



TATYASAHEB KORE DENTAL COLLEGE AND RESEARCH CENTRE

NEW PARGAON – 416 113

Tal.: Hatkanangale Dist.:Kolhapur (Maharashtra State)

National Dental Commission

INFORMATION REGARDING INSTITUTIONAL COMPLIANCE



3. Medical Hospital Attachment

3.1 Record of Clinical Training in General Medicine and General Surgery

TATYASAHEB KORE DENTAL COLLEGE & RESEARCH CENTRE, NEW PARGAON

RECOGNISED BY DENTAL COUNCIL OF INDIA, NEW DELHI.

AFFILIATED TO MAHARASHTRA UNIVERSITY OF HEALTH SCIENCES, NASHIK.



GENERAL MEDICINE CLINICAL RECORD BOOK

Name: Chavan Rutik Bajirao

Examination No.: 38405

Roll No.: 06



Dr. Harish Kulkarni M.D.S.
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DEPARTMENT OF GENERAL MEDICINE CLINICAL RECORD BOOK

CERTIFICATE

This is to Certify that this is a bonafide clinical work done in the Department of General Medicine

by Mr./ Miss. Chavan Rutik Bajirao

Reg. No. _____ Student of the year 2022-2023


as prescribed by the Maharashtra University of Health Sciences, Nashik.

Signature of the Staff Incharge

Professor & Head of Department

Place : _____

Date : _____


Signature of the External Examiners

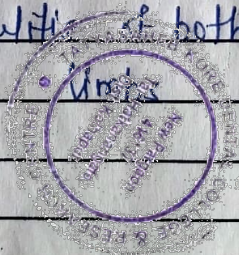



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New Pargaon, Tal. Hatkanangle

Signature of the Internal Examiners

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Case No. : 1

Date : _____

Name : Sanchita Sampat Patil

Age : 30 years Sex : Female

Occupation : Housewife

Religion Status : Hindu

Social Status : Poor class

Marital Status : Married

Date of Admission :

Chief Complaint : Patient complains of weakness, loss of appetite since 1 month and excessive bleeding during menstruation and weight loss.

History of Present illness : Patient was apparently alright before 1 month. She gradually felt tiredness, loss of appetite and weakness. She also developed difficulty in swallowing since 6 days and weight loss.

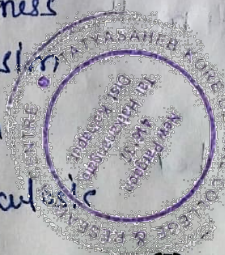
Past Medical History : No relevant history

No history of major illness

No history of hypertension

No history of asthma

No history of tuberculosis



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Family History: No relevant history
No history of hypertension
No history of Diabetes mellitus

Personal History:

No history of adverse habits like alcohol or tobacco is reported.

Diet: Mixed

Appetite: Loss of appetite

Sleep: Disturbed sleep

Bowel: Constipation

Micturition: Normal

Habit: No habit

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is apparently conscious and well oriented.

Built & Nutrition: Normal

Vital Signs:

a) **Temperature:** 98.2°F

b) **Pulse:** 90 beats/min

c) **Respiratory Rate:** 20 cycles/min

d) **Blood Pressure:** 124/84 mmHg

Skin:

a) **Hair:** Normal

b) **Nail:** Positive nail bed Koilonychia

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(11)

c) **Face:** Pale

d) **Eyes:** Pallor on lower palpebral conjunctiva

e) **Nose:** Normal

f) **Mouth:** Pale oral mucosa, Bald tongue

g) **Limbs:** Pallor on palm

h) **Vertebral Coloumn:** Normal

i) **Lymphadenopathy:** Absent

j) **Oedema:** Not seen

k) **Joints:** Normal

SYSTEMATIC EXAMINATION:

Respiratory System:

a) **Inspection:** - Bilaterally symmetrical chest
- No visible superficial vein/scar
- Thora-coabdominal respiration
- No bulging/retraction of chest.

b) **Palpation:** No tenderness
No lump
No lymph node enlargement

c) **Percussion:** Tactile vocal fremitus equal on both sides
Trachea is centrally placed

d) **Auscultation:** - Bronchial breathing is audible all in large bronchus.
- Vesicular breathing is audible all over chest.
- No audible crackles/ wheezes

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(11)

Case No. : 2

Date : _____

Name : Raj Sachin Shinde

Age : 56

Sex : Male

Occupation : Farmer

Religion Status : Hindu

Social Status : Middle class

Marital Status : Married

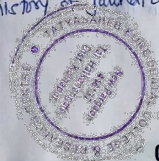
Date of Admission : _____

Chief Complaint : Patient complains of abdominal enlargement, low back pain, indigestion and dysphoea since 2 months.

History of Present illness : Patient was apparently alright 2 months back then he experience lower back pain and abdominal distension which was progressive. Patient also experienced stretching sensation of flanks, indigestion, loss of appetite, dyspnoea and weight loss since 2 months.

Past Medical History :

Patient has history of jaundice and was admitted for same 1 year back



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(1)

Family History: No relevant history
No history of hypertension
No history of Diabetes mellitus

Personal History:
Patient consumes alcohol 2-3 times daily since 30 years and has smoking cigarette habit 7-8 times daily since 3 years

Diet: Mixed

Appetite: Loss of appetite

Sleep: Insomnia

Bowel: Regular after medication

Micturition: Regular after medication

Habit: No habit

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is conscious and well oriented

Built & Nutrition: Poor

Vital Signs:

a) **Temperature:** 99.2°f

b) **Pulse:** 72 beats/min

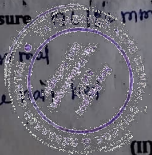
c) **Respiratory Rate:** 21 cycle/min

d) **Blood Pressure:** mmHg

Skin:

a) **Hair:** Normal

b) **Nail:** Pale



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(II)

c) **Face:** Pale

d) **Eyes:** Icterus present

e) **Nose:** Normal

f) **Mouth:** Normal

g) **Limbs:** Normal

h) **Vertebral Column:** Normal

i) **Lymphadenopathy:** Normal

j) **Oedema:** Bilateral Pedal oedema

k) **Joints:** No abnormality detected

SYSTEMATIC EXAMINATION:

Respiratory System:

a) **Inspection:** Bilaterally symmetrical chest.
- There is no visible superficial vein
- Abdomino-thoracic respiration seen

b) **Palpation:** - Slight tenderness
- No lump
- No lymph node enlargement

c) **Percussion:** - Tactile vocal fremitus equal on both sides
- Torcha is centrally placed

d) **Auscultation:**

Normal breath sounds on auscultation



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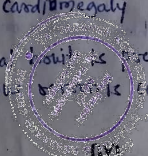
(III)

Gastro Intestinal System :

- a) **Inspection:** Pendulous abdomen with symmetrical globular enlarged and accentuated costaloves folds.
- Tense distended abdomen with umbilicus transversally slit [Weeping umbilicus]
- b) **Palpation:**
- Tenderness may be elicited
- Hepato megaly seen
- Spleno megaly is seen
- c) **Percussion:**
- Shifting dullness is present
- Fluid thrill is present.
- d) **Auscultation:**
- Intestinal sound are feebly audible or may not be audible.

Cardio : Vascular System :

- a) **Inspection:** - Pericardium is smooth
- Apex beat normally placed
- b) **Palpation:** - Apex beat is palpable at left 5th intercostal space.
- No tenderness on palpation
- c) **Percussion:** Right & left cardiac borders produced from lateral to medial side
- No card/megaly
- d) **Auscultation:**
- Atrial S3 is present
- Venous hum is continuous

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CNS: Patient is well oriented and conscious to time, place and person

Provisional Diagnosis :

Generalised distension of abdomen
More fullness in flank

Investigations :

- 1) Ultrasonography of Abdomen
- 2) Complete blood count
- 3) Urine examination
- 4) Stool for occult count
- 5) Liver function test
- 6) Diagnostic paracentesis

Final Diagnosis :


Ascites

Treatment :

- 1) Cessation of alcohol
- 2) Bed rest
- 3) Therapeutic paracentesis - Maximum 1 litre ascites fluid can be removed
- 4) Salt and Water restricted diet.
- 5) Tab. Spironolactone (100-200mg/day) or Triamterene (100-200mg/day)
- 6) Tab. Leptaxime 1.0g IV twice daily
- 7) Cap. Becosule OD - 10 days

Follow Up :




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Case No. : 3

Date : _____

Name : Amit ~~Bhatt~~ Bhoale

Age : 48 yrs

Sex : Male

Occupation : Factory worker

Religion Status : Hindu

Social Status : lower class

Marital Status : Married

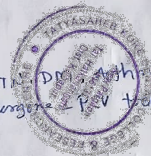
Date of Admission : _____

Chief Complaint : Patient complains of weakness, dizziness, loss of appetite from past 2 month.

History of Present illness : Patient was apparently alright 1 month ago. Then he experienced tiredness, loss of appetite, dyspnoea, breathless ness since past few weeks. He also experienced weight loss from few weeks.

Past Medical History :

- No history of HTN
- Patient had undergone



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Family History: No relevant history

Personal History:

No history of adverse habits.

Diet: Mixed diet.

Appetite: Loss of appetite

Sleep: Insomnia

Bowel: Constipation

Micturition: 4-5 times/day and 2-3 times at night

Habit: No habit

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is apparently conscious and well oriented

Build & Nutrition: Normal

Vital Signs:

a) Temperature: 99.2°F

b) Pulse: 90 beats/min

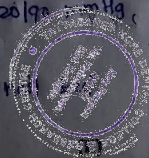
c) Respiratory Rate: 21 cycles/min

d) Blood Pressure: 120/90 mmHg

Skin:

a) Hair: Normal

b) Nail: Pallor on nail



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c) Face: Pale

d) Eyes: Pallor on lower palpebral conjunctiva

e) Nose: Normal

f) Mouth: Pallor on soft palate and tongue

g) Limbs: Pallor on palms

h) Vertebral Column: Normal

i) Lymphadenopathy: Absent

j) Oedema: Absent

k) Joints: No abnormality detected

SYSTEMATIC EXAMINATION:

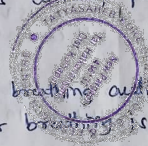
Respiratory System:

a) Inspection: - Bilaterally, symmetrical chest
- No expiratory retraction/scar
- Absent retraction of chest
- Thoracic-abdominal respiration

b) Palpation:
- No tenderness
- No lump
- No lymph node enlargement

c) Percussion:
- Tactile vocal fremitus equal on both sides
- Trachea is centrally placed

d) Auscultation:
- Bronchial breathing audible
- Vesicular breathing is audible



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Gastro Intestinal System:

a) Inspection: - No discoloration, visible swelling
- No dilated superficial veins
- Shape of abdomen is bulging
- Umbilicus is centrally placed and inverted

b) Palpation: - Liver is not palpable
- Spleen and kidney not palpable
- No tenderness

c) Percussion: - Tympanic notes found on percussion
- No abnormalities detected

d) Auscultation: 2-3 peristaltic movements/min are audible.

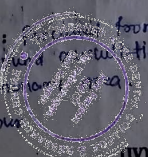
Cardio: Vascular System:

a) Inspection: - Pericardium is smooth
No retraction is seen
Apex beat is normally placed

b) Palpation: - Absence of thrust
- No any tenderness/palpable mass in pericardium

c) Percussion: - Cardiac dullness is within normal limits.
- Right and left cardiac borders.

d) Auscultation: - Heart sound is normal
- No murmurs



(IV)

CNS: Patient is conscious and well-oriented to place, time and people.
- Pupils are equally reactive to light

Provisional Diagnosis:

Iron deficiency anemia

Investigations: 1) Complete blood count: Hb count - 8 gm%; RBC count - 3 million/ μ
WBC count - 8000/ μ mm; RBC morphology - Microcytic, Hypochromic
2) Biochemistry - Blood glucose test & urine test.
3) Serum ferritin level decreased

Final Diagnosis:

Severe microcytic Hypochromic Anaemia

Treatment:

~~Tab. Ferrous Ascorbate 100mg OD - 3 months~~

~~Tab. Ferrous sulphate 300mg TID - 3 months~~

~~Tab. Vitamin C 300mg TID - 3 months~~

- Bed rest
- Iron rich diet
- Tab. Mebendazole 100mg BID - 5 days

Follow Up: Patient is advised C/S check up



(V)

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Case No. : 4

Date : _____

Name: Shwasaj Kale

Age: 57 years

Sex: Male

Occupation: Farmer

Religion Status: Hindu

Social Status: lower class

Marital Status: Married

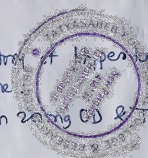
Date of Admission: _____

Chief Complaint: Patient complains of sudden onset severe chest pain, breathlessness, dysphoea and excessive sweating since 1 hour.

History of Present Illness: Patient was apparently alright 1 hour before. Then he experienced sudden onset, prolonged, severe chest pain radiating to left arm & epigastrium and giddiness and excessive sweating since 1 hour.

Past Medical History:

Patient has history of Hypertension on Tab. Telmisartan 20mg OD & Tab. Amlodipine 5mg OD for same.



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Family History: No relevant history

Personal History:

Patient has habit of alcohol consumption 4-5 times daily and smoking since 25 years.

Diet: Mixed diet

Appetite: Reduced

Sleep: Disturbed

Bowel: Normal

Micturition: Reduced

Habit: No habit

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is conscious and well oriented

Built & Nutrition: Normal

Vital Signs:

a) Temperature: 103°F

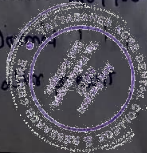
b) Pulse: 109 beats/min

c) Respiratory Rate: 33 cycles/min

d) Blood Pressure: 140/100 mmHg

Skin: a) Hair: Normal

b) Nail: Pale



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(II)

c) Face: Pale

d) Eyes: Pallor

e) Nose: Normal

f) Mouth: Pale oral mucosa

g) Limbs: Pain radiating to left shoulder

h) Vertebral Column: No abnormality detected

i) Lymphadenopathy: Absent

j) Oedema: Absent

k) Joints: No abnormality detected

SYSTEMATIC EXAMINATION:

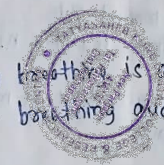
Respiratory System:

a) Inspection: - Bilaterally symmetrical chest.
- No visible superficial veins & scars.
- Thoracoabdominal type of respiration present.
- No bulging or retraction of chest

b) Palpation: - No tenderness
- No lump
- No lymph node enlargement.

c) Percussion:
- Trachea is centrally placed
- Tactile vocal fremitus equal on both sides.

d) Auscultation:
- Bronchial breathing is audible
- Vesicular breathing audible all over



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(III)

Gastro Intestinal System :

- a) Inspection : - No discoloration / visible swelling
- No dilated superficial veins.
- Shape of abdomen is bulging.
- Umbilicus is centrally placed and inverted.

b) Palpation :

- Liver is not palpable
- Spleen and kidney not palpable
- Abdomen is soft
- No tenderness

c) Percussion :

- Tympanic note found on percussion
- Abdomen fullness is due to feces flatulence

d) Auscultation :

2-3 peristaltic movements / min

Cardio : Vascular System :

- a) Inspection : - Pericardium is smooth.
- No excoriation is seen
- Bulging abdomen present
- Apex beat normally placed

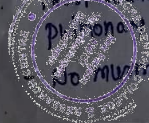
b) Palpation :

- Absence of thrill.
- Apex beat is palpated at left 5th intercostal space.

- c) Percussion : - Right & left cardiac borders percussed from lateral to medial side.
- Cardiac dullness is within normal limits.

d) Auscultation :

Heart sound auscultated in mitral, aortic and



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(iv)

- CNS: Patient is conscious and well oriented to time, place and person.
- Pupils are equally reactive to light.

Provisional Diagnosis :

- Myocardial infarction
- Unstable angina

Investigations :

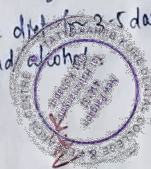
- 1) ECG - ST segment elevation
- 2) Blood - Ted ESR, Leucocytosis
- 3) Biomarkers - CKMB, Cardiac troponin [TonaT] Raised LDH
- 4) Echocardiography

Final Diagnosis :

Anteroseptal myocardial infarction

Treatment :

- 1) Hospitalization
 - 2) Strict bed rest.
 - 3) Oxygen given by mask
 - 4) Procure I.V. line and take blood sample for glucose, lipids and complete hemogram
 - 5) Tab. Disprin [325mg]
- Tab. Clopidogrel 300mg stat.
- Atorvastatin 80 mg
 - 6) Inj. streptokinase 2x [100ml] stat.
 - 7) Inj. low molecular weight heparin 0.4ml [40mg]
 - 8) Tab. Metoprolol 25mg - OD
 - 9) Tab. Ramipril 0.5 mg - OD
 - 10) Diet = low calorie diet for 2-5 days, salt restricted diet
 - 11) Avoid smoking and alcohol
- Follow Up :



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(v)

Case No. : 5

Date : _____

Name: Vilas Patil

Age: 45

Sex: Male

Occupation: Workers

Religion Status: Hindu

Social Status: Middle class

Marital Status: Married

~~Date of Admission :~~

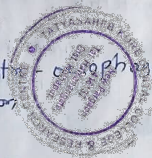
Chief Complaint: Patient complains of severe abdominal pain and tenderness since 30 days. In epigastric region and burning sensation after meal.

History of Present illness :

Patient was apparently alright before 30 days. Then he experienced severe abdominal pain and tenderness, discomfort since 8 days.

Past Medical History :

- Patient has history of Gastric - oesophageal reflux disease.
- No history of hypertension.
- No history of diabetes.
- No history of major illness.



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Family History: - No relevant history
- No history of hypertension
- No history of diabetes

Personal History: Patient has habit of Alcohol consumption and smoking 2-4 times daily since 10 years

Diet: mixed diet

Appetite: loss of appetite

Sleep: Normal

Bowel: Frequency once daily

Micturition: 4-5 times a day

Habit: No habit

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is conscious and well oriented

Built & Nutrition: Normal

Vital Signs:

a) Temperature: 98.6°F

b) Pulse: 80 beats/min

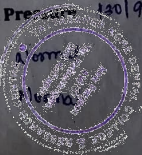
c) Respiratory Rate: 20 cycles/min

d) Blood Pressure: 120/90 mmHg

Skin:

a) Hair

b) Nail



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(II)

c) Face: Normal

d) Eyes: Normal

e) Nose: Normal

f) Mouth: Normal

g) Limbs: Normal

h) Vertebral Column:

i) Lymphadenopathy: Absent

j) Oedema: Absent

k) Joints: No abnormality detected

SYSTEMATIC EXAMINATION:

Respiratory System:

a) Inspection: - Bilaterally symmetrical chest
- No visible superficial vein/scar
- Thoracoabdominal type of respiration
- No bulging or retraction of chest.

b) Palpation: - No tenderness
- No lump
- No lymph node enlargement

c) Percussion: - Tactile vocal fremitus equal on both sides
- Trachea centrally placed

d) Auscultation: - Bronchovesicular sounds
- No crackles and wheezes



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(III)

Gastro Intestinal System :

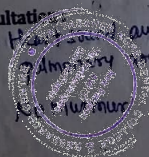
- a) Inspection : - No discoloration / visible swelling
- Dilated superficial veins
- Umbilicus is centrally placed and inverted
- b) Palpation :
- Tenderness is present
- Liver and spleen are not palpable
- c) Percussion :
- Tympanic note found on percussion
- Abdominal fullness is due to gaseous flatulence.

d) Auscultation :

2-3 peristaltic movements / min

Cardio : Vascular System :

- a) Inspection : - Pericardium is smooth
- No retraction is seen
- No pulsation
- Apex beat normally placed
- b) Palpation : - Apex beat is palpated at left 5th intercostal space.
- Absence of thrill
- No any tenderness or palpable mass
- c) Percussion :
- Cardiac dullness is within normal limits
- Right and left cardiac borders percussed
- d) Auscultation :
- Heart sounds auscultated in normal aortic and mitral area



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(IV)

CNS: Patient is conscious and well oriented to time, place and person.

- Pupils are equally reactive to light.

Provisional Diagnosis :

- Gastritis
- Duodenal ulcer

Investigations :

- 1) Complete Blood count
- 2) Serum creatinine
- 3) Blood sugar level
- 4) Barium meal examination
- 5) Gastrosocopy
- 6) Ultrasonography (USG)

Final Diagnosis :

Duodenal ulcer

Treatment :

- 1) Patient is asked to stop alcohol, smoking and avoid spicy food.
- 2) Bland diet is advised
- 3) Liquid antacid - Aluminium Hydroxide & Sodium Hydroxide given.
- 4) Liquid sucralofate TID
- 5) Inj. Pantoprazole 40mg IV OD
- 6) Tab. Aprozolam 0.25 mg

Follow Up : After 5 days of discharge removed.



(V)

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Case No.: 6

Date: _____

Name: Deepak Bhoi

Age: 52 years

Sex: Male

Occupation: Bank employee

Religion Status: Hindu

Social Status: Middle class

Marital Status: Married

~~Date of Admission:~~

Chief Complaint: Patient complains of headache, dizziness, palpitation since 2 weeks. Patient also complains of blurring of vision and dyspnoea.

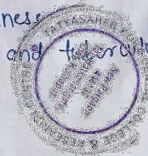
History of Present Illness: Patient was apparently alright 2 weeks back. Then he started experiencing head ache, dizziness, visual disturbance, dyspnoea and palpitation.

Past Medical History:

- No history of major illness
- No history of asthma and tuberculosis



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Dr. Harish Kulkarni M.D.S.
Principal
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Dist. Kolhapur - 416 127

Family History:

No relevant history

Personal History: Patient consumes alcohol once or twice daily has cigarette smoking habit 5-6 times daily since 10 years.

Diet: Mixed

Appetite: Normal

Sleep: Disturbed

Bowel: Frequency twice daily

Micturition: Frequency 6-7 times daily

Habit: No relevant history

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is conscious and well oriented

Build & Nutrition: Obese

Vital Signs:

a) **Temperature:** 99.2°F

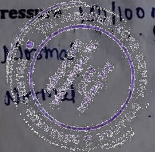
b) **Pulse:** 98 beats/min

c) **Respiratory Rate:** 20 cycle/min

d) **Blood Pressure:** 110 mm Hg

Skin: a) Hair Normal

b) Nail Normal



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c) **Face:** Normal

d) **Eyes:** Normal

e) **Nose:** Normal

f) **Mouth:** Normal

g) **Limbs:** Normal

h) **Vertebral Column:** Oedema present over lower limbs

i) **Lymphadenopathy:** Absent

j) **Oedema:** Bilateral pedal oedema

k) **Joints:** Normal

SYSTEMATIC EXAMINATION:

Respiratory System:

- a) **Inspection:** - Bilaterally symmetrical chest.
- No visible superficial vein (scars)
- Thoraco-abdominal respiration
- No bulging/retraction of chest.

- b) **Palpation:**
 - No tenderness
 - No lump
 - No lymph node enlargement

- c) **Percussion:**
 - Tactile vocal fremitus equal on both sides.
 - Trachea is centrally placed.

- d) **Auscultation:**
 - Bronchial breathing is absent
 - Vesicular breathing is present



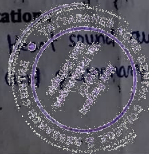
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West Bengal - 735101

Gastro Intestinal System :

- a) Inspection : No discoloration (visible swelling).
- No dilated superficial veins
- Umbilicus is centrally placed and inverted.
- b) Palpation :
- No tenderness
- Liver, spleen and kidney are not palpable.
- c) Percussion :
- Tympanic note found on percussion
- No abnormalities detected
- d) Auscultation :
2-3 peristaltic movements / min are audible

Cardio : Vascular System :

- a) Inspection : - Pericardium is smooth,
- No retraction is seen
- Apex beat is normally placed.
- b) Palpation : - Absence of thrust
- No any tenderness / palpable mass in pericardium
- c) Percussion : - Cardiac dullness is within normal limits
- Right and left Cardiac borders percussed from lateral to medial side.
- d) Auscultation : - No murmurs / rubor in mitral, aortic



(IV)

CNS: Patient is conscious and well-oriented to place, time and people.
- Pupils are equally reactive to light.

Provisional Diagnosis :

- 1) Hypertension with obesity
- 2) Renal insufficiency

Investigations :

- 1) Complete blood count
- 2) Blood glucose
- 3) ECG
- 4) Urine examination
- 5) Renal function test

Final Diagnosis :

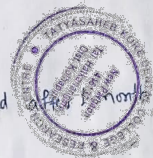
Hypertension with obesity

Treatment :

- 1) Cessation of alcohol consumption and smoking habit
- 2) Salt restriction diet is advised to patient.
- 3) Lifestyle modification - Regular exercise such as fast walking, jogging or swimming is advised.
Relief of stress by relaxation and meditation
- 4) Tab. Amlodipine 5mg OD - 1 month
- 5) Tab. Atorvastatin 80mg OD - 1 month

Follow Up :

Patient is recalled after 1 month for follow up.



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(V)

Case No. : 7 Date : _____

Name : Jayant Shinde

Age : 52 years Sex : Male

Occupation : Sugar factory worker

Religion Status : Hindu

Social Status : Middle class

Marital Status : Married

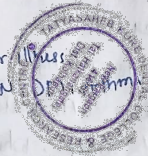
~~Date of Admission :~~

Chief Complaint : Patient complains of weakness, loss of appetite, distension of abdomen and dyspnoea since 22 days.

History of Present illness : Patient was apparently alright 22 days back. Then he experienced weakness, loss of appetite & distension of abdomen. He also experienced bilateral oedema & yellowish discoloration of sclera.

Past Medical History :

- No history of major illness
- No history of HTN



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Family History: No relevant history

Personal History:

Patient consumes alcohol 2-3 times daily since 30 years.

Diet: Mixed

Appetite: Reduced appetite

Sleep: Disturbed

Bowel: Frequency 2 times/day

Micturition: ~~Disturbed~~ Frequency 4-5

Habit:

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is conscious and well oriented.

Build & Nutrition: Normal

Vital Signs:

a) Temperature: 99°F

b) Pulse: 100 beats/min

c) Respiratory Rate: 21 cycles/min

d) Blood Pressure: 126/88 mmHg

Skin: a) Hair: loss of hairs (Alopecia)

b) Nail: Clubbing of fingers, white nail beds

(II)

c) Face: Puffiness of face

d) Eyes: Yellowish discoloration of sclera.

e) Nose: Normal

f) Mouth: Pale oral mucosa

g) Limbs: Redness of thenar and hypothenar eminence of palm
[Palmar erythema]

h) Vertebral Column: Normal

i) Lymphadenopathy: Absent

j) Oedema: Bilateral pedal oedema

k) Joints: Normal

SYSTEMATIC EXAMINATION:

Respiratory System:

a) Inspection: - Bilaterally symmetrical chest.
- There is no visible superficial vein
- Abdomino-thoracic respiration is seen

b) Palpation: - Slight tenderness
- No lump
- No lymph node enlargement.

c) Percussion: - Tactile vocal fremitus equal on both sides.
- Trachea is centrally placed.

d) Auscultation:

- Normal breath sounds
- Normal auscultation



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(III)

Gastro Intestinal System:

- a) **Inspection:** pendulous abdomen with symmetrical globular enlargement and accentuated cutaneous folds.
- Tense distended abdomen with everted umbilicus (weeping umbilicus)
- b) **Palpation:**
- Tenderness may be elicited
- Hepatomegaly seen
- Splenomegaly seen
- c) **Percussion:**
- Shifting dullness present
- Fluid thrill is present.

d) Auscultation:

Intestinal sounds are not audible.

Cardio: Vascular System:

- a) **Inspection:** - Pericardium is smooth.
- Apex beat is normally placed.
- b) **Palpation:** - Apex beat is palpated at left 5th intercostal space.
- No tenderness on palpation
- c) **Percussion:** - Right & left cardiac borders are percussed from lateral to medial side.
- No cardiomegaly.
- d) **Auscultation:**
- Atrial bruit is present
- Venous return is continuous.

(IV)

CNS: Patient is well oriented and conscious to time place and person.

Provisional Diagnosis: 1) Ascites
2) Cirrhosis of liver

Investigations: 1) Complete blood count - Hb concentration - 9 gm
Rbc count - 4 million/cu. mm, Wbc count - 5200/cu. mm, Rbc morphology - Platycoytic
2) Ultrasonography of Abdomen -
3) Liver function test 4) Urine examination
5) Ascitic fluid examination serum - ascitic albumin gradient is > 1.1 g/dl

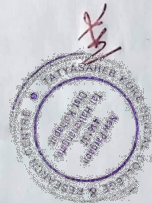
Final Diagnosis:

Cirrhosis of liver

Treatment:

- 1) Cessation of alcohol consumption habit.
- 2) Bed rest is advised to patient.
- 3) Therapeutic Paracentesis - Maximum 1 lit. ascitic fluid can be removed.
- 4) High protein diet (80-100g) and low salt diet
- 5) Cap. Bicosules - OD - 10 days
- 6) Tab. Furosemide (40-160 mg/day)
- 7) Tab. Spironolactone (100-200mg/day)
- 8) Tab. Cefotaxime 2g i.v. twice daily

Follow Up:



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(V)

Case No. : 8

Date : _____

Name : Ramech Mohan Chauhan

Age : 40 years

Sex : Male

Occupation : Farmer

Religion Status : Hindu

Social Status : low class

Marital Status : Married

Date of Admission : _____

Chief Complaint : Patient complains of multiple blisters over both lower limb since 2 months. Discharge from blisters since 40 days. Patient also complains of mild fever, bodyache and slow developing swelling over lower limbs.

History of Present illness : Patient was apparently alright 2 months back. Then he developed swelling gradually over both limbs and multiple blisters which burst and discharge watery fluid.

Past Medical History : Patient has history of fracture of femur neck and was operated for same 2 months back.

- Patient has history of diabetes mellitus and for same since 3 years.
- Patient has history of fever.

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Family History: No relevant history
No history of diabetes & hypertension

Personal History: No history of adverse habits is reported

Diet: Mixed

Appetite: Normal

Sleep: Disturbed

Bowel: Normal

Micturition: Normal

Habit: No habit

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is conscious and well-oriented

Built & Nutrition: Normal

Vital Signs:

a) Temperature: 102°F

b) Pulse: 96 beats/min

c) Respiratory Rate: 20 cycles/min

d) Blood Pressure: 126/84 mmHg

Skin: a) Hair Normal

b) Nail Normal

(II)

c) Face: Normal

d) Eyes: Normal

e) Nose: Normal

f) Mouth: Normal

g) Limbs: Oedema on lower limbs.

h) Vertebral Column: Normal

i) Lymphadenopathy: Absent.

j) Oedema: Present bilaterally over lower limbs.

k) Joints: Normal

SYSTEMATIC EXAMINATION:

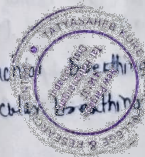
Respiratory System:

a) Inspection: - Bilaterally symmetrical chest.
- No visible superficial vein/cos.
- Thoraco-abdominal respiration seen
- No bulging or retraction of chest.

b) Palpation:
- No tenderness
- No lump
- No lymph node enlargement.

c) Percussion:
- Tactile vocal fremitus equal on both sides.

d) Auscultation:
- Bronchovesicular breathing is audible
- Vesicular breathing is audible



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(III)

Gastro Intestinal System:

- a) **Inspection:** - No discoloration / visible swelling.
- No dilated superficial veins
- Umbilicus is centrally placed and inverted.
- b) **Palpation:** - Liver is not palpable
- Spleen and kidney are not palpable
- No tenderness present.
- c) **Percussion:** - Tympanic note is found on percussion
- No abnormalities detected.

d) Auscultation:

2-3 peristaltic movements / min are audible.

Cardio: Vascular System:

- a) **Inspection:** - Pericardium is smooth
- No retraction is seen
- Apex beat is palpated at normally placed.
- b) **Palpation:** Apex beat is palpated at 5th intercostal space.
- Absence of thrill.
No any tenderness / palpable mass in pericardium
- c) **Percussion:**
- Cordial dullness is within normal limits.
- Right and left cardiac borders perceived from lateral to medial side.
- d) **Auscultation:** - No cardiomegaly
- Heart sound auscultation in mitral, aortic and pulmonary area.
- No murmur.

(IV)

- CNS:** Patient is conscious and well-oriented to place, time and people.
- Pupils are equally reactive to light.

Provisional Diagnosis:

- 1) Cellulitis of both lower limb
- 2) Oedema of both lower limb.

Investigations: 1) Routine investigation - Complete blood count, ESR, Blood sugar level (Fasting & post prandial), Serum creatinine, serum cholesterol, urine examination
2) X-ray of both lower limb below knee (Antero posterior view) Culture sensitivity of discharge from blister.

Final Diagnosis:

Cellulitis of both lower limb.

Treatment:

- 1) Bed rest with elevation of lower limb.
- 2) Regular dressing of worst blister site with hydrogen peroxide, normal saline and betadine
- 3) Inj. ceftriaxone + sulbactam 1.5 gm TID
- 4) Inj. Metronidazole IV TID - 7 days
- 5) Cap. Becasules - OD
- 6) Vit-c 300 mg TID
- 7) Human insulin - Human aetraphane according to BGL.
- 8) Surgical treatment - If cellulitis does not subside with medical treatment - Incision and discharge, debridement.

Follow Up:



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(V)

Case No.: 9

Date: _____

Name: Ravi Patil

Age: 51 years Sex: Male

Occupation: Truck driver

Religion Status: Hindu

Social Status: Middle class

Marital Status: Married

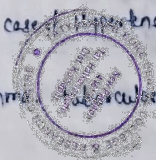
Date of Admission:

Chief Complaint: Patient complains of tingling numbness of lower limb, weakness, dizziness since 20 days. Patient also complains of frequent urination, excessive thirst and disturbed sleep since 20 days.

History of Present illness: Patient was apparently alright 20 days back, then he experienced tingling sensation in lower limbs with numbness, excessive thirst, frequent urination and weakness dizziness and disturbed sleep.

Past Medical History:

- Patient is known case of hypertension and on medication for same since 3 months.
- No history of asthma, tuberculosis or any other chronic illness.



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Family History:

Patient's mother is suffering from Diabetes mellitus and is on medication for same since 20 years.

Personal History:

Patient consumes alcohol 1-2 times daily and has smoking habit since 8 years.

Diet: Mixed

Appetite: Reduced appetite

Sleep: Disturbed sleep

Bowel: Frequency 2-3 times/day

Micturition: Frequency 6-7 times/day, 2-3 times at night.

Habit: No habit

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is conscious and well oriented.

Build & Nutrition: Normal

Vital Signs:

a) Temperature: 98.2°F

b) Pulse: 84 beats/min

c) Respiratory Rate: 22 cycles/min

d) Blood Pressure: 100/100 mm Hg

Skin: a) Hair Normal

b) Nail White nails

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(II)

c) Face: Normal

d) Eyes: Normal

e) Nose: Normal

f) Mouth: Normal

g) Limbs: Normal

h) Vertebral Colour: Normal

i) Lymphadenopathy: Absent

j) Oedema: Absent

k) Joints: Normal

SYSTEMATIC EXAMINATION:**Respiratory System:**

a) Inspection: - Bilaterally symmetric chest.
- No visible superficial vein scar
- Thoraco-abdominal respiration
- No retraction of chest.

b) Palpation: - No tenderness
- No lump
- No lymph node enlargement.

c) Percussion: - Tactile vocal fremitus equal on both sides.
- Trachea is centrally placed.

d) Auscultation: - Bronchial breathing audible in all large bronchi
- Vesicular breathing is audible in all peripheral areas

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(III)

Gastro Intestinal System :

- a) Inspection : No discoloration / visible swelling
- No dilated superficial veins.
- Umbilicus is centrally placed and inverted.
- b) Palpation : - No tenderness
- Liver, spleen and kidney are not palpable.
- c) Percussion :
- Tympanic note is found on percussion
- No abnormalities detected
- d) Auscultation :
2-3 peristaltic movements / min are audible.

Cardio: Vascular System :

- a) Inspection : - Pericardium is smooth
- No retraction is seen.
- b) Palpation : - Absence of thrust
- No any tenderness / palpable mass in pericardium
- c) Percussion : - Cardiac dullness is found within normal limit.
- Right and left cardiac borders percussed from lateral to medial side.
- d) Auscultation :

- Heart sound auscultation in normal,
aortic are secondary area.

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Jawahar, Dr. Hatkanangli
Kolhapur 416 127

(IV)

CNS: Patient is conscious and well oriented to place, time and people.
- Pupils are equally reactive to light.

Provisional Diagnosis :

- 1) Severe anaemia
- 2) Diabetes mellitus

Investigations : 1) Complete blood count - Hb 12g/ml. RBC - 5 million / cu. mm
WBC count - 7000 / cu. mm
2) Blood sugar - Fasting 120mg/dl, Post prandial 210mg/dl
3) Urine examination - Keturia 2) Renal function test 3) Lipidogram

Final Diagnosis :

Diabetes mellitus.

Treatment :

- 1) Cessation of alcohol consumption & ~~smoker~~ smoking habit
- 2) Lifestyle modification - Regular exercise and relief of stress by meditation, Reduction of weight.
- 3) Diet - Carbohydrate restricted diet.
High protein, High fibers, and low salt diet is advised to patient.

Follow Up: Patient is recalled after 1 month for follow up.
Advised for further examination - Blood sugar.

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F.K.D.C. & Research Centre,
Jawahar, Dr. Hatkanangli
Kolhapur 416 127

(V)

Case No. : 10

Date : _____

Name: Girija Bhosale

Age: 47 yrs Sex: Female

Occupation: Housewife

Religion Status: Hindu

Social Status: Low class

Marital Status: Married

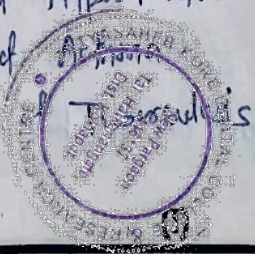
Date of Admission: _____

Chief Complaint: Patient complains of weakness, loss of appetite, dizziness since 20 days

History of Present illness: Patient was apparently alright 20 days ago. Then she experienced tiredness, dyspnoea, loss of appetite since past 20 days and tingling of lower limbs and weight loss.

Past Medical History:

- No history of major illness
- No history of Hypertension
- No history of Diabetes
- No history of _____



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Family History: No relevant history

Personal History:

No history of adverse effects.

Diet: Pure vegetarian diet

Appetite: Reduced appetite

Sleep: Insomnia

Bowel: Frequency 2-3 times a day

Micturition: Frequency 4-5 times daily, 2-3 times at night.

Habit: No relevant history

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is conscious & well oriented

Built & Nutrition: Normal

Vital Signs:

a) **Temperature:** 98.4°F

b) **Pulse:** 85 beats/min

c) **Respiratory Rate:** 22 cycles/min

d) **Blood Pressure:** 120/84 mm Hg

Skin: a) **Hair:** Normal

b) **Nail:** Pallor present on nail bed

(II)

c) **Face:** Pale

d) **Eyes:** Pallor on lower palpebral conjunctiva

e) **Nose:** Normal

f) **Mouth:** Pallor, red tongue

g) **Limbs:** Normal

h) **Vertebral Column:** Normal

i) **Lymphadenopathy:** Absent

j) **Oedema:** Absent

k) **Joints:** Normal

SYSTEMATIC EXAMINATION:

Respiratory System:

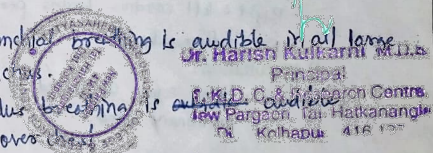
a) **Inspection:** - Bilaterally symmetrical chest.
- No visible superficial vein/scar
- Thoracoabdominal respiration
- No retraction/bulging of chest.

b) **Palpation:** - No tenderness
- No lump
- No lymph node enlargement.

c) **Percussion:**
- Tactile vocal fremitus equal on both sides
- Trachea is centrally placed.

d) **Auscultation:** - Bronchial breathing is audible in all large bronchi.
- Vesicular breathing is audible all over chest.
- No audible sound on wheeze

(III)

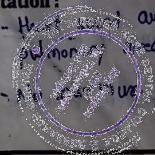


Gastro Intestinal System:

- a) Inspection: - No discoloration / visible swelling
- No dilated superficial veins
- Umbilicus is centrally placed in inverted.
- b) Palpation: - Liver is not palpable
- Spleen and liver not palpable
- No tenderness.
- c) Percussion: - Tympanic note is found on percussion.
- Abdominal fullness is due to faeces & flatulence.
- d) Auscultation: - 2-3 peristaltic movements /str in are audible.

Cardio: Vascular System:

- a) Inspection: - Pericardium is smooth.
- No oedema is seen.
- Apex beat is normally placed.
- b) Palpation: - Absence of thrill.
- No any tenderness / palpable mass in pericardium.
- Apex beat is placed at left 5th intercostal space.
- c) Percussion: - Cardiac dullness is within normal limits.
- Right & left cardiac borders percussed.
- No cardiomegaly.
- d) Auscultation: - Heart auscultated in mitral, aortic and



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(IV)

CNS: Patient is conscious and well oriented to place, time and people.
- Pupils are equally reactive to light.

Provisional Diagnosis:

- Malabsorption syndrome
- Megaloblastic anaemia

Investigations: 1) Complete blood count - Hb count - 8 gm/l.
RBC count - 8 million/ μ l, WBC count - 8000/ μ l, Raised MCV
2) Serum Vitamin B₁₂ assay 3) Schilling test
4) Serum folate assay 5) Blood glucose test

Final Diagnosis:

Megaloblastic anaemia

Treatment:

1) Hydroxocobalamin - Parenterally 1000 μ g twice a week during first week
Followed by 1000 μ g weekly for 6 weeks.

OR

2) Methylcobalamin B₁₂ - 1500 μ g IM daily 7 days
Once a week - 6 weeks

3) Tab. Folic acid 5mg - OD x 3 months.

4) Patient is advised to eat vit. B₁₂ rich diet.

Follow Up:



(V)

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