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

SERVICE IS RELIGION

WARANA HEALTH MOVEMENT

DEPARTMENT OF GENERAL SURGERY

CLINICAL RECORD BOOK

CERTIFICATE

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

Mr./ Miss. Gayatri Sanjeev Bhosale

University Exam No. 38408 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
Dept. of Gen. Surgery
T. K. D. C. & R. C.
New Pargaon - 416 137
Dist. Kolhapur.

Place : _____

Date : _____

Signature of the External Examiners

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Dr. Harish Kulkarni M.D.D.
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GENERAL SURGERY

Name: Sourabh J. Barsode

Age: 50yrs **Sex:** Male

Address: New Pargaon

Occupation: X-ray technician at MGH

Social Status: Middle class

Chief Complaint: Pain & swelling since 10 hrs
Pain at right ankle region & heel region.
Swelling at right ankle joints - 10 hrs

History of Present illness: Patient was apparently all right before 10 hrs. He has history of fall from height. In morning 9.30 am, over the right foot. He got severe pain at right ankle and heel region. Since to last 10 hrs which is localised & referring anywhere after he is hospitalised in MGH and treated anywhere by temporary cast & leg elevated & pain subsided.

- He also complains of swelling at right ankle region. Its more in the morning & subsided after leg elevation and cast

Size of swelling = 15X10 cm

H/o trauma ⟶ present
No history of other swelling
No H/o of fever
No H/o secondary swelling
H/o loss of function = present
No H/o recurrence

Past Medical History:

- Essential hypertension since last 10 years

Drug History / History of Allergy:

- No allergy to any drug or food

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Family History :

- No major illness

Personal History :

- No personal habits
- Mixed diet

GENERAL PHYSICAL EXAMINATION :

Mental State (Level of Consciousness) : Patient is conscious & well oriented

Built : Normal **Attitude :** Normal

Gait : Unable to walk **Face :** Normal

Decubitus : Lying comfortably on bed

Pallor : Absent **Cynosis :** Absent

Icterus : Absent **Edema :** Absent

Skin Eruption : Absent

VITAL SIGNS :

Pulse Rate : 20/min - Good volume, good tension equal on both sides

Respiratory Rate : 20 cycles/min

Temperature : Afebrile

Blood Pressure : 120/80 mm of Hg

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SYSTEMATIC EXAMINATION :

Respiratory System :

- clear
- No added sound
- Air entry equal on both sides

Cordiovascular System :

- Heart sound normal
- No gallop
- No murmur

Gastrointestial Track :

- Soft
- Non tender

Central Nervous System :

-
-
- All cranial nerve tested normal
- Plantar nerve tested normal

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LOCAL EXAMINATION :

Inspection :

1) SITUATION → At right ankle region
2) COLOUR → Skin colour
3) SHAPE → Diffused swelling
4) SIZE → 15x10cm
5) SURFACE → Uniform
6) EDGE → Ill defined
7) NUMBER → One in number
8) PULSATION → No pulsation
9) SKIN → It is tense
10) PRESSURE → No pressure effect

Palpation :

1) Temperature → Rise in temperature
2) Tenderness → Present
3) Sensitivity → Soft to mild heat
4) Fluctuations → Absent
5) Surface → Uniform & regular
6) Fluid & Thrill → Absent
7) Pulsation → Absent
8) Transillumination → Absent
9) Regional lymph node → Inguinal lymph node aren't palpable.
10) Peripheral pulsation → Present in dorsalis pedis & posterior tibial artery
11) Compressibility → Slightly present
12) Reducibility → Absent
13) Skin over swelling → Skin is part & parcel of swelling
14) Relation to deeper structure → Free from underlying structure

Percusion : NAD

Ausculation : NAD

PROVISIONAL DIAGNOSIS :

According to history, it is traumatic swelling
query # Right Lateral Malleolus
Tarsal bone

INVESTIGATION :

A) Routine Investigation → CBC, Hb%, ESR, BSL → Fasting / PP
BUL, Serum creatinine, Serum cholesterol, X-ray chest (PA)

B) Special Investigation → X-ray right ankle & foot (AP view, oblique view)

Final Diagnosis :

Right Calcaneous Fracture

Treatment :

1) Medical treatment
- Admission
- Temporary support cast
- Right leg elevation
- Tab Imol -1 BD
- Tab Bidomzen-10mg

2) Surgical treatment
- After reduction of swelling, patient will be post for K-wire, fixation of feagments of a calcaneous under spinal anaesthesia.
- Permanent of final cast is given.
- Weight bearing is avoided for minimum 2-3 months.

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GENERAL SURGERY

Name : Sukhdev Ramu Garade

Age : 60 years **Sex :** Male

Address : Mohare (Kodoli)

Occupation : farmer

Social Status : Middle class

Chief Complaint : Multiple blisters over both lower limb since 8 days
- Discharge from blisters since 8 days
- Mild fever

History of Present Illness : Patient was apparently all right before 8 todays back. He developed mild swelling over both lower limb and also developed patchy red spot. Swelling went on increasing to such an extent, that he was admitted in MGH hospital on 11 January, 2020.
- He was advised rest with antibiotic treatment & leg elevation.
- Patient also complains of multiple blister that burst & watery discharge with some blood strain present.
- Patient also complains of mild to moderate fever since 8 days which subsided in MGH.
- H/o fever
- No H/o other swelling
- No H/o recurrence

Past Medical History : Patient was operated for femoral neck fracture in MGH before 7 days
- H/o diabetes mellitus, hypertension detected after recent admission in M.G.H.

Drug History / History of Allergy : No allergy of any drug or food

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Family History :

- No major illness

Personal History :

- No personal habits
- Mixed diet

GENERAL PHYSICAL EXAMINATION :

Mental State (Level of Consciousness) : Patient is consious & well oriented

Built : Obese **Attitude :** Normal

Gait : Limping with taking support of stick **Face :** Normal

Decubitus :

Pallor : Absent **Cynosis :** Absent

Icterus : Absent **Edema :** Absent

Skin Eruption :

VITAL SIGNS :

Pulse Rate : 80/min · Good volume, good tension equal on both sides

Respiratory Rate : 20 cycles/min · Regular abdominothoracic

Temperature : Mild fever

Blood Pressure : 120/80 mm Hg

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SYSTEMATIC EXAMINATION :

Respiratory System :

- Clear
- No added sound
- Air entry on equal on both sides

Cordiovascular System :

- Heart sound normal
- No gallop
- No murmur

Gastrointestial Track :

- Soft
- Non-tender

Central Nervous System :

- Higher functions well oriented
- Sensory, motor & reflux system are normal
- All cranial nerve tested normal
- Plantar nerve tested normal

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LOCAL EXAMINATION :

Inspection :

1) Situation → Both lower limb below knee
2) Shape → Diffuse
3) Size → Involving lower limb
4) Surface → Smooth
5) Edge → Ill defined
6) Number →
7) Pulsation → No pulsation
8) Skin → Tense shiny with multiple small blister
9) Surface → Distal foot is oedematous due to pressure of swelling over veins.

Palpation :

1) Temperature → Raised
2) Tenderness → No tenderness
3) Consistency → Soft
4) Surface → Uniform
5) Fluctuation → Present
6) Fluid thrill → Absent
7) Pulsation → Absent
8) Transillumination → Absent
9) Lymph node → Inguinal lymph node palpable slightly enlarged
10) Peripheral pulsation → Well felt (Dorsalis pedis & posterior tibial artery)
11) Reducability → Present
12) Compression → Present

Percusion :

Not relevant

Ausculation :

Not relevant

PROVISIONAL DIAGNOSIS :

1) Cellulitis of both lower limb below knee
2) Oedema of both lower limb due to venous - obstruction

INVESTIGATION :

A) Routine :- CBC, ESR, BSL (PP & fasting), BUL
- Serum creatinine, serum cholesterol, urine examination complete
- X-ray chest (PA) view

B) Special :-
- X-ray of both lower limb below knee (AP) view
- Culture sensitivity of discharge from blister or doppler of lower limb.

Final Diagnosis :

Cellulitis of both lower limb

Treatment :

A] Medical Treatment :

- Hospitalisation –

1) Bed rest & elevation of both lower limb to reduce edema due to cellulitis
2) Regular dressing of burst blisters site with hydrogen peroxide, normal saline & betadiene
3) (Mg sulfate) Magsul dressing to reduce intestinal edema.
4) Antibiotics
5) – Amoxicillin
   –
   – Tab. Ibuprofen 400mg & paracetamol
   – Serratiopeptidase 10mg TDS

B] Surgical Treatment :

If cellulitis does not subside ☐ medical treatment

Incision & drainage under spinal GA

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GENERAL SURGERY

Name : Sara Nikam

Age : 82 years **Sex :** Female

Address : New Pargaon, Kolhapur

Social Status : Middle class

Chief Complaint : Patient c/o swelling in the upper right back region since 5 years which was a small nodule in size and patient has no other complaints.

History of Present Illness :

- Patient noticed swelling in the upper right back region since 5 years which was a small nodule in size & gradually increased to attain its size. No history of trauma, pain, elsewhere similar swelling in the body, fever, secondary changes

Past Medical History :

- Patient is known to be hypertensive since 5 years & is on medication & is on hydrochlorothiazide since 5 years.
- No H/o any major illness or surgery in past

Drug History / History of Allergy :

- No relevant history

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Family History :
No history of any major illness, like diabetes & hypertension, etc.

Personal History : Diet ⟶ Mixed
Marital Status ⟶ Married
Menstrual cycle ⟶ Not applicable
Bowel & Bladder ⟶ Normal

GENERAL PHYSICAL EXAMINATION :

Mental State (Level of Consciousness) :

Built : Normal

Attitude : Normal

Gait : Normal

Face : Normal

Decubitus :

Pallor : Absent

Cynosis : Absent

Icterus : Absent

Edema : Absent

Skin Eruption : Absent

VITAL SIGNS :

Pulse Rate : 80 beats/min

Respiratory Rate : 20 cycle/min

Temperature : Afebrile

Blood Pressure : 142/88 mm Hg

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SYSTEMATIC EXAMINATION :

Respiratory System :

- clear
- No added sound
- Air entry equal on both sides

Cordiovascular System :

- Heart sound normal
- No gallop
- No murmur

Gastrointestial Track :

- Soft
- Non-tender

Central Nervous System :

- Ankle reflex absent
-
- Plantar

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LOCAL EXAMINATION :

Inspection :

1) Situation ⟶ Upper right back region
2) Shape ⟶ Round to oval
3) Size ⟶ 4X5 cm
4) Surface ⟶ Smooth
5) Edge ⟶ well-defined
6) Number ⟶ one in number
7) Pulsation ⟶ No pulsation
8) Skin ⟶ Skin over swelling is normal
9) Pressure ⟶ No pressure effect

Palpation :

1) Temperature ⟶ Not raised
2) Tenderness ⟶ Tender
3) Sensitivity ⟶ 4X5 cm
4) Fluctuations ⟶ Present
5) Surface ⟶ Smooth
6) Fluid & thrill ⟶ Absent
7) Pulsation ⟶ Absent
8) Transillumination ⟶ Negative
9) Regional lymph node ⟶ Not palpable
10) Peripheral pulsation ⟶ Absent
11) Compressibility ⟶ Absent
12) Reducibility ⟶ Absent
13) Skin over swelling ⟶ Normal
14) Relation to deeper structure ⟶ No relation

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Percusion :

Not relevant

Ausculation :

Not relevant

PROVISIONAL DIAGNOSIS :

- Implantation dermoid cyst when occur in feet or hand.
- Exostosis of bone, If swelling is very hard.
- Sebaceous cyst

INVESTIGATION :

A) Routine - CBC, ESR, BSL [PP & fasting), BUL.
- Serum creatinine, serum cholesterol, urine examination complete
- X-ray chest (PA view)

B) Special - Culture sensitivity of discharge from the swelling
- Serological test
- X-ray of back region

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Final Diagnosis :

- Sebaceous cyst

Treatment :

- Excision under local anaesthesia

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GENERAL SURGERY

Name : Sarvesh Tambe

Age : 45 year **Sex :** Male

Address : Kolhapur

Social Status : Middle class

Chief Complaint : Patient c/o swelling over lower limb.

History of Present illness :

- Patient noticed swelling 2-3 days ago.
- No H/O pain, trauma, sudden increase or decrease in size of swelling, no weight loss, no fever reported.

Past Medical History :

- No relevant past medical history
- No relevant past surgical history

Drug History / History of Allergy :

No H/O allergy
No H/O other allergy
No H/O trauma
No H/O recurrence

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Family History :

- No relevant past medical history in family.
- No relevant past surgical history in family.

Personal History : Diet → Mixed
Marital status → Married
Bowel & bladder → Normal

GENERAL PHYSICAL EXAMINATION :

Mental State (Level of Consciousness) :

Built : Normal **Attitude :** Normal

Gait : Normal **Face :** Normal

Decubitus :

Pallor : Absent **Cynosis :** Absent

Icterus : Absent **Edema :** Absent

Skin Eruption :

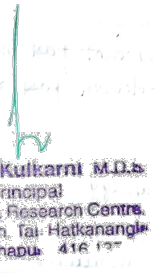
VITAL SIGNS :

Pulse Rate : 80 beats/min

Respiratory Rate : 22 cycles/min

Temperature : 95°F

Blood Pressure : 110/80 mm Hg



SYSTEMATIC EXAMINATION :

Respiratory System :

- clear
- No added sound
- Air entry equal on both sides

Cordiovascular System :

- Heart sound normal
- No gallop
- No murmur

Gastrointestial Track :

- Soft - no
- Non-tender
-

Central Nervous System :

- Ankle reflex absent
- All cranial nerves are normal
- Plantar region ↓↓

LOCAL EXAMINATION :

Inspection :

1) Position of swelling ⟶ over left lower limb
2) Color ⟶ Coral pink
3) Number ⟶ one
4) Size & shape ⟶ 1X1 cm, spherical
5) Surface ⟶ smooth
6) Edge of swelling ⟶ Indistinct
7) Pulsation ⟶ Absent
8) Impulse on cough ⟶ Absent
9) Mucosa over swelling ⟶ Normal

Palpation :

1) Temperature ⟶ Normal
2) Tenderness ⟶ Non-tender
3) Size & shape ⟶ 1X1cm, ovoid
4) Surface ⟶ smooth
5) Edge ⟶ well- defined
6) Consistency ⟶ firm
7) Fluctuation ⟶ Absent
8) Fluid thrill ⟶ Absent
9) Impulse on cough ⟶ Absent
10) Reducability ⟶ Absent
11) Compressibility ⟶ No compressibility
12) Pulsability ⟶ No pulsability
13) Regional lymph node ⟶ Not effected
14) Transillumination ⟶
15) Pressure effect ⟶ No pressure effect
16) Fixity to overlying skin ⟶ fixity

Percusion :

No significant

Ausculation :

No significant finding on auscultation

PROVISIONAL DIAGNOSIS :

Lipoma

INVESTIGATION :

1) Blood sugar levels
2) CBC
3) Urine examination

Final Diagnosis :

Lipoma

Treatment :

Surgical excision under local anaesthesia

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GENERAL SURGERY

Name : Ramesh Vijay Deshmukh

Age : 45years **Sex :** Male

Address : Pargaon ; Tal :- Hatkanangale ; Dist :- Kolhapur

Social Status : Middle class

Chief Complaint :
Patient c/o swelling in upper right back region since 6-7 months & pain in the region since 2-3 days

History of Present illness :
- Patient noticed swelling which was small since 6-7 months ago.
- It attained to its present size by growing gradually.
- Patient noticed pain in swelling 2-3 days ago.
- No h/o fever, secondary changes, loss of body weight. sudden increase in size.

Past Medical History :
- No H/o major illness in past.
- No H/o surgery in past.

Drug History / History of Allergy :
- No H/o allergy

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Family History :

- No H/o major illness in family.
- No H/o major surgery in family.

Personal History :

- Diet ⟶ Mixed
- Marital status ⟶ Married
- Bowel & bladder ⟶ Normal

GENERAL PHYSICAL EXAMINATION :

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

Built : Normal **Attitude :** Normal

Gait : Normal **Face :** Normal

Decubitus :

Pallor : Absent **Cynosis :** Absent

Icterus : Absent **Edema :** Absent

Skin Eruption : Absent

VITAL SIGNS :

Pulse Rate : 72 beats/min

Respiratory Rate : 20 cycles/min

Temperature : Afebrile

Blood Pressure : 120/80 mm of Hg

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SYSTEMATIC EXAMINATION :

Respiratory System :

- clear
- No added sound
- Air entry equal on both side.

Cordiovascular System :

- Heart sound normal
- No gallop
- No murmur

Gastrointestial Track :

- Soft
- Non-tender

Central Nervous System :

- Power Normal
- All cranial nerve tested normal

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LOCAL EXAMINATION :

Inspection :

1) Position → Upper right posterior region of neck
2) Number → Single
3) Color → Reddish brown
4) Size & shape → Asymmetrical
5) Surface → Smooth
6) Edge → Distinct
7) Pulsation → Non-pulsatile
8) Skin over swelling → Reddish
9) Any pressure effect → No pressure effect
10) Impulse on cough → Absent

Palpation : 1) Temperature → Not raised
2) Tenderness → Tender
3) Size & shape → 5X5cm ; Spherical
4) Surface → Smooth
5) Edge → Distinct
6) Consistency → Soft
7) Fluctuation → Present
8) Fluid thrill → Absent
9) Impulse on cough → Absent
10) Reducibility → Absent
11) Compressibility → Absent
12) Fixity over skin → Fixed
13) Regional lymph node → Not palpable
14) Any pressure effect → No pressure effect

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Percusion :

No significant finding on percussion

Ausculation :

No significant finding on auscultation

PROVISIONAL DIAGNOSIS :

Sebaceous cyst

INVESTIGATION :

- Sugar level
- CBC
- B.P
- Urine examination

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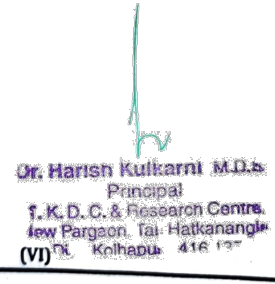
Final Diagnosis :

Sebaceous cyst

Treatment :

- Excision under local anaesthesia.



GENERAL SURGERY

Name : Nikhil M. Patil

Age : 20 years **Sex :** Male

Address : AP - Islampur ; Tal : Walwa
Dist. - Sangli

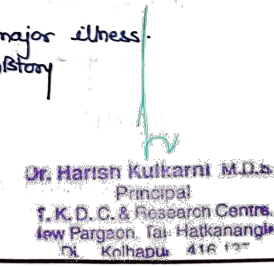
Social Status : Middle class

Chief Complaint :
Patient c/o swelling on stomach (abdomen) since 15 days & since 8 days there is pain over swelling.

History of Present illness :
- patient noticed swelling which was small in size 15 days ago & it has reached to attain the present size.
- patient also had pain in swelling since past 8 days.
- These is no H/o fever, weight loss, trauma, secondary changes, sudden increase or decrease in size of swelling.

Past Medical History :
- No relevant past H/o for any major illness.
- No relevant past surgical history

Drug History / History of Allergy :
No H/o allergy



Family History :

- No relevant past family hfo any major illness.
- No relevant past family hfo major surgery

Personal History :

Diet ⟶ mixed
Marital ⟶ Unmarried
Bowel & bladder ⟶ Normal

GENERAL PHYSICAL EXAMINATION :

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

Built : Normal

Attitude : Normal

Gait : Normal

Face : Normal

Decubitus : Supine position

Pallor : Absent

Cynosis : Absent

Icterus : Absent

Edema : Absent

Skin Eruption : Absent

VITAL SIGNS :

Pulse Rate : 70 beats/min

Respiratory Rate : 18 cycles/min

Temperature : 95.0°F

Blood Pressure : 120/80 mmHg

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SYSTEMATIC EXAMINATION :

Respiratory System :

- Clear
- No added sound
- Air entry equal on both sides

Cordiovascular System :

- Heart sound normal
- No gallop
- No murmur

Gastrointestial Track :

- Soft
- Tenderness present

Central Nervous System :

- Power normal
- All cranial nerves tested normal

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LOCAL EXAMINATION :

Inspection :

1) Position ⟶ On upper right quadrant of abdomen
2) Number ⟶ single
3) colour ⟶ Normal skin colour
4) Size & shape ⟶ 8x2cm, non-spherical shape
5) Surface ⟶ smooth
6) Edge ⟶ well-defined
7) Pulsation ⟶ Present
8) Skin over swelling ⟶ Normal
9) Any pressure effect ⟶ Yes
10) Impulse on cough ⟶ Yes

Palpation : 1) Temperature ⟶ Raised
2) Tenderness ⟶ Present
3) Size & shape ⟶ 8x2 mm, spherical
4) Surface ⟶ smooth
5) Edge ⟶ Distinct
6) Consistency ⟶ Firm
7) Fluctuation ⟶ Present
8) Fluid thrill ⟶ Present
9) Transillumination ⟶ Absent
10) Impulse on cough ⟶ Present
11) Reducibility ⟶ Present
12) Compressibility ⟶ No
13) Pulsability ⟶ Yes
14) Fixity to overlying skin ⟶ Present

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Percusion :

No significant finding on percussion

Ausculation :

No significant finding of auscultation

PROVISIONAL DIAGNOSIS :

Dermal cyst

INVESTIGATION :

1) CBC
2) Urine examination
3) Sugar estimation

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Final Diagnosis :

Dermoid cyst

Treatment :

Surgical excision under local anaesthesia

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(VI)

GENERAL SURGERY

Name : Sohan Sakharam Bhandare

Age : 40 years **Sex :** Male

Address : At p- Jakhale ; Tal- Hatkanangle ; Dist- Kolhapur

Social Status : Lower middle class

Chief Complaint : Pt. c/o ① Ulcer over right buttock region since 8 days
② Pain at site of ulcer since 8 days
③ Mild discharge from ulcer since 8 days

History of Present illness :

- Patient was apparently alright, 15 days back he recieved I.M. injection in gluteal region from local doctor. After 3-4 days, he noticed pain at injection site. It was throbbing at nature & swelling at site was seen. So he was admitted in MGM 3 days back & was treated with incision & drainage under GA.
- Pt presents ulcer (5x9x1.5 cm) over buttock & also pt c/o pain & water discharge.

Past Medical History : No H/o diabetes, HTN
No H/o TB, Bleeding disorders
No H/o trauma
No H/o Syphillis

Drug History / History of Allergy :

- At present, patient is on serratiose 2 cm
- Tab Amox + clavulanic acid 625 mg 0-0-1
- No other drug + H/o any allergy

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Family History :

- No major illness
- No H/o diabetes
- No H/o hypertension

Personal History :

- No adverse habit
- Diet – mixed diet
- Marital status – Married & having 2 children

GENERAL PHYSICAL EXAMINATION :

Mental State (Level of Consciousness) : Fully conscious & well oriented

Built : Average **Attitude :** Normal (Comfortable)

Gait : Mild limping gait **Face :** Normal

Decubitus : Patient lies on lateral position

Pallor : Absent **Cynosis :** Absent

Icterus : Absent **Edema :** Present

Skin Eruption : Absent

VITAL SIGNS :

Pulse Rate : 80 beats/min

Respiratory Rate : 20 cycles/min

Temperature : 37°C

Blood Pressure : 130/90 mm Hg

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(II)

SYSTEMATIC EXAMINATION :

Respiratory System :

- Clear
- No added sounds
- Air entry equal on both sides

Cordiovascular System :

- Heart sounds are normal
- No gallop
- No murmur

Gastrointestinal Track :

- Soft & tender

Central Nervous System :

- Ankle reflexes are normal
- No muscle wasting

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(III)

LOCAL EXAMINATION :

Inspection :

1) Size ⟶ About 4X3cm
2) Shape ⟶ Oval
3) Number ⟶ 1
4) Site ⟶ posterior superior quadrant of gluteal region
5) Edge ⟶ Punched out
6) Base ⟶
7) Discharge ⟶ serous & scanty
8) Smell ⟶ Absent
9) Surrounding area ⟶ Normal
10) Lower limb ⟶ Normal

Palpation :

1) Size ⟶
2) Tenderness ⟶ Mild
3) Edge ⟶ Mildly indurated
4) Base ⟶
5) Bleeding on touch ⟶ Absent
6) Relation with deeper structure ⟶ Free from ulcer
7) Surrounding skin ⟶ Normal
8) Regional lymph node ⟶ Inguinal lymph node are slightly enlarged & tender

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Percusion :

- No significant finding on percussion.

Ausculation :

- No significant finding on auscultation
- No Bruits | thrills

PROVISIONAL DIAGNOSIS :

- Post subcutaneous pyogenic abscess leading to healing ulcer in gluteal region.

INVESTIGATION :

- Routine investigation - Routine hemogram, Hb% CBC
- Urine examination ; BSL ; post prandial sugar
- X-ray in hip region
- Culture sensitivity
- Test per swab from ulcer

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Final Diagnosis :

- Post subcutaneous pyogenic abscess leading to healing ulcer with drainage in gluteal region.

Treatment :

- Bed rest & leg elevation
- High protein diet
- Cap. Amox 625 mg BD + clavulanic acid
- Cap. Omeprazole 20 mg BD
- Daily dressing using normal saline betadine with rubber gauze packing.
- Follow up

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GENERAL SURGERY

Name : Rohit Ram Bhosale

Age : 45 years **Sex :** Male

Address :
At/p – Phalewadi ; Dist :- Kolhapur

Social Status : Middle class

Chief Complaint :
- Patient c/o swelling since 6-9 months in upper right back region of scalp.
- Patient also c/o pain since 2-3 days

History of Present illness :
- Patient was apparently alright 6-9 months back. He noticed a small nodular swelling that was painless & slowly increasing in size.
- Swelling also resulted in loss of hair as it was growing & then suddenly, change in size & color of swelling was noticed. He approached to MGH.

Past Medical History : No H/o diabetes, No H/o hypertension
No H/o bleeding disorder & T.B.
No H/o syphilis & no H/o surgery

Drug History / History of Allergy : No relevant history

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Family History :

- No H/o diabetes, hypertension
- No H/o bleeding disorders

Personal History :

Diet - Mixed diet
Marital status - married with 3 children
No habit of tobacco / alcohol

GENERAL PHYSICAL EXAMINATION :

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

Built : Average **Attitude :** Comfortable

Gait : Normal **Face :** Normal

Decubitus : Supine position

Pallor : Absent **Cynosis :** Absent

Icterus : Absent **Edema :** Absent

Skin Eruption : Absent

VITAL SIGNS :

Pulse Rate : 72 beats/min

Respiratory Rate : 18 cycles/min

Temperature : 97-5°F

Blood Pressure : 128/82 mm Hg

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SYSTEMATIC EXAMINATION :

Respiratory System :

- clear
- No added sounds
- Air entry equal on both sides

Cardiovascular System :

- Heart sounds are normal
- No gallop
- No murmur

Gastrointestial Track :

- Soft
- Non-tender

Central Nervous System :

- Ankle reflexes normal
- All cranial nerves tested are normal.

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LOCAL EXAMINATION :

Inspection :

1) Size ⟶ 5X5cm
2) Shape ⟶ Rounded
3) Number ⟶ Single
4) Site ⟶ Upper right posterior region of scalp
5) Colour ⟶ Reddish brown
6) Surface ⟶ Smooth
7) Edge ⟶ Distinct
8) Pressure effect ⟶ Absent
9) Age ⟶ 6-9 months

Palpation :

1) Temperature ⟶ Raised
2) Tenderness ⟶ Present
3) Size ⟶ 5X5cm2
4) Shape ⟶ Spherical
5) Surface ⟶ Smooth
6) Consistency ⟶ Soft
7) Fluctuation ⟶ Present
8) Fluid thrill ⟶ Absent
9) Transillumination ⟶ Absent
10) Impulse on cough ⟶ Absent
11) Compressibility ⟶ Absent
12) Reducibility ⟶ Absent
13) Durability ⟶ Absent

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Percusion :

No relevant history

Ausculation :

No bruits | thrills

PROVISIONAL DIAGNOSIS :

Infected sebaceous cyst

INVESTIGATION :

1) Routine Blood Count
2) Sugar ⟶ fasting, post-prandial
3) Urine examination
4) If pus present, then culture sensitivity
5) X-ray skull : to check fixity present or not

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Final Diagnosis :

Infected sebaceous cyst

Treatment :

1) Antibiotic administration & supportive treatment
   Amoxicillin 500mg TID
   Tab Ibuprofen 400mg + Paracetamol 885mg TID

2) Surgical
   Incision & drainage under GA.
   ↓ followed by
   Avulsion

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GENERAL SURGERY

Name : Shreya Rajaram Chavan

Age : 40 years **Sex :** Female

Address : PHP :- June Pargaon, Tal :- Hatkanangle;
District :- Kolhapur

Social Status : Middle class

Chief Complaint :

- Patient c/o multiple swelling over neck since 1 year.
- Swelling resulted into difficulty in breathing & eating.

History of Present Illness :

- Patient was apparently normal 1 year before. Then she saw small swelling developing over neck. They were three in number. Each swelling measures about 2x3cm in size. Later swelling resulted in quite difficulty in breathing & slight discomfort during swallowing.
- Hence she was admitted in MGH for complete relief from swelling.

Past Medical History : No H/o diabetes
No H/o hypertension
No H/o bleeding disorder
No H/o Thyroid disorder
No H/o surgery

Drug History / History of Allergy :
No H/o any drug
No H/o allergy

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Family History :

- Mother is hypertensive
- No H/o major illness

Personal History :

Diet ⟶ Mixed diet
Marital Status ⟶ Married with 2 children
No H/o tobacco / alcohol

GENERAL PHYSICAL EXAMINATION :

Mental State (Level of Consciousness) :

Built : Obese

Attitude : Comfortable

Gait : Normal

Face : Normal

Decubitus : Supine

Pallor : Absent

Cynosis : Absent

Icterus : Absent

Edema : Absent

Skin Eruption : Absent

VITAL SIGNS :

Pulse Rate : 80 beats/min

Respiratory Rate : 22 cycles/min

Temperature : 99°F

Blood Pressure : 130/80 mm Hg

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(II)

SYSTEMATIC EXAMINATION :

Respiratory System :

- No added sound
- Clear airway
- Air entry is equal on both sides
- Forceful breathing seen due to dyspnoea

Cordiovascular System :

- Normal heart sounds
- No gallop
- No murmur

Gastrointestial Track :

- For abdomen : soft, non-tender

Central Nervous System :

- Ankle reflexes are normal
- No muscle wasting

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(III)

LOCAL EXAMINATION :

Inspection :

1) Site ⟶ Neck (anterior surface)
2) size ⟶ Two swellings of 2x3cm & one swelling 4x3cm
3) Shape ⟶ Butterfly shaped | Hemispherical
4) Surface ⟶ Nodular
5) Number ⟶ Three
6) Movement with deglutition ⟶ Present
7) Movement with protrusion of tongue ⟶ Present
8) Lower border of swelling ⟶ seen
9) Colour ⟶ Normal

Palpation :

1) Shape ⟶ Spherical
2) Size ⟶ Two swelling measure 2x3cm, one swelling 4x3cm
3) Surface ⟶ Bosselated
4) Consistency ⟶ Firm
5) Pulsation ⟶ Absent
6) Fixity ⟶ Absent
7) Transillumination ⟶ Absent
8) Compressibility ⟶ Absent
9) Temperature ⟶ Normal (Afebrile)
10) Tenderness ⟶ Absent
11) Sternocleidomastoid test ⟶ Performed
12) Lahey's method ⟶ performed

Percusion : No relevant history

Ausculation :

Multinodular goitre of thyroid
No bruits | thrills

PROVISIONAL DIAGNOSIS :

Multinodular goitre of thyroid

INVESTIGATION :

- CBC, thyroid hormone examination (T_4, T_3, TSH)
- Thyroid Isotope scan
- USG
- Indirect laryngoscopy
- X-ray
- FNAC

Final Diagnosis :

Multinodular goitre of thyroid

Treatment :

- Total / Near total thyroidectomy
- Followed by Thyroxine tab 200 µg / day
- Followed up to see for any complications of surgery

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GENERAL SURGERY

Name : Ruhaan Mohammad Rafi

Age : 56 years **Sex :** Male

Address : A/P :- Shahuwadi, Tal :- Panhala ; Dist. : Kolhapur

Social Status : Middle class

Chief Complaint :

Patient c/o ulcer over right foot after amputation since 1 month.
Mild discharge from ulcer since 5 days.

History of Present illness :

Patient was apparently normal after amputation before 1 month. He noticed ulcer following trauma after amputation of lateral four toes. Yellow, foul, swelling, blood stained discharge from affected side. No H/O fever, chills, cold, burning micturition, loose stools.

Past Medical History :

type II DM diagnosed 10 year back & is on oral hypoglycemic drug (metformin 500mg). He underwent amputation of 2nd & 5th toe one month back, ↓ spinal anaesthesia.
No H/O TB, HTN, Asthma.

Drug History / History of Allergy :

Pt was on metformin 500mg B.D. for 1st 3 years & then since last 2 years he has been taking Glibenclamide & Metformin (2.5/500 mg B.D.)

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Family History :

No relevant history

Personal History :

Diet ⟶ Mixed diet

Bowel & bladder ⟶ Feequency of micturition

GENERAL PHYSICAL EXAMINATION :

Mental State (Level of Consciousness) : Conscious & well-oriented

Built : Normal **Attitude :** Normal

Gait : Normal **Face :** Normal

Decubitus : Supine with right leg raised resting slightly abducted & flexed at knee on pillow.

Pallor : Absent **Cynosis :** Absent

Icterus : Absent **Edema :** Present

Skin Eruption : Absent

VITAL SIGNS :

Pulse Rate : 84 beats/min

Respiratory Rate : 16/min

Temperature : Afebrile

Blood Pressure : 120/80 mm Hg in supine position

120/90 mm Hg

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SYSTEMATIC EXAMINATION :

Respiratory System :

- clear
- No added sound
- Air entry equal on both sides

Cordiovascular System :

- S_1, S_2 are heard
- No murmur
- No gallop

Gastrointestial Track :

- Soft
- No tenderness
- Bowel sound present

Central Nervous System :

- No muscle wasting
- Cranial nerve examination is normal

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LOCAL EXAMINATION :

Inspection :

1) Size ⟶ 7×8 cm^2
2) Shape ⟶ Not defined, irregular
3) Number ⟶ Single
4) Colour ⟶ Red, inflamed
5) Surface ⟶ ulcerated
6) Site ⟶ Extending from base of amputed stump of 2nd metatarsal to 5th metatarsal.
7) Edge ⟶ Indistinct
8) Peressure effect ⟶ Absent
9) Discharge ⟶ Yellow, foul smelling, blood strained discharge.

Palpation :

1) Temperature ⟶ Slightly raised
2) Tenderness ⟶ Present
3) Size ⟶ 7×8 cm^2
4) Depth ⟶ 3mm
5) Edge ⟶ Sloping edge
6) Margin ⟶ Irregular
7) Fluctuation ⟶ Present
8) Bleeding on touch ⟶ Present
9) Surrounding skin ⟶ Warm
10) Peripheral pulses are palpable ⟶ Present
11) Transillumination ⟶ Absent
12) Compressibility ⟶ Absent

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Percusion :

No relevant finding on percussion

Ausculation :

No relevant finding on auscultation
No Bruits / thrills

PROVISIONAL DIAGNOSIS :

Type II diabetes mellitus associated with peripheral neuropathy & non-healing amputed stump ulcer on right foot.

INVESTIGATION :

- Hb : 8.1 gm/dl
- Blood sugar level ⟶ fasting : 142 mg/dl ; PP = 230 mg/dl
- Blood urea ⟶ 97 mg/dl ; serum creatinine = 3.1 mg/dl
- X-ray chest ⟶ No relevant history

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Final Diagnosis :

Type II D.M. associated with peripheral neuropathy with non-healing amputated stump ulcer over eight foots.

Treatment :

1) Optimize the medical condition. control the blood sugar levels.
2) Debridement by surgical procedure & necrotic or unhealthy tissue is removed.
3) Antibiotics according to severity of injection & culture sensitivity test of discharging pus.
4) Dressing with normal saline, Betadiene & antiseptic agents.
5) Advice patient to wear appropriate footwear
6) Follow up.

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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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