TATYASAHEB KORE DENTAL COLLEGE AND RESEARCH CENTRE
NEW PARGAON – 416 113

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

National Dental Commission

INFORMATION REGARDING INSTITUTIONAL COMPLIANCE

3. Medical Hospital Attachment

3.1 Record of Clinical Training in General Medicine and General Surgery

TATYASAHEB KORE DENTAL COLLEGE & RESEARCH CENTRE, NEW PARGAON

SERVICE IS RELIGION

WARANA
HEALTH MOVEMENT

DEPARTMENT OF GENERAL MEDICINE

CLINICAL RECORD BOOK

CERTIFICATE

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

by Mr./ Miss. Ashlesh Vilas Chougale

Reg. No. 0218181280 Student of the year 2023-24

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

Signature of the Staff Incharge

Professor & Head of Department

Place : Pargaon

Date : 1/1/

Dr. Harish Kulkarni M.D.s
Principal
T.K.D.C. & Research Centre,
New Pargaon, Tal. Hatkanangle
Dt. Kolhapur 416 13?

Signature of the External Examiners

Signature of the Internal Examiners

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Case No. : 1 **Date :**

Name : Sanchita Sampat Patil.

Age : 35 yr. **Sex :** Female.

Occupation : Farmer.

Religion Status : Hindu.

Social Status : Poor class.

Marital Status : Married

Date of Admission :

Chief Complaint : Patient c/o weakness, loss of apetite excersive bleeding during menstruation & breathlessness.

History of Present illness : Patient was apparently alright before one month. she gradually started complaining about loss of apetite, dyspnoea, fullness of abdomen. Due to this admite to Mahatma Gandhi Hospital, New Pargaon.

Past Medical History : No relevant history.

No H/o major illness
No H/o Hypertension
No H/o Asthma.
No. H/o tuberculosis.

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c) Face : Pale

d) Eyes : Pallor on lower palpebral conjuctiva.

e) Nose : Normal

f) Mouth : Normal

g) Limbs : Pallor on palm.

h) Vertebral Coloumn : Normal

I) Lymphadenopathy : Not seen.

j) Oedema : not seen.

k) Joints : normal.

SYSTEMATIC EXAMINATION :

Respiratory System :

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

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

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

d) Auscultation :
- bronchial breathing is available in large bronchus.
- Vesicular breathing is available all over chest
- No available sound, wheeze & rhonchi

Gastro Intestinal System :

a) Inspection : No discolouration / visible swelling.
- No dialated superficial veins.
- shape of abdomen is bulging.
- Umbilus centrally placed & inverted.

b) Palpation :
- Liver is not palpable.
- Spleen & kidney are not palpable.
- Abdomen is soft.
- No tenderness.

c) Percussion :
- Tympanic note is found on percussion.
- Abdomen fullness is due to faces & flatus.

d) Auscultation :
- 2-3 paraysystolic movements 1min are audible.

Cardio : Vascular System :

a) Inspection : Pericordium is smooth.
- No retraction is seen.
- Bulging abdomen present.
- Apex beat is seen in left 5th intercostal space.

b) Palpation :
- Apex beat is palpated in left 5th intercostal space.
- Absence of thrust. No any tenderness or palpable mass in pericardium.

c) Percussion :
- Right & left cardiac border percussed from lateral to medial side.
- No cardime goly seem.

d) Auscultation :
- Heart sound S1 S2 auscultation in mitral, aortic & pal monary area.
- No murmur.

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

Provisional Diagnosis : Iron deficiency anemia.
- Lower respiratory tract infection.

Investigations :
- Blood - Hb count & RBC, TLC - 8,400/mm3, Platelets - 1,46,000/mm3
- Biochemical - Blood glucose test & urine test.
- Serological - HIV - non reactive.

Final Diagnosis :
- Iron deficiency Anemia. (microcytic hypochromic anemia)
- Lower respiratory infection.

Treatment :
- Tab. Ferconia XT OD. (Ferrous oscerbate & folic acid 100mg)
- Tab. Folvita (folic acid tab) - 5 mg.
- Inj. Dextrono - lunp (Dexbmethasone, sodium phosphate).
- Tab A to Z (multivitamin)
- Inj. Avil 1amp (2ml) pheneramine maleate.
- Expectorant.
- Tab Lavoflox 500 BD.
- Tab Mebex 100mg BD x 3 days.

Follow Up :

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Case No. : 2 **Date :**

Name : Mohan Pandurang Waydande

Age : 60 yrs. **Sex :** M.

Occupation : Farmer.

Religion Status : Hindu.

Social Status : Middle class.

Marital Status : married.

Date of Admission :

Chief Complaint : Patient clo pain, weakness, abdominal muscle spasm, abdominal pain & oedema over foot.

History of Present illness : patient has a H/o orthopedic pain at wrist joint. Patient was apparently normal before 1 month. patient has severe pain all over the abdomen.

Past Medical History : patient has undergone orthopedic surgery of left upper limb before 8 years.

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Family History : No relevant history
No H/o hypertension.
No H/o diabetes

Personal History : Patient has H/o alcohol consumption everyday & smoking 12-15 beedies throughout the day. for more than 25 years.

Diet : Mixed.

Appetite : Loss of appetite.

Sleep : Insomnia.

Bowel : Irregular after medication.

Micturition :

Habit : No.

GENERAL PHYSICAL EXAMINATION :

Attitude : conscious & well oriented.

Built & Nutrition : Poor.

Vital Signs :

a) Temperature : Cold extremities with fluctuation in temperature

b) Pulse : 74 beats/min.

c) Respiratory Rate : 20 cycles/min

d) Blood Pressure 130/82 mm

Skin : **a) Hair** Normal

b) Nail Pale.

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c) Face : Normal

d) Eyes : Pallor

e) Nose : Normal

f) Mouth : Normal

g) Limbs : Normal

h) Vertebral Coloumn : Normal

I) Lymphadenopathy : Normal

j) Oedema : Present over feet

k) Joints : absent

SYSTEMATIC EXAMINATION :

Respiratory System :

a) Inspection : Bilaterally symmetrical chest.
- There is no visible superficial vein or scar.
- Thoraco abdominal type of respiration is seen.

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

c) Percussion :
- Trachea is centrally placed.

d) Auscultation :
- Normal breathing sound on auscultation

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Gastro Intestinal System :

a) Inspection : Pedenculous abdomen, with symmetrical globular, enlarged & accentuated cutaneous folds.
- Umbilicus is transversly streched or flattened or enverted.

b) Palpation :
- Tenderness is present.
- Marked splenomegaly.
- marked hepatomegaly.

c) Percussion :
- shifting dullness is present.
- Horse shoe shaped dullness present.
- Fluid thrill present.
- Positive puddle sign.

d) Auscultation :
Absence of bowel sound.

Cardio : Vascular System :

a) Inspection :
- Dialated veins.
- Pericardium is smooth.

b) Palpation :
- Apex beat is palpable on left side.
- No any tenderness on palpation.

c) Percussion :
Right & left cardiac borders precussed. from lateral to medial side.

d) Auscultation : -No cardiomegaly.
- Arterial bruits are present.
- venous hum is present.

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CNS : Patient is concious & well oriented to time, place & person.

Provisional Diagnosis :
Generalized distension of abdomen with more fullness in the flanks.

Investigations : - Ultrasonography of abdomen.
- laproscopy & peritoneal fluid biopsy.
- Routine blood & urine examination.
- Paracentesis
- serum Ascites albumin gradient.

Final Diagnosis :
Ascites

Treatment :
- salt, water restriction, bedrest & water intake less than 1.5 L/day.
- Tab. aldacton 100 mg - OD.
- Inj. Lasix 40 mg - BD.
- Inj. Mofest 400 mg - OD.
- Inje. Resek 1ampute - OD
- If not recovered, liver transplant is adviced.

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Case No. : 8. **Date :**

Name : vivek Dinkar Bhoi.

Age : 28 yrs **Sex :** M.

Occupation : factory worker.

Religion Status : Hindu

Social Status : Lower class.

Marital Status : married

Date of Admission :

Chief Complaint : Patient c/o weakness & dizziness from past 4 days.

History of Present illness : Patient was apparently alright one week ago. He started feeling dizzy & shorthen of breath since past 4-5 days He had undergone check up of complete blood count for same.

Past Medical History : No H/o asthma, hypertension, diabetes, epilepsy. Patient had undergone 2PCV transfusion at the time.

Family History : No relevant history

Personal History : No H/o adverse habits.

Diet : Mixed

Appetite : loss of appetite.

Sleep : Insomnia.

Bowel : Patient passes stools two times a day.

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

Habit : No

GENERAL PHYSICAL EXAMINATION :

Attitude : comfortable & normal.

Built & Nutrition : normal.

Vital Signs :

a) Temperature : 97.4° F

b) Pulse : 84 beats / min.

c) Respiratory Rate : 21 cycles / min.

d) Blood Pressure 110/80 mmHg

a) Hair Normal

b) Nail Pallor present in nail bed

c) Face : Pale

d) Eyes : Pallor lower palpabral conjuctiva.

e) Nose : Normal

f) Mouth : Normal Pallor on soft palate & tongue.

g) Limbs : Pallor on palm.

h) Vertebral Coloumn : Normal

I) Lymphadenopathy : Not seen.

j) Oedema : Not seen.

k) Joints : Normal.

SYSTEMATIC EXAMINATION :

Respiratory System :

a) Inspection :

- Bilateraly symmetrical chest.
- There is no visible superficial vein or scar.
- Type of respiration is abdominothoracic.
- There is bulging absent or retraction of chest.

b) Palpation :

- No tenderness.
- No lump.
- No lymph node enlargement.

c) Percussion :

- Trachea is centrally placed.

d) Auscultation :

- Bronchial breathing is available in large bronchus.
- Vesicular breathing is available all over chest.
- No audible sound, wheeze & ronch.

Gastro Intestinal System :

a) Inspection :
- No abnormality detected.
- No discolouration of visible swelling.
- No dialated superfacial veins.
- Shape of abdomen in bulging.

b) Palpation :
- Liver is not palpable.
- Spleen & kidney are not palpable
- Abdomen is soft
- No tenderness

c) Percussion :
- liver is not palpable.
- spleen & kidney are not palpable.
- Abdomen is soft.
- No tenderness

c) Auscultation :
- No abnormality detected.
- Tympanic note found on percussion

d) Auscultation :→
- 2-3 peristal H.L movements/min are audible.

Cardio : Vascular System :

a) Inspection :
- Pericardium is smooth, no retraction seen.
- No abnormality detected.
- Apex beat is present in left 5th intercostal space.

b) Palpation :
- No abnormality detected.
- Absence of tenderness.
- No palpable mass in pericardium.

c) Percussion :
- Right & left cardiac borders percussed from lateral to medial side.
- No cardiomegaly is seen.

d) Auscultation :
- Heart sound auscultation in mitral, aortic & pulmonary area.

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

Provisional Diagnosis :

Iron deficiency anemia.

Investigations :
- Blood investigation - decreased Hb %, MCV, MCH, Normal reticulocytes count, normal platelet count.
- Peripheral smear - microcytic, hypochromic RBCs.
- Bone marrow findings - Atered myloid / erythroid ratio
- decreased plasma transferin saturation.

Final Diagnosis : decreased serum ferritin level.

Severe microcytic hypochronic Anemia.

Treatment :
- Tab. mebex 100 mg - BID for 3 days
- Inj. Eldemit - alternate day.
- Tab. feronia - 100 mg - TID.
- Tab. Liv 52 DS - BID.

Tab. Foluite 5 mg BD.
Inj. Lasix 20 mg IV (before blood transfusion)
Tab. ferrous sulphate 800 mg TID.
Iron sorbitol 1.5 mg/kg body weight IM.

Follow Up :

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Case No. : 4 **Date :**

Name : Balwant Sayaji Patil.

Age : 55 yrs. **Sex :** M.

Occupation : Farmer.

Religion Status : Hindu

Social Status : middle class.

Marital Status : married

Date of Admission :

Chief Complaint : pt c/o chest pain, breathlessness, sleep disortion, pain in chest region & upper n abdomen, burning sensation since 2 days.

History of Present illness : Patient was apparently alright 3 days before. Patient felt a mild chest pain in left side & radiating to left shoulder. The pain was neglected but on consious, patient reported to MGH.

Past Medical History :

Patient has a H/o. hypertension since 10 years. & is on medication for same.

Tab. Temsan 20 mg OD &

Tab. Rozavel 10 mg

Family History : No relevant history.

Personal History : Patient has habit of alcohol consumption & smoking for past 20 yrs.

Diet : Mixed.

Appetite : Reduced.

Sleep : Disturbed.

Bowel : Patient passed stool once per day.

Micturition : Patient micturate 3-4 times in 24 hrs.

Habit : NRH.

GENERAL PHYSICAL EXAMINATION :

Attitude : Concious & well oriented.

Built & Nutrition : normal

Vital Signs :

a) Temperature : Afebrile on touch.

b) Pulse : 84 beats / min

c) Respiratory Rate : 33 cycles / min.

d) Blood Pressure 154/110 mm Hg.

Skin : **a) Hair** Normal

b) Nail No pallor.

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c) Face : Normal

d) Eyes : Normal

e) Nose : Normal

f) Mouth : Normal

g) Limbs : mild pain radiating to left shoulder.

h) Vertebral Coloumn : No abnormality detected

I) Lymphadenopathy : Not seen.

j) Oedema : Not seen.

k) Joints : No abnormality detected.

SYSTEMATIC EXAMINATION :

Respiratory System :

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

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

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

d) Auscultation :
- Bronchial breathing is available in large bronchus.
- vesicular breathing available all over the chest.
- wheeze or ronchi not heard.

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Gastro Intestinal System :

a) Inspection :
- There is no discolouration or visible swelling.
- No dialated superficial veins.
- Shape of abdomen is bulging.
- Umbilicus in centrally placed.

b) Palpation :
- Liver is not palpable.
- spleen & kidney are not palpable.
- Abdomen is soft.
- No any tenderness.

c) Percussion :
- Tympanic note is found on percussion
- Abdomen fullness is due to faeces & flatus.

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

Cardio : Vascular System :

a) Inspection : Pericardium is smooth.
- No retraction seen.
- bulging of abdomens is present.
- apex beat is seen in left 5th intercostal space

b) Palpation :
Apex beat palpated in 5th (left) intercostal space.
Absence of thrust.
No tenderness /palpable mass is in pericardium.

c) Percussion :
Right & left cardiac borders percussed from lateral to medial side. - No cardiomegaly.

d) Auscultation :
Heart sound auscultated in mitral, aortic & pulmonary area.

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

Provisional Diagnosis : Myocardial infarction.
unstable angina.

Investigations :
- ECG - ST segment elevation, Qwave, Twave inversion.
- Blood - ↑ESR, leucocytosis.
- Biomarkers - ck-MB, cardiac troponin I & I, LDF level raised.

Final Diagnosis :
Anteroseptal infarct.
Ateroseptal wall myocardial infarction.

Treatment : Bed rest, O_2 by nasal pongs.
- Inj. LMW heparin 0.5 ml SC BID x 5 days.
- Inj. pantin 40 mg IV - OD (proton pump inhibitor).
- Tab. Nitroglycerine 2.6 mg-BD (prevent angina)
- Tab. Clopivas 75 mg. - OD (Antiplatelet).
- Tab. stator 40 mg. (reduce cholesterol & triglycerides)
- Tab Ecosprin 150 mg.
- Liq. germaffin.
- Tab Nikoran 5 mg (OD) reduce pain & strain on heart. Advice coronary angiography & further managment accordingly.
- Inj. NTG in 500 ml normal saline 6u drops/min for 1st day.

Follow Up : patient is recalled for follow up 1 week.

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Case No. : 5 **Date :**

Name : Ananda Mahadik.

Age : 43 yrs **Sex :** M.

Occupation : Farmar.

Religion Status : Hindu.

Social Status : Poor class

Marital Status : married

Date of Admission :

Chief Complaint : patient c/o severe abdominal pain & tenderness since 1 day.

History of Present illness : Patient was apparently alright before 8 days ~~c/o severe abdominal pain &~~ pt. had severe pain all over the abdomen. pt. was admitted to ~~tenderness since 1day.~~ local hospital & given IV analgesis. Then he was admitted to MGH for further treatment.

Past Medical History :

Patient has H/o acidity in morning.
no H/o hypertension.
no H/o diabetes.
no H/o any major illness.

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ID

Family History : No relevant history.
No H/o hypertension.
No H/o diabetes.

Personal History : Patient gives history of alcohol consumption everyday & smoking 12-15 beedies throughout the day for more than 10 years.

Diet : Mixed

Appetite : loss of apetite.

Sleep : Normal

Bowel : frequency is once in day

Micturition : 4-5 times a day

Habit : NRH.

GENERAL PHYSICAL EXAMINATION :

Attitude : Concious & well oriented.

Built & Nutrition : Normal

Vital Signs :

a) Temperature : 95.6 °F

b) Pulse : 82 beats / min.

c) Respiratory Rate : 25 cycles / min.

d) Blood Pressure 130 / 90 mm Hg.

Skin : **a) Hair** Normal

b) Nail Normal

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c) Face : Normal

d) Eyes : Normal

e) Nose : Normal

f) Mouth : Normal

g) Limbs : Normal

h) Vertebral Coloumn : normal

I) Lymphadenopathy : Not seen

j) Oedema : not seen

k) Joints : normal.

SYSTEMATIC EXAMINATION :

Respiratory System :

a) Inspection :
- Bilaterally symmetrical chest.
- There is no visible superficial vein or scar.
- Thoraco abdominal type of respiration is seen.
- There is no bulging or retraction of chest anywhere.

b) Palpation :
No tenderness
No lump.
No lymphnode enlargment.

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

d) Auscultation :
- Bronchial breathing is avaible in large bronchus
- vesicular breathing is avaible all over chest.
- No available sound s where & ronch

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Gastro Intestinal System :

a) Inspection :
- Peristalsis is present. There is no discolouration or visible swelling.
- No dialated superficial veins.
- Umbilicus centrally placed & inverted.

b) Palpation :
Abdomen is hard.
Tenderness is seen.
Liver, spleen are not palpable.

c) Percussion :
Resonant note on percusion.
No liver, kidney dullness.

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

Cardio : Vascular System :

a) Inspection : Pericardium is smooth.
No bulging / retraction. No pulsation.
No distended vein in neck, thorax.

b) Palpation :
Apex beat is palpable on left side.
Absence of thrust. No tenderness / palpable mass.

c) Percussion :
Left & Right cardiac borders percussed from lateral to medial side.
No cardiomegaly.

d) Auscultation :
Heart sound auscultated in mitral, tricuspid, aortic, pulmonary areas
No murmur.

CNS : Patient is concious & well oriented to time & person
Pupils are equally retracted

Provisional Diagnosis :
Perforations of duodenal ulcer.

Investigations : Frictional chest meal
- barium meal examination.
- Gastroscopy.
- X ray - chest - PA view, erect abdomen - AP view

Final Diagnosis :
Duodenal ulcer.

Treatment : Exploratory laprotomy of perforated ulcer done

Inj. Tazar	4.5 mg	BD	100 ml + normal saline
Inj. Amokis	500 mg	BD.	10 ml + N.S.
Inj. Metro	100 mg	TID.	
Rabe prazole	40 mg	OD. iv	100 ml + N.S.

Nil by mouth (NBM)

IV Fluid 3 lit / day.

Follow Up :
After 5 days of discharge, abdominal sutures are removed, wound is clean.

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Case No. : 6. **Date :**

Name : Abdul Hussain Mulla.

Age : 50 yrs. **Sex :** Male.

Occupation : Post man.

Religion Status : Muslim.

Social Status : middle class.

Marital Status : married.

Date of Admission :

Chief Complaint : patient complains of generalised weakness, loss of apetite, neck pain, dyspheea.

History of Present illness : Patient is know case of hypertension & chronic renal failure & is on medication. Patient gets dyspnoea after regular work or talking. Pain is mild, intermittent.

Past Medical History : Patient has H/o diabetes since 10 yrs. Patient has H/o hypertension & is on medication. patient has H/o chronic renal Failure.

Family History : No relevant history
No H/o diabetes
No H/o hypertension

Personal History : No H/o adverse Habits

Diet : Mixed

Appetite : decreased

Sleep : Insomnia

Bowel : Frequency is once in 24 hrs.

Micturition : 3-4 times in day & 1-2 times in night.

Habit : NRH

GENERAL PHYSICAL EXAMINATION :

Attitude : Conscious & well-oriented

Built & Nutrition : Normal

Vital Signs :

a) Temperature : 95.1 °F

b) Pulse : 86 beats/min.

c) Respiratory Rate : 25 cycles/min.

d) Blood Pressure 140/90 mm Hg

Skin : **a) Hair** Normal

b) Nail Pallar present

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c) Face : Normal symmetry & facial Puffiness.

d) Eyes : Pallor present.

e) Nose : Normal

f) Mouth : Normal

g) Limbs : Pitting type of edema present on left side.

h) Vertebral Coloumn : No abnormality detected.

I) Lymphadenopathy : Not seen.

j) Oedema : Pitting edema on lower left limb.

k) Joints : Painful joints

SYSTEMATIC EXAMINATION :

Respiratory System :

a) Inspection : Bilaterally symmetrical chest.
Increased & disturbed respiratory movements.

b) Palpation : No tenderness
No lumps
No lymph node enlargement.

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

d) Auscultation : Crepitus present.
No wheeze / ronchi.

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Gastro Intestinal System :

a) Inspection : There is no discolouration / visible swelling.
No dilated superficial veins.
shape of abdomen is bulging.
Umbilicus centrally placed & inverted.

b) Palpation :
Liver is not palpable.
Spleen & kidney are also not palpable.
Abdomen is soft.
No any tenderness.

c) Percussion :
Tympanic note is found on percussion.
Abdomen fullness is due to faces & flatus.

d) Auscultation :
2-3 peristaltic movements.

Cardio : Vascular System :

a) Inspection : Pericardium is smooth.
Bulging of abdomen is present.
Apex beat is seen in 5th intercostal space.

b) Palpation :
Apex beat palpable in left 5th I.C space.
Absence of thrust. No tenderness / palpable mass in pericardium

c) Percussion : Rt & Lt cardiac borders percussed from lateral to medial side.
- No cardiomegaly seen.

d) Auscultation :
Heart sounds are ausculted in mitral, aortic, tricuspid & pulmonary area.

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CNS : Patient is concious & well oriented to places, time & people.
- Pupils are equally reactive to light.

Provisional Diagnosis : Obesity with hypertension & diabetes mellitus

Investigations : CBC → Hb - 4.5 gm %, TLC - 12000 / mm³.
Platelet - 3,51,000 / mm³.
urine analysis - 180 gm %, blood urea - 30 mg.
serum creatinine - 1.4 gm %.

Final Diagnosis :
Obesity ⊂ severe anemia & hypertension.

Treatment :
Tab. Telsor - 40 mg OD.
Tab. IVobid - 5 mg. BD.
Tab. Clopin AP - 75 mg OD.
Tab. Zeformin - 60 mg OD.
Tab. Findor - 0.4 mg
Tab. Dnotor - 5 mg OD.
PCV. infurlor.

Follow Up : Advice - weight reduction, iron rich diet, including jaggery, leafy vegetables, peanut.
Patient is recalled for follow up after

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Case No.: 7. **Date:**

Name: Vilas Patil.

Age: 46 yrs. **Sex:** Male.

Occupation: Sugar factory worker.

Religion Status: Hindu.

Social Status: Lower middle class.

Marital Status: married.

Chief complaint→

~~**Date of Admission:**~~ Patient complains of continuous hiccups & burning sensation in retrosternal region during swallowing from last 3yrs.

~~**Chief Complaint:**~~

Date of Admission→

History of Present illness: Patient was apparently alright before 3days. He had a burning sensation & vomiting before 3days & he was unable to take food.

Past Medical History: No H/o hypertension.
No H/o diabetes mellitus.
No H/o arthama epilepsy.

Family History: Patients father is hypertensive since last 5 yrs - 4 yrs & is on medication for same.

Personal History: NRH

Diet: Mixed

Appetite: Decreased

Sleep: Insomnia.

Bowel: Frequency is 2 times a day.

Micturition: 4-5 times a day, 2-3 times at night.

Habit: NRH.

GENERAL PHYSICAL EXAMINATION:

Attitude: Conscious & well oriented.

Built & Nutrition: Normal

Vital Signs:

a) **Temperature:** 97 °F

b) **Pulse:** 80 beats/min.

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

d) **Blood Pressure** 130/170 mmHg.

Skin: a) **Hair** Normal

b) **Nail** Pallor & clubbing

c) **Face:** Puffy face.

d) **Eyes:** Pallor present

e) **Nose:** Normal

f) **Mouth:** Pallor at soft palate, tongue

g) **Limbs:** Edematous.

h) **Vertebral Coloumn:** Normal

I) **Lymphadenopathy:** Not seen.

j) **Oedema:** Present

k) **Joints:** No abnormality detected.

SYSTEMATIC EXAMINATION:

Respiratory System:

a) **Inspection:** Bilateral symmetrical chest.
There is no superficial visible vein / scar.
Thoracoabdominal type of respiration seen.
There is bulging / retraction of chest anywhere.

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

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

d) **Auscultation:**
Branchial breathing is available in large bronchus.
Vesicular breathing is auscultated all over the chest.
No avaible chest sounds / crepts / bronchi

Gastro Intestinal System :

a) Inspection : peristalsis is present.
There is no discolouration / visible swelling.
No dialated superficial veins.
Umbilicus is centrally placed & involved.

b) Palpation : Abdomen is hard.
liver, kidney are not palpable.
Tenderness seen.

c) Percussion : Resonant percussion note.
No liver, kidney dullness.

d) Auscultation :
2-3 peristaltic movement / min.

Cardio : Vascular System :

a) Inspection : Pericardium is smooth
No bulging / retraction. No distended veins in neck & thorax.

b) Palpation : Apex beat is palpable in fifth left IC space
Absence of thrust
No any tenderness on palpable mass.

c) Percussion :
Lt & Rt cardiac borders percussed from lateral to medial side.
No cardiomegaly.

d) Auscultation :
Heart sound auscultated in aortic / pulmonary tricuspid / mitral area.
- No murmur

CNS : Patient is cocious & well oriented about time, place & people.

Provisional Diagnosis : Peptic ulcer.
Liver cirrhosis.
Duodenal ulcer.
GERD.

Investigations : Routine investigation.
- Frictional meal analysis.
- Barium meal examination
- chest X ray - PA view, except abdomen AP view
- Gastroscopy.

Final Diagnosis : LFT - ↑SGOT, ↑SGPT, ↑alkaline phosphatase levels.
- Chronic gastritis & chronic alcoholism
- Liver cirrhosis.

Treatment :

Inj. omeprazole - 40 mg - IV. BD.
Inj.e Emeset 10 amp. IV BD.
Tab Liv 52 DS TID.
Ringer lactose 20 %, Normal saline 20 %.
Dextrose - 10 %.
Sodium chloride IV - 0.9 %.

Follow Up :

Case No. : 8. **Date :**

Name : Sadashiv Ramu Garade.

Age : 65 yrs **Sex :** male.

Occupation : Farmer

Religion Status : Hindu.

Social Status : Poor status.

Marital Status : married

Date of Admission :

Chief Complaint : patient c/o multiple blisters over both lower below the knee since 8 days.
- Discharge from blisters since 8 days.
- H/o mild fever.

History of Present illness : patient is apperantly all right before 8 days He developed mild swelling over both lower limb & also patchy red spot. swelling goes on increasing & for that he was admitted in MGH.

Past Medical History :
Patient has H/o fracture of neck of femur.
H/o diabetes mellitus, hypertension,
H/o fever.

Family History : NRH.

Personal History : No relevant history.

Diet : mixed

Appetite : disturbed

Sleep : normal

Bowel : normal

Micturition : normal

Habit : NRH.

GENERAL PHYSICAL EXAMINATION :

Attitude : well oriented & conscious

Built & Nutrition : normal

Vital Signs :

a) Temperature : 98.9 of

b) Pulse : 80 /min.

c) Respiratory Rate : 25 cycle/min

d) Blood Pressure 128 / 84 mmHg

Skin : **a) Hair** normal

b) Nail normal.

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(II)

c) Face : normal

d) Eyes : normal

e) Nose : normal

f) Mouth : normal

g) Limbs : Oedema present.

h) Vertebral Coloumn : normal

I) Lymphadenopathy : Not present.

j) Oedema : present

k) Joints : Normal.

SYSTEMATIC EXAMINATION :

Respiratory System :

a) Inspection : Bilateral symmetrical chest.
There is no superficial visible vein or scar.
Thoracoabdominal type of respiration seen.
There is no bulging or retraction of chest anywhere.

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

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

d) Auscultation :
Bronchial breathing is available is large bronchus vesicul
breathing is available all over the chest.
No available chest sounds / wheeze / rhonchi.

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Gastro Intestinal System :

a) Inspection : No abnormality detected.
No. discolouration or swelling seen.
No dilated superficial veins.
Abdomino-thoracic respiration.

b) Palpation :
Liver is not palpable.
Spleen & kidney are not palpable.
Abdomen is soft, no tenderness present.

c) Percussion :
No abnormality detected.
Tympanic note is found on percussion

d) Auscultation :
No abnormality detected
2-3 peristaltic movements /min are auscultated.

Cardio : Vascular System :

a) Inspection : pericardium is smooth. No retraction seen.
No abnormality detected. Apex beat is seen in left 5th intercostal space.

b) Palpation : Aper beat palpated in 5th interiastal space.
Absence of thurst. No tenderness / palpable mass in pericardium.

c) Percussion :
Rt & Lt. cardiac borders percussed from lateral to medial side - No cardiomegaly.

d) Auscultation :
Heart sounds auscultated in mitral, aortic & pulmonary area
No murmur.

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

Provisional Diagnosis : Cellulitis of both lower limb below knee.
- Oedema of both lower limb due to venous obstruction.

Investigations : Routine → CBC, ESR, BSL - fasting & PP, Serum creatinine serum cholesterol, urine examination
Special → Culture sensitivity from discharge doppler of lower limb.

Final Diagnosis :
Cellulitis of both lower limb.

Treatment : Bed rest c elevation of both lower limb to reduce edema due to cellulitis.
- regular dressing of burst blisters, site c H_2O_2, normal saline, betadine, $MgSO_4$ dressing to reduce oedema.
- Tab. Amoxicillin - 500 mg TID.
  Tab. Metrozel 400 mg TID.
  Tab. Ibuprofen 400 mg + Paracetamol 325 mg TID
  -- Sedaso peptidase - 10mg TID.

Follow Up :

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Case No.: 9

Name: Sunil. V. Bansode.

Date:

Age: 54 yrs. **Sex:** male.

Occupation: farmer.

Religion Status: Hindu

Social Status: Poor status.

Marital Status: Married

Date of Admission:

Chief Complaint: Pt. c/o bleeding gums & difficulty during chewing & burning sensation while consumption of hot & cold, spicy food.

History of Present illness:

Patient complaints of fever since 1 week. before admission.

Past Medical History: patient has H/o diabetes milletus.

No H/o asthma.

No H/o Hypertension.

No H/o epilepsy

Family History: No relevant history.

Personal History: Patient has a habit of smoking beedi 15-20 times a day since 20 yrs.

Diet: mixed

Appetite: normal

Sleep: normal

Bowel: normal

Micturition: normal

Habit: NRH.

GENERAL PHYSICAL EXAMINATION:

Attitude: well oriented & concious

Built & Nutrition: normal

Vital Signs:

a) **Temperature:** 98.7 °F

b) **Pulse:** 84 beats/min.

c) **Respiratory Rate:** 25 cycles/min.

d) **Blood Pressure** 128/84 mm Hg.

Skin: a) Hair normal

b) Nail normal

c) **Face:** normal

d) **Eyes:** normal

e) **Nose:** normal

f) **Mouth:** Ulcerated oral & gingival mucosa & bleeding.

g) **Limbs:** normal

h) **Vertebral Coloumn:** Normal

I) **Lymphadenopathy:** not seen.

j) **Oedema:** not seen.

k) **Joints:** normal

SYSTEMATIC EXAMINATION:

Respiratory System:

a) **Inspection:** Bilaterally symmetrical chest.
Pursed lip breathing.
Air entry is equal on both sides.
No visible superficial veins or scar.

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

c) **Percussion:**
Polyphonic wheeze not pressure.

d) **Auscultation:**
Ronchi are heard.

Gastro Intestinal System :

a) Inspection :
Red & swollen gingiva.
No dilated superficial veins.
Shape of abdomen is normal.

b) Palpation :
Bleeding on probing; gingiva is present.
No other abnormality is detected.
Liver, spleen, kidney is not palpable.

c) Percussion :
No abnormality detected.

d) Auscultation :
No abnormality detected.

Cardio : Vascular System :

a) Inspection : Pericardium is smooth, no abnormality seen.

b) Palpation : Apex beat palpated left 5th intercostal space.
No abnormality detected.

c) Percussion :
Rt. & Lt. cardiac borders percussed.
No cardiomegaly is seen.

d) Auscultation :
Heart sounds are normal.
No murmur.

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CNS : Patient is concious & well oriented to place, time & people.
Pupils are equally reactive to light.

Provisional Diagnosis : Chronic gingivitis.
Vit. C deficiency.
Acute necrotizing ulcerative girgivitis.

Investigations :- CBC – Neutrophils increased.
- Bacterial culture sensitivity test.
- Silver staining of sample & observed under dark field microscope.

Final Diagnosis :
Acute necrotizing ulcerative gingivitis.

Treatment :
- Oral hygiene maintainance.
mouth wash, frequent gargles after meals.
- Oral amoxicillin 500 mg TID.
- vit. C - 250 mg TID.

Follow Up :

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Case No. : 10 **Date :**

Name : Lata Vitthal Kamble.

Age : 45 yrs. **Sex :** Female.

Occupation : House wife.

Religion Status : Hindu

Social Status : Poor class.

Marital Status : Married

Date of Admission :

Chief Complaint : Patient complains of weakness & diziness from past 4 days.

History of Present illness : Patient was apparently alright one week ago, she started feeling dizzy & was short of breath from past 4-5 days. She had undergone check up of complete blood count for same.

Past Medical History : No. H/o hypertension, No. H/o diabetes, no H/o asthma, No. H/o epilepsy.
H/o severe anemia 1½ yrs. ago. Patient had undergone 2 PCV transfusion at the time.

Family History: No relevant history.

Personal History: No history of adverse habits.

Diet: mixed

Appetite: loss of apetite from 4 days.

Sleep: Insomnia.

Bowel: Patient passes stools two times a day.

Micturition: 4-5 times in a day, 2-3 times at night.

Habit: No relevant history.

GENERAL PHYSICAL EXAMINATION:

Attitude: Concious & well oriented

Gait & Nutrition: normal.

Signs:

a) Temperature: 97.4°F

b) Pulse: 84 beats/min.

c) Respiratory Rate: 21 cycles/min

d) Blood Pressure 110/80 mm Hg

a) Hair normal

b) Nail pallor present on nail

c) Face: Pale.

d) Eyes: Pallor on lowers palpebral conjuctiva.

e) Nose: normal

f) Mouth: Pallor on soft palate & tongue.

g) Limbs: Pallor on palm.

h) Vertebral Coloumn: normal.

I) Lymphadenopathy: not seen.

j) Oedema: not seen.

k) Joints: normal.

SYSTEMATIC EXAMINATION:

Respiratory System:

a) Inspection: Bilaterally symmetrical chest.
There is no visible superficial vein/scar.
Type of respiration is abdomino ~~~~Thoracic.
There is bulging absent on retraction of chest any where.

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

c) Percussion:
Trachea is centrally placed.

d) Auscultation:
Audible chest sound.

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Gastro Intestinal System :

a) Inspection : No abnormality detected.
No discolouration of visible swelling.
No dilated superficial veins
Shape of abdomen is bulging

b) Palpation :
Liver is not palpable.
Spleen & kidney are not palpable.
Abdomen is soft. No any tenderness.

c) Percussion :
No abnormality detected.
Tympanic note found on percussion.

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

ardio : Vascular System :

a) Inspection : Pericardium is smooth, No retraction seen.
No abnormality detected.
Apex beat seen in left 5th intercostal space.

b) Palpation :
No abnormality detected.
Absence of thrust, No tenderness.

c) Percussion :
Rt & Lt cardiac boarders percussed from lateral to medial side. No cardiomegaly seen.

d) Auscultation :
Heart sound auscultation in mitral, aortic & pulmonary area

CNS : Patient is conciow & well oriented to place, time & people.
Pupils are equally reactive to light.

Provisional Diagnosis : Coeliac sprue.
Megaloblastic anaemia.
Malabsorption.

Investigations : CBC & routine blood investigation.
Hb% ↓, MCV ↑, MCH ↑, MCHC normal, RBC ↓, TLC ↓
reticulocyte ↓, blood folate levels ↓, serum vit. B12 ↓
peripheral smear → Macrocytic hyperchromic RBC's.

Final Diagnosis :

Megaloblastic Anaemia.

Treatment :
- Cobalamin Therapy — 25-100 mcg/day.
  monthly 200-1000 mcg IM. given as maintaince dose.
- Folate therapy — 0.5-1 mg/day orally or parentally.
- Hydroxy Cobalamin — 100ug deep IM / 1 week.
- Pack cell volume transfusion.
- T/t underlying cause of disease.

Follow Up :

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DEPARTMENT OF GENERAL MEDICINE

CLINICAL RECORD BOOK

CERTIFICATE

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

by Mr./ Miss. Payal Prakash Patil

Reg. No. _____ Student of the year 2022-23

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

Signature of the Staff Incharge

Professor & Head of Department

Place : TKDC & RC

Date : 20/11/2023

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Signature of the External Examiners

Signature of the Internal Examiners

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	Diagnosis - Megaloblastic anaemia		

Case No.: 1 **Date:** _____

Name: Supriya Pandurang Waghmare

Age: 30 years **Sex:** Female

Occupation: Housewife.

Religion Status: Hindu

Social Status: Poor class

Marital Status: Married.

Date of Admission:

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

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

Past Medical History: No relevant history
No history of Major Illness
No history of Hypertension
No history of Asthma
No history of Tuberculosis

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Family History: No relevant history
No history of Hypertension
No history of Diabetes Mellitus.

Personal History: No history of adverse habits like alcohol or tobacco is reported

Diet: Mixed.

Appetite: loss of appetite

Sleep: Disturbed sleep

Bowel: Constipation

Micturition: Normal

Habit: No habit

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is apparently conscious and well oriented.

Built & Nutrition: Normal

Vital Signs:

a) **Temperature:** 98.2 °F

b) **Pulse:** 90/min

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

d) **Blood Pressure:** 126/84 mm Hg

Skin: a) **Hair** Normal

b) **Nail** Pallor on nail bed

Kollony nail

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c) **Face:** Pale

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

e) **Nose:** Normal

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

g) **Limbs:** Pallor on palm

h) **Vertebral Coloumn:** Normal

I) **Lymphadenopathy:** Absent

j) **Oedema:** Not seen

k) **Joints:** Normal

SYSTEMATIC EXAMINATION:

Respiratory System:

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

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

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

d) **Auscultation:** Bronchial breathing is audible over large trachea
Vesicular breathing is audible all over chest
No audible sound, wheeze

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Gastro Intestinal System :

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

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

c) Percussion :
- Tympanic note is found on percussion
- Abdominal fullness is due to faeces flatulence

d) Auscultation :

2-3 peristaltic movements/min are audible

Cardio : Vascular System :

a) Inspection : Pericardium is smooth
- No retraction is seen
- Bulging abdomen present

b) Palpation : - Apex beat is normally placed
- Absence of thrust
- No any tenderness / palpable mass in pericardium
- Apex beat is placed at Left 5th intercostal space

c) Percussion :
- Cardiac dullness is within normal limits
- Right and left cardiac borders percussed
- No cardiomegaly seen

d) Auscultation :
- Heart sounds auscultated in mitral, [illegible]
- No murmurs

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

Provisional Diagnosis : Iron deficiency anaemia
Lower respiratory tract infection.

Investigations : 1) Complete Blood count - Hb count - 8 gm%, RBC count - 3.1 million/uL, WBC count - 8000/cu mm, Platelet - 146000/cmm
RBC morphology - Microcytic, Hypochromic
2) Biochemical - Blood glucose test & Urine test
3) Serological - HIV - Non-reactive

Final Diagnosis :
- Iron deficiency anaemia
i.e Microcytic Hypochromic anaemia

Treatment :

Tab. Ferrous Ascorbate 100 mg - OD - for 6 months

Tab. Mebendazole 100 mg BID - 3 days

Tab folic acid 5 mg - OD - 6 months

Patient is adviced to eat iron rich diet

Follow Up : Patient is recalled after [illegible] for follow up.

Case No.: 2 **Date:**

Name: Shivam Sanjay Jadhav

Age: 56 **Sex:** Male

Occupation: Farmer

Religion Status: Hindu

Social Status: Middle class

Marital Status: Married

Date of Admission:

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

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

Past Medical History: Patient has history of jaundice and was admitted for same 1 year back.

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Family History: No relevant history
NO history of Hypertension
NO history of Diabetes Mellitus

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

Diet: Mixed

Appetite: Loss of appetite

Sleep: Insomnia

Bowel: Regular after medication

Micturition: Regular after medication

Habit: NO habit

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is conscious and well-oriented

Built & Nutrition: Poor

Vital Signs:

a) **Temperature:** 99.2 °F

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

c) **Respiratory Rate:** [illegible] /min

d) **Blood Pressure:** [illegible] mm Hg

Skin:

a) **Hair,** Normal

b) **Nail** - Pale nail bed

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c) **Face:** Pale

d) **Eyes:** Icterus present

e) **Nose:** Normal

f) **Mouth:** Normal

g) **Limbs:** Normal

h) **Vertebral Coloumn:** Normal

I) **Lymphadenopathy:** Normal

j) **Oedema:** Bilateral Pedal oedema

k) **Joints:** No abnormality detected

SYSTEMATIC EXAMINATION:

Respiratory System:

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

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

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

d) **Auscultation:** [illegible] breath sounds on [illegible]

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Gastro Intestinal System :

a) Inspection : - Pendulous abdomen with symmetrical globular, enlarged and accentuated cutaneous folds.
- Tense distended abdomen with umbilicus transversely slit [Weeping umbilicus]

b) Palpation :
- Tenderness may be elicited
- Hepatomegaly seen
- Splenomegaly is seen

c) Percussion :
- Shifting dullness is present
- [illegible]
- Fluid thrill is present

d) Auscultation :
- Intestinal sounds are feebly audible or may not be audible

Cardio : Vascular System :

a) Inspection : - Pericardium is smooth
- Apex beat normally placed

b) Palpation : - Apex beat is palpable at left 5th intercostal space
- No tenderness on palpation

c) Percussion : - Right and left cardiac borders percussed from lateral to medial side
- No cardiomegaly

d) Auscultation :
- Atrial bruit is [illegible]
- Venous return is continuous

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

Provisional Diagnosis : Generalised distension of abdomen c̄ More fullness in flank

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

Final Diagnosis :

Ascites

Treatment :
1] Cessation of alcohol
2] Bed rest
3] Therapeutic paracentesis - Maximum 1 litre ascitic fluid can be removed
4] Salt and water restricted diet
5] Tab. Spironolactone [100-200mg / day] or Triamterene [100-200 mg / day]
6] Tab. Cefotaxime 1.0g I.V. twice daily
7] Cap. Becosules OD - 10 days

Follow Up :

Case No.: 3 **Date:**

Name: Aniket Kamble

Age: 48 years **Sex:** Male

Occupation: Factory worker

Religion Status: Hindu

Social Status: Lower class

Marital Status: Married

Date of Admission:

Chief Complaint: Patient complains of weakness, drziness, loss of appetite from past 1 month.

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

Past Medical History:

- NO history of HTN, DM, Asthma, Epilepsy
- Patrent had undergone 2 PC transfusion 5 years ago.

Family History: No relevant history

Personal History: No history of adverse habits

Diet: Mixed diet

Appetite: Loss of appetite

Sleep: Insomnia

Bowel: Constipation

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

Habit: No habit

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is apparently constious and well orrented

Built & Nutrition: Normal

Vital Signs:

a) **Temperature:** 99.2°F

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

c) **Respiratory Rate:** [illegible] cycles / min

d) **Blood Pressure:** [illegible] mm Hg

Skin: a) **Hair** Normal

b) **Nail** Pallor on nail bed

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c) **Face:** Pale

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

e) **Nose:** Normal

f) **Mouth:** Pallor on soft palate and tongue

g) **Limbs:** Pallor on palm

h) **Vertebral Coloumn:** Normal

I) **Lymphadenopathy:** Absent

j) **Oedema:** Absent

k) **Joints:** No abnormality detected

SYSTEMATIC EXAMINATION:

Respiratory System:

a) **Inspection:**
- Bilaterally, symmetrical chest
- No superficial vein / scar
- Absent retraction of chest
- Thoracoabdominal respiration

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

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

d) **Auscultation:**
- Bronchial breathing [illegible] in [illegible] bronchus
- Vesicular breathing [illegible] all over chest

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Gastro Intestinal System :

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

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

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

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

Cardio : Vascular System :

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

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

c) Percussion :
- Precordial dullness is within normal limits
- Right and left cardiac borders percussed from lateral to medial still

d) Auscultation :
- Heart sound auscultated in mitral, aortic & pulmonary area
- No murmur

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

Provisional Diagnosis :
Iron Deficiency anemia

Investigations : 1) Complete Blood count : Hb count - 3 gm%
RBC count - 3 million / μL, WBC count - 8000 / cu mm
RBC morphology - Microcytic, Hypochromic
2) Biochemical - Blood glucose test & Urine test
3) Serum ferritin level decreased

Final Diagnosis :
Severe Microcytic Hypochromic Anaemia

Treatment :
Tab. Ferrous Ascorbate 100 mg OD - 3 months
OR
Tab. Ferrous Sulphate 300 mg TID - 3 months
Tab. Vitamin C 300 mg TID - 3 days months.
- Bed rest
- Iron Rich diet
- Tab. Mebendazole 100 mg BID - 5 days

Follow Up : Patient discharged. CBC after 1 month

Case No.: 4 **Date:**

Name: Swaraj Ankush Kanekar

Age: 57 years **Sex:** Male

Occupation: Farmer

Religion Status: Hindu

Social Status: Lower class

Marital Status: Married

Date of Admission:

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

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

Past Medical History:

Patient has history of Hypertension since 10 years and is on medication for same.

Tab. Telmisartan 20mg OD & Tab Rozavel 10mg OD

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Family History: No relevant history

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

Diet: Mixed diet

Appetite: Reduced

Sleep: Disturbed

Bowel: Normal

Micturition: Reduced

Habit: No habit

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is conscious and well oriented

Built & Nutrition: Normal

Vital Signs:

a) **Temperature:** 98.3 °F

b) **Pulse:** 80 beats/min

c) **Respiratory Rate:** 30 cycles/min

d) **Blood Pressure:** 140/100 mm Hg

Skin: a) **Hair** Normal

b) **Nail** Pallor present

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c) **Face:** Pale

d) **Eyes:** Pallor

e) **Nose:** Normal

f) **Mouth:** Pale oral mucosa

g) **Limbs:** Pain radiating to left shoulder

h) **Vertebral Coloumn:** No abnormality detected

I) **Lymphadenopathy:** Absent

j) **Oedema:** Absent

k) **Joints:** No abnormality detected

SYSTEMATIC EXAMINATION:

Respiratory System:

a) **Inspection:**
- Bilaterally symmetrical chest
- No visible superficial veins/scars
- Thoracoabdominal type of respiration present.

b) **Palpation:**
- No bulging or retraction of chest
- No tenderness
- No lump
- No lymph node enlargement

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

d) **Auscultation:**
- Bronchial breathing is audible in large bronchi
- Vesicular breathing audible all over chest

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Gastro Intestinal System :

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

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

c) Percussion :
- Tympanic note found on percussion
- Abdomen fullness is due to faeces flatulence

d) Auscultation :
1-2-3 peristaltic movements / min

Cardio : Vascular System :

a) Inspection :
- Precordium is smooth
- No retraction is seen
- Bulging abdomen present
- Apex beat normally placed

b) Palpation :
- Absence of thrust
- Aper beat is palpated at left 5th intercostal space

c) Percussion :
Right and left cardiac borders percussed from lateral to medial side

d) Auscultation :
Cardiac dullness is within normal limits
Heart sounds auscultated in mitral, aortic and pulmonary area
- NO murmur

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

Provisional Diagnosis :
- Myocardial infarction
- Unstable angina

Investigations :
1] ECG = ST segment elevation
2] Blood - ↑ed ESR, leucocytosis
3] Biomarkers - CKMB, cardiac troponins [T and I], Raised LDH
4] Echocardiography

Final Diagnosis :
Anteroseptal Myocardial Infarction

Treatment :
1] Hospitalisation
2] Strict bed rest
3] Oxygen given by mask
4] Procure I.V line and take blood sample for glucose, lipids and complete hemogram
5] - Tab. Disprin [325 mg]
- Tab. Clopidogrel 300mg stat
- Atorvastatin 80mg
6) Inj streptokinase IV [100ml] stat
7] Inj. low molecular weight heparin 0.4ml [40mg]
8] Tab. metoprolol 25mg - OD
9) Tab. Ramipril 5.5mg - OD
10] Diet = low calorie diet for 5-6 days. Salt restricted diet
11] Avoid smoking and alcohol

Follow Up :

Case No.: 5 **Date:**

Name: Vilas Patil

Age: 45 **Sex:** Male

Occupation: Worker

Religion Status: Hindu

Social Status: Middle class

Marital Status: Married

Date of Admission:

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

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

Past Medical History:

Patient has history of Gastro-oesophageal reflux disease

- No history of hypertension
- No history of diabetes
- No history of major illness

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(1)

Family History: NO relevant history
- No history of Hypertension
- No history of Diabetes

Personal History: Patient has habit of Alcohol consumption and smoking 3-4 times daily since 10 years

Diet: Mixed died

Appetite: loss of appetite

Sleep: Normal

Bowel: Frequency - once daily

Micturition: 4-5 times a day

Habit: No habit

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is conscious and well-oriented

Built & Nutrition: Normal

Vital Signs:

a) **Temperature:** 98.6°F

b) **Pulse:** 80 beats/min

c) **Respiratory Rate:** [illegible] cycles/min

d) **Blood Pressure:** [illegible] mm Hg

Skin: a) **Hair** Normal

b) **Nail** Normal

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c) **Face:** Normal

d) **Eyes:** Normal

e) **Nose:** Normal

f) **Mouth:** Normal

g) **Limbs:** Normal

h) **Vertebral Coloumn:** Normal

I) **Lymphadenopathy:** Absent

j) **Oedema:** Absent

k) **Joints:** No abnormality detected

SYSTEMATIC EXAMINATION:

Respiratory System:

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

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

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

d) **Auscultation:**
- Bronchial breath sound
- No audible sound

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Gastro Intestinal System:

a) Inspection:
- No discoloration / visible swelling
- No dilated superficial veins
- Umbilicus is centrally placed and inverted

b) Palpation:
- Tenderness is present
- Liver and spleen are not palpable

c) Percussion:
- Tympanic note found on percussion
- Abdominal fullness is due to faeces flatulence

d) Auscultation:
2-3 peristaltic movements / min

Cardio: Vascular System:

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

b) Palpation:
- Apex beat is palpated at left 5th intercostal space
- Absence of thrust
- No any tenderness or palpable mass

c) Percussion:
- ar... within normal limits
- Right and left ... borders percussed

d) Auscultation:
- Heart sound auscultated in mitral, aortic and pulmonary area
- No murmur

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

Provisional Diagnosis:
- Gastritis
- Duodenal ulcer

Investigations: 1) Complete Blood count 2) Serum creatinine 3) Blood sugar level 4) Barrium meal examination 5) Gastroscopy 6) Ultrasonography (USG)

Final Diagnosis:
Duodenal ulcer

Treatment:
1) Patient is asked to stop alcohol, smoking and avoid spicy meal
2) Bland diet is advised
3) Liquid antacid - Aluminium Hydroxide & Sodium Hydroxide given
4) Liq. Sucralfate TID
5) Inj. Pantoprazole 40mg I.V OD
6) Tab Alprazolam 0.25mg

Follow Up: After 6 days of discharge, abdominal sutures are removed

Case No. : 6 **Date :**

Name : Deepak Bhoi

Age : 52 years **Sex :** Male

Occupation : Bank employee

Religion Status : Hindu

Social Status : Middle class

Marital Status : Married

Date of Admission :

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

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

Past Medical History :

No history of Major illness

No history of Asthma and tuberculosis

Family History : No relevant history

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

Diet : Mixed

Appetite : Normal

Sleep : Disturbed

Bowel : Frequency twice daily

Micturition : Frequency 6-7 times daily

Habit : NO relevant history

GENERAL PHYSICAL EXAMINATION :

Attitude : Patient is conscious and well-oriented.

Built & Nutrition : Obese

Vital Signs :

a) **Temperature :** 99.2°F

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

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

d) **Blood Pressure :** 150/100 mm Hg

Skin : a) **Hair** Normal

b) **Nail** Normal

c) **Face :** Normal

d) **Eyes :** Normal

e) **Nose :** Normal

f) **Mouth :** Normal

g) **Limbs :** Normal

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

i) **Lymphadenopathy :** Absent

j) **Oedema :** Bilateral pedal Oedema

k) **Joints :** Normal

SYSTEMATIC EXAMINATION :

Respiratory System :

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

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

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

d) **Auscultation :**
- Broncho-vesicular breathing is audible in all large bronchi
- Vesicular breathing is audible all over chest

Gastro Intestinal System :

a) Inspection : - No discoloration / visible swelling
- No dilated superficial veins
- Umbilicus is centrally placed and inverted

b) Palpation : - No tenderness
- Liver, spleen and kidney are not palpable

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

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

Cardio : Vascular System :

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

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

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

d) Auscultation : - Heart sound auscultation in mitral, aortic and pulmonary area.

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

Provisional Diagnosis :

1) Hypertension with Obesity
2) Renal insufficiency

Investigations :
1) Complete Blood count
2) Blood glucose
3) ECG
4) Urine examination
5) Renal Function test
6) Lipidogram

Final Diagnosis : Hypertension with Obesity

Treatment :

1] Cessation of alcohol consumption and smoking habit

2] Salt Restriction diet is adviced to patient.

3] Lifestyle modification - Regular exercises such as fast walking / jogging or swimming is advised. Relief of stress by relaxation and meditation

4] Tablet Amlodipine 5mg OD — 1 month

5) Tablet Atorvastatin 80mg OD - 1 month

Follow Up : Patient is recalled after 10 days for follow-up

Case No. : 7 **Date :** _____

Name : Jayant Kadam

Age : 52 years **Sex :** Male

Occupation : Sugar Factory worker

Religion Status : Hindu

Social Status : Middle class

Marital Status : Married

Date of Admission :

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

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

Past Medical History :

NO history of major illness

NO history of HTN, DM, Asthma and epilepsy

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Family History: No relevant history

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

Diet: Mixed

Appetite: Reduced appetite

Sleep: Disturbed

Bowel: Frequency - 2 times/day

Micturition: Frequency 4-5 times/day, 3-4 times at night

Habit: No relevant history

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is conscious and well-oriented

Built & Nutrition: Normal

Vital Signs:

a) **Temperature:** 99°F

b) **Pulse:** 100 beats/min

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

d) **Blood Pressure:** 126/88 mm Hg

Skin: a) **Hair** loss of hair (Alopecia)

b) **Nail** Clubbing of fingers, White Nail beds

c) **Face:** Puffiness of face

d) **Eyes:** Yellowish discoloration of sclera

e) **Nose:** Normal

f) **Mouth:** Pale oral mucosa

g) **Limbs:** Redness of thenar and hypothenar eminences of Palm [Palmer erythema]

h) **Vertebral Coloumn:** Normal

I) **Lymphadenopathy:** Absent

j) **Oedema:** Bilateral pedal oedema

k) **Joints:** Normal

SYSTEMATIC EXAMINATION:

Respiratory System:

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

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

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

d) **Auscultation:**
- Normal breathing sounds heard on auscultation

Gastro Intestinal System :

a) Inspection : Pendulous abdomen with symmetrical, globular, enlarged and accentuated cutaneous folds
- Tense distended abdomen with everted umbilicus [weeping umbilicus]

b) Palpation :
- Tenderness may be elicited
- Hepatomegaly seen
- Splenomegaly seen

c) Percussion :
- Shifting dullness present
- Fluid thrill is present.

d) Auscultation :
- Intestinal sounds are not audible

Cardio : Vascular System :

a) Inspection : - Pericardium is smooth
- Apex beat is normally placed.

b) Palpation : - Apex beat is palpated at left 5th intercostal space.
- No tenderness on palpation

c) Percussion : - Right and left cardiac borders percussed from lateral to medial side
- No cardiomegaly

d) Auscultation : - Arterial bruit is present
- Venous return is continuous

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

Provisional Diagnosis : 1) Ascites
2) Cirrhosis of liver

Investigations : 1] Complete Blood count - Hb concentration - 9 gm%, RBC count - 4 million/uL, WBC count - 5000/cu mm
RBC morphology - Macrocytosis
2] Ultrasonography of Abdomen
3) Liver function test 4) Urine examination
5] Ascitic fluid examination - Serum-ascites albumin gradient is >1.1 g/dL

Final Diagnosis : Cirrhosis of liver

Treatment :
1] Cessation of alcohol consumption habit
2] Bed rest is advised to Patient
3] Therapeutic Paracentesis - Maximum 3 litre ascitic fluid can be removed
4] High protein diet [80-100g] and low salt diet
5] Cap. Becosules F OD - 10 days
6] Tab Furosemide [40-160 mg/day]
7) Tab. Spironolactone [100-200 mg/day]
8) Tab. cefotaxime 1g I.V. twice daily

Follow Up :

Case No.: 8 **Date:**

Name: Balwant Mohan Patil

Age: 40 years **Sex:** Male

Occupation: Farmer

Religion Status: Hindu

Social Status: Low class

Marital Status: Married

Date of Admission:

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

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

Past Medical History:

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

- Patient has history of diabetes mellitus and on medication for same since 2 years
- Patient has history of Fever

Family History: No relevant history
No history of Diabetes & Hypertension

Personal History: No history of adverse habits is reported

Diet: Mixed diet
Appetite: Normal
Sleep: Disturbed
Bowel: Normal
Micturition: Normal
Habit: No habit

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is conscious and well-oriented
Built & Nutrition: Normal

Vital Signs:

a) **Temperature:** 102°F
b) **Pulse:** 96 beats/min
c) **Respiratory Rate:** 20 cycles/min
d) **Blood Pressure:** 120/84 mm Hg

Skin: a) **Hair** Normal
b) **Nail** Normal

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c) **Face:** Normal
d) **Eyes:** Normal
e) **Nose:** Normal
f) **Mouth:** Normal
g) **Limbs:** Oedema on lower limbs
h) **Vertebral Coloumn:** Normal
I) **Lymphadenopathy:** Absent
j) **Oedema:** Present bilaterally over lower limbs
k) **Joints:** Normal

SYSTEMATIC EXAMINATION:

Respiratory System:

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

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

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

d) **Auscultation:**
- Bronchial breathing heard in large bronchi
- Vesicular breathing audible all over chest

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Gastro Intestinal System :

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

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

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

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

Cardio : Vascular System :

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

b) Palpation :
- Apex beat is palpated at Left 5th intercostal space
- Absence of thrust

c) Percussion : - No any tenderness/palpable mass in pericardium
- Cardiac dullness is within normal limits
- Right and left cardiac borders percussed from lateral to medial side

d) Auscultation - No cardiac sound auscultated in mitral, aortic and pulmonary area
- No murmurs

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

Provisional Diagnosis : 1) Cellulitis of both lower limb
2) Oedema of both lower limb

Investigations : 1] Routine Investigation - Complete Blood count, ESL, Blood Sugar level [Fasting & Post Prandial], Serum Creatinine, Serum cholesterol, Urine examination
2] X-ray of both lower limb below knee [Anteroposterior view],
Culture sensitivity of discharge from blister.

Final Diagnosis :
Cellulitis of both lower limb

Treatment : 1) ~~Best~~ Bed rest with elevation of lower limb
2) Regular dressing of burst blisters site with hydrogen peroxide, normal saline and betadiene
3) Inj. ceftriazone + sulbactum 1.5 gm TID
4] Inj. Metronidazole i.v. TID — 7 days
5] Cap. Becasules - OD
6] Vit. C 300 mg TID
7] Human insulin - Human actraphane according to BSL
8] Surgical treatment - If cellulitis does not subside with medical treatment - Incision and drainage, Debridement.

Follow Up :

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Case No. : 9 **Date :** _____

Name : Sanved Mane

Age : 51 years **Sex :** Male

Occupation : Truck driver

Religion Status : Hindu

Social Status : Middle class

Marital Status : Married

Date of Admission :

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

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

Past Medical History :

- Patient is a known case of Hypertension and on medication for same since 2 months
- No history of Asthma, Tuberculosis or Epilepsy

Family History :
Patient's Mother is suffering from Diabetes Mellitus and is on medication for same since 20 years

Personal History : Patient consumes alcohol 1-2 times daily and has smoking habit since 8 years

Diet : Mixed

Appetite : Reduced Appetite

Sleep : Disturbed sleep

Bowel : Frequency - 2-3 times / day

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

Habit : No habit

GENERAL PHYSICAL EXAMINATION :

Attitude : Patient is conscious and well oriented

Built & Nutrition : Normal

Vital Signs :

a) **Temperature :** 98.2°F

b) **Pulse :** [illegible] /min

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

d) **Blood Pressure :** 130/100 mm Hg

Skin : a) **Hair** Normal

b) **Nail** White nail

c) **Face :** Normal

d) **Eyes :** Normal

e) **Nose :** Normal

f) **Mouth :** Normal

g) **Limbs :** Normal

h) **Vertebral Coloumn :** Normal

I) **Lymphadenopathy :** Absent

j) **Oedema :** Absent

k) **Joints :** Normal

SYSTEMATIC EXAMINATION :

Respiratory System :

a) **Inspection :-** Bilaterally symmetrical chest
- No visible superficial vein / scar
- Thoraco-abdominal respiration
+ No retraction of chest

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

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

d) **Auscultation :**
- Bronchial breathing is audible in all major bronchus
- Vesicular breathing is audible all over chest.

Gastro Intestinal System :

a) Inspection : - No discoloration / visible swelling
- No dilated superficial veins
- Umbilicus is centrally placed and inverted

b) Palpation :
- No tenderness
- Liver, spleen and kidney are not palpable

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

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

Cardio : Vascular System :

a) Inspection : - Pericardium is smooth
- No retraction is seen

b) Palpation :
- Absences of thrust
- No any tenderness / palpable mass in Pericardium

c) Percussion : - Cardiac dullness found within normal limits
- Right and left radial borders percussed from internal to mid clavicular line

d) Auscultation : - Heart sound auscultation in mitral, aortic and pulmonary area.

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

Provisional Diagnosis :
1) Severe Anaemia
2) Diabetes Mellitus

Investigations : 1] Complete Blood count - Hb - 12 gm% RBC count - 5 million/cu, WBC count - 7000/cu mm
2] Blood sugar - Fasting 120 mg/dL, Post Prandial 210 mg/dL
3] Urine Examination - Ketonuria 4] Renal function test
5] Lipidogram

Final Diagnosis : Diabetes Mellitus.

Treatment :
1] Cessation of alcohol consumption & smoking habit
2] Lifestyle Modification - Regular excercise and relief of stress by meditation Reduction of weight
3] Diet - carbohydrate restricted diet High Protein, High fibres and low salt diet is advised to Patient
4) Tablet Metformin 500 mg - OD - 1 month

Follow Up : Patient is recalled after 1 month for Follow-up
Advised for Routine examination

Case No. : 10 **Date :**

Name : Tanvi Nitin Minde

Age : 47 years **Sex :** Female

Occupation : Housewife

Religion Status : Hindu

Social Status : Low class

Marital Status : Married

Date of Admission :

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

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

Past Medical History :

No history of Major Illness
No history of Hypertension
No history of Asthma
No history of Tuberculosis

Family History: No relevant history

Personal History: No history of adverse effects

Diet: Pure vegetarian diet

Appetite: Reduced appetite

Sleep: Insomnia

Bowel: Frequency 2-3 times a day

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

Habit: No relevant history

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is conscious and well-oriented

Built & Nutrition: Normal

Vital Signs:

a) **Temperature:** 98.4°F

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

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

d) **Blood Pressure:** 122/84 mm Hg

Skin: a) **Hair:** Normal

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

c) Face: Pale

d) Eyes: Pallor on lower palpebral conjunctiva

e) Nose: Normal

f) Mouth: Pallor, Red tongue

g) Limbs: Normal

h) Vertebral Coloumn: Normal

I) Lymphadenopathy: Absent

j) Oedema: Absent

k) Joints: Normal

SYSTEMATIC EXAMINATION:

Respiratory System:

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

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

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

d) Auscultation:
- Normal breathing sounds/dibia
- Small large bronchial/vesicular breath sounds audible over chest
- No audible sound or wheeze

Gastro Intestinal System :

a) Inspection : - No discoloration / visible swelling
- No dilated superficial veins.
- Umbilicus is centrally placed in inverted

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

c) Percussion : - Tympanic note is found on percussion
- Abdominal fullness is due to faeces flatulence

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

Cardio : Vascular System :

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

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

c) Percussion : - Apex beat is placed at left 5th intercostal space.
- cardiac dullness is within normal limits
- Right and left cardiac borders percussed

d) Auscultation : - No cardiomegaly
- Heart sound auscultated in mitral, aortic, pulmonary
- No murmur

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

Provisional Diagnosis :
- Malabsorption syndrome
- Megaloblastic anaemia

Investigations : 1] Complete Blood count - Hb count - 8 gm%, RBC count - 3 million / cu mm, WBC count - 8000 / cu mm, Raised MCV RBC morphology - Macrocytic
2] Serum Vitamin B_{12} assay 3] Schilling Test
4] Serum Folate assay 5] Blood glucose Test

Final Diagnosis :
Megaloblastic anaemia

Treatment :

1] Hydroxocobalamin - parenterally 1000 µg twice a week during first week
Followed by 1000 µg weekly for 6 weeks

OR

2] Methylcobalamin B_{12} - 1500 mg I.M daily 7 days
Once a week - 6 weeks.

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

4] Patient is advised to eat Vitamin B_{12} rich diet.

Follow Up : Patient is recalled after 1 month for follow-up

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