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

Mahatma Gandhi Charitable Medical Trust, Warananagar

TATYASAHEB KORE DENTAL COLLEGE AND RESEARCH CENTRE, NEW PARGAON

RECOGNISED BY DENTAL COUNCIL OF INDIA, NEW DELHI

AFFILIATED TO MAHARASHTRA UNIVERSITY OF HEALTH SCIENCES, NASHIK

'SERVICE IS RELIGION'

WARANA

HEALTH MOVEMENT

Est : 1992

GENERAL SURGERY

CLINICAL RECORD BOOK

NAME : Trigunа V Desai

MUHS P. R. No. : 0223125933

Roll No. : 7

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'SERVICE IS RELIGION'
WARANA HEALTH MOVEMENT
Est : 1992

DEPARTMENT OF GENERAL MEDICINE

CLINICAL RECORD BOOK

CERTIFICATE

This is to certify that this is a bonafide clinical work done in the Department of Department of General Surgery

by Mr./Miss. Triguna V Desai

University Exam No. 156717 **Student of the year** 2024-25

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

Signature of the Staff Incharge

Professor & Head of the Department

Place :

Date :

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Signature of the External Examiners

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GENERAL SURGERY

Name: Pramod Bane

Age: 45 year **Sex:** Male

Address: Rajarampuri 8th Lane, Sharada Housing society Plot no. 12, Kolhapur

Social Status: Middle class

Chief Complaint: Pt c/o painless swelling over upper back since 1yr

History of Present illness :

Pt noticed a small pea sized swelling over the upper back 1year ago, which gradually increased to its present size. The swelling is painless, non progressive for last 3 months No history of trauma, discharge, redness, fever or similar swellings elsewhere. No difficulty in shoulder movement

Past Medical History :

No history of diabetes, hypertension, tuberculosis or major medical illness

Drug History/History of Allergy : Not on long term medication No known drug allergy

(I)

Family History: No similar swellings in family members
No hereditary disorders

Personal History:
Appetite normal, sleep adequate
Regular bowel & bladder habits
No smoking or alcohol consumption

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): conscious, alert, oriented

Built : Average build & nourishment **Attitude :** co-operative

Gait : Normal **Face :** normal, no assymmetry

Decubitus : comfortable, supine

Pallor : Absent **Cynosis :** Absent

Icterus : Absent **Edema :** Absent

Skin Eruption: None

VITAL SIGNS :

Pulse Rate: 78/min, regular

Respiratory Rate: 18 / min

Temperature: Afebrile

Blood Pressure: 124/78 mm/Hg

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SYSTEMATIC EXAMINATION:

Respiratory System:
Chest symmetrical, bilateral equal air entry
no added sounds

Cordiovascular System:
S1 and S2 heard
No murmur or added sounds

Gastrointestial Track:
Abdomen soft, non tender, no organomegaly
bowel sounds normal

Central Nervous System:
Conscious, oriented, no motor or sensory deficits.

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LOCAL EXAMINATION :

Inspection :

Site - upper back, right paraspinal region at level of T_4.

Size - 4x3 cm

shape - ovoid

number - single

skin over swelling - normal colour, no scars or ulcerations

Visible pulsation : Absent

Palpation :

Temperature - normal

Tenderness - Absent

Surface - smooth

Consistency - soft, doughy

mobility - freely mobile in all direction (slips under fingers)

fluctuation - negative

transillumination - negative

compressibility - negative

cough impulse - absent

skin pinch test - skin freely mobile over swelling

No regional lymphadenopathy

Precusion : Not contributory

Ausculation : No sound heard

PROVISIONAL DIAGNOSIS :

Benign subcutaneous lipoma of upper back

INVESTIGATION :

Complete blood count - within normal limits

Blood sugar, renal function test - normal

Ultrasonography of swelling - well defined, hypoechoic lesion consistent with lipoma

FNAC - mature adipocytes confirming benign lipoma

Final Diagnosis :

Subcutaneous lipoma of upper back (4x3cm)
Benign adipose tissue

Treatment :

1) Surgical excision of lipoma under local anaesthesia
2) Pressure dressing applied post-operatively
3) Analgesics & antibiotics for 3-5 days
4) Histopathological confirmation of excised specimen
5) Follow up in 7 days for suture removal.

℞

GENERAL SURGERY

Name: Anisha Parab

Age: 38 yr **Sex:** Female

Address: 140, Vrundavan Villas Township
Near Spurti chowk
Gort colony, Vishrambag, Sangli

Social Status: Middle class

Chief Complaint: Pt c/o of wound over the left leg since 3 weeks

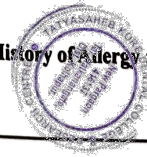
History of Present illness :

Pt noticed a small painful wound over the left lower leg following minor trauma 3 weeks ago. Initially the wound was red and tender with mild discharge. Over the last 10 days, pain has decreased & granulation tissue has appeared. Wound size is gradually reducing. No fever, no foul smelling discharge and no history of repeated trauma. No similar ulcer in the past

Past Medical History :

No history of diabetes, hypertension, varicose veins, peripheral vascular disease
No previous ulcer episodes

Drug History/History of Allergy : Not on any regular medications
No known drug allergies



Family History: No history of diabetes or ulcer tendency

Personal History: Apetite good
Normal bowel & bladder habits
Sleep adequate
No smoking or alcohol

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): Conscious, alert, oriented

Built : Average

Attitude : Co-operative

Gait : Normal

Face : Normal

Decubitus : comfortable

Pallor : absent

Cynosis : Absent

Icterus : absent

Edema : Absent

Skin Eruption: none

VITAL SIGNS :

Pulse Rate: 80/min, regular

Respiratory Rate: 18/min

Temperature: Afebrile

Blood Pressure: 118/76 mmHg

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SYSTEMATIC EXAMINATION:

Respiratory System:

Air entry equal bilaterally, no added sounds

Cordiovascular System:

S1, S2 normal, no murmurs

Gastrointestial Track:

Abdomen soft, non tender, no organomegaly

Central Nervous System:

Conscious, oriented, no focal deficit

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LOCAL EXAMINATION :

Inspection :

Site - left lower leg, medial aspect
number - single
size - 2x1.5cm
shape - oval
edge - sloping edges
floor - healthy red granulation tissue
margins - regular
discharge - minimal serous discharge
base - not fixed to deeper tissues
surrounding skin - slight hyperpigmentation, no cellulitis

Palpation :

Tenderness - mild
Temperature - normal
bleeding on touch - mild
depth - superficial, no undermining
Pulses (Dorsalis pedis & post tibial) - present & normal
Lymph nodes - No inguinal lymphadenopathy

Precusion : Not contributory

Ausculation : No bruit over the limb

PROVISIONAL DIAGNOSIS :

Healing traumatic ulcer of left leg

INVESTIGATION :

1) Complete blood count normal
2) Random blood sugar - normal
3) ESR - mildly elevated
4) Wound swab culture - normal flora, no pathogenic growth
5) X ray leg - no bone involvement

Final Diagnosis :

Healing traumatic ulcer with healthy granulation tissue, left lower leg.

Treatment :

1) Daily sterile dressing with saline & antiseptic
2) Topical antibiotic ointment
3) Analgesics are needed
4) Advice. to avoid trauma & maintain limb hygene
5) High protein diet to promote wound healing
6) Follow up every 3-5 days to assess healing progress

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(VI)

GENERAL SURGERY

Name: Sangeeta Samant

Age: 26yr **Sex:** Female

Address: Tulip Housing society
Gokul Shirgaon
Kolhapur-416234

Social Status: Middle class

Chief Complaint: Pt c/o of raised scar over the right earlobe since 8 months

History of Present illness :

Pt underwent ear piercing 1 year ago. After 2 months she noticed a small firm swelling of piercing site which gradually increased in size over 6 months. The swelling is painless & causes cosmetic concern. No itching, discharge or bleeding. No history of trauma, apart from piercing. No restriction of ear movement

Past Medical History :

No history of diabetes, hypertension or hypertropic scars in past wounds

Drug History/History of Allergy : No long term medication

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Family History:

Mother had similar thick scars after injury (positive family tendency)

Personal History:

Normal sleep, apetite & bowel / bladder habits
No smoking or alcohol

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): Conscious, alert, well oriented

Built : Average

Attitude : Co-operative

Gait : Normal

Face Normal, no assymmetry

Decubitus : comfortable

Pallor : Absent

Cynosis : Absent

Icterus : Absent

Edema : Absent

Skin Eruption: None elsewhere

VITAL SIGNS :

Pulse Rate: 76/min, regular

Respiratory Rate: 18/min

Temperature: Afebrile

Blood Pressure: 120/78 mm Hg

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SYSTEMATIC EXAMINATION:

Respiratory System:

Bilateral air entry equal
No added sounds

Cordiovascular System:

S1 S2 normal
no murmurs

Gastrointestial Track:

soft, non tender
no organomegaly

Central Nervous System:

Normal, no deficit

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LOCAL EXAMINATION :

Inspection :

Site - right earlobe
number - single
size - 2x1.5 cm
shape - oval
colour - shiny, reddish brown
surface - smooth, elevated
borders - well defined, extending beyond original wound margins
skin changes - skin stretched & glossy
movements - No movement with swallowing or facial expression
sign of inflammation - absent
ulceration - absent
Pulsation - absent

Palpation :

1) local temp - normal
2) Tenderness - Absent
3) Surface - smooth
4) Consistency - firm to hard
5) mobility - slightly mobile but not freely mobile
6) compressibility - non compressible
7) Fluctuation - Negative
8) slip sign - Negative
9) Skin pinch test - Skin can be pinched easily
10) Adherence - Not fixed to deeper structures

Precusion : Not contributory

Ausculation : No bruit

PROVISIONAL DIAGNOSIS :

Keloid of right earlobe (Post piercing)

INVESTIGATION :

1) Complete blood count - normal
2) Random blood sugar - normal
3) Ultrasound of swelling - shows dense fibrous tissue

Final Diagnosis :

Keloid of right earlobe, secondary to ear piercing

Treatment :

Intralesional corticosteroid injection
(Triamcinolone 10-40 mg/ml) every 3-4 weeks
silicone gel sheet application
Pressure therapy for earlobe keloid
If large - surgical excision followed by
Post op steroid injections
silicone therapy
Pressure earrings
Avoid further trauma or piercing

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(Vit)

GENERAL SURGERY

Name: Vinita Salkpal

Age: 32 yr **Sex:** Female

Address: Sonargram Society
Shirgi Nagar
Kolhapur - 416012

Social Status: Middle class

Chief Complaint: pt c/o of swelling in front of neck since 6 months

History of Present illness :

Pt noticed a small swelling in lower front part of neck 6 months back. It gradually increase in size. swelling moves with swallowing. No pain, no difficulty in breathing and no change in voice. No history of rapid increase in size. No palpations, heat tolerance, weight loss, tremors or excessive sweating. No history of constipation, wt gain, cold intolerance

Past Medical History : No history of thyroid disorders neck irritation, diabetes hypertension or autoimmune diseases

Drug History/History of Allergy : Not on any Pharmaterm medications
No known drug allergies

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(I)

Family History:

Mother has hypothyroidism
No family history of thyroid cancer or goitre

Personal History:

Apetite normal. Sleep adequate. Bowel & bladder habits normal. No smoking or alcohol intake
Mixed diet

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): Conscious, alert, oriented

Built : moderately built & nourished **Attitude :** cooperative

Gait : normal **Face :** No exophthalmos, no lid lag, no periorbital edema

Decubitus : comfortable

Pallor : Absent **Cynosis :** Absent

Icterus : Absent **Edema :** Absent

Skin Eruption: none

VITAL SIGNS :

Pulse Rate: 82/min, regular, normal vol

Respiratory Rate: 18/min

Temperature: Afebrile

Blood Pressure: 118/74 mm of Hg

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(II)

SYSTEMATIC EXAMINATION:

Respiratory System:

Air entry equal
no added sounds

Cordiovascular System: S1, S2 normal
no murmurs

Gastrointestial Track: Soft abdomen
No organomegaly

Central Nervous System: normal
no tremors

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(III)

LOCAL EXAMINATION :

Inspection :

site - anterior neck, predominantly right lobe region
size - 4x3 cm
shape - oval
number - single swelling
symmetry - Rt lobe appears slightly enlarged
surface - smooth
skin over swelling - normal. no dilated vens
no scars
movement - moves upwards with swallowing
Pulsation - absent
Tracheal deviation - absent

Palpation : (Pt examined from behind)

Temperature - normal
Tenderness - Absent
consistency - firm & smooth
surface - smooth
mobility - mobile moves with deglutition
fluctuation - negative
fixity - not fixed to skin or surrounding structures
Lower borders - palpable
carotid pulsation - transmitted No
Thrills - absent
No cervical lymphadenopathy

Precusion :

No dullness over sternum → no retrosternal extension

Ausculation : No bruit over the swelling

PROVISIONAL DIAGNOSIS : Right sided solitary thyroid nodule
(likely benign)

INVESTIGATION :

CBC, ESR - normal
Thyroid function test (T_3, T_4, TSH) - TSH normal
Ultrasound thyroid - single well defined hypoechoic nodule in right lobe
FNAC - Benign colloid nodule
X ray neck - Trachea central

Final Diagnosis :

Euthyroid solitary benign colloid nodule of right thyroid lobe

Treatment :

Surgical- Hemithyroidectomy (right lobectomy) recommended

Preoperative- Thyroid function optimization, routine labs

Post-op - 1) Analgesics
2) Wound care
3) Monitor for hoarseness (recurrent laryngeal nerve)
4) Monitor Ca levels (Parathyroid prevention)

Follow up - Histopathology confirmation, monitor thyroid function

GENERAL SURGERY

Name: Sanjay Ingale

Age: 55yr **Sex:** Male

Address: Plot no 45, Shriram colony
Gaon bag, Miraj
Sangli - 416 416
Maharashtra

Social Status: Lower middle class

Chief Complaint: Pt c/o of non healing ulcer over the right foot since 2 months

History of Present illness :

Pt noticed a small wound over the lateral aspect of the right foot 2 months ago following accidental rubbing of footwear. The ulcer failed to heal & gradually increased in size. Initial pain was mild, now moderately on walking. Ulcer discharges scanty serous fluid. No fever or foul smelling discharges. He reports tingling & decreased sensation in right foot for last 1year.

Past Medical History : known diabetic for 8years
irregular medication compliance
no hypertension or peripheral vascular disease previously diagnosed

Drug History/History of Allergy : Takes metformin irregularly
No known drug allergies

Family History:

Positive family history of diabetes in father
No family history of chronic ulcers or skin cancers

Personal History:

Apetite normal
Bowel & bladder habits normal
Non-smoker, occassional alcohol consumption
Use tight footwear.

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): Conscious, alert, oriented

Built : moderate built mildly nourished

Attitude : Co-operative

Gait : Antalgic

Face : normal

Decubitus : comfortable

Pallor : mild

Cynosis : Absent

Icterus : Absent

Edema : Absent

Skin Eruption: None

VITAL SIGNS :

Pulse Rate: 84/min

Respiratory Rate: 18/min

Temperature: Afebrile

Blood Pressure: 124/82 mm Hg

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SYSTEMATIC EXAMINATION:

Respiratory System:

Air entry equal
No added sounds

Cordiovascular System:

S1, S2 normal
No murmurs

Gastrointestial Track:

soft abdomen
no tenderness
no organomegaly

Central Nervous System:

Higher functions normal
sensory examination of right feet
Decreased touch & pain sensation (mild neuropathy)

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LOCAL EXAMINATION :

Inspection :

site - lateral side of right foot
size - 3x2 cm
number - single
shape - oval
edges - punched out, irregular
margins - thickened
floor - pale granulation tissue with slough
depth - deep involving subcutaneous tissue
discharge - minimal serious discharge
surrounding skin - dry, callused, hyperpigmented
sign of inflammation - mild redness

Palpation :

Local temp slightly warm
Tenderness - present on pressure
edge - hard, non healing type
base - indurated
floor - rough, unhealthy
depth - no bone felt → no exposed bone
mobility - ulcer fixed to skin, not fixed to deeper structures
Fluctuation - negative
crepitus - absent

Precusion : Not contributory

Ausculation : No bruit over foot arteries

PROVISIONAL DIAGNOSIS :

Non healing diabetic neuropathic ulcer of right foot with peripheral vascular insufficiency.

INVESTIGATION :

CBC : mild anaemia
Random blood sugar - elevated
HbA1c - high
Wound swab culture - mixed flora, no resistant organisms
Xray foot - no bone involvement, no osteomyelitis

Final Diagnosis :

Non healing diabetic neuropathic ulcer of right foot with multiple peripheral arterial disease.

Treatment :

Medical - Glycemic control with insulin
Broad spectrum antibiotics based on culture
Analgesics
Vit B complex for neuropathy

Local wound care - Daily saline dressing
Removal of slough
Application of moist wound healing agent
Off loading pressure using specialized footwear

Vascular management -
Antiplatelet therapy
Peripheral vasodilators
Advice to avoid tight footwear

Pt advice - strict diabetic control
foot hygiene, daily foot check
Avoid trauma to foot

Followup - Wound healing review every 4-5 days
Repeat doppler if ulcer not healing

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GENERAL SURGERY

Name: Satish shet

Age: 18 **Sex:** Male

Address: Kamble Nivas
Rankala Lake Road
Kolhapur - 416001

Social Status: Middle class

Chief Complaint: Pt c/o swelling below the chin since 8 months

History of Present illness :

Pt noticed a small swelling in submental region 8 months ago. It gradually increased in size. The swelling is painless. No history of trauma, fever discharge or ulceration. No difficulty in swallowing or breathing

Past Medical History :

No history of diabetes, TB, major illness

Drug History/History of Allergy : No long term medication. No known allergy

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Family History:
No similar complaints in family members

Personal History:

Normal diet
Normal bowel & bladder habits
No addiction

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): Conscious, well oriented

Built : average built

Attitude : co-operative

Gait : normal

Face : normal, no asymmetry

Decubitus : comfortable, free mobility

Pallor : absent

Cynosis : absent

Icterus : absent

Edema : absent

Skin Eruption: none

VITAL SIGNS :

Pulse Rate: 78/min, regular

Respiratory Rate: 16/min

Temperature: Afebrile

Blood Pressure: 118/76 mm Hg

SYSTEMATIC EXAMINATION:

Respiratory System: Bilateral air entry present
No added sounds

Cordiovascular System: S1, S2 normal
No murmurs.

Gastrointestial Track: soft abdomen
No organomegaly

Central Nervous System: conscious oriented.
no focal deficit

LOCAL EXAMINATION :

Inspection :

Swelling present in submental region
Oval about 3x3cm
skin over swelling normal
No redness, ulceration or sinus
no visible pulsation or scar

Palpation :

Local temperature normal
non tender
Surface smooth, borders well defined
consistency - doughy leystic
Fluctuation - present
Transillumination - negative

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Precusion : Not contributory

Ausculation : Not contributory

PROVISIONAL DIAGNOSIS :

Dermoid cyst - submental region.

INVESTIGATION :

Ultrasound of neck
MRI for exact extent & place
FNAC showing keratinous debris
Histopathology confirmation.

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Family History:

No similar illness in family members

Personal History:

Normal apetite, sleep, bowel & bladder habits
No addictions.

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): conscious, oriented.

Built : average

Attitude : co-operative

Gait : normal

Face : no facial swelling or distress.

Decubitus : comfortable, ambulatory

Pallor : absent

Cynosis : absent

Icterus : absent

Edema : absent

Skin Eruption: none apart from local swelling

VITAL SIGNS :

Pulse Rate: 92/min, regular

Respiratory Rate: 18/min

Temperature: 100.2°F

Blood Pressure: 122/80 mmHg

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SYSTEMATIC EXAMINATION:

Respiratory System: Bilateral air entry equal
No added sounds

Cordiovascular System:

S1, S2 normal
No murmurs

Gastrointestial Track:

Soft, non tender
no organomegaly

Central Nervous System:

Consious, oriented
no motor or sensory deficits.

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LOCAL EXAMINATION :

(Right thigh swelling - Pyogenic abscess)

Inspection :

1) Swelling present on anterior right thigh
2) Size approx 4x5 cm
3) Overlying skin red, stretched, shiny
4) Localized rise of temperature visible
5) No ulceration or sinus
6) No visible discharge
7) No visible pulsations

Palpation :

1. Local temperature increased
2. Tenderness present
3. Swelling soft to firm
4. Fluctuation present
5. Induration present around swelling
6. No crepitus
7. No regional lymphadenopathy
8. Skin not pinchable over centre due to tension

Precusion : (Local)

- Tenderness increased on gentle tapping
- No bony involvement

Ausculation : No bruit or abnormal sound over swelling

PROVISIONAL DIAGNOSIS :

Pyogenic abscess - right thigh

INVESTIGATION :

1) Complete blood count - Raised WBC, neutrophilia
2) Blood sugar levels
3) Ultrasound of swelling (to confirm abscess cavity)
4) Pus culture & sensitivity after drainage.

Final Diagnosis :

Pyogenic abscess confirmed by clinical findings & pus examination

Treatment :

1) Incision drainage under aseptic condition
2) Broad spectrum antibiotics
3) Anti-inflammatory & analgesics
4) Daily dressing of wound
5) Control predisposing factors
6) Follow up until complete healing.

GENERAL SURGERY

Name: Rajesh Khandori

Age: 27 **Sex:** Male

Address: Suyog society
Shendapark
Kolhapur - 416008

Social Status: Middle class

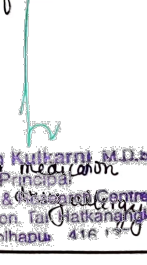
Chief Complaint: Pt c/o of pain & difficulty in mouth opening after facial trauma since 1day.

History of Present illness :

Pt met with a road traffic accident 1 day ago & sustained injury to lower jaw. Pain started immediately, severe, continous, difficulty in mouth opening & chewing. Pt noticed swelling over lower jaw and slight bleeding from mouth. Pain increases on talking or chewing. No loss of consciousness or vomiting

Past Medical History : No previous jaw fractures
no epilepsy
No chronic illness

Drug History/History of Allergy : No regular medication
no known allergies



Family History:

No similar complaints in family members

Personal History:

Normal diet. No additions

Normal bowel & bladder habits

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): conscious, oriented

Built : average

Attitude : co-operative but pain.

Gait : normal

Face : Facial asymmetry due to swelling on left masseter

Decubitus : absent

Pallor : absent

Cynosis : absent

Icterus : Absent

Edema : absent

Skin Eruption: None

VITAL SIGNS :

Pulse Rate: 88/min, regular

Respiratory Rate: 18/min

Temperature: Afebrile

Blood Pressure: 118/76 mm Hg

SYSTEMATIC EXAMINATION:

Respiratory System:

Bilateral airentry present

No added sounds

Cordiovascular System:

S1, S2 normal

No murmurs

Gastrointestial Track:

Soft, non tender

No organomegaly

Central Nervous System: conscious, oriented

no motor or sensory deficit

LOCAL EXAMINATION :

(Mandible)

Inspection :

1) Swelling over left lower jaw
2) Facial asymmetry present
3) Bruising present over the chin / mandibular region
4) Mouth opening reduced
5) Malocclusion visible (uneven bite)
6) Possible step deformity along the lower jaw line
7) Drooling of saliva present
8) No external bleeding at present

Palpation :

1) Local temperature slightly raised
2) Tenderness present over mandible (esp at left body region)
3) Step deformity palpable
4) Mobility of fractured fragments present
5) Crepitus present on gentle movement
6) Sublingual hematoma present
7) TMJ tenderness may be present
8) Teeth in fractured segment may be tender to percussion
9) No lymphadenopathy

Precusion : Local percussion
Adjacent teeth tender on percussion
No abnormal resonance

Ausculation : No bruit
no abnormal vascular sound

PROVISIONAL DIAGNOSIS :

Mandibular fracture - likely left body fracture

INVESTIGATION :

1. X ray mandible (PA lateral, oblique view)
2. Orthopantogram (OPG)
3. CT scan mandible for exact fracture line
4. Hemogram
5. Blood sugar coagulation profile

Final Diagnosis :

Left body fracture of mandible confirmed by radiographs.

Treatment :

1) Pain management & antibiotics
2) Soft diet, oral hygiene maintenance
3) closed reduction with intermaxillary fixation (IMF) if non-displaced
4) Open reduction & internal fixation (ORF) with miniplates if displaced
5) Follow up for wound healing & occlusion correction

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(VI)

GENERAL SURGERY

Name: Vinod Nair

Age: 34 **Sex:** male

Address: Rukmini Nivas
Ichalkaranji
Kolhapur - 416115

Social Status: middle class

Chief Complaint: Pt c/o of painful swelling below the jaw with difficulty in swallowing since 2 days

History of Present illness :

Pt developed pain in the lower jaw region 2 years ago followed by rapidly progressive swelling in the submandibular and sublingual region. Pain is severe, continuous & increases on swallowing & speaking. Pt reports difficulty in swallowing & mild breathing discomfort. Fever with chills present. History of untreated lower molar toothache for 1 week. No history of trauma

Past Medical History : No history of diabetes, TB or Immunocompromised state

Drug History/History of Allergy : Not on regular medication
No known drug allergy

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(I)

Family History:
No similar illness in family

Personal History:
Reduced appetite due to pain
Normal bowel & bladder habits
No addictions

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): conscious, anxious

Built : Average

Attitude : co-operative but distressed

Gait : Normal

Face : facial dullness & anxiety due to breathing difficulty

Decubitus : prefer sitting posture due to discomfort in supine position

Pallor : Absent

Cynosis : Absent

Icterus : Absent

Edema : Absent (general)

Skin Eruption: None

VITAL SIGNS :

Pulse Rate: 104/min, regular

Respiratory Rate: 24/min

Temperature: 101.4°F

Blood Pressure: 126/84 mm Hg

SYSTEMATIC EXAMINATION:

Respiratory System: Mild respiratory distress
Bilateral air entry present
No added sounds

Cordiovascular System:
S1, S2 normal
No murmurs

Gastrointestial Track:
soft abdomen
No organomegaly

Central Nervous System: conscious, oriented
no neurological deficit

LOCAL EXAMINATION :

(submandibular-sublingual region)

Inspection :

1. Diffuse swelling in submandibular region bilaterally
2. Elevation of floor of mouth
3. Tongue raised & pushed posteriorly
4. Skin over swelling is stretched & shiny
5. No obvious fluctuation visible (as it is cellulitis, not an abscess)
6. Mouth opening restricted (trismus)
7. No internal discharge.

Palpation :

1) Local temperature raised
2) Tenderness severe
3) swelling is board-like, brawny & indurated (Typical of Ludwig's angina)
4) Cellulitis (No fluctuation)
5) Tongue tense on palpation
6) Sublingual space firm & elevated
7) No lymphadenopathy initially but may appear.

Precusion : (Local)

- Adjacent lower molar tender to percussion (possible odontogenic source)
- No abnormal percussion note over swelling

Ausculation : (Local)

No bruit
no added vascular sound
Airway sounds slightly harsh due to obstruction risk

PROVISIONAL DIAGNOSIS :

Ludwig's angina- bilateral cellulitis of submandibular sublingual & submental spaces

INVESTIGATION :

1) Complete blood count (leukocytosis)
2) Blood sugar levels
3) Culture & sensitivity from any aspirate if present
4) X ray OPG to identify dental source
5) CT scan neck if airway compromise suspected
6) Airway assessment

Final Diagnosis :

Ludwig's angina secretory to odontogenic infection
(likely infected mandibular molar)

Treatment :

1) Emergency airway management
(nasal intubation / tracheostomy if required)
2) IV broad spectrum antibiotics
3) IV fluid & analgesics
4) Incision & drainage if abscess forms
5) Extraction of offending tooth after stabilisation
6) Monitoring for airway obstruction.

GENERAL SURGERY

Name: Subhash Kadam

Age: 29 **Sex:** Male

Address: Avanti Housing society
Rajaramnagar
Kolhapur-416004

Social Status: Middle class

Chief Complaint: Pt c/o of painful swelling over left leg since 3 days

History of Present illness :

Pt developed redness & mild pain over left lower leg 3 days ago. Swelling gradually increased with severe pain and warmth. Pain is throbbing & continuous. Difficulty in walking due to pain. Pt reports fever with chills. No history of trauma, insect bite or previous similar episodes

Past Medical History : No diabetes, hypertension, tuberculosis
long-term illness

Drug History/History of Allergy : Not on regular medication
No known drug allergy

Family History:
No relevant family medical history

Personal History: Normal appetite & bowel habits
No addictions

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): conscious, oriented

Built : average

Attitude : co-operative

Gait : Limping due to leg pain

Face : normal
no distress except pain

Decubitus : comfortable

Pallor : absent

Cynosis : absent

Icterus : absent

Edema : absent (general)

Skin Eruption: none apart from local lesion

VITAL SIGNS :

Pulse Rate: 96/min, regular

Respiratory Rate: 20/min

Temperature: 100.6°F

Blood Pressure: 120 / 78 mm Hg

SYSTEMATIC EXAMINATION:

Respiratory System: Bilateral air entry present
No added sounds

Cordiovascular System:
S1, S2 normal
no murmurs

Gastrointestial Track: Soft, non tender
no organomegaly

Central Nervous System:
conscious oriented
no focal deficits

LOCAL EXAMINATION :

(Left leg - cellulitis)

Inspection :

1) Diffuse swelling present over left leg
2) Skin red, warm, stretched, shiny
3) Borders not sharply demarcated
4) No ulcer, no visible pus point
5) No or blackening
6) No visible sinus
7) No fluctuance

Palpation :

1) Local temperature increased
2) Severe tenderness present
3) Skin firm and indurated
4) No fluctuation (cellulitis is diffuse)
5) No crepitus
6) No regional lymphadenopathy
7) Sensation intact
8) Capillary refill normal

Precusion : Increased pain on tapping
No abnormal resonance

Ausculation : No bruit
No vascular abnormal sound

PROVISIONAL DIAGNOSIS :

Acute cellulitis of left leg

INVESTIGATION :

1) Complete blood count (leukocytosis)
2) ESR, CRP elevated
3) Blood sugar levels
4) Doppler if vascular compromise suspected
5) Ultrasound soft tissue (to rule out abscess).
6) Blood culture if fever is high.

Final Diagnosis :

Acute cellulitis confirmed clinically and by investigations

Treatment :

1) IV broad spectrum antibiotics
2) Analgesics & anti inflammatory drugs
3) Elevation of limbs
4) Warm compresses
5) Treat underlying cause (tinea, trauma if present)
6) Monitor for abscess formation, necrotizing changes or systemic spread.

GENERAL SURGERY

Name: Satyajeet Kulkarni

Age: 58 **Sex:** Male

Address: Gokhale Sadan
New Shahupuri
Kolhapur - 416001

Social Status: Middle class

Chief Complaint: Pt c/o of non healing ulcer on right foot since 2 weeks.

History of Present illness :

Pt noticed a small wound on sole of his right foot 2 weeks ago after walking bare foot. Ulcer gradually increased in size & become painful. Foul smelling discharge developed. Surrounding skin became red & swollen. Patient complains of numbness in feet. No fever initially, but mild fever for last 2 days. Difficulty in walking due to pain

Past Medical History : Known diabetic for 10 years on irregular treatment. No hypertension. No tuberculosis

Drug History/History of Allergy : Taken oral hypoglycemic irregularly
No known drug allergy

Family History: Positive family history of diabetes (father)

Personal History: Mixed diet, Irregular exercise
No smoking or alcohol
Normal bowel & bladder habits

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): conscious, oriented

Built : average

Attitude : co-operative

Gait : limping due to foot pain

Face : no distress except discomfort

Decubitus : comfortable

Pallor : mild

Cynosis : Absent

Icterus : absent

Edema : Absent (General)

Skin Eruption: none

VITAL SIGNS :

Pulse Rate: 94/min, regular

Respiratory Rate: 18/min

Temperature: 99.8°F

Blood Pressure: 130/82 mm Hg

SYSTEMATIC EXAMINATION:

Respiratory System: Bilateral air entry present
No added sounds

Cordiovascular System: S1, S2 normal
No murmurs

Gastrointestial Track: soft, non tender
No organomegaly.

Central Nervous System: conscious, oriented
Peripheral neuropathy suspected.

LOCAL EXAMINATION :

(Diabetic foot ulcer – right foot)

Inspection :

1) Ulcer present over plantar surface near metatarsal head
2) Size approx 3x3 cm
3) Floor contains slough & unhealthy granulation tissue
4) Margins irregular
5) Surrounding skin swollen, erythematous
6) Foul smelling (seropurulent discharge present)
7) No visible bone but depth appears significant
8) No gangrenous discoloration present
9) Callus formation around ulcer edges
10) Foot deformity absent

Palpation :

1) Local temperature raised
2) Tenderness present
3) Induration around ulcer present
4) Base soft, mild fluctuation may be present if collection underneath
5) Sensation reduced (neuropathy)
6) Dorsalis pedis & posterior tibial pulses weakly palpable
7) Capillary refill moderately delayed
8) Probe-to-bone test may be positive (if needed gently)

Precusion : Tenderness increased on tapping around ulcer
No abnormal resonance

Ausculation :

No bruit over arteries
No abnormal vascular sound.

PROVISIONAL DIAGNOSIS :

Diabetic foot ulcer with peripheral neuropathy & early infection

INVESTIGATION :

1) Complete blood count (leukocytosis)
2) Blood sugar (FBS, PPBS, HbA1C)
3) Wound swab culture & sensitivity
4) Doppler study of lower limb (to assess arterial supply)
5) Xray foot (To rule of osteomyelitis)
6) CRP, ESR (marker of infection)
7) Renal function test (before antibiotics).

Final Diagnosis :

Infected diabetic foot ulcer
(Wagner, Grade II / III depending on depth)
with peripheral neuropathy

Treatment :

1] Broad spectrum antibiotics based on culture report
2] Surgical debridement of necrotic tissue
3] Blood sugar control (insulin therapy)
4] Daily dressing with antiseptic agents
5] Offloading of foot (avoid pressure)
6] Analgesics and anti-inflammatory drugs
7] Vasodilators / antiplatelet agents if vascular compromise
8] Diabetic foot wear after healing
9] Pt education on foot care

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GENERAL SURGERY

Name:

Age: **Sex:**

Address:

Social Status:

Chief Complaint:

History of Present illness :

Past Medical History :

Drug History/History of Allergy

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WARANA HEALTH MOVEMENT Est : 1992

GENERAL SURGERY

CLINICAL RECORD BOOK

NAME : Samrudhi Dattakumar Raktade

MUHS P. R. No. : 2192125969

Roll No. : 10

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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 Department of General Surgery

by Mr./Miss. Samrudhi Dattakumar Raktade

University Exam No. 156751 Student of the year 2024-25

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

Signature of the Staff Incharge

Professor & Head of the Department

Place : Pargaon

Date : 12/02/2026

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12/02/26

Signature of the External Examiner

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GENERAL SURGERY

Name: Ram Ganesh Patil

Age: 45yrs. **Sex:** Male

Address: Ram Nivas, Gandhinagar, Kolhapur

Social Status: Middle class

Chief Complaint: Pt c/o painless swelling over the upper back since 1yr.

History of Present illness :

Pt. noticed a small pea-sized swelling over the upper back 1yr. ago, which gradually increases to its present size. The swelling is painless, non progressive for last 3months. No history of trauma, discharge, redness, fever or similar swelling elsewhere. No difficulty in shoulder movement.

Past Medical History :

No history of diabetes, hypertension, tuberculosis or major medical illness.

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Drug History/History of Allergy : Not on any long term medications
No known drug allergies.

Family History: No similar swelling in family members
No hereditory disorders.

Personal History: Appetite normal, sleep adequate
Regular bowel & bladder habits
No smoking or alcohol consumption.

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): Conscious, alert, oriented

Built: Average build & nourishment **Attitude:** Co-operative

Gait: Normal **Face:** Normal, No asymmetry.

Decubitus: Comfortable, supine

Pallor: Absent **Cynosis:** Absent

Icterus: Absent **Edema:** Absent.

Skin Eruption: None

VITAL SIGNS:

Pulse Rate: 78 beats/min. regular

Respiratory Rate: 18 cycles/min.

Temperature: Afebrile

Blood Pressure: 124/70 mmHg

SYSTEMATIC EXAMINATION:

Respiratory System:

- Chest symmetrical, bilateral equal air entry
- no added sounds.

Cordiovascular System:

- S1 & S2 heard
- No murmur or added sounds.

Gastrointestial Track:

- Abdomen soft, non-tender, no organomegaly
- bowel sounds normal

Central Nervous System:

- Conscious, oriented, no motor or sensory deficits.

LOCAL EXAMINATION :

Inspection :

Site : Upper back, right paraspinal region at level of T4

Size : 4 x 3 cm

Shape : Ovoid

Number : Single

Skin over swelling : Normal, color, no scars or ulcerations

Visible pulsation :- Absent

Palpation :

- Temperature - Normal
- Tenderness - Absent
- Surface - Smooth
- Consistency - Soft, doughy
- Mobility - Freely mobile in all directions (slips under fingers)
- Fluctuation - Negative
- Transillumination - Negative
- Compressibility - Negative
- Cough impulse - Absent
- Skin pinch test - Skin freely moves over swelling
- No regional lymphadenopathy.

Precusion : No contributory

Ausculation : No bruit heard.

PROVISIONAL DIAGNOSIS :

Benign subcutaneous lipoma of upper back

INVESTIGATION :

- Complete blood count - within normal limits.
- Blood sugar, renal function test - normal
- Ultrasonography of swelling - well defined, hypoechoic lesion consistent with lipoma
- FNAC - mature adipocytes confirming benign lipoma

Final Diagnosis :

Subcutaneous lipoma of upper back (4x3cm) benign adipose tumor.

Treatment :

1) Surgical excision of lipoma under local anesthesia.
2) Pressure dressing applied post-operatively
3) Analgesics & antibiotics for 3-5 days.
4) Histopathological confirmation of excised specimens.
5) Follow up in 7 days for suture material removal.

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GENERAL SURGERY

Name: Neelima Sanjay More

Age: 38 yr. **Sex:** Female.

Address: 152, Kalpana Nivas,
Near Dayasa Chowk,
Govt. colony, Vishrambag, Sangli.

Social Status: Middle class.

Chief Complaint: Pt c/o wound over the left leg since 3 weeks.

History of Present illness :

Pt noticed a small painful wound over the left lower leg following minor trauma 3 weeks ago. Initially, the wound was red and tender with mild discharge. Over the last 10 days, the pain has decreased & granulation tissue has appeared. Wound size is gradually reducing. No fever, no foul smelling, discharge & no history of repeated trauma. No similar ulcers in the past.

Past Medical History :

No history of diabetes, hypertension, varicose veins peripheral vascular disease.
No previous ulcer episodes.

Drug History/History of Allergy Not on any regular medications
No known drug allergies.

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Family History: No history of diabetes or ulcer tendency

Personal History: Apetite good
Normal bowel & bladder habits.
Sleep adequate.
No smoking or alcohol.

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): Conscious, alert, oriented

Built : Average

Attitude : Co-operative

Gait : Normal

Face : Normal

Decubitus : Comfortable

Pallor : Absent

Cynosis : Absent

Icterus : Absent

Edema : Absent.

Skin Eruption: None

VITAL SIGNS :

Pulse Rate: 80/min, regular

Respiratory Rate: 18/min

Temperature: Afebrile

Blood Pressure: 118/76 mmHg

SYSTEMATIC EXAMINATION:

Respiratory System:

Air entry equal bilaterally, no added sounds

Cordiovascular System:

S1, S2 normal, no murmur

Gastrointestial Track:

Abdomen soft, non-tender, no organomegaly

Central Nervous System:

Conscious, oriented, no focal deficits.

LOCAL EXAMINATION :

Inspection :

Site - left lower leg, medial aspect.
Number - single
Size - 2×1.5cm
Shape - Oval
Edge - Sloping edges.
Floor - Healthy red granulation tissue
Margins - regular
Discharge - Minimal serous discharge
Base - not fixed to deeper tissues
Surrounding skin - Slight hyperpigmentation
No cellulitis.

Palpation :

Tenderness - mild.
Temperature - Normal
Bleeding on touch - mild.
Depth - Superficial, no undermining
Pulses (Dorsalis pedis & post. tibial) - Present & normal
lymph nodes - No inguinal lymphadenopathy.

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Precusion :

No contributory

Ausculation :

No bruit over the limb

PROVISIONAL DIAGNOSIS :

Healing traumatic ulcer of left leg.

INVESTIGATION :

1) Complete blood count - normal
2) Random sugar level - normal
3) ESR - mildly elevated
4) Wound swab culture - normal flora, no pathogenic growth
5) X ray leg - no bone

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Final Diagnosis :

Healing traumatic ulcer with healthy granulation tissue, left lower leg.

Treatment :

1) Daily sterile dressing with saline & antiseptic
2) Topical antibiotic ointment
3) Analgesics as needed.
4) Advice to avoid trauma & maintain limb hygiene.
5) High protein diet to promote wound healing
6) Follow up every 3-5 days to assess healing progress.

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(VI)

GENERAL SURGERY

Name: Sonam Rakesh Gavali

Age: 26 Yr **Sex:** Female

Address: Flat no. 3, Shree Apartment
Rajarampuri 5th lane,
Kolhapur.

Social Status: Middle class.

Chief Complaint: Pt c/o raised scar over the right earlobe

History of Present illness :

Pt undergone ear piercing 1 year ago. After 2 months she noticed a small, firm swelling at the piercing site which gradually increased in size over 6 months. The swelling is painless & causes cosmetic concern. No itching, discharge or bleeding. No history of trauma, apart from piercing. No restriction of ear movements.

Past Medical History :

No history of diabetes, hypertension or hypertrophic scars in past wounds.

Drug History/History of Allergy: No long term medications
No known drug allergies.

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Family History:
Mother had similar thick scarss after injury (positive family tendency)

Personal History:
Normal sleep, apetite &bowel /bladder habits.
No smoking or alcohol.

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): Conscious, alert, oriented.

Built : Average

Attitude : Co-operative

Gait : Normal

Face : Normal, no asymmetry

Decubitus : Comfortable

Pallor : Absent

Cynosis : Absent

Icterus : Absent

Edema : Absent

Skin Eruption: None elsewhere

VITAL SIGNS :

Pulse Rate: 76 beats / min. regular.

Respiratory Rate: 18 / min

Temperature: Afebrile

Blood Pressure: 120/78 mmHg

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SYSTEMATIC EXAMINATION:

Respiratory System:
Bilateral air entry equal
No added sounds

Cordiovascular System:
S1, S2 Normal
No murmur.

Gastrointestial Track:
Soft, non-tender
no organomegaly.

Central Nervous System:
Normal, No deficits.

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LOCAL EXAMINATION :

Inspection :

- Site - Right earlobe
- Number - Single
- Size - 2 × 1.5 cm.
- Shape - Oval
- Color - Shiny, reddish brown.
- Surface - Smooth, elevated.
- Borderss - Well defined, extending beyond origina wound margins.
- Skin changes - Skin streched & glossy
- Movements - No movements ē swallowing / facial expre
- Signs & symptoms of inflammation - Absent
- Ulceration - Absent
- Pulsation - Absent

Palpation :

- Local temperature - Normal
- Tenderness - Absent
- Surface - Smooth
- Consistency - Firm to hard
- Mobility - Slightly mobile but not freely mobile
- Compressibility - Non-compressible
- Fluctuation - Negative
- Slip sign - Negative
- Skin pinch test - skin can't be pinched easily.
- Adherance - Not fixed to underlying structures.

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Precusion : Not contributery.

Ausculation : No bruit

PROVISIONAL DIAGNOSIS : Keloid of right earlobe (Post-piercing)

INVESTIGATION :

1) Complete blood count - normal
2) Random blood sugar - Normal
3) Ultrasound of swelling - Shows dense fibrous tissue

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Final Diagnosis :

Keloid of right earlobe, secondary to ear piercing

Treatment :

- Intralesional corticosteroid injection. (Triamcinolone 10-40mg/ml) every 3-4 weeks
- Silicone gel sheet application
- Pressure therapy for earlobe keloid
- If large - Surgical excision followed by
  - Post-op steroid injections
  - Silicone therapy
  - Pressure earrings.
- Avoid further trauma or piercing.

℞

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GENERAL SURGERY (Thyroid swelling)

Name: Aishwarya Tanaji Javale.

Age: 32yr. **Sex:** Female

Address: Sai Home, A/p - Kotoli, Kolhapur.

Social Status: Middle class.

Chief Complaint: Pt c/o of swelling in front of neck since 6 months.

History of Present illness :

Pt noticed a small swelling in the lower front part of neck 6 months back. It gradually increase in size, swelling moves ↕ swallowing. No pain, no difficulty in breathing and no change in voice. No history of rapid increase in size. No palpations heat tolerance, wt. loss, tremors or excessive sweating. No history of constipation, wt gain, cold intolerance.

Past Medical History : No history of thyroid disorders neck irritation, diabetes, hypertension, or autoimmune diseases

Drug History/History of Allergy : No any long term medications No known drug allergies.

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Family History: Mother has hypothyroidism
No family history of thyroid cancer or goitre.

Personal History:
Apetite normal, sleep adequate, Bowel & bladder habits normal. No smoking or alcohol intake. Mixed diet.

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): Conscious, alert, oriented

Built: Moderately built & nourished.

Attitude: Co-operative

Gait: Normal

Face: No exophthalmos, no lid lag, no periorbital edema

Decubitus: Comfortable

Pallor: Absent

Cynosis: Absent

Icterus: Absent

Edema: Absent

Skin Eruption: None

VITAL SIGNS:

Pulse Rate: 82 beats/min, regular, normal volume.

Respiratory Rate: 18 cycles/min.

Temperature: Afebrile

Blood Pressure: 118/76 mmHg

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SYSTEMATIC EXAMINATION:

Respiratory System: Air entry equal
No added sounds

Cordiovascular System: S1, S2 Normal
No murmur

Gastrointestial Track: Soft abdomen
No organomegaly

Central Nervous System: Normal
No tremors.

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LOCAL EXAMINATION :

Inspection :

- Site - Anterior neck, predominantly right lobe region
- Size - 4×3 cm
- Shape - Oval
- Number - Single swelling
- Symmetry - Rt lobe appears slightly enlarged
- Surface - Smooth.
- Skin over swelling - normal. no dilated veins no scars.
- Movement - Moves upwards with swallowing
- Pulsation - Absent
- Tracheal deviation - Absent

Palpation : (Pt examined from behind)

- Temperature - Normal
- Tenderness - Absent
- Consistency - Firm, smooth.
- Mobility - Mobile, moves ↕ deglutition
- Fluctuation - Negative
- Fixity - Not fixed to skin or surrounding structures
- Lower border - Palpable
- Carotid pulsation - transmitted ? → No.
- Thrill - Absent
- No cervical lymphadenopathy.

Precusion : No dullness over sternum → no retrosternal extension

Ausculation : No bruit over the swelling

PROVISIONAL DIAGNOSIS :

Right sided solitary thyroid nodule (likely benign)

INVESTIGATION :

- CBC, ESR - Normal,
- Thyroid function test (T3, T4, TSH) - TSH normal euthyroid.
- Ultrasound thyroid - single well defined hypoechoic nodule in right lobe.
- X ray neck - Trachea central
- FNAC - benign colloid nodule

Final Diagnosis :

Euthyroid solitary benign colloid nodule of the right thyroid lobe.

Treatment :

- Surgical - Hemithyroidectomy (right lobectomy) recommended.
- Pre-operative - Thyroid function optimization, routine labs
- Post-op. - 1) Analgesics
  2) Wound care
  3) Monitor for hoarseness (Recurrent laryngeal N.)
  4) Monitor Ca+ levels (Parathyroid Prevention)
- follow-up - Histopathology confirmation. monitor thyroid function.

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GENERAL SURGERY

Non healing ulcer

Name: Raju Prakash Kamble.

Age: 55 yr. **Sex:** Male.

Address: Plot no. 45, Shriram Colony Gaonbhag, Miraj. Sangli - 416410

Social Status: Lower middle class.

Chief Complaint: Pt c/o of non-healing ulcer over the right foot since 2 months.

History of Present illness :

Pt noticed a small wound over the lateral aspect of the right foot 2 months ago following accidental rubbing of footwear. The ulcer failed to heal & gradually increased in size. Initial pain was mild, now moderately on walking. Ulcer discharges scanty serous fluid. No fever or foul smelling discharge. He reports tingling & decreased sensation in the right foot for last 1 yr.

Past Medical History : Known diabetic pt. for 8 yrs. Irregular medication compliance. No hypertension or peripheral vascular disease previously diagnosed.

Drug History/History of Allergy : Currently taking Metformin irregularly. No known drug allergies.

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Family History: Positive family history of diabetes in father.
No family history of chronic ulcers or skin cancers.

Personal History:

Apetite Normal
Bowel & bladder habits normal.
Non-smoker · occassional alcohol consumption
Use tight footwear.

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): Conscious, alert, oriented.

Built: Moderate built.
Mildly nourished

Attitude: Co-operative

Gait: Antalgic.

Face: Normal

Decubitus: Comfortable

Pallor: Mild

Cynosis: Absent

Icterus: Absent

Edema: Absent

Skin Eruption: None

VITAL SIGNS :

Pulse Rate: 84 beats/min, regular

Respiratory Rate: 18 cycles/min

Temperature: Afebrile

Blood Pressure: 126/8[illegible]

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SYSTEMATIC EXAMINATION:

Respiratory System: Air entry equal
No added sounds.

Cordiovascular System: S1, S2 normal
No murmur.

Gastrointestial Track: Soft abdomen
No tenderness
No organomegaly.

Central Nervous System: Higher functions normal
Sensory function examination of right foot - Decreased touch & pain sensation (mild neuropathy)

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LOCAL EXAMINATION :

Inspection :

- Site - Lateral side of right foot
- Number - single
- Size - 3×2cm
- Shape - oval
- Edges - punched-out, irregular
- Margins - Thickened.
- Floor - Pale granulation tissue with slough
- Depth - Deep, involving subcutaneous tissues
- Discharge - Minimal serious discharge.
- Surrounding skin - Dryg & colloused, hyperpigmented.
- Signs of inflammation - Mild redness.

Palpation :

- Local temp. - Slightly warm,
- Temperature - Normal (Body)
- Edge - Hard, non-healing type
- Tenderness - Present on pressure
- Base - Indurated.
- Floor - Rough, unhealthy.
- Depth - No bone felt - no exposed bone
- Mobility - Ulcer fixed to skin, not fixed to deeper structures.
- Fluctuation - Negative
- Crepitus - Absent

Precusion : Not contributery.

Ausculation : No bruit over foot arteries.

PROVISIONAL DIAGNOSIS :

Non-healing diabetic neuropathic ulcer of right foot with peripheral vascular insufficiency.

INVESTIGATION :

CBC - mild anemia

Random blood sugar - elevated.

HbA1c - high

Wound swab culture - mixed flora, no resistant organisms.

X-ray foot - no bone involvement, no osteomylitis.

Final Diagnosis :

Non-healing diabetic neuropathic ulcer of the right foot with mild peripheral arterial disease.

Treatment :

Medical - Glycemic control with insulin
Broad spectrum antibiotics based on culture
analgesics.
Vit B complex for neuropathy,

Local wound care - Daily saline dressing.
Removal of slough.
Application of moist wound-healing agent
Off loading pressure using specialized footwears.

Vascular management - Antiplatelet therapy
Peripheral vasodilator.
Advice to avoid tight footwear.

Pt advice - strict diabetic control
foot hygiene, daily foot check.
Avoid trauma to foot.

Follow-up - wound healing review every 4-5 days
Repeat doppler if ulcer not improving.

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GENERAL SURGERY

Name: Rahul Suresh More

Age: 18 **Sex:** Male

Address: Flat No. 14, A wing, Shraddha Apartment
Powai Naka,
Satara - 415001.

Social Status: Middle class

Chief Complaint: Pt c/o of swelling below the chin since 8 months.

History of Present illness :

Pt. noticed a small swelling in submental region 8 months ago. It gradually increased in size. The swelling is painless. No history of trauma, fever, discharge or ulceration. No difficulty in swallowing or breathing.

Past Medical History : No history of diabetes, TB, major illness.

Drug History/History of Allergy : No long term medication.
No known allergy.

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Family History: No similar complaints in family members.

Personal History: Normal diet
Normal bowel & bladder habits.
No addictions.

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): Conscious, well oriented.

Built : Average Built. **Attitude :** Co-operative

Gait : Normal **Face :** Normal, no asymmetry.

Decubitus : Comfortable, free mobility.

Pallor : Absent **Cynosis :** Absent

Icterus : Absent **Edema :** Absent

Skin Eruption: None

VITAL SIGNS :

Pulse Rate: 78 beats/min, regular

Respiratory Rate: 16 cycles/min

Temperature: Afebrile

Blood Pressure: 118/76 mmHg

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SYSTEMATIC EXAMINATION:

Respiratory System: Bilateral air entry present
No added sounds.

Cordiovascular System: S1, S2 normal
No murmur.

Gastrointestial Track: Soft abdomen
No organomegaly

Central Nervous System: Conscious, oriented
No focal deficit.

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LOCAL EXAMINATION :

Inspection :

- Swelling present in submental region.
- Oval, about 3 × 3 cm.
- Skin over swelling normal.
- No redness, ulceration or sinus.
- No visible pulsation or scar.

Palpation :

- Local temperature normal
- Non-tender
- Surface smooth, borders well-defined.
- Consistency, doughy / cystic
- Fluctuatia present
- Transillumination negative

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Precusion : No contributery

Ausculation : Not contributery.

PROVISIONAL DIAGNOSIS :

Dermoid cyst - submental region

INVESTIGATION :

Ultrasound of neck
MRI for exact extent & plane
FNAC showing keratinous debris.
Histopathology confirmation.

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Final Diagnosis :

Dermoid cyst (confirmed by histopathology)

Treatment :

- Surgical excision of cyst
- Intraoral approach if above mylohyoid
- Extra oral approach if below mylohyoid
- Post-operative follow-up.

GENERAL SURGERY

Name: Sandesh Jayesh Mane.
Age: 22 **Sex:** Male
Address: Samarth Nivas, Amrut nagar, Warna, Kolhapur - 416 113
Social Status: Middle class

Chief Complaint: Pt c/o painful swelling over the right since 5 days.

History of Present illness :

Pt noticed a small painful swelling on the right thigh 5 days ago. Pain gradually increased & become throbbing in nature. Swelling increased in size with redness & warmth. Pt reports mild fever with chills. No history of trauma or insect bite. No discharge noted.

Past Medical History : No history of diabetes, TB, immuno-suppression or major illness.

Drug History/History of Allergy Not on any regular medications
Not known drug allergies.

Family History: No similar illness in family members.

Personal History: Normal apetite, sleep, bowel & bladder habits.
No addictions

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): Conscious, oriented

Built : Average

Attitude : Co-operative

Gait : Normal

Face : No facial swelling or distress

Decubitus : Comfortable, ambulatory

Pallor : Absent

Cynosis : Absent

Icterus : Absent

Edema : Absent

Skin Eruption: None apart from local swellings.

VITAL SIGNS :

Pulse Rate: 92 beats / min, regular

Respiratory Rate: 18 cycles / min

Temperature: 100.2°F

Blood Pressure: 122/80 mm Hg

SYSTEMATIC EXAMINATION:

Respiratory System: Bilateral air entry equal
No added sounds

Cordiovascular System: S1, S2 normal
No murmur

Gastrointestial Track: Soft, Non tender
No organomegaly.

Central Nervous System: Conscious, oriented.
No motor or sensory deficits.

LOCAL EXAMINATION :

(Right thigh swelling - Pyogenic abscess)

Inspection :

1) Swelling present on anterior right thigh.
2) Size approx. 4 x 5 cm
3) Overlying skin red, stretched, shiny
4) Localized rise of temperature visible.
5) No ulceration or sinus
6) No visible discharge
7) No visible pulsations.

Palpation :

1) Local temperature increased.
2) Tenderness present.
3) Swelling soft to firm
4) Fluctuation present.
5) Induration present around swelling
6) No crepitus
7) No regional lymphadenopathy.
8) Skin not pinchable over centre due to tension.

Precusion : (local)

Tenderness increased on gentle tapping
No bony involvement

Ausculation : No bruit or abnormal sound over swelling.

PROVISIONAL DIAGNOSIS : Pyogenic abscess - right thigh

INVESTIGATION :

1) Complete blood count - Raised WBC, neutrophilia.
2) Blood sugar levels.
3) Ultrasound of swelling (to confirm abscess cavity)
4) Pus culture & sensitivity after drainage.

Final Diagnosis :

Pyogenic abscess confirmed by clinical finding & pus examination

Treatment :

1) Incision drainage under aseptic condition
2) Broad-spectrum antibiotics.
3) Anti-inflammatory & analgesics.
4) Daily dressing of wound.
5) Control predisposing factors.
6) Follow up until complete healing.

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GENERAL SURGERY

Name: Ajit Sampat Patil

Age: 27 **Sex:** Male

Address: Shahaji housing society.
Malkapur road, Karad
Satara - 415 124.

Social Status: Middle class.

Chief Complaint: Pt c/o of pain & difficulty in mouth opening after facial trauma since 1 day.

History of Present illness :

Pt met with a road traffic accident 1 day ago & sustained injury to the lower jaw. Pain started immediately, severe, continuous. Difficulty in mouth opening & chewing. Pt noticed swelling over lower jaw and slight bleeding from mouth. Pain increases on talking or chewing. No loss of consciousness or vomiting.

Past Medical History : No previous jaw fractures.
No epilepsy
No chronic illness.

Drug History/History of Allergy : No regular medications.
No drug allergy.

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Family History: No similar complaints in family members.

Personal History: Normal diet, no addictions.
Normal bowel & bladder habits.

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): Conscious, oriented

Built : Average

Attitude : Co-operative but pain

Gait : Normal

Face : facial asymmetry due to swelling on left mandible

Decubitus : Comfortable

Pallor : Absent

Cynosis : Absent

Icterus : Absent

Edema : Absent

Skin Eruption: None

VITAL SIGNS :

Pulse Rate: 88 beats / min, regular

Respiratory Rate: 18 cycles / min.

Temperature: Afebrile.

Blood Pressure: 118 / 76 mmHg

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SYSTEMATIC EXAMINATION:

Respiratory System: Bilateral air entry present
No added sounds.

Cordiovascular System: S1, S2 normal
No murmur

Gastrointestial Track: Soft, non-tender
No organomegaly

Central Nervous System: Conscious, oriented
No motor or sensory deficit

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LOCAL EXAMINATION :

(mandible)

Inspection :

1) Swelling over left lower jaw
2) Facial asymmetry present
3) Bruising present over the chin / mandibular region.
4) Mouth opening reduced.
5) Malocclusion visible (uneven bite)
6) Possible step deformity along the lower jaw line.
7) Drooling of saliva present.
8) No external bleeding at present.

Palpation :

1) Local temperature slightly raised
2) Tenderness present over mandible
3) (esp. at left body region)
4) Step deformity palpable.
5) Mobility of fractured fragments present
6) Crepitus present on gentle movement
7) Sublingual hematoma present
8) Teeth in fractured segment may be tender is percussion
9) TMJ tenderness may be present
10) No lymphadenopathy

Precusion : Local percussion
Adjacent teeth tender on percussion
No abnormal resonance.

Ausculation : No bruit
No abnormal vascular sound

PROVISIONAL DIAGNOSIS :

Mandibular fracture - likely left body fracture

INVESTIGATION :

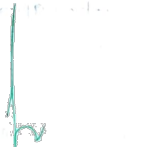
1) X ray mandible (PA, lateral, oblique view)
2) Orthopantogram (OPG)
3) CT scan mandible for exact fracture line
4) Hemogram
5) Blood sugar, coagulation profile

Final Diagnosis :

Left body fracture of mandible confirmed by radiography.

Treatment :

1) Pain management & antibiotics
2) Soft diet, oral hygiene maintainance
3) Closed reduction with intermaxillary fixation (IMF) of non-displaced.
4) Open reduction & internal fixation (ORF) with miniplates if displaced.
5) Follow up for wound healing & occlusion correction.



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GENERAL SURGERY

Name: Sanjay Ramkumar kamate

Age: 34 **Sex:** Male

Address: Near Market Yard Area.
Gandhinagar
Kolhapur 416 119

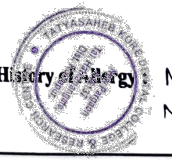
Social Status: Middle class

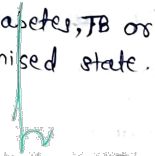
Chief Complaint: Pt c/o painful swelling below the jaw with difficulty in swallowing since 2days.

History of Present illness :

Pt developed pain in the lower jaw region 2years ago followed by rapidly progressive swelling in the submandibular & sublingual region. Pain is severe, continuous & increases on swallowing & speaking. Pt reports difficulty in swallowing & mild breathing discomfort. fevers with chills present. History of untreated lowers molar toothache for 1 week. No history of trauma.

Past Medical History : No history of diabetes, TB or immunocompromised state.





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Drug History/History of Allergy : Not on any medication. No drug allergy.

Family History: No similar illness in family

Personal History: Reduced appetite due to pain
Normal bowel & bladder habits
No addictions

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): Conscious, anxious.

Built : Average

Attitude : Co-operative but distressed.

Gait : Normal

Face : Facial pallness & anxiety due to breathing difficulty.

Decubitus : Absent Prefers sitting posture due to discomfort in supine position.

Pallor : Absent

Cynosis : Absent

Icterus : Absent

Edema : Absent (general)

Skin Eruption: None

VITAL SIGNS :

Pulse Rate: 104 beats /min

Respiratory Rate: 24 /min

Temperature: 101.4°F

Blood Pressure: 126 / 84 mmHg

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SYSTEMATIC EXAMINATION:

Respiratory System: Mild respiratory distress.
Bilateral air entry present
No added sounds.

Cordiovascular System: S1, S2 normal
No murmur

Gastrointestial Track: Soft abdomen
No organomegaly.

Central Nervous System: Conscious, oriented.
No neurological deficit.

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LOCAL EXAMINATION :

(Submandibular - Sublingual region)

Inspection :

1) Diffuse swelling in submandibular region bilaterally.
2) Elevation of floor of mouth.
3) Tongue raised & pushed posteriorly.
4) Skin over swelling is stretched & shiny
5) No obvious fluctuation visible (as it is cellulitis, not an abscess)
6) Mouth opening restricted (trismus)
7) No intraoral discharge

Palpation :

1) Local temperature raised.
2) tenderness severe
3) Swelling is board-like, brawny & indurated (Typical of ludwig's angina)
4) No fluctuation (cellulitis)
5) Tongue tense on palpation.
6) Sublingual space firm & elevated
7) No lymphadenopathy initially but may appear.

Precusion : (Local)

- Adjacent lowers molars tenders to percussion. (Possible odontogenic source)
- No abnormal percussion note over swelling.

Ausculation : (Local)

- No bruit
- No added vascular sound
- Airway sounds slightly harsh due to obstruction risk.

PROVISIONAL DIAGNOSIS :

Ludwig's angina, - bilateral cellulitis of submandibular sublingual & submental spaces.

INVESTIGATION :

1) Complete blood count (leukocytosis)
2) Blood sugar levels.
3) Culture & sensitivity from any aspirate if present
4) X-ray / OPG to identify dental source.
5) CT scan both if airway compromise suspected.
6) Airway assessment.

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Final Diagnosis :

Ludwig's angina secondary to odontogenic infection (likely infected mandibular molar)

Treatment :

1) Emergency airway management
Nasal intubation / tracheostomy if required
2) IV broad-spectrum antibiotics
3) IV fluids & analgesics.
4) Incision & drainage if abscess forms.
5) Extraction of offending tooth after stabilisation
6) Monitoring for airway obstruction

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GENERAL SURGERY

Name: Mukesh Ramlal Khot

Age: 29 **Sex:** Male

Address: Room no. 10, 2nd floor
Rajkar Colony,
Dist - Kolhapur.

Social Status: Middle class

Chief Complaint: Pt c/o painful swelling over the left leg since 3 days.

History of Present illness :

Pt developed redness & mild pain over the left lower leg 3 days ago. Swelling gradually increased with severe pain & warmth. Pain is throbbing & continuous. Difficulty in walking due to pain. Pt reports fever with chills. No history of trauma, insect bite or previous similar episodes.

Past Medical History : No diabetes, hypertension, tuberculosis long-term illness.

Drug History/History of Allergy : Not on any medication
No known drug allergy.

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Family History: No relevant family's medical history.

Personal History: Normal appetite & bowel habits.
No addictions.

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): Conscious, oriented.

Built : Average

Attitude : Co-operative

Gait : Limping due to leg pain

Face : Normal
no distress, except pain

Decubitus : Comfortable

Pallor : Absent

Cynosis : Absent

Icterus : Absent

Edema : Absent (general)

Skin Eruption: None apart from local lesion

VITAL SIGNS :

Pulse Rate: 96 beats/min regular

Respiratory Rate: 20 cycles/min.

Temperature: 100.6°F

Blood Pressure: 120/78 mm Hg

SYSTEMATIC EXAMINATION:

Respiratory System: Bilateral air entry present
No added sounds.

Cordiovascular System: S1, S2 normal
No murmur.

Gastrointestial Track: Soft, non-tender
No organomegaly.

Central Nervous System: Conscious; oriented
No focal deficits

LOCAL EXAMINATION :

(left leg -cellulitis)

Inspection :

1) Diffuse swelling present over left leg.
2) Skin red, warm, stretched, shiny.
3) Borders not sharply demarcated.
4) No ulcer, no visible pus point
5) No - or blackening.
6) No visible sinus.
7) No fluctuance.

Palpation :

1) Local temperature increased
2) Severe tenderness present
3) Skin firm & indurated
4) No fluctuation (cellulitis is diffused)
5) No crepitus
6) No regional lymphadenopathy
7) Sensation intact
8) Capillary refill - normal

Precusion : Increased pain on tapping
No abnormal resonance.

Ausculation : No bruit
No vascular abnormal sound.

PROVISIONAL DIAGNOSIS :

Acute cellulitis of left leg.

INVESTIGATION :

1) Complete blood count (leukocytosis)
2) ESR, CRP elevated
3) Blood sugar levels.
4) Doppler if vascular compromise suspected
5) Ultrasound soft tissue (to rule out abscess)
6) Blood culture if fever

Final Diagnosis :

Acute cellulitis confirmed clinically and by investigations.

Treatment :

1) IV broad-spectrum antibiotics
2) Analgesics & anti-inflammatory drugs.
3) Elevation of limbs.
4) Warm compresses
5) Treat underlying cause (tinea, trauma if present)
6) Monitor for abscess formation, necrotizing changes or systemic spread.

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(VI)

GENERAL SURGERY

Name: Mangesh Tukaram Khorate
Age: 58 **Sex:** Male
Address: Mauli Nivas, Aazad Colony, A/P - Kodoli, Dist - Kolhapur

Social Status: Middle class.

Chief Complaint: Pt c/o non-healing ulcer on right foot since 2 weeks.

History of Present illness :

Pt noticed a small wound on the sole of his right foot 2 weeks ago after walking barefoot. Ulcer gradually increased in size & became painful. Foul smelling discharge developed. Surrounding skin became red & swollen. Patient complains of numbness in feet. No fever initially, but mild fever for past 2 days. Difficulty in walking due to pain.

Past Medical History : Known diabetic for 10 yrs on irregular treatment. No hypertension, no tuberculosis.

Drug History/History of Allergy : Takes OHA for hyperglycemic irregularly. No known drug allergy

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(I)

Family History: Positive family history of diabetes (father)

Personal History: Mixed diet, regular exercise, No smoking or alcohol Normal bowel & bladder habits.

GENERAL PHYSICAL EXAMINATION:

Mental State (Level of Consciousness): Conscious, oriented.

Built : Average

Attitude : Co-operative

Gait : Limping due to foot pain

Face : No distress except discomfort

Decubitus : Comfortable

Pallor : Mild

Cynosis : Absent

Icterus : Absent

Edema : Absent (general)

Skin Eruption: None

VITAL SIGNS :

Pulse Rate: 94 beats/min

Respiratory Rate: 18 cycles/min

Temperature: 99.8°F

Blood Pressure: 130/82 mm/Hg

SYSTEMATIC EXAMINATION:

Respiratory System: Bilateral air entry present
No added sounds.

Cordiovascular System: S1, S2 normal
No murmur

Gastrointestial Track: Soft, non-tender
No organomegaly.

Central Nervous System: Conscious, oriented
Peripheral neuropathy suspected.

LOCAL EXAMINATION :

(Diabetic foot ulcer - right foot)

Inspection :

1) Ulcer present over plantar surface near metatarsal head.
2) Size approx. 3 × 3 cm.
3) Floor contains slough & healthy granulation tissue.
4) Margins irregular.
5) Surrounding skin swollen, erythematous
6) Foul smelling sempurulent discharge present.
7) No visible bone but depth appears significant.
8) No gangrenous discoloration at present.
9) Callus formation around ulcer edges.
10) Foot deformity absent.

Palpation :

1) Local temperature raised
2) Tenderness present
3) Induration around ulcer present
4) Base soft, mild fluctuation may be present if collection underneath.
5) Sensation reduced (neuropathy)
6) Dorsalis pedis & posterior tibial pulses weakly palpable
7) Capillary refill moderately delayed.
8) Probe to bone test may be positive (if needed, gently)

Precusion : Tenderness increased on tapping around ulcer. No abnormal resonance.

Ausculation : No bruit over arteries.
No abnormal vascular sound.

PROVISIONAL DIAGNOSIS : Diabetic foot ulcer with peripheral neuropathy & early infection.

INVESTIGATION :

1) Complete blood count (leuko cytosis)
2) Blood sugar (FBS, PPBS, HbA1C)
3) Wound swab culture & sensitivity.
4) Doppler study of lower limb. (to assess arterial supply)
5) X ray foot (to rule of osteomyelitis)
6) CRP, ESR (markers of infection)
7) Renal function test (before starting antibiotics)

Final Diagnosis :

Infected diabetic foot ulcer
(Wagner Grade II / III depending on depth)
with peripheral neuropathy.

Treatment :

1) Broad spectrum antibiotics based on culture report.
2) Surgical debridement of necrotic tissue
3) Blood sugar control (insulin therapy)
4) Daily dressing ē antiseptic agents.
5) Offloading of foot (avoid pressure)
6) Analgesics and anti-inflammatory drugs.
7) Vasodilators / antiplatelets agents if vascular compromise.
8) Diabetic foot wear after healing.
9) Pt education on foot care.

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GENERAL SURGERY

Name:

Age: **Sex:**

Address:

Social Status:

Chief Complaint:

History of Present illness :

Past Medical History :

Drug History / History of Allergy :

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