# Department Of Cardiology

PATIENT COPY

## Discharge Summary

Patient Name : MRS. SAROJA G S

Age: 43 years / Female

Ward : 535 NS / 533 A

**Admission Date : 02.08.2014**
**Discharge Date : 30.09.2014**

**CONSULTANT : DR. ANUJ KAPADIYA**

FINAL DIAGNOSIS :

**# TYPE 2 DM**
**# HYPERTENSION**
**# HYPOTHYRODISM**
**# MORBID OBESITY**
**# CKD – STAGE 2**
**DIABETIC NEPHROPATHY**

PRESENT ADMISSION:

**# CARBUNCLE OVER RIGHT BREAST WITH ABSCESS FORMATION - WIDE LOCAL EXCISION OF RIGHT BREAST WAS DONE UNDER LA ON 05.08.2014**
**# AKI ON CKD**
**# RESPIRATORY ARREST – POST MECHANICAL VENTILATION (REVIVED) – 07.08.2014**
**# SEPSIS (MSSA)**
**# UNCONTROLLED DIABETES**
**# OSA – ON BiPAP**
**# RECURRENT LVF**

**HISTORY**

Mrs. Saroja aged 43 years lady is admitted in CARE Hospital on an emergency basis on 02.08.2014, Vide I.P. No: 96961. She is known hypertensive, hypothyroid, diabetic, CKD – stage 2 with diabetic nephropathy. She had a carbuncle over right breast with abscess formation and pus drainage from there; admitted for further management.

**CLINICAL EXAMINATION:**

Patient is Conscious / Coherent / Afebrile

No Icterus/ Clubbing / Pallor / Pedal edema

| | |
|---|---|
| PR : 84/min | PP+ |
| BP : 170/80 mmHg | RR : 38 /min |
| Heart : S1+, S2+ | JVP : Normal |
| Lungs : Cl. Clear | P/A : Soft, BS + |
| CNS: NAD | |

**COURSE IN THE HOSPITAL:**

Mrs. Saroja aged 43 years lady was admitted on 02.08.2014 with the above mentioned history. She was managed with IV antibiotic (Magnex Forte, Clindamycin) and other supportive measures. Surgical opinion was taken, suggested surgical intervention.

Blood analysis showed raised renal parameters (creatinine 2.4, TLC – 22500). Urine examination showed pus cells of 15 – 20 and with 4 – 6 RBC. Nephrology opinion was taken, suggested high risk surgery and possibility of dialysis post

OP in view of AKI on CKD. Cardiology evaluation also was done pre OP, ECG no ST – T changes. Echo showed no RWMA, good LV function. Pulmonologist also saw her as her chest X ray showed poor expansion and ABG showed metabolic acidosis. PFT was suggestive of severe restriction. BNP was high (1954), managed with diuretics.

Modearte to high risk wide local excision of right breast was done under LA on 05.08.2014 uneventfully. IV antibiotics were continued and managed with IV analgesics and LMWH. Her saturation was low, managed with NIV (C-PAP) support.

On 07.08.2014 she had sudden unresponsiveness, resuscitation started as per ACLS protocol. Emergency intubation done and connected to mechanical ventilator. Review ECG and echo were normal. She was in severe bronchospasm, IV steroids were continued. Serial ECGs showed prolonged QT.

She was hemodynamically stable, ventilator supports were weaned off and was extubated on 09.08.2014. Serial ABGs showed metabolic + respiratory alkalosis, NIV was continued.

Her wound was healthy, no drain. Pus culture grew staphylococcus (MSSA), clindamycin was continued as per sensitivity.

On 10.08.2014 she had an episode of desaturation, managed with bronchodilators. Chest X ray was suggestive of right middle zone infiltrates and bilateral basal collapse. Her blood sugar levels were on higher side, was managed with insulin doses accordingly.

On 11.08.2014 her ECG showed new onset T inversions in inferolateral leads. Review echo showed normal study. Troponin was raised (1.29). She was treated as ACS and was managed with antiplatelets and statins. Her Hb dropped to 6.2%, one unit PRBC transfused. She had persistent tachycardia, betablockers were titrated up. She was planned for coronary evaluation later after stabilization.

Her subsequent swab culture grew enterococcus aureus, antibiotic was upgraded to Teicoplannin.

She was improving, ambulated. Aggressive physiotherapy given. She had persistent hyperglycemia, managed with insulin infusion. Her renal parameters were improving. She was requiring NIV support.

Pulmonologist were following her, suggested Home Bi-PAP with oxygen concentrator for her severe OSA.

She was shifted out of ICU, is ambulated. Her renal parameters are raising (creatinine (2.2). Blood sugar levels were controlled, Endocrinology opinion was taken for glycemic control.

During her further stay she was not maintaining oxygen saturations (84% on room air saturation), chest X ray was suggestive of congestion. She was in LVF, was managed with low dose diuretics. Had hypoglycemia during further stay which she recovered.

She was ambulated, no further episode of LVF or desaturation and is being discharged on 30.09.204 with the advice to follow on OP basis.

**INVESTIGATIONS:**

02/08/2014 INR 1.00

02/08/2014 MEAN CONTROL VALUE 12.6 seconds

02/08/2014 TEST 12.6 seconds

02/08/2014 APTT 35.1 seconds

02/09/2014 SERUM CREATININE 2.09 mg/dl

02/09/2014 SERUM POTASSIUM 4.0 mEq/L

03/08/2014 RANDOM PLASMA GLUCOSE.. 232 mg/dl

03/08/2014 SERUM UREA 73 mg/dl