tab Stamlo 2.5mg 1 OD (Once a day)- As per the physician

DATE OF FOLLOW-UP:
Review on 05/04/2023 at 9.00 AM in Ortho OPD for Removal of Sutures

-------the discharge sheet for mr shivanand jee ends here-------

-------the discharge sheet for Mrs Nisha Rajak starts here-------

PATIENT NAME: Mrs. Nisha Rajak

ADMISSION NO: IP2303104

AGE/GENDER: 30 Years/Female

WEIGHT: 78

UMR NO: UMR13117

ADMISSION DATE: 21-Mar-2023

DISCHARGE DATE: 25-Mar-2023

CONSULTANT: Dr.ORTHOPEDIC DEPARTMENT

REFERRED BY: Dr.THC

DEPARTMENT: ORTHOPAEDICS

WARD : 4TH FLOOR/406/3

PATIENT ADDRESS :
Singrauli
Singrauli, Madhya Pradesh
7376287432

DIAGNOSIS:
Osteoid Osteoma Medial Side of Lower Tibia Lt. ? Osteomyelitis of Garre.

ICD CODE:
D16.25,

CHIEF COMPLAINTS:
C/o- Mild Pain in Lt. leg for 3-4 years.
Severe pain in Lt. leg for 5-6 months.
Primary t/t at Baidhan.

CLINICAL EXAMINATION:
Local: Tenderness Lt. leg.

General: HR- 90/min, BP- 110/80 mmHg, RR- 20/min, SpO2- 98%, Temp.- 98.5º F.
RS - B/L Clear.
CVS - S1 S2+.
PA - Soft.
CNS - Conscious.

INVESTIGATION:
HB- 10.3, TLC- 9700, ESR- 57, Platelets- 1.87, Creatinine- 0.7, B.Urea- 18, SGOT- 19, SGPT- 20, FBS- 132, HbA1c- 6.8, PT Test- 18.9, INR- 1.4, HBsAg- Negative, HIV- Negative, B.Group- "O" +VE,
22/03/2023 2D Echo Shows- Good LV function at rest. LVEF 60%. No valvular pathology.
24/03/2023 Marrow Fluid Culture- Sterile.

PROCEDURE:
- Decortication/ Saucerisation tibia Lt. done under SA on 22/03/2023.

TREATMENT GIVEN:
Inj. Cetriax S 1.5gm, Inj. Oflokem 100ml, Inj. Peploc 1amp, Inj. Tramazac 100mg, Inj. Phenargan, Inj. Rubuphine, Inj. Decifen AQ,

COURSE IN HOSPITAL:
Mrs. Nisha Rajak, 30y/F, a case of osteoid osteoma medial side of the lower tibia left. osteomyelitis of Garre. Took primary treatment at Baidhan. Admitted on 21/03/2023 with complaint of severe pain in left leg since 5-6 months. Seen by an Orthopedic surgeon advised saucerization. Blood investigations were done, which were normal. After medical fitness & pre-anesthetic checkup, the patient was planned for a procedure. Decortication/ saucerisation tibia left was done under spinal anesthesia on 22/03/2023. The postoperative period was uneventful. The patient is being discharged in stable condition.

SPECIAL INSTRUCTION:
Bed Rest. - Diabetic Diet (HbA1c- 6.8).
Elevation and Toes exercises.
Static quadriceps exercises.
Back Care with terogood powder.

TREATMENT ON DISCHARGE:
Tab Xolid 600mg 1 BD (Twice a day) x 12 days
Tab Alvix 500mg 1 OD (Once a day) x 12 days
Tab Sporlac 1 BD (Twice a day) x 12 days
Tab Dompan SR 1 OD (Once a day) x 12 days
Tab Calastan 1 HS (Once a day at night) x 30 days
Tab Limcee 1 OD (Once a day) x 30 days
Tab Aciz SP 1 BD (Twice a day) x 5 days
Tab Ketotru S/L SOS (for severe pain)

DATE OF FOLLOW-UP:
Review on 06/04/2023 at 9.00 AM in Ortho OPD for Removal of Sutures.

-------the discharge sheet for Mrs. Nisha Rajak ends here-------

-------the discharge sheet for Mrs. Shanti Trivedi starts here-------

PATIENT NAME: Mrs. Shanti Trivedi

ADMISSION NO: IP2303125

AGE/GENDER: 59 Years/Female

UMR NO: UMR13331

ADMISSION DATE: 25-Mar-2023

DISCHARGE DATE: 25-Mar-2023

CONSULTANT: Dr.ORTHOPEDIC DEPARTMENT

REFERRED BY: Dr.THC

DEPARTMENT: ORTHOPAEDICS

Ward : 4TH FLOOR/402

PATIENT ADDRESS :
JBP Jabalpur , MADHYA PRADESH
7379900650

DIAGNOSIS:
7 Days Old Intracapsular # Neck Femur Lt.

ICD CODE:
S72.012,

CHIEF COMPLAINTS:
Trauma on 17.03.2023 at around 08.30 AM due to fall at home.
Primary t/t elsewhere.
C/o- Pain & Swelling- Lt. hip & thigh since trauma

CLINICAL EXAMINATION:
Local: Oedema, Tenderness & Deformity- Lt. hip & thigh.
General: HR- 89/min, BP- 130/90mmHg, RR- 21/min, SpO2- 98%, Temp.- 97.6º F.
RS - B/L Clear.
CVS - S1 S2+.
PA - Soft.
CNS - Conscious.

INVESTIGATION:
HB- 11.2, TLC- 7400, Platelets- 1.89, BSR- 102, Creatinine- 0.8, B.Urea- 31, PT Test- 15.6, INR- 1.1,
Total Bilirubin- 0.59, SGPT- 52, SGOT- 36, Total Protein- 6.6, Alkaline Phosphatase- 274, HBsAg- Negative, HIV- Negative,

TREATMENT GIVEN:
Tab Cefquin, Tab Need SP, Tab Dompan SR, Tab Ketotru,

COURSE IN HOSPITAL:
Mrs. Shanti Trivedi, 59y/F, presented with pain & swelling left hip & thigh due to a fall at home on 17/03/2023 at around 08.30 AM. Seen by an Orthopedic surgeon, an X-ray shows an intracapsular fracture neck femur left, and advised partial hip replacement. Blood investigations were done, which were normal and medical fitness was done. Discharged on request due to nonavailability of implant.

SPECIAL INSTRUCTION:
Bed Rest.
Elevation and Toes exercises.
Keep the limb in wide abduction.
Static quadriceps exercises.
Back Care with terogood powder

TREATMENT ON DISCHARGE:
Inj. Decofact 50mg Stat-1
Inj. Kalzin 6 lakh units Stat-1
Tab Cefquin 1 BD (Twice a day) x 2 days
Cap Vitagut 1 BD (Twice a day) x 2 days Tab Dompan SR 1 OD (Once a day) x 2 days
Tab Calastan 1 HS (Once a day at night) x 2 days
Tab Need SP 1 BD (Twice a day) x 2 days
Tab Ketotru S/L SOS (for severe pain)

DATE OF FOLLOW-UP:
Review for Surgery on 27/03/2023

-------the discharge sheet for Mrs. Shanti Trivedi ends here-------

-------the discharge sheet for Mr. Deepak Kumar Singh starts here-------

PATIENT NAME: Mr. Deepak Kumar Singh

ADMISSION NO: IP2303044

AGE/GENDER: 46 Years/Male

UMR NO: UMR12457

ADMISSION DATE: 10-Mar-2023

DISCHARGE DATE: 24-Mar-2023

CONSULTANT: Dr.ORTHOPEDIC DEPARTMENT

REFERRED BY: Walk-in

DEPARTMENT: ORTHOPAEDICS

Ward : 4TH FLOOR/410/2

PATIENT ADDRESS :
SATNA
Satna, MADHYA PRADESH
9131032037

DIAGNOSIS:
2 Days Old Central # Dislocation Lt. Hip with # Lower End Radius Lt. with Head Injury

ICD CODE:
S73.005A, S52.5, S09

CHIEF COMPLAINTS:
Trauma on 07.03.2023 at around 06.00 PM due to a fall from height (2nd floor).
Primary t/t elsewhere.
C/o- Pain & Swelling- Lt. hip & Lt. wrist with sutured wound forehead since the trauma.

PAST HISTORY:
Catheterization done & BE Cast Lt. given on 07/03/2023 elsewhere.

CLINICAL EXAMINATION:
Local: Oedema, Tenderness & Deformity- Lt. hip & Lt. wrist. Sutured wound Lt. forehead.
General: HR- 88/min, BP- 110/60 mmHg, RR- 20/min, SpO2- 97%, Temp.- 98.1 Degree F.

RS - B/L Clear.
CVS - S1 S2+.
PA - Soft.
CNS - Conscious

INVESTIGATION:
HB- 7.8, TLC- 7300, Platelets- 1.66, BSR- 96, B.Urea- 44, Creatinine- 1.1, TSH- 2.08, Total Bilirubin- 1.09, SGPT- 58,
SGOT- 65, Total Protein- 5.8, PT Test- 17.4, INR- 1.3, HBsAg- Negative, HIV- Negative, B.Group-"O" +VE,
08/03/2023 CT Brain- Fracture of the left nasal bone.
09/03/2023 CXR AP View- No significant abnormality noted. 09/03/2023 CT Scan Pelvis with Both Hips- Comminuted fracture noted in iliac bone on the left side. Fracture extending upto the ileopectineal line involving roof and floor of acetabulum. Fractures also extend upto the superior and inferior pubic rami

PROCEDURE:
Lower femoral pin traction Lt. done under GA on 11/03/2023.
Pelvis fixed with ilioinguinal and stoppa's approach Lt. done under SA on 17/03/2023

IMPLANT:
16 hole Recon plate, 4mm Cancellous screw-1, Small waser-1 (SS Orthomax)

TREATMENT GIVEN:
ICU Care, Blood Transfusion- 4 units given, Inj. Tazofic 4.5gm, Inj. Oflokem 100ml, Inj. Histac 1amp, Inj. Tramazac 100mg, Inj. Nacphin, Inj. Phenargan, Inj. Delphi-L 1amp x 3 given,

COURSE IN HOSPITAL:
Mr. Deepak Kumar, 46y/M, presented with pain & swelling left hip and left wrist with a head injury with sutured wound forehead left side due to a fall from a height (2nd floor) on 07/03/2023 at around 06.00 PM. Catheterization & BE Cast left was given on 07/03/2023 elsewhere. Seen by an Orthopedic surgeon, an x-ray shows central fracture dislocation left hip with a fracture lower end radius left, advised pin traction followed by acetabulum plating. A blood investigation was done, which revealed anemia (HB7.8gm%) therefore 2 units of PRBC were given. After medical fitness & pre-anesthetic checkup were planned for the procedure. Lower femoral pin traction left was done under general anesthesia on 11/03/2023. Fracture of pelvis fixed with recon plate left done under spinal anesthesia on 17/03/2023. The postoperative period was uneventful. 2 units of PRBC were given. Physiotherapy is given as advised by the physiotherapist. The patient is being discharged in stable condition.

SPECIAL INSTRUCTION:
Complete Bed Rest with traction over pully with 3 bricks.
Elevation, Finger, and Toes exercises.
Keep the limb in wide abduction.

Static quadriceps exercises.
Back Care with terogood powder.

TREATMENT ON DISCHARGE:
Tab Cefakind 1 BD (Twice a day) x 10 days
Tab Levoflox 750mg 1 OD (Once a day) x 15 days
Tab Nifty SR 1 BD (Twice a day) x 5 days
Tab Sporlac 1 BD (Twice a day) x 15 days
Tab Dompan SR 1 OD (Once a day) x 10 days
Tab Calastan 1 HS (Once a day at night) x 30 days
Tab Limcee 1 OD (Once a day) x 30 days
Tab Convidex Forte 1 BD (Twice a day) x 15 days
Tab Modvita Forte 1 OD (Once a day) x 15 days
Tab Aciz SP 1 BD (Twice a day) x 5 days
Tab Ketotru S/L SOS (for severe pain)
Tab Gabaneuron NT 1 HS (Once a day at night) x 15 days (Before dinner)
Tab Montair FX 1 HS (Once a day at night) x 5 days
Tab Pyridium 1 TDS (Thrice a day) x 3 days
Syp Cital 2tsf TDS with one cup of water thrice a day x 5 days

DATE OF FOLLOW-UP:
Review on 07/04/2023 at 9.00 AM in Ortho OPD for Removal of Sutures, Removal of Pin & Application of Long Bucks Traction.

-------the discharge sheet for Mr. Deepak Kumar Singh ends here-------

-------the discharge sheet for Mr. Vipin Kumar Vishwakarma (Badhai) starts here-------

PATIENT NAME: Mr. Vipin Kumar Vishwakarma (Badhai)

ADMISSION NO: IP2303019

AGE/GENDER: 23 Years/Male

WEIGHT: 68

UMR NO: UMR12230

ADMISSION DATE: 05-Mar-2023

Discharge DATE: 24-Mar-2023

CONSULTANT: Dr.ORTHO

REFERRED BY: Dr. NITIN MISHRA

DEPARTMENT: ORTHOPAEDICS

WARD: 4 SHARING ROOM/406/1

PATIENT ADDRESS:
GRAM MOHAN TOLA, POST VIJAYRAGHAVGARH, KATNI M.P.
Katni, MADHYA PRADESH
8251877399

DIAGNOSIS:
Crush Injury Lt. Foot with Traumatic Amputation Lt. Foot with Traumatic Skin Loss Lt. Upper Limb and Leg with Comp. # Radius Ulna Lt. with Anemia.

ICD CODE
S97.82XA, S98.912A, S41.102A, S52.602A, D64.9,

CHIEF COMPLAINTS:
Trauma on 24.02.2023 at around 11.00 AM due to RSA.
Primary t/t at Medical College & Hospital Jabalpur.
C/o- Pain and swelling Lt. foot & leg and Lt. upper limb with soakage since the trauma.

CLINICAL EXAMINATION:

Local: Crush injury Lt. foot & leg. Traumatic amputation Lt. foot with skin loss++ with crush injury Lt. upper limb with avulsion of skin. Skin loss volar aspect of arm & forearm. Slught++ with frank purulent discharge. Patches of necrotic skin+.
General: HR- 102/min, BP- 130/80 mmHg, RR- 24/min, SpO2- 98% on room air, Temp.- Normal. RS - B/L Clear.
CVS - S1 S2+.
PA - Soft.
CNS - Conscious.

INVESTIGATION:
HB- 6.4, TLC- 18200, Platelets- 3.99, Creatinine- 1.1, B.Urea- 39, Total Bilirubin- 0.69, SGPT- 153,
SGOT- 74, Total Protein- 4.9, PT Test- 22.9, INR- 1.8, HBsAg- Negative, HIV- Negative, B.Group-"B" +VE,
08/03/2023 Pus Culture- Growth of E. coli seen.

PROCEDURE:
- Revision BK Amputation for crushed degloving Lt. lower limb done under SA on 14/03/2023.
- Debridement Lt. arm & forearm under IV GA by Dr.Sethi on 14/03/2023.
- Radius ulna plating Lt. with insertion of antibiotic beads done and Split skin graft, taken from right thigh and applied over raw area Lt. arm done under GA (by Dr.Sethi) on 16/03/2023. (Incision made through big raw area over the forearm. Patient to be counseled regarding infection & bone grafting in the future if necessary).

IMPLANT:
6 hole semitubular plate, 7 hole semitubular plate (SS Orthomax)

TREATMENT GIVEN:
ICU Care, Blood Transfusion- 5 units given, Inj. Tazar 4.5gm, Inj. Lines 2ml, Inj. Aciloc 1amp, Inj. Tramazac 100mg, Inj. Vivian 1amp, Inj. Kenadion 1amp, Inj. Phenargan, Inj. Rubuphine,

COURSE IN HOSPITAL:
Mr. Vipin Kumar Vishwakarma, 23y/M, presented with crush injury left upper limb with traumatic amputation due to RSA on 24/02/2023 at around 11.00 AM. Took primary treatment at Katni & Medical College Jabalpur. Seen by Orthopedic surgeon & Plastic surgeon planned wound debridement, lavage, bony fixation, skin grafting & revision BK amputation. Blood investigation were done, which revealed anemia (HB-6.4gm%) therefore 3 units of PRBC given. After medical fitness & pre anesthetic checkup, patient was planned for procedure. Revision BK Amputation for crushed degloving left lower limb done under spinal anesthesia and debridement left arm & forearm under IV general anesthesia on 14/03/2023. Post op 2 units of PRBC given. Radius ulna plating left with insertion of antibiotic beads and split skin grafting raw area left arm done under general anesthesia on 16/03/2023. Incision made through big raw area over forearm. Patient & relatives is counseled regarding infection & possibility of bone grafting in future if

necessary. Post operative period was uneventful. Patient is being discharged in stable condition.

SPECIAL INSTRUCTION:
Bed Rest.
Elevation and Finger exercises.

TREATMENT ON DISCHARGE:
Tab Cefquin 1 BD (Twice a day) x 15 days
Tab Xolid 600mg 1 BD (Twice a day) x 15 days
Tab Dompan SR 1 OD (Once a day) x 15 days
Tab Calastan 1 HS (Once a day at night) x 30 days
Tab Limcee 1 OD (Once a day) x 30 days
Tab ConvidexForte 1 BD (Twice a day) x 15 days
Tab Modvita Forte 1 OD (Once a day) x 15 days
Tab Gabacott NT 1 HS (Once a day at night) x 15 days (Before dinner)
Tab Aciz P 1 BD (Twice a day) x 5 days
Tab Ketotram S/L SOS (for severe pain)
Tab Libotryp DS 1 HS (Once a day at night) x 7 days
Syp Alex 2tsf TDS (Thrice a day) x 7 days
Syp Oslax 15ml HS/SOS (for constipation

DATE OF FOLLOW-UP:
Review on 08/04/2023 at 9.00 AM in Ortho OPD & Review to Dr. K. S. Sethi.

-------the discharge sheet for Mr. Vipin Kumar Vishwakarma (Badhai) ends here-------