CLINICAL CASE PRESENTATION FROM DEPARTMENT OF GENERAL MEDICINE

CHIEF COMPLAINTS:

A 36-year-old male who is a painter, resident of Gannavaram presented to ER with chief complaint of pain abdomen, vomitings for 3 days, cough since 3 days.

HISTORY OF PRESENT ILLNESS: The patient was apparently normal 5 days prior to presentation, then patient had complaints of fever, high grade, continuous, associated with chills and rigors, relieved with medications, associated with sore throat, not associated with headache, arthralgia, myalgias. Patient went to outside hospital (RMP) and got treated and had symptomatic relief within 2 days.Later patient had pain in upper abdomen since 3 days, burning type, non radiating, continuous, aggravated with food and Water intake.C/o vomitings since 3 days, 3-4 episodes per day, non bilious, associated with nausea, watery, soon after food and water intake, non blood stained, preceded by cough.C/o cough since 3 days, associated with whitish, scanty, mucoid expectoration, non foul smelling, aggravated on drinking and eating, associated with vomiting.C/o shortness of breath since 2 days, grade II, non progressive, not associated with Orthopnea, PND, wheeze. C/o difficulty in swallowing for liquids more than solids, accompanied by nasal regurgitation and cough. No C/o involuntary movements, difficulty in walking. No H/o suggestive of other cranial nerve involvement. No c/o abdominal distension, loose stools. No c/o burning micturition, increased/decreased frequency of micturition. No c/o wt loss.

PAST HISTORY: No history of similar complaint in the past. No comorbidities.

PERSONAL HISTORY: Takes mixed diet. Sleep and appetite decreased since 4 days. Bowel habits previously regular, now not passing stools since 3 days, bladder habits are regular. Known Smoker since 6 years, 1 pack cigarettes per day, 3 pack years. Known Alcoholic since 6 years, takes about 180ml/day, 3-4 times per week, last binge 3 days prior to presentation

SURGICAL HISTORY: Nil significant

FAMILY HISTORY: Nil significant

TREATMENT HISTORY: He was kept on Tab AZITHROMYCIN 500mg PO 24th hourly, TAB. DOXOFYLLINE 400mg PO 12th hourly, Tab. LEVOFLOXACIN 500mg PO 24th hourly at outside RMP hospital for fever and sore throat. Pt used these medications and then stopped 3 days prior to presentation

GCOE: Patient is conscious, coherent and oriented. Moderately built, malnourished, BMI: 17.57 kg/m2 No pallor, icterus, cyanosis, clubbing, lymphadenopathy, edema. Oral cavity examination showed poor oral hygiene, nicotine staining (+).

VITALS AT THE TIME OF ADMISSION:

BP: 130/70 mmhg **PR: 80 bpm.** **Temp :98.6F**

RR:-20 cpm **SPO2: 98%RA.** **GRBS: 132mg/dl**

SYSTEMIC EXAMINATION: P/A: Tenderness present in epigastrium, rest of examination is normal, BS (+)

RESPIRATORY SYSTEM: Trachea midline, chest movements are equal on both sides, **VF& VR increased in Right infraclavicular area, right mammary area, Right Supra scapular area. Bronchial breath sounds were heard in same areas**

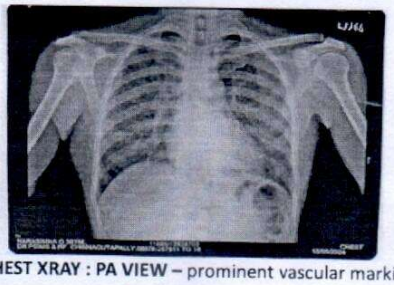
NERVOUS SYSTEM: HMF -Normal, **Cranial Nerves – Uvula deviated to right side, decreased palatal arch movements on left side, Gag absent on left side,** rest of examination is Normal.

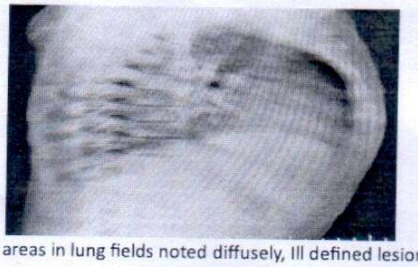
CVS: Normal.

PROVISIONAL DIAGNOSIS : RIGHT UPPER LOBE CONSOLIDATION, ? ALCOHOL GASTRITIS,? ACUTE PANCREATITIS, BULBAR PALSY (? CAUSE)

INVESTIGATIONS:

CBP	Day 1	Day 3
Hb	11.6 gm%	11.0gm%
TLC	**13,670**	**17,700**
N/L/E/M/B	85/7/1/7/0	85/7/1/7/0
Platelets	577k	622k
ESR	40	43 mm/hr
PCV	**33.2**	**31.3**
MCV	**88.4 fl**	**88.4 fl**
Impression	Normocytic Normochromic Anaemia with neutrophilic leukocytosis with reactive thrombocytosis.	Normocytic Normochromic Anaemia with neutrophilic leukocytosis with reactive thrombocytosis





CHEST XRAY : PA VIEW – prominent vascular markings than fibrotic areas in lung fields noted diffusely, Ill defined lesion noted adjacent to right hilar region abutting mediastinal pleura, appears to be parenchymal lesion. LATERAL VIEW- irregular wall with central cysts or cavitations in view of regurgitation and aspiration history and CNS condition this might represent aspiration pneumonia with cavitation (pyogenic/ tuberculous) or early abscess formation.

USG ABD AND PELVIS: GB- partially distended, multiple hyperechoic foci with posterior accoustic shadowing noted in lumen of gall bladder, largest measuring 11mm. No pericholecystic fluid, wall thickness appears normal; Pancreas: visualised part of head and body appears normal. Rest obscured by bowel gas shadows. Rest of the study is normal.

Other investigations: VIRALS – NEGATIVE; S ELECTROLYTES , RFT B UREA – 66 mg/dl, s creatinine 1.0mg/dl, S. Amylase -96U/L, S. Lipase 32 U/L, LFT SGOT – 90 U/L, SGPT 78U/L rest normal

SPUTUM ANALYSIS: AFB – Negative, GRAM STAIN- plenty of pus cells, occasional epithelial cells, Gram positive cocci seen in pairs **CULTURE Streptococcus species isolated,** sensitive to linezolid, tetracycline, vancomycin,

2D ECHO: Normal study.

Course in the hospital – patient was kept on NBM and Ryles tube insertion was done, IV FLUIDS RL/NS WITH OPTINEURON @75ml/hour, INJ. CEFAPERAZONE+SULBACTUM 1.5gm IV 12th hourly, INJ. CLINDAMYCIN 600 mg IV 12th hourly, PPI's, Anti emetics, syp. SUCRAL O 5ml RT 6th hourly.

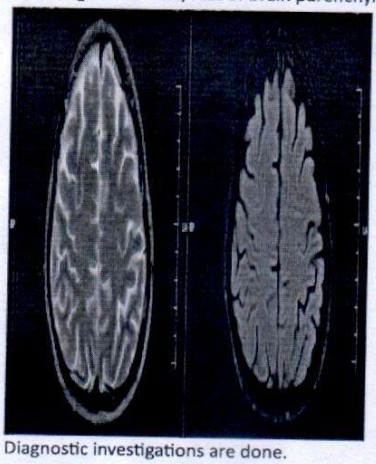
DAY 1: patient had one fever spikes 100F, sputum samples were sent, ENT, Neurology opinions were taken

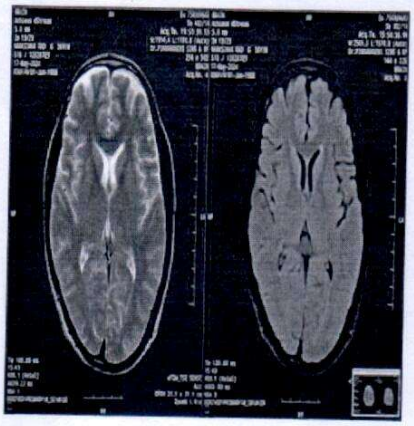
Neurology Opinion: facial symmetry (+), Gag absent, uvula deviation (+) to Right; palatal arch movement decreased on left side Advised MRI brain (p)

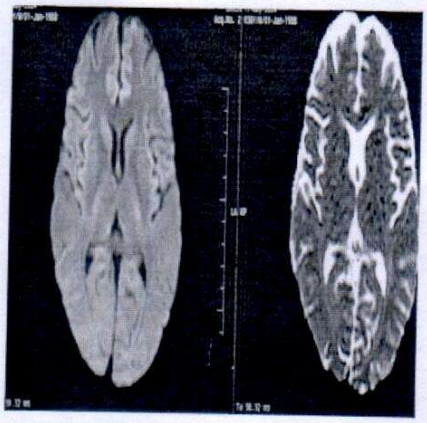
ENT opinion (I/V/O dysphagia): VLS: Normal.

DAY 3: patient had chest pain central and 2-3 fever spikes/ day present (100-102F); c/o cough with expectoration (+), Counts increased from 13000/cumm to 17000/cumm Antibiotics were added based on culture reports INJ.LINEZOLID 600 mg IV BD Added, INJ CEFAPERAZONE + SULBACTUM 1.5gm continued, CLINDAMYCIN stopped.

MRI Brain: Impression-very dot like signal changes seen in right side of pons and right parietal region, these are too small to explain any obvious neurological deficits, rest of brain parenchyma is showing normal signal intensity.







Diagnostic investigations are done.