



**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**



**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 :

Date :



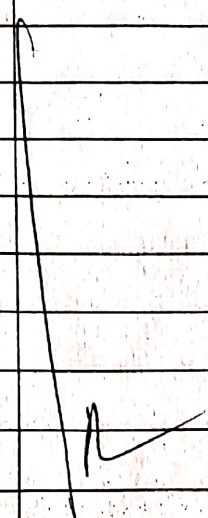
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Principal
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New Pargaon, Tal. Hatkanangle,
Dist. Kolhapur, 416 137

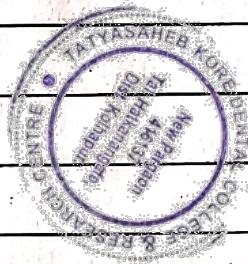
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Signature of the Internal Examiners



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 Dist. Kolhapur, 416 132

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 appetite, excessive bleeding during menstruation & breathlessness.

History of Present illness: Patient was apparently alright before one month. She gradually started complaining about loss of appetite, dyspnoea, fullness of abdomen. Due to this admitted 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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(1)

- c) Face: pale
- d) Eyes: Pallor on lower palpebral conjunctiva.
- 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 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 large bronchus.
 - Vesicular breathing is available all over chest.
 - No available sound, wheeze or crackle.



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Gastro Intestinal System :

- a) **Inspection:** No discoloration / visible swelling.
- No dilated superior facial 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 faeces & flatus.

d) Auscultation :

- 2-3 parasytolic movements / min 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 cardiac galy seem.

d) Auscultation :

- Heart sound auscultation in mitral, aortic & pulmonary area.
- No murmur.

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(IV)

CNS: Patient is conscious & well oriented to place, time & people.

- Both 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 ascorbate & folic acid 100mg)
- Tab. Folvita (folic acid tab) - 5 mg.
- Inj. Dextrono - 1 amp. (Dextromethosone, sodium phosphate).
- Tab A to Z (multivitamin)
- Inj. Avil 1 amp (2ml) pheneramine maleate.
- Expectorant.
- Tab Lavo flox 500 BD.
- Tab Mebex 100 mg BD x 3 days.

Follow Up :



(V)

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Case No. : 2

Date : _____

Name: Mohan Pandurang Wajdande

Age: 60 yrs

Sex: M

Occupation: Farmer

Religion Status: Hindu

Social Status: Middle class

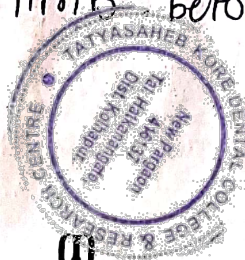
Marital Status: married

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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(1)

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

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

Diet: Mixed

Appetite: loss of appetite

Sleep: Insomnia

Bowel: } regular 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 mmHg

Skin:

a) Hair: Normal

b) Nail: Pale



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(II)

c) Face: Normal

d) Eyes: Pallor

e) Nose: Normal

f) Mouth: Normal

g) Limbs: Normal

h) Vertebral Column: 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

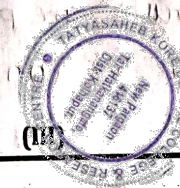
- No lymph node enlargement

c) Percussion:

- Trachea is centrally placed

d) Auscultation:

- Normal breathing sound on auscultation



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Gastro Intestinal System :

a) Inspection: Pedunculous abdomen with symmetrical globular, enlarged & accentuated cutaneous folds

- Umbilicus is transversely stretched or flattened or everted

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 sounds

Cardio : Vascular System :

a) Inspection :

- Dilated 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 conscious & well oriented to time, place & person.

Provisional Diagnosis :

Generalized distension of abdomen with more fullness in the flanks.

Investigations: - Ultrasonography of abdomen.

- Laparoscopy & 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 100mg - OD

- Inj. Lasix 40 mg - BD

- Inj. Mofest 400 mg - OD

- Inje. Resek 1ampule - OD

- If not recovered, liver transplant is advised.

Follow Up :



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Case No.: 13.

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 clo weakness & diziness 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 EPCV transfusion at the time.



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(1)



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

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c) **Face:** Pale

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

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:

- Bilaterally 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

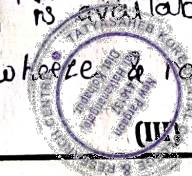
c) Percussion:

- Trachea is centrally placed

d) Auscultation:

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

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Gastro Intestinal System :

a) Inspection :

- No abnormality detected.
- No discolouration of visible swelling.
- No dilated superficial 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.

d) Auscultation :

- No abnormality detected.

- Tympanic note found on percussion.

d) Auscultation →
- 2-3 peristaltic 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 :

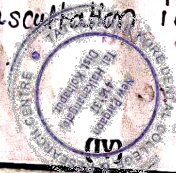
- No abnormality detected.
- Absence of tenderness.
- No palpable mass in pericardium.

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 conscious & 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 reticulocyte count, normal platelet count.

- Peripheral smear - microcytic, hypochromic RBCs.

- Bone marrow findings - Altered myloid/erythroid ratio.

- decreased plasma transferrin saturation.

Final Diagnosis: decreased serum ferritin level.

Severe microcytic hypochromic 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. Folvite 5 mg BD.

Inj. Lasix 20 mg IV (before blood transfusion)

Tab. ferrous sulphate 800 mg TID.

Iron sorbitol 15 mg/kg body weight IM.

Follow Up :



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Case No.: 4 Date: 01/01/2021

Name: Balwant Sayaji Patil.

Age: 55 yrs. Sex: M.

Occupation: Farmer.

Religion Status: Hindu

Social Status: middle class.

Marital Status: married

Date of Admission: 01/01/2021

Chief Complaint: pt clo chest pain, breathlessness, sleep disortion, pain in chest region & upper 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 conscious, patient reported to MGH.

Past Medical History:

patient has a H/o. Hypertension since 10 years. & is on medication for same.

Tab. Temisan 40 mg OD 2

Tab. Rozavel 10 mg



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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: Conscious & 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 nail



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(II)

c) Face: Normal

d) Eyes: Normal

e) Nose: Normal

f) Mouth: Normal

g) Limbs: mild pain radiating to left shoulder.

h) Vertebral Column: 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 fremitus equal on both sides.
- Trachea is centrally placed.

d) Auscultation:

- Bronchial breathing is available in large bronchus.
- Vesicular breathing available elsewhere the chest.
- wheeze or ronchi not heard.



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(III)

Gastro Intestinal System:

- a) Inspection: visible bubbling.
- There is no discolouration or visible bubbling.
 - No dilated superficial veins.
 - Shape of abdomen is bulging.
 - Umbilicus is 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 abdomen is present.
 - apex beat is seen in left 5th intercostal space.

b) Palpation: Apex beat palpated in 5th (left) intercostal space.

Absence of thrush.
No tenderness/palpable mass 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 conscious & well oriented to time, place & person.

- Pupils are equally reactive to light.

Provisional Diagnosis: myocardial infarction.
unstable angina.

Investigations:

- ECG - ST segment elevation, Q wave, T wave inversion.
- Blood - ↑ ESR, leucocytosis.
- Biomarkers - ck-MB, cardiac troponin I & I, LDF level raised.

Final Diagnosis:

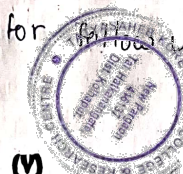
Anteroseptal infarct.

Anteroseptal wall myocardial infarction.

Treatment: Bed rest, O₂ by nasal prongs.

- Inj. LMW heparin 0.5 ml ~~sc~~ BID x 5 days.
- Inj. panton 40 mg IV - OD (proton pump inhibitor).
- Tab. Nitroglycerine 2.6 mg - BD (prevent angina).
- Tab. Clopivas 75 mg - OD (Antiplatelet).
- Tab. staton 40 mg (reduce cholesterol & triglycerides).
- Tab. Ecosprin 100 mg.
- Liq. germaffin.
- Tab. Nikoron 5 mg (OD) reduce pain & strain on heart. Advise coronary angiography & further management accordingly.
- Inj. NTG in 500 ml normal saline 6-8 drops/min for 1st day.

Follow Up: patient is recalled for follow up.



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Case No. : 5

Date : _____

Name: Ananda Mahadik.

Age: 43 yrs

Sex: M.

Occupation: Farmer.

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 at right before 8 days pt. had severe pain all over the abdomen. Pt. was admitted to local hospital & given IV analgesis. Then he was admitted to MGH for further treatment.

Past Medical History:

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



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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 appetite.
Sleep: Normal
Bowel: frequency is once in day
Micturition: 4-5 times a day
Habit: NRH.

GENERAL PHYSICAL EXAMINATION:

Attitude: Conscious & 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.

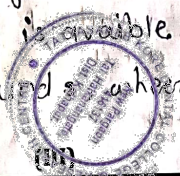
SYSTEMATIC EXAMINATION:

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 enlargement.

c) Percussion:
Tachile vocal fremitus 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 sounds wheeze & rales.



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Gastro Intestinal System:

- a) Inspection:
 - Peristalsis is present. There is no discoloration or visible swelling.
 - No dilated superficial veins.
 - Umbilicus centrally placed & inverted.
- b) Palpation:
 - Abdomen is hard.
 - Tenderness is seen.
 - Liver, spleen are not palpable.
- c) Percussion:
 - Resonant note on percussion.
 - 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.

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

Provisional Diagnosis:
Perforations of duodenal ulcer.

Investigations: Fictional 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. Tazor 45 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 cleaned.

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Case No.: 6. Date: 11/11/14

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 appetite, neck pain, dysphagia.

History of Present illness: Patient is know case of hypertension & chronic renal failure & is on medication. Patient gets dysphoea 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.



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Jew Pargaon, Hatkanangle

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: 95.4 °F

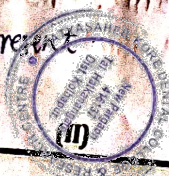
b) Pulse: 86 beats/min

c) Respiratory Rate: 25 cycles/min

d) Blood Pressure: 140/90 mm Hg

Skin: a) Hair: Normal

b) Nail: Pallor 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.
Tracheal his centrally placed.
- d) Auscultation: Crepitus present.
No wheeze / ronchi.



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Gastro Intestinal System :

a) **Inspection:** There is no discoloration / 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 cordiac 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 conscious & 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 - 30mg.
serum creatinine - 1.4 gm%.

Final Diagnosis: Obesity & severe anemia & hypertension.

Treatment: Tab. Telsor - 40 mg OD.
Tab. IV obid - 15 mg BD.
Tab. Clopin AP - 75 mg OD.
Tab. Ze formin - 60 mg OD.
Tab. Findor - 0.4 mg
Tab. Dinator - 5 mg OD.
PCV. infurion.

Follow Up: Advice - weight reduction, iron rich diet including jaggery, leafy vegetables, peanut.
Patient is recalled for follow up after 1 month.

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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 hicups & burning sensation in retrosternal region during swallowing from last 3 yrs.

Chief Complaint:

Date of Admission →

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

Past Medical History:

No. H/o hypertension

No. H/o diabetes mellitus.

No. H/o asthma epilepsy.

(1)



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Family History: Patient's father is hypertensive since last 5 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

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c) Face: Puffy face.

d) Eyes: Pallor present

e) Nose: Normal

f) Mouth: Pallor at soft palate, tongue.

g) Limbs: Edematous.

h) Vertebral Column: 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:

Bronchial breathing is available in large bronchus. Vesicular breathing is auscultated all over the chest.

No audible chest sound.

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(III)

Gastro Intestinal System:

a) Inspection: Peristalsis is present.
There is no discoloration / visible swelling.
No dilated 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.

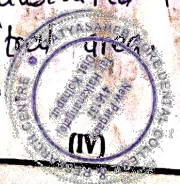
Cardio: Vascular System:

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 thrill.
No any tenderness on palpable mast.

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

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



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CNS: patient is conscious & 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.

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

Treatment:

Ing. omeprazole - 40 mg IV. BD.

Inj.e Emeset 10amp. IV BD.

Tab Liv 52 DS TID.

Ringer lactose 20%, Normal saline 20%.

Dextrose - 10%.

Sodium chloride IV - 0.9%.

Follow Up:



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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: _____

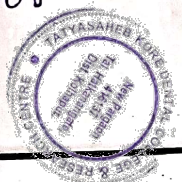
Chief Complaint: patient do multiple blisters over both lower below the knee since 8 days

- Discharge from blisters since 8 days
- H/o mild fever

History of Present illness: patient is apparently all right before 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.



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Jew Pargeon, Hatkanangali,
Dist. Solapur, Maharashtra 416 137

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 °F

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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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 both side.

Trachea is centrally placed.

d) Auscultation:

Bronchial breathing is available in large bronchus vesicular breathing is available all over the chest.

No available chest sounds wheeze / crackle.



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Gastro Intestinal System :

a) **Inspection:** No abnormality detected.
No discoloration 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:** Apex beat palpated in 5th intercostal space.
Absence of thrust. 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 + elevation of both lower limb to reduce edema due to cellulitis.

- regular dressing of burst blisters, site + H₂O₂, normal saline, betadine, Mg SO₄ dressing to reduce oedema.

- Tab. Amoxicillin - 500 mg TID.

Tab. Metrozole 400 mg TID.

Tab. Ibuprofen 400mg + Paracetamol 325 mg TID

-- Sedaso peptidase - 10mg TID.

Follow Up :



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Principal
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Dist. Kolhapur. 416 127

Case No.: 9

Date: 07/01

Name: Sunil. V. Bansode.

Age: 54 yrs.

Sex: male.

Occupation: farmer.

Religion Status: Hindu

Social Status: Poor status.

Marital Status: Married

Date of Admission:

Chief Complaint: pt. clo 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 mellitus.

No H/O asthma

No H/O Hypertension.

No H/O epilepsy



Dr. Harish Kulkarni M.D.S. Principal T.K.D.C. & Research Centre, Jaw Pargan, Tal. Hatkanangli, Dist. Kolhapur.

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 & conscious

Built & Nutrition: normal

Vital Signs:

a) Temperature: 98.7°F

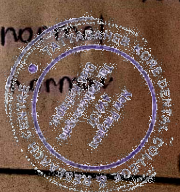
b) Pulse: 84 beats/min.

c) Respiratory Rate: 25 cycles/min.

d) Blood Pressure 128/84 mmHg.

Skin: a) Hair normal

b) Nail



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c) Face: normal

d) Eyes: normal

e) Nose: normal

f) Mouth: ulcerated oral & gingival mucosa & bleeding.

g) Limbs: normal

h) Vertebral Column: Normal

i) Lymphadenopathy: not seen.

j) Oedema: not seen.

k) Joints: normal.

SYSTEMATIC EXAMINATION:

Respiratory System:

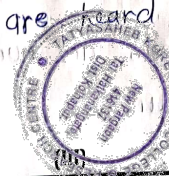
a) Inspection: Bilaterally symmetrical chest.
Pursed lip breathing.
Air entry is equal on both sides.
No visible superficial veins or scars.

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

c) Percussion: polyphonic wheezes, no hyper-resonance.

d) Auscultation:

Ronchi are heard.



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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:

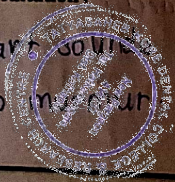
Rt. & Lt. cardiac borders percussed.
No cardiomegaly is seen.

d) Auscultation:

Heart sounds are normal.

No murmurs.

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(IV)



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

Provisional Diagnosis: Chronic gingivitis,
vit. C deficiency.

Acute necrotizing ulcerative gingivitis.

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 maintenance - 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 & dizziness 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 anaemia 1 1/2 yrs ago. Patient had undergone 2 PCV transfusion at the time.

(1)



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Dist. Kolhapur. 416 137

Family History: No relevant history.

Personal History: No history of adverse habits.

Diet: mixed

Appetite: loss of appetite 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:

State: conscious & well oriented

Weight & Nutrition: normal.

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.



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c) Face: Pale.

d) Eyes: Pallor on lower palpebral conjunctiva.

e) Nose: normal.

f) Mouth: Pallor on soft palate & tongue.

g) Limbs: Pallor on palm.

h) Vertebral Column: 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 ~~retro~~ thoracic. There is bulging absent on retraction of chest anywhere.

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 discoloration 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

Cardio : 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 borders percussed from lateral to medial side. No cardiomegaly seen.

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



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

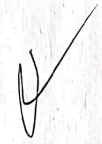
Provisional Diagnosis : Coeliac sprue.
Megaloblastic anaemia.
Malabsorption.

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 maintenance 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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Dist. Kolhapur, 416 127

**TATYASAHEB KORE DENTAL COLLEGE & RESEARCH CENTRE,
NEW PARGAON**



**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

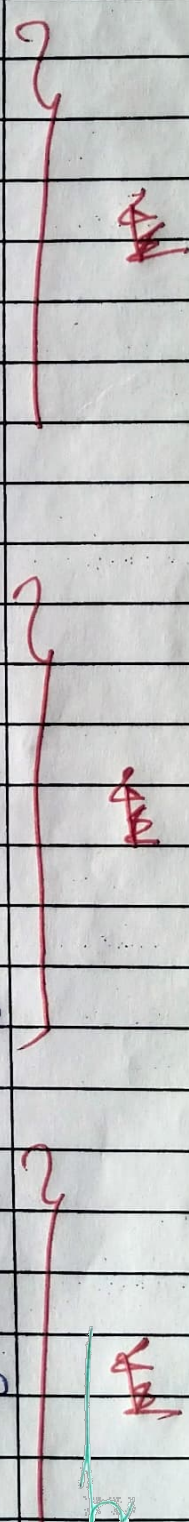
Signature of the External Examiners

Signature of the Internal Examiners



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
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	Diagnosis - Megaloblastic anaemia		



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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 difficulty in swallowing since 6 days and weight loss.

Past Medical History: No relevant history

No history of Major Illness

No history of Hypertension

No history of Asthma

No history of Tuberculosis

(1)



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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: 20 cycles/min

d) Blood Pressure: 126/34 mm Hg

Skin: a) Hair Normal

b) Nail Pallor on nail bed
Kollonychia

(II)

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 Column: 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: Tactile vocal fremitus equal on both sides
Trachea is centrally placed

d) Auscultation: Bilateral breathing is audible
No crackles, wheezes, or rhales
No hyper-resonance or dullness
No decreased breath sounds

(III)

Gastro Intestinal System :

- a) Inspection: No discoloration / visible swelling
- No dilated superficial veins
- Shape of abdomen is bulging
- Umbilicus is centrally placed and inverted
- b) Palpation:
- Liver is not palpable
- Spleen and kidney not palpable
- Abdomen is soft
- No tenderness
- c) Percussion:
- Tympanic note 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 thrill
- No any tenderness / palpable mass in pericardium
- Apex beat is placed at left 5th intercostal space
- c) Percussion:
- Cardiac dullness is within normal limits
- Right and left cardiac borders percussed
- No cardiomegaly seen
- d) Auscultation:
- Heart sound is normal in mitral, aortic, & pulmonary area
- No murmur

(IV)

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

Provisional Diagnosis: Iron deficiency anaemia
Lower respiratory tract infection.

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

Final Diagnosis:

- Iron deficiency anaemia
ie 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 advised to eat iron rich diet

Follow Up: Patient is reassured and advised to follow up.

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(V)

Case No.: 2

Date: _____

Name: Shivam Sanjay Jadhav

Age: 56 Sex: Male

Occupation: Farmer

Religion Status: Hindu

Social Status: Middle class

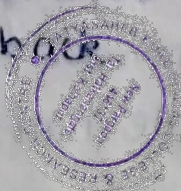
Marital Status: Married

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:

Patrent 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: 20 breaths/min

d) Blood Pressure: 120/82 mm Hg

Skin: a) Hair: Normal

b) Nail: Pale nail bed

(II)

c) Face: Pale

d) Eyes: Icterus present

e) Nose: Normal

f) Mouth: Normal

g) Limbs: Normal

h) Vertebral Coloum: 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

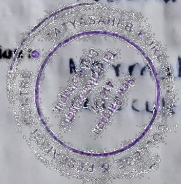
b) Palpation: - Slight tenderness
- No lump
- No lymph node enlargement

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

d) Auscultation: Normal breathing sounds on both sides

(III)

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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
- 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: - Normal and left cardiac borders
- No cardiomegaly
- d) Auscultation: - Atrial bruit is present
- Venous return is continuous

(IV)

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

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

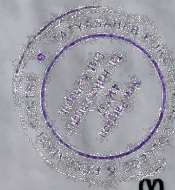
- Investigations: 1] Ultrasonography of Abdomen
2] Complete blood count
3] Urine examination
4] Stool for occult blood
5] Liver function test
6] Diagnostic paracentesis

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] 1st Spironoladone [100-200mg/day] or Toramterene [100-200mg/day]
- 6] 1st Cefotaxime 1.0g i.v. twice daily
- 7] Cap: Becosules oo - 10 days

Follow Up:



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(V)

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, dizziness, loss of appetite from past 1 month.

History of Present illness: Patient 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

- Patient had undergone 2 PCV transfusion 5 years ago.



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Family History: No relevant history

Personal History: No history of adverse habits

Diet: Mixed diet

Appetite: Loss of appetite

Sleep: Insomniac

Bowel: Constipation

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

Habit: No habit

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is apparently conscious and well oriented

Built & Nutrition: Normal

Vital Signs:

a) Temperature: 99.2°F

b) Pulse: 90 beats / min

c) Respiratory Rate: 22 cycles / min

d) Blood Pressure: 120 / 80 mm Hg

Skin: a) Hair Normal

b) Nail Pallor on nail bed

(II)

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 Column: 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 breath sounds and clear wheezes bilaterally
- Vesicular breath sounds in all areas of chest

(III)

Gastro Intestinal System:

- a) Inspection: - NO discoloration / visible swelling
- NO dilated superficial veins
- shape of abdomen is bulging
- Umbilicus is centrally placed and inverted.
- b) Palpation: - Liver is not palpable
- Spleen and kidney not palpable
- 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: - Cardiac dullness is within normal limits
- Right and left cardiac borders parallel from costal margin to mid axillary line
- d) Auscultation: - Heart sound audible in aortic & pulmonary area
- 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:

Iron Deficiency anemia

Investigations: 1) Complete Blood Count: Hb count - 8 gm%
RBC count - 3 million / μ L, WBC count - 3000 / 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 disclosed to K.D.C. & Education Centre, Jew Parganah, Hatkanangali, Tal. Kolhapur 416 107
1 month

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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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Panchajanya
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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: $92/\text{min}$

c) Respiratory Rate: 30 cycles/min

d) Blood Pressure: $140/100$

Skin: a) Hair

b) Nail
Pallor present

(II)

c) Face: Pale

d) Eyes: Pallor

e) Nose: Normal

f) Mouth: Pale oral mucosa

g) Limbs: Pain radiating to left shoulder

h) Vertebral Column: No abnormality detected

i) Lymphadenopathy: Absent

j) Oedema: Absent

k) Joints: No abnormality detected

SYSTEMATIC EXAMINATION:

Respiratory System:

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

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 present in both sides

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

(III)

Gastro Intestinal System :

- a) Inspection : - No discoloration / visible swelling
- No dilated superficial veins
- Shape of abdomen is bulging
- Umbilicus is centrally placed and inverted.
- b) Palpation : - Liver is not palpable
- Spleen and kidney not palpable
- Abdomen is soft
- No tenderness
- c) Percussion : - Tympanic note found on percussion
- Abdomen fullness is due to faeces flatulence

d) Auscultation :

1. 2-3 peristaltic movements / min

Cardio : Vascular System :

- a) Inspection : - Pericardium is smooth
- No retraction is seen
- Bulging abdomen present
- Apex beat normally placed
- b) Palpation : - Absence of thrust
- Apex beat is palpated at left 5th intercostal space.
- c) Percussion : - Right & Left lateral borders percussed from lateral to medial side
- Cardiac dullness within normal limits
- d) Auscultation : - Heart sounds auscultated in mitral, aortic and pulmonary area
- NO murmur

(IV)

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

- Provisional Diagnosis : - Myocardial infarction
- Unstable angina

- Investigations : 1] ECG = ST segment elevation
2] Blood - ↑ ESR, leucocytosis
3] Biomarkers - cTnB, Cardiac troponins (T and I), Raised LDH
- Final Diagnosis : 4] Echocardiography
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. Dsrprin [325 mg]

- Tab. Clopidogrel 300mg stat

6] Inj. Atorvastatin 80mg
Inj. streptokinase IV [100ml] stat

7] Inj. low molecular weight heparin 0.4ml [40mg]

8] Tab. metoprolol 25mg - OD

9] Tab. Ramipril 5.0mg - Dr. Harish Kulkarni M.D.S.

10] Diet = low cal diet for 5-6 days
Follow Up : diet

11] Avoid smoking and alcohol

(V)

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 diet

Appetite: loss of appetite

Sleep: Normal

Bowel: Frequency - once daily

Micturition: 4-5 times a day

Habit: No habit

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is conscious and well-oriented

Built & Nutrition: Normal

Vital Signs:

a) Temperature: 98.6°F

b) Pulse: 80 beats/min

c) Respiratory Rate: 20 sides/min

d) Blood Pressure: 120/80 mm Hg

Skin: a) Hair Normal

b) Nail Normal

(II)

c) Face: Normal

d) Eyes: Normal

e) Nose: Normal

f) Mouth: Normal

g) Limbs: Normal

h) Vertebral Column: Normal

i) Lymphadenopathy: Absent

j) Oedema: Absent

k) Joints: No abnormality detected

SYSTEMATIC EXAMINATION:

Respiratory System:

a) Inspection: - Bilaterally symmetrical chest
- No 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: - ~~Tracheal~~ ~~bronchial~~ ~~by~~ ~~coarse~~ ~~crackles~~ ~~at~~ ~~base~~ ~~of~~ ~~lung~~ ~~field~~
- No audible sound

(III)

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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 :
- Right and left heart borders percussed within normal limits
- 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) Barium 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 Qwen.
- 4) Lq. Sucralfate TID
- 5) Inj. Pantoprazole 40 mg i.v OD
- 6) Tab Alprazolam 0.25mg

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

Case No.: 6 Date: 18/01/2020

Name: Deepak Bhoi

Age: 52 years Sex: Male

Occupation: Bank employee

Religion Status: Hindu

Social Status: Middle class

Marital Status: Married

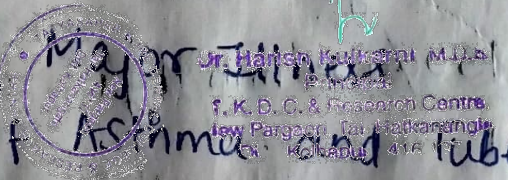
Date of Admission:

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 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 mmHg

Skin: a) Hair Normal

b) Nail Normal

(II)

c) Face: Normal

d) Eyes: Normal

e) Nose: Normal

f) Mouth: Normal

g) Limbs: Normal

h) Vertebral Column: Oedema present over lower limbs

i) Lymphadenopathy: Absent

j) Oedema: Bilateral pedal oedema

k) Joints: Normal

SYSTEMATIC EXAMINATION:

Respiratory System:

a) Inspection: Bilaterally symmetrical chest
- No visible superficial vein/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
- Tracer is centrally placed

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

(III)

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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** : - 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 lower borders

d) **Auscultation** :
- Heart sound is normal in mitral, aortic and pulmonary area.

(IV)

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

Provisional Diagnosis :

- 1) Hypertension with Obesity
- 2) Renal insufficiency

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

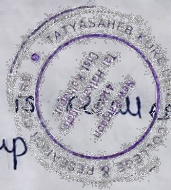
Final Diagnosis : 6) Lipidogram

Hypertension with Obesity

Treatment :

- 1) Cessation of alcohol consumption and smoking habit
- 2) Salt Restriction diet is advised 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 followed up after 1 month.



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(V)

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  HIN, 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: 128/88 mmHg

Skin:

- a) Hair: Loss of hair [Alopecia]
- b) Nail: Clubbing of fingers, White Nail beds

(II)

c) Face: Puffiness of face

d) Eyes: Yellowish discoloration of sclera

e) Nose: Normal

f) Mouth: Pale oral mucosa

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

h) Vertebral Column: Normal

i) Lymphadenopathy: Absent

j) Oedema: Bilateral pedal oedema

k) Joints: Normal

SYSTEMATIC EXAMINATION:

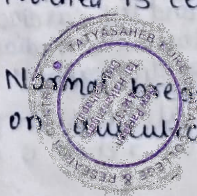
Respiratory System:

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

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

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

d) Auscultation: - Normal breathing sounds heard on auscultation



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(III)

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 obscured from lateral & medial side.
 - No cardiomegaly.
- d) **Auscultation:**
- Atrial bruit is present
 - Venous return is continuous

(IV)

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

Provisional Diagnosis:

- 1) Ascites
- 2) Cirrhosis of liver

Investigations:

- 1] Complete Blood count - Hb concentration - 9 gm%, RBC count - 4 million/ μ L, WBC count - 5000/ cu mm
- 2] RBC morphology - Macrocytosis

2] Ultrasonography of Abdomen

3] Liver function test

4] Urine examination

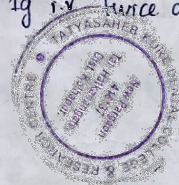
Final Diagnosis: 5] Ascitic fluid examination - Serum-ascites albumin gradient is $>1.1 \text{ g/dL}$

Cirrhosis of liver

Treatment:

- 1] Cessation of alcohol consumption habit
- 2] Bed rest is advised to Patient
- 3] Therapeutic Paracentesis - Maximum 1 litre ascitic fluid can be removed
- 4] High protein diet [80-100g] and low salt diet
- 5] Cap. Becosules E 100 05 - 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 :



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(V)

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 :

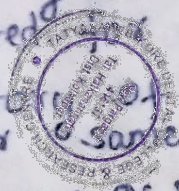
Chief Complaint : Patient complains of multiple blisters over both lower limb since 2 months. Discharge from blisters since 40 days. Patient also complains of mild fever, bodyache and slow developing swelling over lower limbs.

History of Present Illness : Patient was apparently alright 2 months back. Then 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 same 2 months back.

- Patient has history of diabetes mellitus and on medication for same.
- Patient has history of fever.



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

Personal History: No history of adverse habits is reported

Diet: Mixed 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 mmHg

Skin: a) Hair Normal

b) Nail Normal

(II)

c) Face: Normal

d) Eyes: Normal

e) Nose: Normal

f) Mouth: Normal

g) Limbs: Oedema on lower limbs

h) Vertebral Column: Normal

i) Lymphadenopathy: Absent

j) Oedema: Present bilaterally over lower limbs

k) Joints: Normal

SYSTEMATIC EXAMINATION:

Respiratory System:

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

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

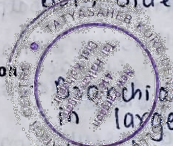
c) Percussion: - Tactile vocal fremitus equal on both sides

d) Auscultation: - Bronchial breathing in large vessels over chest
- Vesicular breathing audible all over chest

(III)

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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 murmur

(IV)

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

Provisional Diagnosis :

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

Investigations : 1) Routine Investigation - Complete Blood Count, ESI, Blood Sugar level [Fasting & Post Prandial], Serum Creatinine, Serum cholesterol, Urine examination

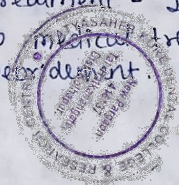
2) X-ray of both lower limb below knee [Anteroposterior view],

Final Diagnosis : Culture sensitivity of discharge from blister.

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 betadine
3) Inj. ceftriazone + sulbadam 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 adraphane according to BSL
8) Surgical treatment - If cellulite does not subside with medical treatment - Incision and drainage, Debridement.

Follow Up :



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(V)

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: _____

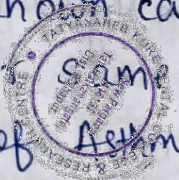
Chief Complaint: Patient complains of tingling numbness of lower limbs, weakness, dizziness since 20 days.

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 3 months
- No history of Asthma, Tuberculosis or Epilepsy



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Family History:

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

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

Diet: Mixed

Appetite: Reduced Appetite

Sleep: Disturbed sleep

Bowel: Frequency - 2-3 times/day

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

Habit: No habit

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is conscious and well oriented

Built & Nutrition: Normal

Vital Signs:

a) Temperature: 98.2°F

b) Pulse: 84 beats/min

c) Respiratory Rate: 22 cycles/min

d) Blood Pressure: 100/60 mmHg

Skin:

a) Hair: Normal

b) Nail: White nail

(ii)

c) Face: Normal

d) Eyes: Normal

e) Nose: Normal

f) Mouth: Normal

g) Limbs: Normal

h) Vertebral Column: Normal

i) Lymphadenopathy: Absent

j) Oedema: Absent

k) Joints: Normal

SYSTEMATIC EXAMINATION:

Respiratory System:

a) Inspection:- Bilaterally symmetrical chest
- No visible superficial vein/scar
- 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 these bronchus
- Vesicular breathing is audible all over chest.

(iii)

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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:
- No tenderness
- Liver, spleen and kidney are not palpable
- c) Percussion:
- Tympanic note is found on percussion
- No abnormalities detected

d) Auscultation:

- 2-3 peristaltic movements/min are audible

Cardio: Vascular System:

- a) Inspection: - Pericardium is smooth
- No retraction is seen
- b) Palpation:
- Absence of Thrust
- No any tenderness / palpable mass in
- c) Percussion: Pericardium
Cardiac dullness is found within normal limits. Right and left midaxillary borders percussed from front to back to midaxillary line.
- d) Auscultation:
Heart sound auscultation in Mitral, aortic and pulmonary area.

(IV)

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

Provisional Diagnosis:

- 1) Severe Anaemia
- 2) Diabetes Mellitus

Investigations: 1) Complete Blood count - Hb - 12 gm/l.
RBC count - 5 million/ μ L, 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
Final Diagnosis: 1) Lipidogram

Diabetes Mellitus.

Treatment:

- 1) Cessation of alcohol consumption & smoking habit
- 2) Lifestyle Modification - Regular exercise 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 called after 1 month for follow up. Advised for routine examination.

(V)

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.

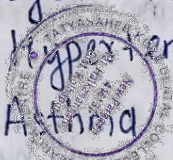
Past Medical History :

No history of Major Illness

No history of Hypertension

No history of Asthma

No history of Tuberculosis



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Family History: No relevant history

Personal History: No history of adverse effects

Diet: Pure vegetarian diet

Appetite: Reduced appetite

Sleep: Insomnia

Bowel: Frequency 2-3 times a day

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

Habit: No relevant history

GENERAL PHYSICAL EXAMINATION:

Attitude: Patient is conscious 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 mmHg

Skin: a) Hair: Normal

b) Nail: Pallor present on nail bed

(11)

c) Face: Pale

d) Eyes: Pallor on lower palpebral conjunctiva

e) Nose: Normal

f) Mouth: Pallor, Red tongue

g) Limbs: Normal

h) Vertebral Column: Normal

i) Lymphadenopathy: Absent

j) Oedema: Absent

k) Joints: Normal

SYSTEMATIC EXAMINATION:

Respiratory System:

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

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

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

d) Auscultation: - Bronchial breathing in all lung fields
- Vesicular breathing in all lung fields
- No audible wheeze

(11)

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 :

- Heart sound auscultation in mitral, aortic and pulmonary area
No murmur

(IV)

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

- Pupils are equally reactive to light.

Provisional Diagnosis :

- Malabsorption syndrome
- Megaloblastic anaemia

Investigations :

- 1] Complete Blood count - Hb count - 8 gm/l, RBC count - 3 million / μ l, WBC count - 8000 /cu mm, Raised MCV
- 2] RBC morphology - Macrocytic
- 3] Serum Vitamin B₁₂ assay
- 4] Schilling Test
- 5] Serum Folate assay
- 6] Blood glucose Test

Final Diagnosis :

Megaloblastic anaemia

Treatment :

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

OR

- 2] Methylcobalamin B₁₂ - 1500 mg I.M daily 7 days
Once a week - 6 weeks.

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

- 4] Patient is advised to eat Vitamin B₁₂ rich diet.

Follow Up :

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(V)