# 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

Dr. Harish Kulkarni M.D.S.
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Dt. Kolhapur 416 137

Mahatma Gandhi Charitable Medical Trust, Waranangar.

# TATYASAHEB KORE DENTAL COLLEGE & RESEARCH CENTRE, NEW PARGAON

RECOGNISED BY DENTAL COUNCIL OF INDIA , NEW DELHI.

AFFILIATED TO MAHARASHTRA UNIVERSITY OF HEALTH SCIENCES, NASHIK.

## GENERAL SURGERY

# CLINICAL RECORD BOOK

Name : Pranjal Bhalchandra Tandale

MUHS P. R. No. : BAB0120200919

Roll No. : 02

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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. Pranjal Bhalchandra Tandale

University Exam No. 447986 Student of the year 2023-2024

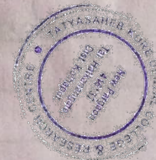
as prescribed by the Maharashtra University of Health Sciences, Nashik.

Signature of the Staff Incharge

Professor & Head of Department

Place : New Pargaon

Date : 13/06/2024



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10/07/24

Signature of the External Examiners

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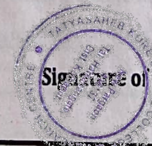

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**Signature of the External Examiners**

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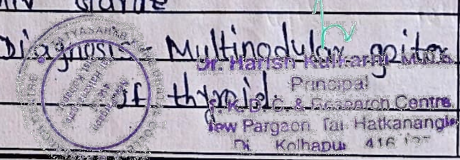

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# GENERAL SURGERY

**Name:** Savita Rajaram kale.

**Age:** 40 years **Sex:** female

**Address:** A/P - June Pargaon, Tal. - Hatkanangle
Dist. - kolhapur

**Social Status:** Middle class

**Chief Complaint:** Pain and swelling sience 10 hours.
Pain at the right ankle region and heels region
swelling at right ankle joints - 10 hours

**History of Present illness:** Pt. was apperantly all right before 10 hrs. He has history of fall from height In morning 9:30 am over right foot. He got severe pain at right angle + heel region sience angle and heel over where after he is hospitialized in MGH and treated by temporary cast and leg elevated and leg subsides.

- He also complains of swelling at right ankle region, its more in morning + subsides after elevation and cast

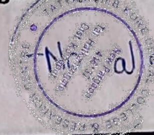
size of swelling.
= 15 x 10 cm

H/O trauma present.
No history of other swelling
No H/O of fever.

No H/O secondary swelling
H/O loss of function
No H/O recurrence.

**Past Medical History:**
- Essential hypertension sience 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) :** Pt is conseous & well oriented

**Built :** Normal

**Attitude :** Normal

**Gait :** Unable to walk

**Face :** Normal

**Decubitus :** Lying comfortably to 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 side.

**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 :**

- Heat sound normal
- No gallop
- No murmur

**Gastrointestial Track :**

- soft
- Non-tender

**Central Nervous System :**

- Power normal
- Ankle present
- 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) Size – Diffused swelling (15 x 10 cm)
4) Shape – Diffused
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) Tenderners – Present.
3) Sensitivity – soft and present mildly.
4) fluctuation – Absent.
5) Surface – Uniform and Regular.
6) fluid & thrill – Absent.
7) Pulsation – Absent
8) Transillumination – Absent
9) Regional Lymphnode – Inguinal lymph node aren't palpable
10) Peripheral pulsation – Present in dorsalis pedis & posterior tibial anterior.
11) Compresscebility – slightly present.
12) Reducability – Absent
13) skin over swelling – skin is a part of swelling.
14) Relation to deeper structure free from underlying str.

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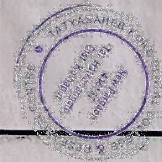
**Percusion :** NAD

**Ausculation :** NAD

**PROVISIONAL DIAGNOSIS :**
According to history it is traumatic swelling
query # right lateral malleatus
# Tarsal bone.

**INVESTIGATION :**

1) Routine investigation – CBC, HB%, ESR, BSL → fasting, → PP. BUL, Serum creatinine, serum, cholesterol, x-ray chest (PA)
2) special investigation – x-ray, right ankel & foot (AP view, oblique view)



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**Final Diagnosis :**

Right calcanum fracture

**Treatment :**

1) Treatment medical –
- Admission
- Temporary support cast.
- Right leg elevation
- Tab. T mol – 1 BD
- Tab. Bidanzem – 10 mg.

2) Surgical treatment –
- After reduction of swelling, patient will be post. for k-wite, fixation of fragments of a calcaneum under spinal anasthesia.
- Permanent of a final cast is given.
- Weight bearing is avoidable for 2-3 months.

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## GENERAL SURGERY

**Name :** Rajesh ram Patel

**Age :** 43 **Sex :** Male

**Address :** A/P Phulewadi, Dist – Kolhapur.

**Social Status :** Middle class

**Chief Complaint :** Multiple blisters over both lower limb sience 8 days.
- Discharge from bristles sience 8 days.
- Mild fever.

**History of Present illness :** Patient is apparently all right before 8-10 days back. He developed mild swelling over bothe lower limb and also developed patchy, red spot swelling goes on increasing for that he was admitted in MG Hospital on Jan 11, 2020.
- He was advised with along with antibiotic treatment and leg elevation.
- Pt. also complains of multiple blisters are brust & watery discharge with some blood stain there.
- Pt. also c/o mild to moderate fever science 8 days which subsides in M.G.H.

**Past Medical History :**

Pt. was operated fracture of neck femur in M.G.H. before 7 days.
- H/o DM, HTN, detected after rescent admission of M.G.H

**Drug History / History of Allergy :** No Allergy detected of any drug or food.
- H/o fever
- No H/o other swelling
- No H/o recurrent

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**Family History :**

- No major illness.

**Personal History :**

- No personal habits
- Mixed diet.

**GENERAL PHYSICAL EXAMINATION :**

**Mental State (Level of Consciousness) :** Pt. is conseous and well oriented.

**Built :** obuse

**Attitude :** Normal

**Gait :** Limping with taking support & stick

**Face :** Normal

**Decubitus :**

**Pallor :** Mild

**Cynosis :** Absent

**Icterus :** Absent.

**Edema :** Absent.

**Skin Eruption :** Absent.

**VITAL SIGNS :**

**Pulse Rate :** 80/ min, good volume, good tension equal on both side.

**Respiratory Rate :** 20 cycles/min, Regular Abdominothoracic.

**Temperature :**

**Blood Pressure :** 120 / 80 mm Hg

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**SYSTEMATIC EXAMINATION :**

**Respiratory System :**

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

**Cordiovascular System :**

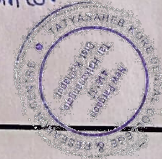
- Heart sound normal
- No ll group
- No murmur.

**Gastrointestial Track :**

- Soft
- Non-tender.

**Central Nervous System :**

- Power normal
- Ankle present
- All cranical nerve tested normal
- Plantor.



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**LOCAL EXAMINATION :**

**Inspection :**

1) Situation - Both lower limb below knee
2) Shape - diffuse
3) Size - Involving lower limb below knee joint
4) Surface - Smooth
5) EDGE - Ill defined
6) Number - Two in number
7) Pulsation - No pulsation
8) Skin - tense shiny with multiple small blisters
9) Surface - Distal foot is edematous due to pressure swelling over veins.

**Palpation :**

1) Temperature - Raised
2) Tenderness - No tenderness.
3) Consistency - soft
4) Surface - Uniform
5) Fluctuation - Present
6) No fluid thrill seen.
7) Pulsation - Absent
8) Transillumination - Absent.
9) Peripheral pulsation - Well felt alar dorsa pedis & posterior or tibial artery.
10) Lymph node - Inguinal lymph node is palpable & slightly enlarged.
11) Reductability - enlarged
12) compression - Present

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**Percusion :**

- No Relevant

**Ausculation :**

- No relevant

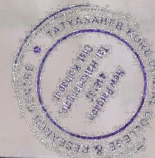
**PROVISIONAL DIAGNOSIS :**

1) Cellulitis of Both lower limb & knee
2) Oedema of Both lower limb due to venous obstruction.

**INVESTIGATION :**

1) Routine - CBC, ESR, BSR [PP & fasting] BVL
   - Serum creatinine, serum cholesterol urine examination complete
   - X-ray chest (PA) view.

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



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**Final Diagnosis :**

- Cellulitis of Both lower limb.

**Treatment :**

A) Medical Treatment
- Hospitalization.

1) Bed rest c̄ elevation of both lower limb to reduce edema due to cellulitis.

- Antibiotics-
  - Amoxicillin
  - Metrozel (400 mg) TDS
  - Tab. Ibuprofen 400 mg & Paracetamol 325 mg

B) Surgical T/t-
- If cellulitis does not subside c̄ medical T/t.
- Incision & drainage under (spinal) G/A.

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## GENERAL SURGERY

**Name :** Pintu Sakharam Sawant

**Age :** 36 years **Sex :** Male

**Address :** A/P, Takhale. Tal.- Hatkanangle
Dist.- Kolhapur

**Social Status :**

**Chief Complaint :** Pt complains of swelling in the upper right back region sience 5 years which was a small nodule in size and pt has no other complains

**History of Present illness :**

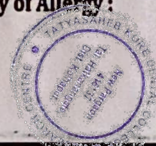
- Pt. continued swelling upper right back region sience 5 years which was small nodule in size and gradually increased to attain in size
- No H/O of trauma, pain, elsewhere, simillar swelling in body, fever & secoundary changes are often seen.

**Past Medical History :**

- Pt. is known hypertensive sience 5 years & is on medication hydrochlorothiazide sience 5 years, No history of any major illness or surgery in past.

**Drug History / History of Allergy :**

- NKH.



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**Family History :**

**Personal History :** Diet - mixed
Maternal status - Married
Menstrual cycle - No 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 cycles/min.

**Temperature :** Abriable.

**Blood Pressure :** 142/80 mm Hg

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**SYSTEMATIC EXAMINATION :**

**Respiratory System :**

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

**Cordiovascular System :**

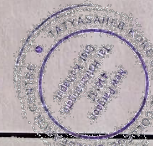
- Heart sound normal
- No gallop.
- No murmur.

**Gastrointestial Track :**

- soft
- Non-tender
- Losoko

**Central Nervous System :**

- Ankle reflex absent
- All CN are normal
- Plantor ↓↓



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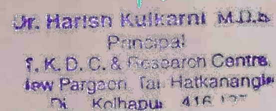
## LOCAL EXAMINATION :

**Inspection :**

1) Position - Right upper back region
2) Number - single
3) color - darker than adjecent skin
4) Size & shape - roughly 5×5 cm. spherical
5) surface - smooth
6) Edge - Distored.
7) Pulsation - non pulsatile
8) skin over swelling - Normal with black spot seen
9) Any pressure effect - Absent.

**Palpation :**

1) Temperature - not raised
2) Tenderness - non - tender
3) size & shape - 5×5 cm, spherical
4) surface - smooth
5) Edge - distinct
6) consistency - soft
7) Fluctuation - soft.
8) Fluid, thrill, impulse on cough - Absent.
9) Transillumination - reducibility, absent
10) compressibility - Absent






**Percusion :**

- No significant findings

**Ausculation :**

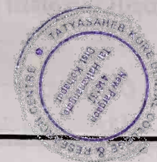
- No significant findings

**PROVISIONAL DIAGNOSIS :**

- sebaceous cyst

**INVESTIGATION :**

Blood sugar level
CBC
Urine examination.



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**Final Diagnosis :**

- Sebaceous cyst.

**Treatment :**

- Excision / under local anasthesia.

(Is drawn)

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## GENERAL SURGERY

**Name :** Kailas H. Bhuwad

**Age :** 18 **Sex :** Male

**Address :** A/P. Islampur, Tal.- Walwa
Dist.- Sangli

**Social Status :** Middle class

**Chief Complaint :** Pt. complains of swelling over lower limb.

**History of Present illness :**

- Pt. noticed swelling 2-3 days ago
- No H/o Pain, trauma, sudden increase or decrease in size of swelling, No wt. No fever.

**Past Medical History :**

- No relevent past history
- No relevent past surgical history.

**Drug History / History of Allergy :**

- No H/o surgery
- No H/o other swelling
- No H/o trauma

No H/o of recurence.

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**Family History :**
- No relevent past medical history in family.
- No relevent past surgical history in family.

**Personal History :**
- Mixed diet.
- Bowel & Bladder – Normal
- Material status – Married.

**GENERAL PHYSICAL EXAMINATION :**

**Mental State (Level of Consciousness) :**

**Built :** Normal

**Attitude :** Normal

**Gait :** Normal

**Face :** Normal.

**Decubitus :** Absent

**Pallor :** Absent.

**Cynosis :** Absent

**Icterus :** Absent

**Edema :** Absent.

**Skin Eruption :** Absent.

**VITAL SIGNS :**

**Pulse Rate :** 80 beast/min.

**Respiratory Rate :** 22 cycle/min.

**Temperature :** 95° F

**Blood Pressure :** 110/80 mm Hg.

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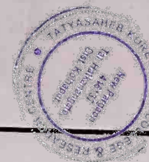
**SYSTEMATIC EXAMINATION :**

**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
- Losoko.

**Central Nervous System :**
- Ankle reflex absent.
- All cranial nerves are normal
- Plantar reflex decreased.



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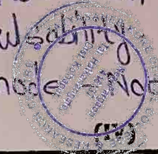
**LOCAL EXAMINATION :**

**Inspection :**

1) Position of swelling – over left lower limb.
2) colour – coral pink.
3) Number – one
4) size & shape – 1×1 cm spherical.
5) surface – smooth
6) Edge of swelling – Indistinct
7) Pulsation – Absent
8) Impulse on cough – absent
9) Mucosa over sw – Normal

**Palpation :**

1) Temperature – Normal
2) Tenderness – Non-tender
3) size & shape – 1×1 cm, ovoid.
4) surface – smooth
5) Edge – well defined.
6) consistency – firm
7) Fluctuation – Absent
8) Fluid thrill – Absent.
9) Impulse on cough – Absent.
10) Reductability – Absent.
11) comparesibility – Not seen
12) Pulsation – No pulsatility
13) Regional lymph node – Not affected



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**Percusion :**

– No significance.

**Ausculation :**

– No significance finding on osculation.

**PROVISIONAL DIAGNOSIS :**

– Lipoma.

**INVESTIGATION :**

1) Blood sugar level
2) CBC
3) Urine Examination.

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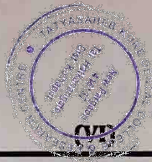
**Final Diagnosis :**

- Lipoma

**Treatment :**

- surgical excision under local Anasthesia.



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## GENERAL SURGERY

**Name :** Dada Mukunda Deshmukh

**Age :** 43 **Sex :** Male

**Address :** A/P - Pargaon, Tal.- Hatkanangle, Dist.- Kolhapur

**Social Status :** Middle class

**Chief Complaint :**

Pt. c/o swelling in upper right back region sience 6-7 months & pain in the region sience 2-3 days.

**History of Present illness :**

- Pt. noticed swelling which has small sience 6-7 months.
- It attained to its present size by growing gradually.
- pt. noticed pain & swelling 2-3 days ago. No history of fever, secoundary changes, loss of body weight, sudden increase in size respectively.

**Past Medical History :**

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

**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.
- Martial status → Normal
- Bowel & Bladder → Normal.

**GENERAL PHYSICAL EXAMINATION :**

**Mental State (Level of Consciousness) :**

**Built :** Normal

**Attitude :** Normal

**Gait :** Normal

**Face :** Normal.

**Decubitus :** ~~Abs~~

**Pallor :** Absent

**Cynosis :** Absent

**Icterus :** Absent

**Edema :** Absent.

**Skin Eruption :** Absent.

**VITAL SIGNS :**

**Pulse Rate :** 72 beats/min.

**Respiratory Rate :** 20 cycle/min

**Temperature :** Afrlable

**Blood Pressure :** 124/84 mm Hg

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**SYSTEMATIC EXAMINATION :**

**Respiratory System :**

- clear
- No added sound
- Arition equal on both sides.

**Cordiovascular System :**

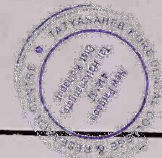
- H.S → Normal
- No gallop.
- No murmur.

**Gastrointestial Track :**

- soft
- Non-tender
- Losoko.

**Central Nervous System :**

- ~~Lo~~ Power Normal
- All cranial nerve tested normal.



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**LOCAL EXAMINATION :**

**Inspection :**

1) Position - Upper right posterior Region.
2) Number - Single
3) Colour - Reddish brown.
4) Size & shape - Asymmetrical
5) Surface - Smooth
6) Edge - Distinct
7) Pulsation - Non- pulsatile
8) Skin over swelling - Raddish.
9) Any pressure Effect - No.
10) Impulse on cough - Absent.

**Palpation :**

Temperature - not raised
Tenderness - Tender
size & shape - spherical
surface - smooth
Edge - Distinct
consistency - soft
fluctuation - present

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**Percusion :**

No significant finding on Percusion.

**Ausculation :**

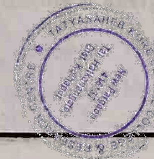
No significant finding on Ausultation.

**PROVISIONAL DIAGNOSIS :**

Sebaceous cyst

**INVESTIGATION :**

- Sugar level
- CBC
- BP
- Urine Examination.



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**Final Diagnosis :**

- Sebaceous cyst

**Treatment :**

- Excision Under local Anasthesia.

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# GENERAL SURGERY

**Name :** Suresh Tambe

**Age :** 40 yr **Sex :** Male

**Address :** Kolhapur

**Social Status :** Middle class

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

**History of Present illness :**

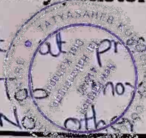
- Pt. was apparently all right, 15 days Back he relieved I.M. injection in gluteal region from local doctor.
- After 3-4 days he noticed pain at the injection site It was throbbing in nature and swelling at the site. so he was admitted in MGM 3 days back and was treated with incision and drainage Under.
- At present ulcer (5×9×1.5 cm) over thick buttock also c/o patient and water discharge.

**Past Medical History :**

- No H/O diabetic HTN.
- No H/O Bleeding disorder.
- No H/O Trauma
- No H/O Syphilis.

**Drug History / History of Allergy :**

- Pt. at present requiring cefotaxime 200 mg.
- Tab Amox + clavulanic acid 625 mg OD.
- No other drug + known Allergy.



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**Family History :**

- No major Allergies
- No H/o Diabates
- No H/o hypertension.

**Personal History :**

- No adverse habit
- Mixed diet
- Married healing children.

**GENERAL PHYSICAL EXAMINATION :**

**Mental State (Level of Consciousness) :** fully conseous well oriented.

**Built :** Average

**Attitude :** Comfortable.

**Gait :** Mild

**Face :** Normal

**Decubitus :** Lies on lateral position.

**Pallor :** Absent

**Cynosis :** Absent

**Icterus :** Absent

**Edema :** Absent.

**Skin Eruption :** Absent

**VITAL SIGNS :**

**Pulse Rate :** 80 beats/ min.

**Respiratory Rate :** 20 cycle /min

**Temperature :** 37°c.

**Blood Pressure :** 130/90 mm Hg.

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**SYSTEMATIC EXAMINATION :**

**Respiratory System :**

- clear no added sounds.
- Air entry equal on both side.

**Cordiovascular System :**

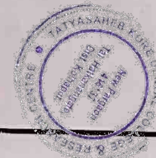
- Heart sounds are normal
- No gallop, no murmur.

**Gastrointestial Track :**

- Per abdomen, soft & tender.
- Losoko

**Central Nervous System :**

- No power loss
- Ankele reflexes are normal
- No muscle wasting.



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**LOCAL EXAMINATION :**

**Inspection :**

1) size - About 4x3 cm.
2) Shape - oval
3) site - Posterior superior quadrant.
4) Number - one
5) Edge - Punched out
6) Base - formed
7) Discharge - serous & scanty.
8) smell - Absent
9) surrounding area - Normal
10) Lower limb - Normal.

**Palpation :**

1) size - 5x3x1.5 cm.
2) Tenderness - Mild
3) Edge - Mild indurated.
4) Base - formed by gluteal mummr.
5) Bleeding on touch - Absent
6) Relation from deeper structure - free from ulcer.
7) surrounded skin - Normal
8) Regional lymph node - Inguinal L/N are slightly enlarged & tender.

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**Percusion :**

- Not relevant.

**Ausculation :**

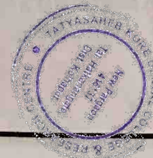
- Not relevent
- No bruits / thrills.

**PROVISIONAL DIAGNOSIS :**

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

**INVESTIGATION :**

- Routine investigation hemoogram, Hb, CBC,
- Urine Examination, BSL, Post prandial sugar.
- x-ray in hip region.
- cultural sensitivity.
- test per swab from ulcer.



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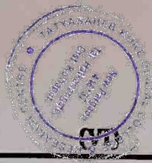
**Final Diagnosis :**

- Post subcutaneous pyogenic abescess healing type and ulcer due to drainage.

**Treatment :**

- Bed rest and leg elevation.
- cap Amox 625 mg BD + clavulnic acid
- follow up.

Kale



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## GENERAL SURGERY

**Name :** Sangeeta Nikam

**Age :** 62 years **Sex :** female

**Address :** New Pargaon

**Social Status :** Middle class

**Chief Complaint :**

- Pt. c/o of swelling sience 6-9 months in upper right back region of scalp.
- Pt. also c/o pain sience 2-3 days.

**History of Present illness :**

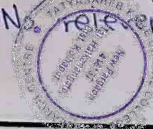
- Pt. was apperently alright 6-9 months back. He has noticed small nodular swelling that was painless and slowely increased in size.
- Swelling also result in loss of hair as it was growing and then suddenly charge in size and colour of swelling.
- He approched MGH.

**Past Medical History :**

- No H/o diabetes, No H/o hypertension
- No H/o bleeding disorder and T.B.
- No H/o syphilis and H/o surgery.

**Drug History / History of Allergy :**

- No relevent history



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**Family History :**

- No H/o diabates, hypertension.
- No H/o bleeding disorder.

**Personal History :**

- Diet – Mixed
- Married & has 3 child
- No habit of tobaco/alcohol.

**GENERAL PHYSICAL EXAMINATION :**

**Mental State (Level of Consciousness) :** conseous & well-oriented.

**Built :** Average  **Attitude :** comfortable.

**Gait :** Normal  **Face :** Normal

**Decubitus :** supine position

**Pallor :** Absent  **Cynosis :** Absent

**Icterus :** Absent  **Edema :** Absent.

**Skin Eruption :** Absent.

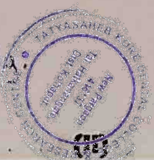
**VITAL SIGNS :**

**Pulse Rate :** 72 beats/min.

**Respiratory Rate :** 18 cycle/min.

**Temperature :** 97.5°F

**Blood Pressure :** 128/86 mm Hg



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**SYSTEMATIC EXAMINATION :**

**Respiratory System :**

- clear, No added sound.
- Air entry equal no both sides.

**Cordiovascular System :**

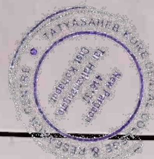
- Heart sounds normal
- No gallop.
- No murmur.

**Gastrointestial Track :**

- soft non-tender
- Lo so ko

**Central Nervous System :**

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



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**LOCAL EXAMINATION :**

**Inspection :**

1) size - 5×5 cm.
2) Shape - Rounded
3) Number - single
4) size - Upper right posterior region.
5) color - Reddish brown
6) surface - smooth
7) Edge - Distinct
8) Pressure effect - Absent.
9) Age - 6-4 months.

**Palpation :**

1) Temperature - Raised.
2) Tenderness - Present.
3) size - 5×5 $cm^2$
4) Shape - spherical
5) surface - smooth
6) consistency - soft
7) Fluctuation - present
8) fluid thrill - Absent
9) Transillumination - Present.
10) Impulse on cough - Absent.

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**Percusion :**

- NRH

**Ausculation :**

- No braits / thrills.

**PROVISIONAL DIAGNOSIS :**

- Infected sebaceous cyst.

**INVESTIGATION :**

- Routine blood count.
- sugar - fasting, post pradial.
- Urine - examination.
- If purpresent, then culture sensitivity.
- X-ray skull - to see fixity present or not.

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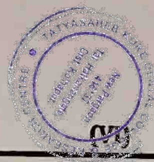
**Final Diagnosis :**

- Infected subcutaneously.

**Treatment :**

1) Antibiotic administration and supportive.
   Rx Amoxicillin 500 mg TDS.
   Tab. Ibuprofen 400 mg + Paracetamol 385 mg TID.



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## GENERAL SURGERY

**Name :** Sadashiv Ramu Garade

**Age :** 65 **Sex :** Male

**Address :** Mohare (kodoli)

**Social Status :** Middle class

**Chief Complaint :**

- Pt. complains of multiple over next size 1 year.
- Swelling results into difficulty in breathing & eating.

**History of Present illness :**

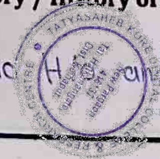
- Pt. was apperently normal 1 year before. Then she saw small swelling developing over neck. They were three in number.
- Each swelling measures 2×3 cm in size. Later swelling result in quite difficulty in breathing and slightly discomfort during swallowing.

**Past Medical History :**

- No H/o diabetes.
- No H/o bleeding disorder.
- No H/o surgery.

**Drug History / History of Allergy :**

- No H/o any drug allergy.



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**Family History :**

– Mother is hypertensive.

**Personal History :**

– Married 2 children.

– Mixed diet.

**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.

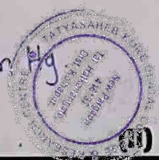
**VITAL SIGNS :**

**Pulse Rate :** 20 beats/min.

**Respiratory Rate :** 22 cycle/min

**Temperature :** 99°F

**Blood Pressure :** 136 / 88 mm Hg



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**SYSTEMATIC EXAMINATION :**

**Respiratory System :**

– No added sounds.

– clear air away.

– Forcefull breathing seen due to dysponea.

**Cordiovascular System :**

– Normal heart sound.

– No gallop, No murmur.

**Gastrointestial Track :**

– No abdomen, soft, non-tender.

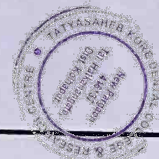
– Loso ko

**Central Nervous System :**

– No Power loss.

– Ankle reflex are normal

– No muscle westing.



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**LOCAL EXAMINATION :**

**Inspection :**

1) site - Neck (Anterior surface)
2) size - Two swellings of 2x3cm + 1 swelling 4x3cm.
3) shape - Butterfly shaped / Hemispherical.
4) surface - Nodular.
5) Number - Three
6) Moment with deglutition - present.
7) lower border swelling - seen.
8) colour - Normal
9) chin - lowest.
10) Pixillos method.

**Palpation :**

1) shape - spherical
2) size - two swellings, measure 2x3cm, one swelling 4x3 cm.
3) surface - Bossulated
4) consistency - firm
5) Pulsation - Absent
6) fixicity - Absent
7) Translumination - Present
8) compressibility - Absent
9) Temperature - Normal
10) Tenderness - Absent.

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(IV)

**Percusion :**

- No relevent history.

**Ausculation :**

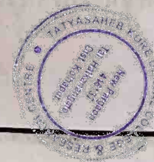
- Multinodular goitre of thyroid.
- No bruits / thirll.

**PROVISIONAL DIAGNOSIS :**

- Multinodular goiter of thyroid.

**INVESTIGATION :**

- CBC, thyroid hormone examination ($T_4$, $T_3$, TSH)
- Thyroid istope seen.
- USG
- FNAG



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(V)

**Final Diagnosis :**

- Multinodular Goitre of thyroid.

**Treatment :**

- Total thyroidectomy.
- followed by thyroxine tab 200 ug/day.
- follow up to see for any complications of surgery.

Kale

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## GENERAL SURGERY

**Name :** Mr. Sunil V. Bansode

**Age :** 54 yr. **Sex :** Male

**Address :** New Pargaon

occupation - x-ray technician at MGH

**Social Status :** Middle class

**Chief Complaint :**

- Pt. complains of ulcer over right foot after amputation sience 1 mouth.
- Mild discharge from ulcer sience 5 days.

**History of Present illness :**

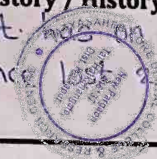
- Pt. was apparantly normal after ampulation before 1 month. He noticed ulcer following trauma after ampulation of lateral four toes. Yellow, foul, swelling, blood stained discharge from affected side.
- No H/o fever, chills, cold, burning micturation, loose stool.

**Past Medical History :**

- Pt. is known as type II. DM diagnosed 10 years back is an oral hypoglycemic drug / cM formin 500 mg.
- He underwent ampulation of 2nd and 5th toe one month back decreased spinal anasthetia.

**Drug History / History of Allergy :**

- Pt. was on metform 500 mg BD for 1st 3 years and then sience last 2 yrs he has been taking glabenclonamide.



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**Family History :**

- NRH

**Personal History :**

- Diet - Mixed.

**GENERAL PHYSICAL EXAMINATION :**

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

**Built :** Normal **Attitude :** Normal

**Gait :** Normal **Face :** Normal.

**Decubitus :** supine

**Pallor :** Absent **Cynosis :** Absent

**Icterus :** Absent **Edema :** Absent.

**Skin Eruption :** Absent.

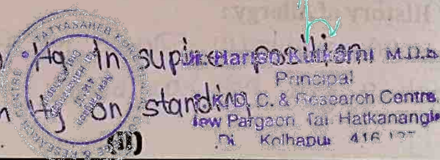
**VITAL SIGNS :**

**Pulse Rate :** 84 beats/min No Radio-femoral delay.

**Respiratory Rate :** 16/min

**Temperature :** afriable.

**Blood Pressure :** 126/86 mm Hg in supine position
120/86 mm Hg on standing



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**SYSTEMATIC EXAMINATION :**

**Respiratory System :**

- clear
- No added sound

**Cordiovascular System :**

- $S_1$ $S_2$ are heared
- No murmur
- No gallop.

**Gastrointestial Track :**

- Soft
- Bowel sound present
- Non-tender.

**Central Nervous System :**

- No power less.
- No muscle wasting.
- Cranial nerve examination is normal.

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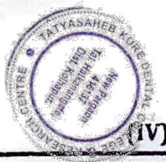
**LOCAL EXAMINATION :**

**Inspection :**

1) Size – 7×8 $cm^2$
2) Shape – Not defined irregular
3) Number – Single.
4) Colour – Red, inflammed
5) Surface – Uncleared
6) Site – extending from base of amputation stump.
7) Edge – Indirect
8) Pressure effect – Absent.
9) Discharge – Yellow, fowl swelling.

**Palpation :**

1) Temperature – slightly raised
2) Tenderness – Present.
3) Size – 7×8 $cm^2$
4) Depth – 3 mm
5) Edge – sleeping edge
6) Margins – Irregular
7) Fluctuations – Present
8) Bleeding on touch – Present
9) Surrounding skin – Present.
10) Peripheral impulses – Present.



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**Percusion :**

– No relevent finding on purcussion.

**Ausculation :**

– No relevent finding on osculation.
– No Bruits / thrills

**PROVISIONAL DIAGNOSIS :**

– Type II diabetes m ass with peripheral neuropathy.

**INVESTIGATION :**

– Hb – 8.1 gm/dl
– BS – fasting .2 mg/dl . PP – 230 mg/dL
Blood urea – 97 mg/dl, S. creatinine – 3.1 mg/dL
X-ray chest – NRH.

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**Final Diagnosis :**

- Type II DM also with peripheral neuropathy with no healing amputed stumpulcer.

**Treatment :**

1) optimize medical condition controll the blood sugar levels.
2) Debriment by surgical procedure and necrotic dead / unhealthy tissue is removed.
3) Antibiotic acc. to severity of infection & culture sensitivity test.
4) Advice pt to wear appropriate footware.
5) follow up.

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## GENERAL SURGERY

**Name :** Abdul Sutar

**Age :** 56 yr. **Sex :** Male

**Address :** At Post. Shahuwadi. Tal.- Panhala Dist. Kolhapur.

**Social Status :** Middle class.

**Chief Complaint :** pt c/o Ulcer over right foot after amuptation since 1 month.
- Mild discharge from ulcer since 5 days.

**History of Present illness :**

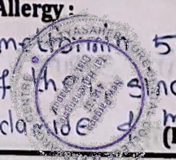
- Pt. was apparently normal after amputation before 1 month
- He noticed ulcer following trauma after amputation of lateral four toes.
- Yellow, foul swelling blood stained discharge from affected side
- No H/o fever, chills, cold, burning micturation loose stool.

**Past Medical History :**

- Pt. is type 2 DM. Diagnosed 10 yr back an oral hypoglycemia drug [Metformin 500mg].
- He underwent amputation of 2nd & 5th toe one months back & Spinal anaesthesia. No H/O TB, HTN, Asthma.

**Drug History / History of Allergy :**

Pt. was on metformin 500 mg BD for 1st 3 year & then since last 2 years he has been taking Glibenclamide & metformin.



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**Family History :**
NRH

**Personal History :**
Diet - Mixed
Bowel & bladder - frequency of micturation - 15 / day.
3-4 times / night.

**GENERAL PHYSICAL EXAMINATION :**

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

**Built :** Normal

**Attitude :** Normal

**Gait :** Normal

**Face :** symmetrical

**Decubitus :** supine with Right leg 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. No radio-femoral delay.

**Respiratory Rate :** 16 /min.

**Temperature :** Afebrile

**Blood Pressure :** 126/86 mm Hg in supine position.

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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
- bowel sound present
- Non - tender.

**Central Nervous System :**
- No power loss
- No Muscle wasting
- cranial nerve examination normal.

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**LOCAL EXAMINATION :**

**Inspection :**

1) size - 7×8 cm²
2) Shape - Not defined, irregular
3) Number - single
4) colour - Red, inflammed
5) surface - Ulcerated
6) site - Extending from base of ampulsed stump of 2nd metatarsal to 5th metatorsal
7) Edge - Indistinct
8) Pressure effect - Absent.
9) Dishcharge - yellow, foul smelling, blood stained discharge.

**Palpation :**

1) Temperature - slightly raised
2) Tenderness - Present
3) size - 7×8 cm²
4) Depth - 3 mm
5) Edge - Sloping edge
6) Margins - Irregular
7) Flucutuation - Present
8) Bleeding on touch.
9) Peripheral pulses are palpable
10) surrounding skin - warm.

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**Percusion :**

- No relevant finding in percussion

**Ausculation :**

- No relevant finding on auscultation
- No bruits/ thrills.

**PROVISIONAL DIAGNOSIS :**

Type 2 Diabetes mellitus associated with Peripheral neuropathy with non-healing amputed stump.
Ulcer on right foot.

**INVESTIGATION :**

Hb - 8.1 gm/dl
B.S - Fasting 142 mg/dl PP-220 mg/dl
Blood urea - 97 mg/dl
S. creatinine - 3.1 mg/dl
X-ray chest - NAD.

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**Final Diagnosis :**

- Type 2 DM. associated c̄ Peripheral neuropathy with non-healing amputeed stump ulcer over right foot.

**Treatment :**

1) Optimize medical condition.
2) control blood sugar level.
3) Debridement by surgical procedure & necrotic or unhealthy tissue is removed.
4) Antibiotics according to severity of infection & culture sensitivity test of discharging pus.
   - Amoxicilin 500 mg TID.
5) Dressing with normal saline, Betadine. & antiseptic agent.
6) Advice pt to wear appropriate foot wear. To avoid plantar pressure & pt is educated about further complication.
7) Follow up.

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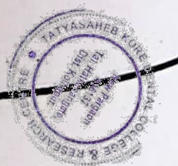

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RECOGNISED BY DENTAL COUNCIL OF INDIA, NEW DELHI
AFFILIATED TO MAHARASHTRA UNIVERSITY OF HEALTH SCIENCES, NASHIK

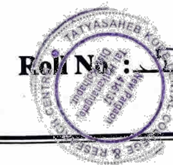
## GENERAL SURGERY

# CLINICAL RECORD BOOK

**NAME :** Manasi Amar Tibile

**MUHS P. R. No. :** 0222281812

**Roll No. :** 54



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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. Manasi Amar Tibile

University Exam No. 514478 Student of the year 2023 - 24

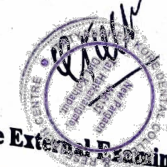
as prescribed by the Maharashtra University of Health Sciences, Nashik.

Signature of the Staff Incharge

Professor & Head of the Department

Place :

Date :



Signature of the External Examiners

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19/1/24

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## GENERAL SURGERY

**Name:** Keshav Suresh Jadhav

**Age:** 23 year **Sex:** Male

**Address:**
A/p Kapshi (S). Tal- Kagal , Dist :- Kolhapur

**Social Status:** Middle Class

**Chief Complaint:**
1. Ulcer over dorsum of left foot since 15 days.
2. Pain at ulcer site since 15 days.
3. Unable to make movement at ankle joint since 15 days.
4. Multiple healed ulcer since 1 week.

**History of Present illness :**

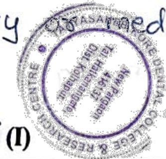
1. Patient was apparently alright before 15 days.
2. He had road traffic accident 15 days back and had multiple traumatic ulcer and for same admitted to (PR hospital)
3. He is treated with , hospitalization, IV fluids and local dressings.
4. Patient taken discharge against medical advice.
5. At present he had ulcer at dorsum of root 5x4cm in size and has pain.
6. H/o fever - intermittent.
7. Loss of appetite and bleeding.

**Past Medical History :**

1. No H/o diabetes mellitus
2. No H/o hypertension
3. No H/o bleeding & tuberculosis
4. No H/o major surgery or medication.

**Drug History/History of Allergy :**

No relevant history.



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**Family History:**

1. Non-relevant history.
2. No H/o diabetes mellitus.
3. No H/o hypertension & bleeding.
4. No H/o tuberculosis

**Personal History:**

No any habit present

Diet - Mixed

Marital status - Not married

Sleep disturb due to pain.

**GENERAL PHYSICAL EXAMINATION:**

**Mental State (Level of Consciousness):** Conscious and well oriented

**Built :** Normal **Attitude :** Comfortable

**Gait :** Unable (due to ulcer in dorsum of feet) **Face :** Normal

**Decubitus :** lying - comfortable in supine position with leg elevation.

**Pallor :** Absent **Cynosis :** Absent

**Icterus :** Absent **Edema :** Absent

**Skin Eruption:**

Multiple traumatic skin eruption present.

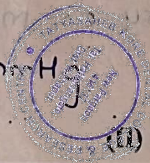
**VITAL SIGNS :**

**Pulse Rate:** 90 beats/minute (Regular and equal on both side)

**Respiratory Rate:** 14 cycle/minute

**Temperature:** Afebrillar

**Blood Pressure:** 130/90 mmHg



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**SYSTEMATIC EXAMINATION:**

**Respiratory System:**

Clear sound

No sound added

**Cordiovascular System:**

Heart sound normal

No murmur

No group galop (3rd sound)

**Gastrointestial Track:**

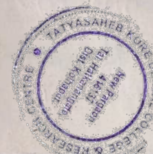
P/A soft

No tenderness

**Central Nervous System:**

No neurological disorder

Planter ↓↓



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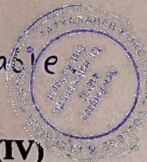
## LOCAL EXAMINATION :

**Inspection :**

1). Situation :- over dorsum of left foot.
2) Size - 5 - 4 cm
3). Shape - circular
4). Number - 1 in number
5) Edge - Sloping edge
6) Floor - Red granulation with minimal slough.
7) Discharge - slanty discharge.
8) Surrounding area :- pigmented with mild inflammation.

**Palpation :**

1). Tenderness - present.
2). Base - Mild induration
3). Depth - 0.5mm
4). Margin - well demarked.
5) Relation with deeper tissues - mild adhesion
6) Surrounding skin - mild edema
7) fluctuation - absent.
8) fluid - absent
9) Reducibility - Not reduceable
10) Pulsation - absent.



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**Precusion :**

Not relevant

**Ausculation :**

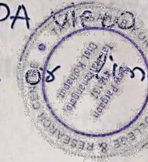
Not relevant

**PROVISIONAL DIAGNOSIS :**

Traumatic callus type of healing ulcer.

**INVESTIGATION :**

1) CBC
2) Urine examination.
3) fasting pp :
4) BOL
5) Serum creatinine ulcer
6) X ray chest (PA view)
7). X-ray of ankle or limb



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**Final Diagnosis :**

Traumatic ulcer callus type

**Treatment :**

Swab - for culture and sensitivity of discharge of ulcer.

Rx - 1) Hospitalisation
2) Rise with leg elevation

Medical line Rx
- Antibiotics
- Vit. C
- Imol - 50mg
- Multi Vitamine
- Dressing

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# GENERAL SURGERY

**Name:** Mohini Sunil Kesarkar
**Age:** 55 years **Sex:** Female
**Address:** Pargaon

**Social Status:** Lower class

**Chief Complaint:**
1. Pt complains of pain at right wrist region since 8 days
2. Swelling at the site since 8 days.

**History of Present illness :**
1. Patient was apparently alright before 8 days.

**Past Medical History :**
- No H/o major illness present.
- No H/o hypertension.
- No diabetes mellitus detected at MG hospital 1 day back.
- No H/o bleeding disorder.

**Drug History/History of Allergy :**
Non - relevant history.

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**Family History:**

- H/o of IHD (Ischemic heart disease) to brother.
- No H/o hypertension & diabetes mellitus.

**Personal History:**

- No any adverse habit present.
- Diet - Mixed
- B/B - Normal
- Married - 1 male & 2 female child.

**GENERAL PHYSICAL EXAMINATION:**

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

**Built :** Normal

**Attitude :** Comfortable

**Gait :** Normal

**Face :** Normal

**Decubitus :** lying comfortable in supine position, Rt - forearm elevated.

**Pallor :** Absent

**Cynosis :** Absent

**Icterus :** Absent

**Edema :** Present

**Skin Eruption:** Not present.

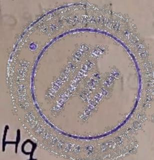
**VITAL SIGNS :**

**Pulse Rate:** 82 beats/min (Regular and equal on both side)

**Respiratory Rate:** 10 cycle/min

**Temperature:** A febrile

**Blood Pressure:** 120/80 mm Hg



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**SYSTEMATIC EXAMINATION:**

**Respiratory System:**

Clear sound
No sound added

**Cordiovascular System:**

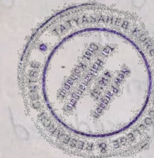
Heart sound normal
No gallop (3rd sound)
No murmur

**Gastrointestial Track:**

P/A soft
No tenderness

**Central Nervous System:**

No Neurological disorder
Planter ↓↓



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## LOCAL EXAMINATION :

**Inspection :**

1. Situation - swelling just below, right wrist region and including right wrist.
2. Colour :- Normal (skin colour)
3. Shape - Diffused
4. Size - 4×5 cm
5. Surface - Regular and smooth.
6. Edge - ill-defined.
7. Number - 1 in number.
8. Skin over swelling - slight elevation.
9. Pulsation - Not present.

**Palpation :**

1. Temperature - slightly raised.
2. Tenderness - present.
3. Size - 4 x 5 x 1 mm
4. Extend - from right wrist 5cm below.
5. Surface - Regular & smooth.
6. Edge - Diffuse i.e ill-defined.
7. Consistency - Soft & uniform
8. fluctuation - Absent
9. fluid thrill - Absent.
10. Reducibility - Not reduced
11. Pulsability - Absent.
12. Skin over swelling - slightly edematous

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13. Regional lymph node - Not palpable.
14. Compressibility - Not present.

**Precusion :**

Not relevant

**Ausculation :**

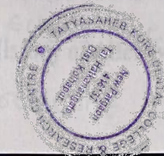
Not relevant

**PROVISIONAL DIAGNOSIS :**

# fracture of lower end of ~~ulner~~ ulnar.

**INVESTIGATION :**

- Routine - CBC, Hb count
- Special - X-ray, - Rt wrist AP and x-ray in oblique view.



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**Final Diagnosis :**

- Fracture of lower end of ulnar.

**Treatment :**

Analgesia
- Tab. Imol
- Elevation of forearm
- Advice K wire fixation of lower end of ulnar under G/A before operation sugar must be controlled with injectable insulin.

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## GENERAL SURGERY

**Name:** Anil Santosh Powar

**Age:** 26 year **Sex:** Male

**Address:**

A/p Amtwadi , Tal-panhala , Dist- Kolhapur.

**Social Status:** Middle Class

**Chief Complaint:**

1. Pt c/o swelling over right foot since 15 days.
2. There is mild pain at swelling since 15 days.

**History of Present illness :**

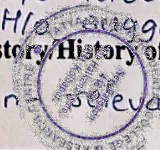
- Patient was apparently alright before 15 days.
- He had road traffic accident for which he had been treated at kolhapur orthopedic center operated by Dr. P.L Kulkarni orthopedic surgeon.
- At that time he had compound fracture for lower end femur.
- At present he is admitted to MG hospital, 3 days back, there is swelling over right foot.
- He is treated with leg elevation, rest, support, the swelling get reduced with

**Past Medical History :**

- No relevant history.
- No H/o hypertension
- No H/o diabetes mellitus
- No H/o Tuberculosis
- No H/o suggestive bleeding disorder.

**Drug History/History of Allergy:**

Non-relevant history.



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**Family History:**

Non- relevant history

**Personal History:**

No any adverse habit is present.

Diet- Mixed

B/B - Normal

**GENERAL PHYSICAL EXAMINATION:**

**Mental State (Level of Consciousness):** Conscious and well oriented

**Built :** Normal **Attitude :** Comfortable

**Gait :** Normal **Face :** Normal

**Decubitus :** Lying comfortable in supine position with right leg elevation

**Pallor :** Absent **Cynosis :** Absent

**Icterus :** Absent **Edema :** Present (over right foot)

**Skin Eruption:** Absent.

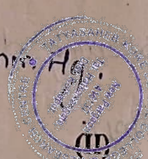
**VITAL SIGNS :**

**Pulse Rate:** 82 beats/min (Regular and equal on both side)

**Respiratory Rate:** 17 cycle/min

**Temperature:** Afebrile

**Blood Pressure:** 120/70 mm Hg.



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(II)

**SYSTEMATIC EXAMINATION:**

**Respiratory System:**

Clear sound

No sound added

**Cordiovascular System:**

Heart sound normal

No gallop (3rd sound)

No murmur.

**Gastrointestial Track:**

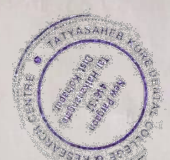
P/A soft

No tenderness

**Central Nervous System:**

No neurological disorder

Planter ↓↓



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(III)

## LOCAL EXAMINATION :

**Inspection :**

1. Situation - Over dorsum of right foot.
2. Size - 5x5 cm
3. Colour - Normal skin colour with slight oedema
4. Shape - Diffuse over or spherical in shape
5. Surface - Smooth
6. Edge - Not well defined.
7. Number - One in number.
8. Pulsation - No pulsation.
9. Skin over swelling - Mild oedematous.

**Palpation :**

1. Temperature - Mild raised
2. Tenderness - Present.
3. Size - 5x5 cm
4. Extend - To the toe of foot.
5. Surface - soft & uniform.
6. Edge - ill-defined
7. Consistency - soft
8. fluctuation - absent
9. fluid thrill - absent.
10. Reducibility - Not reduceable.
11. Compressibility - Not present.
12. fixation - skin is fixed to underlying structure.
13. lymph node palpation - Not palpable.

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**Precusion :**

Not relevant

**Ausculation :**

Not relevant

## PROVISIONAL DIAGNOSIS :

1. Traumatic soft tissue swelling.
2. Varying fracture of metatarsal.

## INVESTIGATION :

1. Heamogram
2. Blood urea
3. Blood sugar

Special investigation - X-ray :- Right foot (AP view)

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**Final Diagnosis :**

Fracture of first uniform bone.

**Treatment :**

1) Bed rest
2) Hospitalization
3) Leg elevation (Right leg)
4) Tab Imol BD
5) Inj. Toxiem BD.
6). Posted from K wire fixation after swelling has decreased.

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## GENERAL SURGERY

**Name:** Rushita Suresh Patil

**Age:** 55 year **Sex:** Female

**Address:**

A/p - Arle Tal - panhala, Dist - kolhapur.

**Social Status:** Middle Class

**Chief Complaint:**

1. Bilateral swelling at TMJ in front of tragus since 4 days.
2. Pain at swelling since 4 days.
3. Difficulty in speaking & deglutition since 4 days.

**History of Present illness :**

1. Patient was apparently alright before 4 days.
2. She had road traffic accident, after accident got bilateral swelling at TMJ.
3. Swelling is diffuse about 3/4 cm.
4. Patient taken medicine from TKDC & RC, - swelling got reduce now.
5. Patient also complain of pain & difficulty in speaking and in mastication and is on liquid diet.

**Past Medical History :**

H/O trauma was present.
No H/O fever
No H/O secondary changes.
No H/O other lumps.
No H/O reccurance.

**Drug History/History of Allergy :**

Non relevant history.

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**Family History:**

Non-relevant history

**Personal History:**

- No any adverse habit present
- B/B - Normal
- Diet - Mixed
- Married

**GENERAL PHYSICAL EXAMINATION:**

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

**Built :** Normal **Attitude :**

**Gait :** Normal **Face :**

**Decubitus :**

**Pallor :** Absent **Cynosis :** Absent.

**Icterus :** Absent **Edema :** Present (Bilaterally over TMJ)

**Skin Eruption:** Absent

**VITAL SIGNS :**

**Pulse Rate:** 72 beats/min (Regular & equal on both side)

**Respiratory Rate:** 15 cycle/min

**Temperature:** Afebrile

**Blood Pressure:** 130/80 mm Hg

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**SYSTEMATIC EXAMINATION:**

**Respiratory System:**

Clear sound
No sound added.

**Cordiovascular System:**

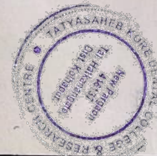
Heart sound normal
No gallop present (3rd sound)
No murmur.

**Gastrointestial Track:**

P/A soft
No tenderness
Lokoso

**Central Nervous System:**

No neurological disorder.
Planter ↓↓.



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**LOCAL EXAMINATION :**

**Inspection :**

1. Situation - At region of TMJ at angle of mandible.
2. Colour - Normal skin colour, No redness present.
3. Shape - Diffused swelling.
4. Size - 4 x 3 cm
5. Surface - Smooth.
6. Edge - Not well oriented.
7. Number of swelling - 2 in number.
8. Pulsation - Not present.
9. Skin over swelling - slightly edematous.

**Palpation :**

1. Temperature - Normal.
2. Tenderness - present.
3. Size - 4 x 3cm x 1mm
4. Extend - extend from tragus to angle of mandible.
5. Surface - smooth & uniform.
6. Edge - ill - defined.
7. Consistency - soft.
8. fluctuation - Absent (paget's test)
9. fluid thrill - absent
10. Reducibility - absent
11. Compressibility - absent.
12. Pulsability - absent.
13. Transillumination test - Absent (-ve)

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14. Fixation to underlying skin - fix to swelling.
15. Relation to underlying structure - Not related.

**Precusion :**

Not relevant

**Ausculation :**

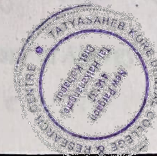
Not relevant

**PROVISIONAL DIAGNOSIS :**

# Traumatic swelling of soft tissue over TMJ.
# ? fracture of TMJ

**INVESTIGATION :**

Routine - CBC, Differential count, ESR, Total platelet count.
Special - X-ray :- Advice OPG.
Examination of TMJ.



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**Final Diagnosis :**

fracture TMJ & angle of Mandible.

**Treatment :**

1]. Immediate surgery
2]. Rest
3]. Imol
4]. Antibiotic
5]. follow up.

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## GENERAL SURGERY

**Name:** Anirudha Anil Swami
**Age:** 45 year **Sex:** Male
**Address:**
Pargaon, Tal- Hatkabangle, Dis- kolhapur.

**Social Status:** Middle Class

**Chief Complaint:**
1. Swelling at back of right side near scapula since 2 year.
2. Pain at swelling since 15 days.

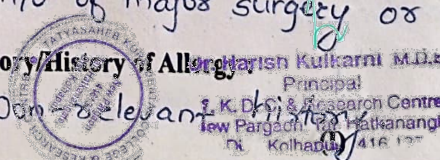
**History of Present illness :**

- Patient was apparently alright 2 years back.
- He noted a swelling on back right side near the middle margin of scapula of peanut size which goes on increasing very slowly to attain a present size of about a lemon.
- Pt also complain of slight pain at swelling during swelling and over right arm.
- No H/o trauma
- No H/o fever
- No H/o secondary changes.
- No H/o of change in consistency.
- No H/o weight loss

**Past Medical History :**

1. No H/o diabetes
2. No H/o hypertension
3. No H/o bleeding & tuberculosis
4. No H/o of major surgery or medication.

**Drug History/History of Allergy:**
Non relevant history



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**Family History:**

Non relevant history

**Personal History:**

No any history of habit.
Diet - Mixed
Marrital status - Married
(Having two child one male & one female)

**GENERAL PHYSICAL EXAMINATION:**

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

**Built :** Average

**Attitude :** Comfortable

**Gait :** Normal

**Face :** Normal

**Decubitus :** lying comfortable on bed on left lateral position.

**Pallor :** Absent

**Cynosis :** Absent

**Icterus :** Absent

**Edema :** Absent

**Skin Eruption:** Absent

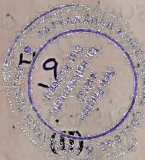
**VITAL SIGNS :**

**Pulse Rate:** 80 min, regular, good volume, equal on both sides.

**Respiratory Rate:** 20 cycles/min, regular

**Temperature:** Afebrile

**Blood Pressure:** 120/30 mm Hg



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**SYSTEMATIC EXAMINATION:**

**Respiratory System:**

Clear sound
No sound added

**Cordiovascular System:**

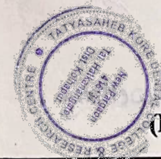
Heart sound = Normal
Nor murmur
No gallop

**Gastrointestial Track:**

Abdomen - Soft & nontender
Lokoso

**Central Nervous System:**

No Neurological defect
Planter ↓↓



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## LOCAL EXAMINATION :

**Inspection :**

Situation :- On right side of back near superior angle of scapula.

Size :- 3 x 3 cm

Shape :- spherical

Colour :- Normal skin colour.

Surface :- smooth.

Edge :- well defined.

Number :- 1 in number.

Pulsation - Absent

Skin over swelling - There is black spot present approximately in the centre of cyst on surface. i.e punctum.

**Palpation :**

1) Temperature :- mildly raised.
2) Tenderness - mild present.
3) Extent - No extension
4) Surface - soft & uniform
5) Edge - well defined
6) Sleep in sign - positive
7) Consistency - soft.
8) fluctuation - slightly present.
9) fluid filled - absent.
10) Reducibility - not reduceable.
11) Compressibility - Not present.
12) Fixation of skin - skin is fixed to swelling.

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13) Lymphnode - Axillary and cervical lymph node are not palpable.
14) Transillumination - Absent.
15) Pulsation - Absent.

**Precusion :**

Not relevant

**Ausculation :**

Not relevant

**PROVISIONAL DIAGNOSIS :**

1) Sebaceous cyst.
2) Lipoma

**INVESTIGATION :**

1) Routine - CBC, HB
2) Special :- a) X-ray chest (PA view)
   b) CT of swelling

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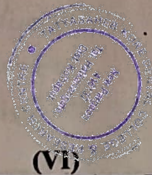
**Final Diagnosis :**

Sebaceous cyst

**Treatment :**

1) Hospitalization
2) Incision and removal of complete cyst under general anaesthesia
3). Inj. Taxim 1g B.D
4) Tab. Imol
5). Inj. Metrodil 400 mg BD IV
6). Follow up after 15 days.



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## GENERAL SURGERY

**Name:** Ramesh Namdev Daphalapurkar

**Age:** 28 year **Sex:** Male

**Address:**

Jakhale , Tal- Panhala , Dist - Kolhapur

**Social Status:** Middle Class

**Chief Complaint:**

1) Swelling at index finger since 1 week.
2) Pain at swelling since 6 days.
3) Mild fever since 4 days.

**History of Present illness :**

- Pt. was apparently alright 1 week before.
- He had minor unknown injury over index finger.
- He developed mild swelling near index finger of minor injury which is diffuse in nature and goes on increasing to involve whole right palm.
- Pain is localized in nature, restricted to index finger.
- Pain is mild and is of throbbing type.

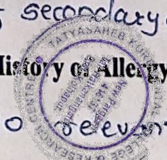
**Past Medical History :**

H/o fever present
H/o trauma present
H/o pain present
No H/o of secondary change.

No H/o diabetes
No H/o hypertension
No H/o bleeding disorder
No loss of function.

**Drug History/History of Allergy :**

No relevant history



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**Family History:**

No relevant history

**Personal History:**

No adverse habit
Diet- mixed
B/B - Normal

**GENERAL PHYSICAL EXAMINATION:**

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

**Built :** Normal **Attitude :** Comfortable

**Gait :** Normal **Face :** Normal

**Decubitus :** lying comfortable in supine position.

**Pallor :** Absent **Cynosis :** Absent

**Icterus :** Absent **Edema :** Absent

**Skin Eruption:** Not present

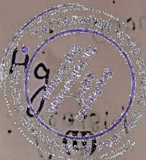
**VITAL SIGNS :**

**Pulse Rate:** 80 beats/min (Regular & equal on both sides)

**Respiratory Rate:** 16 cycle/min

**Temperature:** Afebrile

**Blood Pressure:** 120/78 mm Hg



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**SYSTEMATIC EXAMINATION:**

**Respiratory System:**

No added sound

**Cordiovascular System:**

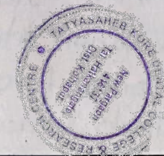
No murmur
No gallop
Heart sounds are normal.

**Gastrointestial Track:**

LO, KO, SO - nonpalpable.

**Central Nervous System:**

No neurological defect
Ankle jerk normal
Planter reflex - Normal



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## LOCAL EXAMINATION :

**Inspection :**

1) Situation - At right index finger involving right palm
2) Size - 5cm x 3cm
3) Shape - Diffuse
4) Colour - Slightly reddish & oedematous.
5) Surface - Uniform & oedematous.
6) Edge - ill defined
7) Number - one
8) Pulsation - absent
9) Skin over swelling - Slightly reddish & edematous.

**Palpation :**

1) Temperature - Increased
2) Tenderness - present.
3) Size - At index finger 5cm x 3cm
   At palm - 10 cm x 6 cm
4) Extent - From tip of index finger to wrist joint.
5) Surface - uniform & smooth.
6) Edge - ill defined
7) Consistency - soft
8) fluctuation - present
9) fluid thrill - absent
10) Reducibility - absent
11) Compressibility - present
12) Lymph node - not enlarged
13) fixity - absent
14) Relation to overlying structure - Not fixed

**Precusion :**

Not relevant

**Ausculation :**

Not relevant

**PROVISIONAL DIAGNOSIS :**

Cellulilitis at right index finger with oedema of right palm.

**INVESTIGATION :**

- Hb - 12.8 g dl,
- TC - 10,900 cells/mm$^3$
- Blood urea
- Serum creatinine
- BSL (fasting)
- Retroviral HIV test
- X ray chest - PA
- X ray right hand AP oblique
- Culture and sensitivity of oedematous fluid or pus after incision & drainage.

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**Diagnosis :**

Cellulitis with right index of finger

**Treatment :**

I). Surgical line of Rx :-
Under short GA :- Incision & drainage done
(Preparation of operating part)
1. removal of air
2. wash with betadine
3. short GA given
4. Incision is taken on most prominent part of swelling
5. With sinus forcep all the loci are broken down. Pressure is applied on all sides of index finger, pus & inflammatory fluid is drained upto blood comes out of incised part.
6. Loose sutures are put.

II) Medical line of Rx :-
1. Antibiotic & hand elevation.
2. Inj. Tramodol 1 ampl 100mg BD
3. Inj. pantoprazole 40mg H.S
4. follow up after 2 days.
5. Dressing every alternate days

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## GENERAL SURGERY

**Name:** Sonali Krushna Sardesai

**Age:** 55 years **Sex:** Female

**Address:**
A/p - Panewadi
Tal- panhala
Dist - kolhapur

**Social Status:**
Middle Class

**Chief Complaint:**
1). Pt c/o of swelling at right cheek from 6 days.
2). Pain at swelling from 6 days.
3). Difficulty in swallowing due to pain.
4) Fever (mild in nature) since 20 days.

**History of Present illness :**
- Pt was apparently alright before 6 days.
- Before 6 days, she had pain in carious tooth of mandibular region.
- She developed swelling at right cheek and submandibular region which goes on increasing within 2 days.
- Swelling is diffuse and throbbing type.
- Pt. c/o of difficulty in swallowing since 2-3 days unable to eat since last 1-2 days and is admitted to MG hospital for the same.

**Past Medical History :**
H/O diabetes since 2 years
No H/O TB
No H/O Bleeding disorder
No H/O hypertension

**Drug History/History of Allergy :**
No relevant history

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**Family History:**

No relevant history.

**Personal History:**

No adverse history
Diet - Mixed
Married - 3 female child, 1 male child.

**GENERAL PHYSICAL EXAMINATION:**

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

**Built :** Normal **Attitude :**

**Gait :** Normal **Face :**

**Decubitus :** lying in supine position

**Pallor :** Absent **Cynosis :**

**Icterus :** Absent **Edema :**

**Skin Eruption:** Absent

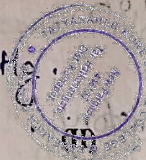
**VITAL SIGNS :**

**Pulse Rate:** 82 beats/min (Regular & equal on both sides)

**Respiratory Rate:** 17 cycles/min

**Temperature:** Afebrile

**Blood Pressure:** 120/70 mmHg



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**SYSTEMATIC EXAMINATION:**

**Respiratory System:**

NAD

**Cardiovascular System:**

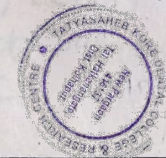
Heart sound is Normal.
No gallop
No murmur

**Gastrointestial Track:**

LO, KO SO - Non palpable

**Central Nervous System:**

No neurological defect.
Ankle jerk Normal
Planter reflex Normal.



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## LOCAL EXAMINATION :

**Inspection :**

1. Situation - Right cheek in submandibular region
2. Shape - diffuse with ill-defined margins.
3. Size - 8x8 cm at right cheek
   4x3 cm
4. Surface - smooth & uniform
5. Colour - Slightly reddish & edematous.
6. Edge - ill-defined
7. Pulsation - Absent.
8. Skin over swelling - edematous & Inflammatory
9. Number - One.

**Palpation :**

1. Temperature - slightly raised
2. Tenderness - present
3. Size - 8x8 cm, 4x3 cm, depth - 3 cm
4. Extent - from tragus of ear to submandibular region.
5. Surface - Smooth & uniform.
6. Edge - ill defined
7. Consistency - soft
8. fluctuation - absent.
9. Reducibility - absent
10. fluid thrill - absent
11. compressibility - absent
12. Relation to deeper structure - absent
13. lymph node - palpable.

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**Precusion :**

Not relevant

**Ausculation :**

Not relevant

## PROVISIONAL DIAGNOSIS :

1) Cellulitis :- of submandibular region including cellulitis of right sided cheek with carious mandibular tooth.
2) Submandibular lymphadenopathy.

## INVESTIGATION :

1) Hb
2) Urine
3) Blood sugar level
4) BUL
5) Serum creatinine
6) X-ray (OPG) - lateral head & neck region.
7) USG of Submandibular region.
8) FNAC

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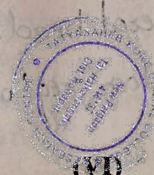
**Final Diagnosis :**

Mandibular carious tooth with Cellulitis and Ludwig's Angina.

**Treatment :**

1. Admission to hospital
2. Rest
3. IV fluids [IV 5% dextrose / IV RL / NS]
4. Ryle's tube feeding.
5. Inj. metronidazole 500 mg TDS
6. Potassium clormate IV BD
7. Serosopepti dase 10 mg TDS
8. If Pt. does not respond to conservative Rx, Pt should be posted for general surgery under GA.



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## GENERAL SURGERY

**Name:** Vimal Bhagwan Kadam

**Age:** 75 years **Sex:** Female

**Address:**
A/P - Manpadale
Tal - Hatkanangale
Dist - Kolhapur

**Social Status:** Middle Class

**Chief Complaint:**

1. Pain at left hip joint and unable to walk.
2. Swelling at left hip joint since one month.

**History of Present illness :**

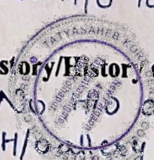
- Pt was apparently alright 1 month ago.
- She had a fall and developed a swelling at left hip joint.
- She has pain which is severe in nature, localised to left hip region and was admitted to CPR hospital for same for last month.
- Pt. came to MG hospital 3 days ago. At present, she has mild swelling at left hip joint and is unable to walk due to pain.
- H/o trauma present, no H/o fever, weight loss present.

**Past Medical History :**

No H/o diabetes
No H/o hypertension
No H/o bleeding disorder
No H/o Tuberculosis

**Drug History/History of Allergy :**

No H/o drug allergy
No H/o allergy to food



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**Family History:**

No relevant history

**Personal History:**

No H/o any adverse habit.
Diet - Mixed
Marital status - Married and having 2 children.

**GENERAL PHYSICAL EXAMINATION:**

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

**Built :** Average **Attitude :** Comfortable

**Gait :** Normal **Face :** Normal

**Decubitus :** Propped up position with leg elevation

**Pallor :** Present **Cynosis :** Absent

**Icterus :** Absent **Edema :** Absent

**Skin Eruption:** Absent

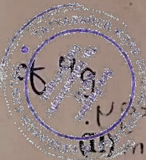
**VITAL SIGNS :**

**Pulse Rate:** 80/min regular, good volume, good tension equal on both sides.

**Respiratory Rate:** 20 cycles/min, regular

**Temperature:** Afebrile

**Blood Pressure:** 120/90 mm of Hg



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**SYSTEMATIC EXAMINATION:**

**Respiratory System:** Clear
No sound added

**Cordiovascular System:**

Heart sound - Normal
No murmur
No gallop

**Gastrointestial Track:**

Abdomen - Soft
Non tender
LO KO SO

**Central Nervous System:**

No neurologic defect
Plantar ↓↓

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**LOCAL EXAMINATION :**

**Inspection :**

1. Situation – At left hip joint.
2. Size – 8 × 10 cm
3. Shape – Diffuse
4. Colour – Normal skin colour
5. Surface – Smooth
6. Edges – Well defined
7. Number – 1 in number
8. Pulsation – Absent.
9. Skin over swelling – Normal.

**Palpation :**

1. Temperature – mildly raised
2. Tenderness – present.
3. Size – 8×10 cm
4. Extent – Up to upper thigh region
5. Surface – Irregular
6. Edge – Ill defined
7. Consistency – soft
8. Fluctuation – Absent
9. fluid thrill – absent
10. Reducibility – absent
11. Compressibility – absent
12. fixity to skin – not fixed
13. Relation to deeper structure – Not fixed

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14. Lymph node – Inguinal lymph node not palpable.

**Precusion :**

Not relevant

**Ausculation :**

Not relevant

**PROVISIONAL DIAGNOSIS :**

1. # Left neck femur
2. Dislocation of hip joint.

**INVESTIGATION :**

1. Routine – Hb – 10gm%
   TLC – 100/cumm
   Platelet – 1,87000/cumm
   BSL – 90 gm
2. Special – X-ray (hip joint)
   [AP & lateral view]

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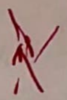
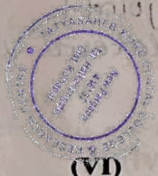
**Final Diagnosis :**

Multiple fracture at left neck femur including lesser and greater trochanter.

**Treatment :**

1. Hospitalization
2. Leg elevation
3. Artificial prosthesis (Head & neck prosthesis of femur)
4. Fixation of greater & lesser trochanter with plating under spinal anaesthesia.





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## GENERAL SURGERY

**Name:** Siddhu Prashant Savant

**Age:** 36 years **Sex:** Male

**Address:**

A/P - Talsande
Tal - Hatkanagale
Dist - Kolhapur

**Social Status:** lower middle class

**Chief Complaint:**

1. Patient c/o ulcer over gluteal region since 2 days.
2. Pain of ulcer since 2 days.
3. Mild discharge from ulcer since 2 days.

**History of Present illness :**

- Patient was apparently alright 15 days back.
- He recieved IM injection in gluteal region from local doctor, After 3-4 days he noticed pain at the site
- For this he was admitted to MG hospital 3 days back and was treated with incision and drainage under GA.
- At present Pt c/o ulcer (5 × 3 × 1.5 cm), pain is dull aching type.
- Pt also c/o of watery discharge from the ulcer site.

**Past Medical History :**

No H/o diabetes
No H/o hypertension
No H/o tuberculosis
No H/o bleeding disorder
No H/o trauma/fever

No H/o pus discharge
No H/o syphilis
No H/o neurological defect.

**Drug History/History of Allergy :** No H/o allergy of drug.

Pt. at present recieving
a) Oral cefotaxime 200 mg BD
b) Tab Amox c - clavunoic acid 0.25 mg BD
c) Cap. Omeprazole 20 mg BD

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**Family History:**

No relevant history.

**Personal History:**

No adverse habit

Diet - Mixed type

Marital status - Married

Having 2 children (1 male & 1 female)

## GENERAL PHYSICAL EXAMINATION:

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

**Built :** Average **Attitude :** Comfortable

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

**Decubitus :** Lies on left lateral position.

**Pallor :** Absent **Cynosis :** Absent

**Icterus :** Absent **Edema :** Absent

**Skin Eruption:** Absent

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**VITAL SIGNS :**

**Pulse Rate:** 80 beats/min

Regular / Good volume / Good tension / equal on both side peripheral pulsation well felt

**Respiratory R...**

## SYSTEMATIC EXAMINATION:

**Respiratory System:** Clear

No added sound.

**Cardiovascular System:**

Heart sound Normal

No gallop

No murmur

**Gastrointestinal Track:**

Per abdomen - soft, Nontender

Lok.

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**Central Nervous System:**

No power loss

No muscle wasting

Ankle reflex normal

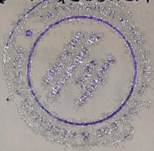
**LOCAL EXAMINATION :**

**Inspection :**

1. Size - Elongated - oval 5 x 3 cm
2. Number - 1 in number.
3. Location - posteriosuperior quadrant of gluteal region.
4. Edges - punched out
5. Discharge - serous, scanty
6. Smell - Absent
7. surrounding area - Normal, non-oedematous.
8. Whole lower limb - Normal

**Palpation :**

1. Tenderness - mild
2. Size - 5 x 3 x 1.5 cm
3. Edge - formed by gluteal muscle with mild induration.
4. Bleeding on touch - No bleeding.
5. Relation to deeper structure - free from underlying structure.
6. surrounding skin - Normal
7. Regional lymph node - Inguinal lymph node - non palpable
8. Pulsation peripheral - Dorsalis pedis, Popliteal, posterior tibial femoral are well felt.



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**Precusion :** Not relevant

**Ausculation :** Not relevant

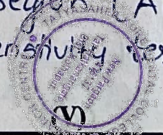
**PROVISIONAL DIAGNOSIS :**

1) Post subcutaneous pyogenic abscess.
2) Healing type of ulcer in gluteal region.

**INVESTIGATION :**

Routine - Haemogram, Hb, CBC, Serum creatinine.
Urine examination
BSL - 1) fasting
2) PP
Urine sugar
BUL (to rule out septicemia)

Special - Xray hip region (AP & oblique)
Culture & sensitivity test of scab of ulcer.



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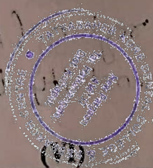
**agnosis :**

Post subcutaneous pyogenic abscess.
Healing type of ulcer in gluteal region due to incision and drainage.

**Treatment :**

1). Rest
2) High protein diet.
3). Cap Amox c – claviulonic acid 25 mg BD
Tab Imol 500 mg BD
Cap. Omeprazole 20 mg BD.
4). Daily dressing using normal saline with betadine
5) Dressing alternate day.
6) Follow-up.



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## GENERAL SURGERY

**Name:** Mahadev Hari Patil

**Age:** 65 years **Sex:** Male

**Address:**
A/p - Pargaon
Tal - Hatkanangale
Dist - Kolhapur.

**Social Status:**
Middle Class

**Chief Complaint:**
1. Pt c/o ulceration over right planter surface of the foot since 3 days.
2. Pain at ulcer since 3 days.
3. Mild discharge from ulcer from 3 days.

**History of Present illness :**
- Pt was apparently alright 3 weeks back.
- He got minor trauma over right plantar aspect of foot
- He noted swelling which was painful which goes on increasing to involve whole of planter surface of right foot.
- For that he was admitted to MG hospital 8 days back and operated.
- At present there is dry (?) single ulcer over planter surface and it pains only during dressing.
- Pt is unable to walk due to pain and ulceration, light serious discharge from site of ulcer.
- No H/o fever, No H/o bleeding disorder.

**Past Medical History :**
Pt. is suffering from DM type II since last 10 year. for that he is on antidiabetic therapy.
H/o similar type of ulceration over the right foot.
No H/o hypertension
No H/o vulnerable disease
No H/o tuberculosis.

**Drug History/History of Allergy :**
Pt. was on antidiabetic drug for last 10 years. At present he is on insulin therapy, 40 [illegible] allergy.

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**Family History:**
No relevant history.

**Personal History:**
No adverse habit
Diet - Mixed
Marrital status - Married
Bowel / Bladder - Normal

**GENERAL PHYSICAL EXAMINATION:** Fully conscious & well oriented.
**Mental State (Level of Consciousness):**

**Built :** Average
**Attitude :** Not fully comfortable

**Gait :** Limping gait
**Face :** Normal

**Decubitus :** Patient was sitting with leg elevation.

**Pallor :** Present
**Cynosis :** Absent.

**Icterus :** Absent
**Edema :** Absent

**Skin Eruption:** Absent

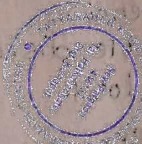
**VITAL SIGNS :**

**Pulse Rate:** 70 beats/min, Regular, Good volume, Tension equal on both sides.

**Respiratory Rate:** 15 cycles per min

**Temperature:** Normal, 37°c

**Blood Pressure:** 140/90 mm of Hg



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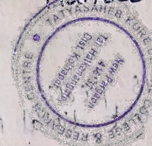
**SYSTEMATIC EXAMINATION:**

**Respiratory System:**
Clear
No sound added.

**Cordiovascular System:**
Heart sounds Normal
No gallope
No murmur

**Gastrointestial Track:**
per abdomen soft
nontender
Lo Ko So

**Central Nervous System:**
No power leis
No muscle coasting
Ankle reflex - Normal
Planter - decreased.



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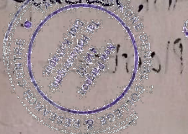
## LOCAL EXAMINATION :

**Inspection :**

1. Size - 15 cm x 5 cm roughly oval.
2. Number - 1 in number.
3. Position - Planter surface of right foot.
4. Edge - Punched out.
5. Discharge - No discharge / slight serous
6. Smell - Absent
7. Surrounding area - Normal
8. ~~Alcohol~~ Whole foot - Rest of foot is normal
9. Floor - Red granulation tissue with a tender of great toe with a minimal stuff.

**Palpation :**

1. Tenderness - mild-moderate at the floor of ulcer.
2. Size - 15 x 5 cm oval
3. Edge - mild moderate induration is present.
4. Base - Base is formed by the plantar tenderness induration is mild-moderate.
5. Depth - upto 2 cm
6. Bleeding of touch present.
7. Relation to deeper structure - Ulcer is free from underlying structure.
8. Surrounding skin - Normal.
9. Pain sensation - Hampered
10. Examination of pulse - Dorsalis pedis post tibial not felt.



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**Precusion :**

Not relevant

**Ausculation :**

Not relevant

## PROVISIONAL DIAGNOSIS :

Diabetic ulcer foot on right plantar region.

## INVESTIGATION :

Routine :- Hb, CBC
- Urine examination
- BSL - fasting, PP
- Urine sugar
- BUL - to rule out septicemia
- Serum creatinine level.

Special investigation
- X-ray of bone & joint of right foot.
- Culture senstivity test of swab of (ulcer)
- Lower limb angiography.

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**Final Diagnosis :**

Diabetic ulcer foot on right plantar region.

**Treatment :**

1. Control of diabetes.
2. Control of infection antibiotic therapy.
3. Local treatment of ulcer - initial treat with iodine solution. When ulcer is converted in healing ulcer, c̄ - pink granulation tissue, a septic skin graft is applied
4. Various types of surgery for diabetic ulcer foot.
5. Care of patient as a whole.
6. Use of microcellular rubber shoes
7. Trimming of nails should be done carefully
8. keep foot dry after proper cleaning of foot.
9. Follow-up.

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# GENERAL SURGERY

**Name:** Vishwa Harish Deshmukh

**Age:** 40 years **Sex:** Male

**Address:** A/p - Chavre
Hatkanangle, Kolhapur
Occupation - Farmer

**Social Status:** Middle Class

**Chief Complaint:**

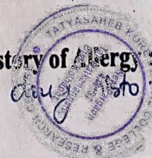
Swelling over right forearm on extension surface from 3 years.

**History of Present illness :**

- Pt was apparently alright 3 years back.
- He noticed a small swelling of peanut size over extensor surface of forearm.
- The swelling grows very slowly in size to attain present walnut size since last 1 year,
- There is no increase in size.
- No H/o trauma, fever, change in consistency.
- No H/o secondary changes.
- No H/o weight loss
- No pain & loss of function.

**Past Medical History :**

No H/o DM
No H/o hypertension
No H/o TB
No H/o Bleeding tendency.



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**Drug History/History of Allergy :**

No major drug history. No H/o allergy to drug & food.

**Family History:**

No relevant history

**Personal History:**

No Habit
Diet - Mixed
B/B - Normal
Marrital status - Married having a male child.

**GENERAL PHYSICAL EXAMINATION:**

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

**Built :** Normal

**Attitude :** Comfortable

**Gait :** Normal

**Face :** Normal

**Decubitus :**

**Pallor :** Absent

**Cynosis :** Absent

**Icterus :** Absent

**Edema :** Absent

**Skin Eruption:** No eruption.

**VITAL SIGNS :**

**Pulse Rate:** 30 beats/min

**Respiratory Rate:** 20 cycles/min regular abdominothoracic

**Temperature:** 37°C

**Blood Pressure:** 130/80 mmHg

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**SYSTEMATIC EXAMINATION:**

**Respiratory System:**

Clear
No added sound

**Cordiovascular System:**

Heart sound are normal
No gallop
No murmur

**Gastrointestial Track:**

Per abdomen soften
LOKOSO

**Central Nervous System:**

No power loss
No muscle wasting
Ankle reflex normal

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**LOCAL EXAMINATION :**

**Inspection :**

1. Size - 3cm x 3cm
2. surface - Uniform
3. Colour - Normal skin colour
4. Shape - spherical
5. Edges - Well defined
6. Number - One in number
7. Pulsation - Absent
8. Skin over swelling - Normal & non edematous.

**Palpation :**

1. No pressure effect, Temp - Normal
2. Tenderness - absent
3. Size - 3x3x1cm.
4. Shape - spherical structure lobules.
5. Consistency - Very short
6. fluid thrill - absent.
7. Reduceability - absent.
8. Compressibility - absent
9. Pulsation - absent
10. Fixation to overlying skin - slightly presen t
11. Regional lymph node - axillary group of lymph node not palpable

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**Precusion :**

Not relevant

**Ausculation :**

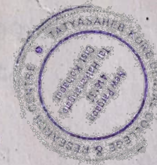
Not relevant

**PROVISIONAL DIAGNOSIS :**

1. Lipoma
2. Dermoid. cyst

**INVESTIGATION :**

Routine - Hb, CBC
- Urine examination
- Aspiration of material inside swelling
- Microbiology of bacterial examination.
- BSL - a) fasting
Special b) PP
- FNAC
- X-ray right forearm
- Ultrasonography Lt. right forearm if required.



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**Final Diagnosis :**

Lipoma

1). Consistency is very soft.

2). The edges are stip out, so it is a solid swelling.

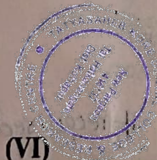
3). Fluid thrills absent - solid swelling (lipoma)

4) Transillumination - positive.

**Treatment :**

No surgical T/t is recquired until it caused a pain/ it is changed into malignancy cause cosemetic disturbances.

- Advice to patient, not to worry it is a benign swelling it will not harm to your health.



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# GENERAL SURGERY

**Name:** Bhavana Pratik Patil

**Age:** 18 years **Sex:** Female

**Address:**

A/P- Chikurade
Sangli

**Social Status:** Average

**Chief Complaint:**

1. Swelling in lower jaw on left side since 15 day & pain with swelling since 10 days.
2. Difficulty in opening mouth with chewing since 7-8 days.

**History of Present illness :**

- History of typhoid 4 months back with hospitalization for same.
- C/o of swelling since 15 days and pain is continuous since 10 days.
- Also has difficulty in opening mouth & chewing since 7-8 days.
- Pain is continuous and coupled with mild degree fever and headache.

**Past Medical History :**

History of typhoid 4 months back with Hospitalization for same
No H/o hypertension
No H/o diabetes
No H/o TB

**Drug History/History of Allergy :**

No allergy of drug & food.

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**Family History:**

No relevant history.

**Personal History:**

Normal diet

Regular bowel and bladder habit

## GENERAL PHYSICAL EXAMINATION:

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

**Built :** Normal

**Attitude :** Normal

**Gait :** Normal

**Face :** Normal

**Decubitus :** lying comfortably on bed in supine position.

**Pallor :** ++ present

**Cynosis :** Absent

**Icterus :** Absent

**Edema :** Absent

**Skin Eruption:** Absent

## VITAL SIGNS :

**Pulse Rate:** 72 beats/min

**Respiratory Rate:** 16 cycles/min

**Temperature:** Mild fever

**Blood Pressure:** 110/80 mm Hg

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## SYSTEMATIC EXAMINATION:

**Respiratory System:**

Clear sound

No added sound

**Cordiovascular System:**

Heart sound - Normal

No gallop

No murmur

**Gastrointestial Track:**

P/A - soft

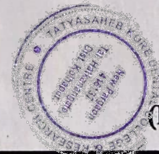
No tenderness

Lo ko So

**Central Nervous System:**

No neurological deficient

Planter ↓↓



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**LOCAL EXAMINATION :**

**Inspection :**

1. Site - submandibular region medial to angle of mandible of left side.
2. Shape - ovoid.
3. Size - 5x4 cm
4. Surface - smooth.
5. Skin over swelling - inflammed
6. Edges - well defined.

**Palpation :**

1. Temperature - Raised
2. Tenderness - present
3. Consistency - soft
4. Surrounding area - oedematous
5. Relation with deeper tissue - Movable over adipose tissue,

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**Precusion :**

Not relevant

**Ausculation :**

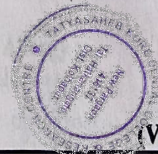
Not relevant

**PROVISIONAL DIAGNOSIS :**

Submandibular adenitis

**INVESTIGATION :**

1. Routine - CBC, Hb count, ESR, Serum creatinine Blood sugar level.
2. Aspiration



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**Final Diagnosis :**

Acute left submandibular adenitis.

**Treatment :**

① Systemic antibiotics

② Anti-inflammatory analgesics drugs.

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## GENERAL SURGERY

**Name:** Sarika Omkar Ghodke

**Age:** 28 years **Sex:** Female

**Address:**
A/p- Kini
Kolhapur

**Social Status:** Average

**Chief Complaint:**
Swelling, in front of neck & difficulty in swallowing.

**History of Present illness :**

- Pt was apparently alright before 6 months.
- Initially swelling was small & nodular that gradually increased.
- She found difficulty in swallowing.

**Past Medical History :** No H/o TB
No H/o DM
No H/o Bleeding tendencies
No H/o hypertension

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**Drug History/History of Allergy :**
No H/o drug allergy.
and allergy of food.

**Family History:**

No relevant history.

**Personal History:**

Diet- Regular
B/B - Normal
Menstruation - Regular

**GENERAL PHYSICAL EXAMINATION:**

**Mental State (Level of Consciousness):**

**Built :** Normal

**Attitude :** Normal

**Gait :** Normal

**Face :** Normal

**Decubitus :** lying comfortably in bed in supine

**Pallor :** Present

**Cynosis :** Absent

**Icterus :** Absent

**Edema :** Absent

**Skin Eruption:** Absent

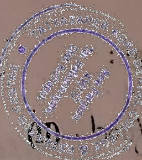
**VITAL SIGNS :**

**Pulse Rate:** 78 beats/min

**Respiratory Rate:** 17 cycles/min

**Temperature:** Afebrile

**Blood Pressure:** 144 / 88 mm Hg



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**SYSTEMATIC EXAMINATION:**

**Respiratory System:**

Clear sound
No added sound

**Cordiovascular System:**

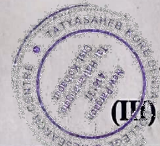
Heart beat - Normal
No gallop
No murmur

**Gastrointestial Track:**

P/A - soft
No tenderness
Lo ko So

**Central Nervous System:**

No neurological defect
Planter ↓↓



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**LOCAL EXAMINATION :**

**Inspection :**

1. Site - Along neck in middle line and extending towards right side.
2. Size - 4 x 12 cm
3. Surface - Smooth.
4. Movement on coughing - present.
5. Movement on deglutition - present
6. Number - single.

**Palpation :**

1. Temperature - Not raised
2. Tenderness - absent
3. Consistency - firm
4. Pulsation - absent
5. Edge - Distinct
6. Relation to deeper structure - Not raised.

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**Precusion :**

Not relevant

**Ausculation :**

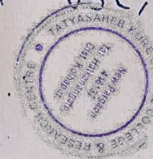
Not relevant

**PROVISIONAL DIAGNOSIS :**

1. Subhyoid bursitis
2. Multinodular toxic goitre
3. Laryngeal
4. Cold abscess

**INVESTIGATION :**

1. Routine - CBC, Hb count, Serum creatinine Blood sugar level,
2. Special - USG, X-ray, Abdomen, Thyroid function test



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**Family History:**

No relevant history.

**Personal History:**

Diet - irregular

History of irregular menstruation since 8 month.

## GENERAL PHYSICAL EXAMINATION:

**Mental State (Level of Consciousness):**

**Built :** Normal

**Attitude :** Normal

**Gait :** Normal

**Face :** Normal

**Decubitus :** lying comfortable on bed in supine position.

**Pallor :** Present

**Cynosis :** Absent

**Icterus :** Absent

**Edema :** Absent

**Skin Eruption:** Absent

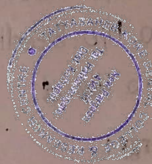
**VITAL SIGNS :**

**Pulse Rate:** 100 beats/min

**Respiratory Rate:** 18 cycles/min

**Temperature:** Afebrile

**Blood Pressure:** 130 / 80 mm Hg



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## SYSTEMATIC EXAMINATION:

**Respiratory System:**

Clear sound

No added sound

**Cordiovascular System:**

Heart sound - Normal

No gallop

No murmur

**Gastrointestial Track:**

P/A :- soft

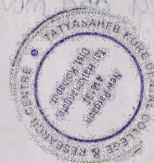
No tenderness

Lo Ko So

**Central Nervous System:**

No neurological defect

Plantar ↓↓



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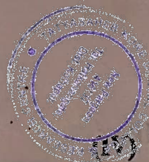
**LOCAL EXAMINATION :**

**Inspection :**

1. Size - 1-2 cm
2. Shape - Semiperiosteal
3. Site - Anterior aspect of neck on right side.
4. Edge - Well defined.
5. Number - Single
6. Surface - Smooth.

**Palpation :**

1. Skin over swelling - Normal
2. Temperature - Not raised
3. Size - 1-2 cm
4. Consistency - firm
5. Tenderness - absent
6. Lymph nodes - cervical group palpated
7. Overlying plain is most fixed and move with deglutition.



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**Precusion :**

Not relevant

**Ausculation :**

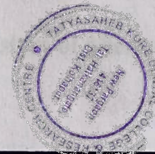
Not relevant

**PROVISIONAL DIAGNOSIS :**

Thyrotoxicosis with solitary nodules

**INVESTIGATION :**

1. Routine - CBC, Urine, Serum creatinine, Blood sugar, X-ray chest.
2. Specific - Thyroid function $T_3$, $T_4$, TSH level.



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**Final Diagnosis :**

Thyrotoxicosis with solitary nodules in right lobe of thyroid.

**Treatment :**

1. Antithyroid drug therapy
2. Subtotal thyroidectomy after contest of thyrotoxicosis.
3. Antithyroid Drugs :-
   a) Propylthiouracil (50 - 180 mg)
   6) Carbimazole (5 - 15 mg) TDS

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# GENERAL SURGERY

**Name:** Swaraj Animesh Bhute

**Age:** 28 years **Sex:** Male

**Address:**
A/p - Panhala.
Tal - panhala
Dist - Kolhapur

**Social Status:** Poor

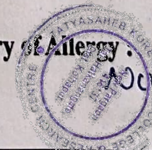
**Chief Complaint:**
Patient has swelling and pain in back region of neck since 4 days.

**History of Present illness :**

- Swelling and throbbing type of pain since 4 days.
- Pain is continuous and radiating till shoulders and neck region.
- No fever
- No swelling in cervical region.

**Past Medical History :**
Patient has similar type of swelling 5 months back & has recovered on medical treatment. No H/O diabetes, hypertension etc.

**Drug History/History of Allergy :**
No allergy to any drug.



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**Family History:**

No relevant history

**Personal History:**
Pt. chews tobacco 4 times a day.
Diet - mixed
B/B - Normal
Normal and regular sleep.

**GENERAL PHYSICAL EXAMINATION:** Conscious & well oriented

**Mental State (Level of Consciousness):**

**Built :** Normal

**Attitude :** Co-operative

**Gait :** Normal

**Face :** Normal

**Decubitus :** lying normally on bed in supine position.

**Pallor :** Absent

**Cynosis :** Absent

**Icterus :** Absent

**Edema :** Absent

**Skin Eruption:** Absent

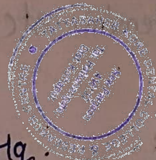
**VITAL SIGNS :**

**Pulse Rate:** 72 beats / min

**Respiratory Rate:** 18 cycles / min

**Temperature:** 36°C

**Blood Pressure:** 120/70 mm Hg



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**SYSTEMATIC EXAMINATION:**

**Respiratory System:**

Clear sound
No added sound

**Cordiovascular System:**

Heart sound - Normal
No gallop
No murmur

**Gastrointestial Track:**

P/A - soft
No tenderness
LO KO SO

**Central Nervous System:**

No neurological defect
Planter ↓↓

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**LOCAL EXAMINATION :**

**Inspection :**

1. Site - back region of neck
2. shape - ovoid
3. size - 3 x 5 cm
4. Surface - irregular
5. Edge - indistinct
6. Pulsation - absent
7. Impulse on coughing - Absent
8. Movement on deglutition - No
9. skin - Yellowish and oedematous
10. Number - single.

**Palpation :**

1. Surface - Regular.
2. Edge - Distinct.
3. site - Back region of neck.
4. Size - 3 x 5 cm.
5. Transillumination - Negative.
6. Fluctuation - Positive.

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**Precusion :**

No relevant history.

**Ausculation :**

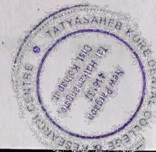
No relevant history.

**PROVISIONAL DIAGNOSIS :**

Boil

**INVESTIGATION :**

1. Complete blood count
2. Aspiration - FNAC
3. Biopsy



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**Final Diagnosis :**

Boil

**Treatment :**

1. Incision and drainage
2. Antibiotic - Cloxacillin 500 mg 6 hourly.
3. Diabetes has to be treated -
   1. Metformin 500 mg OD
   2. Tolbutamide 0.5 - 1.0 MTDS
   3. Glipizide - 5 - 20 mg
   4. Rapaglinide - 1 mg
   5. Acarbose (50-100 mg) with each meal.

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## GENERAL SURGERY

**Name:**

**Age:** **Sex:**

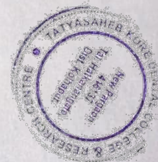
**Address:**

**Social Status:**

**Chief Complaint:**

**History of Present illness :**

**Past Medical History :**



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**Drug History/History of Allergy :**