DISCHARGE SUMMARY

Name of Patient	: MR. KIRAN BHAGWAN TAWARE	**UHID**	: MGM240017131
Age/ Gender	: 56 YEARS, 2 MONTHS / MALE	**IP No.**	: MGMIP2406720
Date of Admission	: 05-10-2024 10:40:34	**Ward / Bed No.**	: SURGICAL WARD UNIT / SW-518
Date of Discharge	: 13-11-2024 10:40:34	**Consultants**	: DR.PRASHANT ATHALE
Document No.	: MGMDS2400007327		:
Discharge	: YES		*MGM240017131*
Diagnosis	: ACUTE APPENDICULAR PERFORATION POST OPERATIVE EXPLORATORY LAPAROTOMY WITH SEPTIC SHOCK WITH DEMYELINATING POLYNEUROPATHY AND POST-OPERATIVE TRACHEOSTOMY AND POST-OPERATIVE BILATERAL VAC SURGERY.		

5/10/2024- Fluids culture- Escheriria coli + kelbsiella
12/10/2024- Abdomen pus culture- escheriria coli
14/10/2024- Blood culture- Acinotobacter baumannii
14/10/2024- Tracheal culture- stenotrophomonas
21/10/2024- Pus culture- Proteus m maltophilisa + escheriria coli
22/10/2024- blood culture- eshcerirria coli
21/10/2024- Anal region pus- escheriria coli + proteus mirabilis
25/10/2024- Abdomen pus culture- proteus + eshceriria coli
3/11/2024- candida tropica

Course in the Hospital

56 years male,was admitted under surgeon,Dr Prashant Athale, with complain of fever with joint pain and headache one week back for 2 days followed by severe abdominal pain and distension since 1 day,urinary incontinence,bilateral pedal edema and giddiness. He was diagnosed Chikungunya (IgM Positive). Computerised Tomgraphy of abdomen was done in outside hospital showed changes of acute appendicitis,air noted sorrounding appendix and pelvic region?perforated appendix. He was electively intubated and ventilated and immediately shifted to operation theatre. Patient underwent exploratory laparotomy with appendicectomy under general anaesthesia. He was received in Intensive Care Unit on ventilatory support. Hydration was resumed,drains and urine output were monitored. Femoral central and arterial lines were cannulated and inotropic support was started. He had refractory hypotension ,hence vasopressors were increased and stress dose steroid was also started. Intravenous packed cell and ALBUMIN were given and gradually inotrope was gradually tapered. Sedation was started and patient was electively ventilated in view of hemodynamic instability. Physician review reference was given and antibiotics were started accordingly. Nephrology reference was given in view of raised creatinine levels. Dermatology opinion was taken as patient had tiny blisters in right forearm and flank. Patient responded to the above treatment and gradually inotrope was tapered and stopped. He had fever spikes, Ultrasound abdomen was done to check for any collection which was normal. Patient had hypernatremia, corrective measures were started. Off sedation trial was given,however as patient was not getting awake,neurology opinion was taken and Magnetoc Resonacne Imaging of Brain plain was done showed leptomeningeal enhancement. Furthur fever spikes were noted and inflammatory markers were raised,hence antibiotic was upgraded, fundoscopy was done to rule out papilloedema and lumbar puncture was done for CSF analysis and sample was sent for biofire and autoimmune encephalitis panel. CSF routine microscopy report showed raised protein levels, EEG was done showed normal study. Patient was drowsy,not getting awake. He underwent tracheostomy on 12/10/2024 in view of difficult to wean. Gradually he was weaned off ventilator and was taken on tpiece.Patient was on T piece,conscious,obeying commands,having quadriparesis. He had fever spikes and culture swab was sent from suture site. Chest and limb physiotherapy are resumed. Central and arterial lines were removed .Enteral feeds were started and rehabilitation was continued. Nerve conduction study was done showed sensorimotor demyelinating generalised polyneuropathy with axonopathic changes(severe). Intravenous Steroid was started and plan of Intravenous IMMUNOGLOBULIN was advised once sepsis subsides.He had hypernatremia,5% DEXTROSE was started alongwith free water was given through Ryles tube. Patient had persistent fever,indwelling arterial and central lines were removed and blood culture grew ACENATOBACTER (Colistin resistant), antibiotic was adjusted accordingly. Strict contact precautions was practised. Persistant fever spikes were present. USG abdomen and pelvis was done on 18/10/2024 showed perihepatic,subhepatic,right paracolic gutter,right iliac region free fluid with dense internal echoes with internal septations present,approximate volume-120-150 ml. He underwent ultrasound guided pigtail insertion by interventional radiologist. Therapeutic and diagnostic aspiration was done.Intravenous ALBUMIN was given. He had fever spikes alongwith increasing trend of inflammatory marker,hence antibiotic was furthur escalated. Chest and limb physiotherapy were resumed.Speech therapist reference was given and speech valve trial was given and ryles tube feeds were increased. Packed cell

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