CASE PRESENTATION

BY DR. ARCHANA
DEPT OF PULMONOLOGY
PG 1ST YEAR

- A 45 year old female patient who is a homemaker ,resident of Kadappa presented to our hospital on 04-12-2017 with the chief complaints of dry Cough since two months, shortness of breath since one month.

History of present illness

- COUGH: Gradual in onset ,dry in nature not associated with chest pain. No aggravating or relieving factors, not associated with syncope.

- Shortness of Breath: Insidious in onset ,gradually progressed from grade 1 to grade 3(MMRC) over 2 months , not associated with wheeze or any aggravating or relieving factors, no diurnal or postural or seasonal variations.

- No history of haemoptysis
  - chest trauma
  - fever
  - pedal oedema
  - syncope, palpitations
  - orthopnea, PND
  - Joint pains or difficulty in swallowing.

History of past illness

- Past history of pulmonary TB 10 yrs back took ATT for 6 months.
- History of Diabetes Mellitus Type-2 since 3 months on medication.
- Not a known case of hypertension
  - No history of asthma
  - epilepsy
  - cardiovascular diseases
  - malignancies

- Menstrual History:

  Attained Menarche at the age of 13 years, 3 /30 days regular.

- Obstetric History:

  P2 L2 Normal vaginal delivery.

  Tubectomised 8years back.

- Personal history:
  - Appetite: decreased
  - Diet: Mixed
  - Sleep: Adequate
  - Bowel and bladder Habits: Regular
  - Non Smoker , Non Alcoholic.
  - No History of Biomass fuel exposure.
- Family history: No History of DM, HTN, TB, epilepsy, Asthma, CAD in the family.

General physical examination

- Patient is conscious, coherent, co-operative, moderately built and moderately nourished with BMI-19.6
- No pallor, icterus, cyanosis, lymphadenopathy, edema, clubbing.
- Head to toe examination: normal
- No scars, sinuses, visible swellings

- VITALS:
  - BP-110/70 mm hg supine position, measured in right brachial artery
  - PR-90 per minute, measured in the right radial artery, normal in rhythm, character, volume, no radio radial delay, no radio femoral delay, all peripheral pulses felt
  - RR- 26 cycles/min, thoracoabdominal
  - Temperature- afebrile
  - Spo2@ room air 94%

Respiratory system examination

INSPECTION:

Upper respiratory tract:

Nasal cavity- No DNS, No polyps, No hypertrophy of turbinates and no PNS tenderness

Oral cavity- Good hygiene, No visible ulcers, No loose dentures, Soft and hard palate normal, No post nasal discharge.

- Lower respiratory tract-
  - Shape-bilaterally symmetrical, transversely elleptical in shape
  - Respiratory movements-equal on both sides
  - Trachea-central in position
  - No kyphosis, scoliosis
  - No scars, sinuses, engorged veins
  - No drooping of shoulder, flatenning of chest wall
  - No intercostal indrawing, No use of accessory muscles of respiration
  - Apical impulse not seen

- Palpation-
- Inspectory findings confirmed
- Chest bilaterally symmetrical
- Chest expansion equal on both sides
- Trachea central in position
- No local raise of temperature and tenderness
- Apex beat palpable at left 5^{th} ICS half inch medial to mid clavicular line
- Tactile vocal fremitus- Equal on both sides.

- Percussion-

-Direct clavicular percussion- Normal resonant note heard

-Indirect- Normal resonant note heard in all areas.

- Auscultation-

- Bilateral air entry present

-Bilateral coarse inspiratory crepts present in IAA and Infra Scapular area

- CVS- S1and S2 heard

  No murmurs and thrills
- Per abdomen-Shape of the abdomen-scaphoid
  - No tenderness, No scars, sinuses and engorged veins
  - Liver and spleen not palpable
  - Bowel sounds are heard
  - Genitals-NAD
- CNS-NAD

PROVISIONAL DIAGNOSIS

- Obstructive pneumonia
- Pulmonary tuberculosis
- Allergic alveolitis
- Interstitial lung disease
- Alveolar microlithiasis
- Alveolar cell carcinoma
- Pneumonia alba or white lung syndrome

- Patient was empirically started on

1) Antibiotics
2) Nebulisation
3) Anti tussives
4) Oxygen inhalation

Investigations

- CBP
  - Hb-13 gm%
  - TLC-8500/cu mm
  - PC-3.03 lakhs /cu mm
  - N64%,L30%,E3%,M3%,B0
- ESR-65mm
- CUE-WNL
- Viral serology- non reactive

- RFT-

Blood urea-28 mg/dl

Serum creatinine- 0.59mg/dl

Serum sodium-136 mmol/l

  - potassium-4.0 mmol/l
  - chloride-99 mmol/l

- ABG-

PH-7.44

PCO2-39.2

PO2-81.6

HCO3-22.8

SPO2-96

- LFT-

TB-0.20 mg/dl

DB-0.10mg/dl

AST-23 IU/L

ALT-13IU/L

ALP-85 IU/L

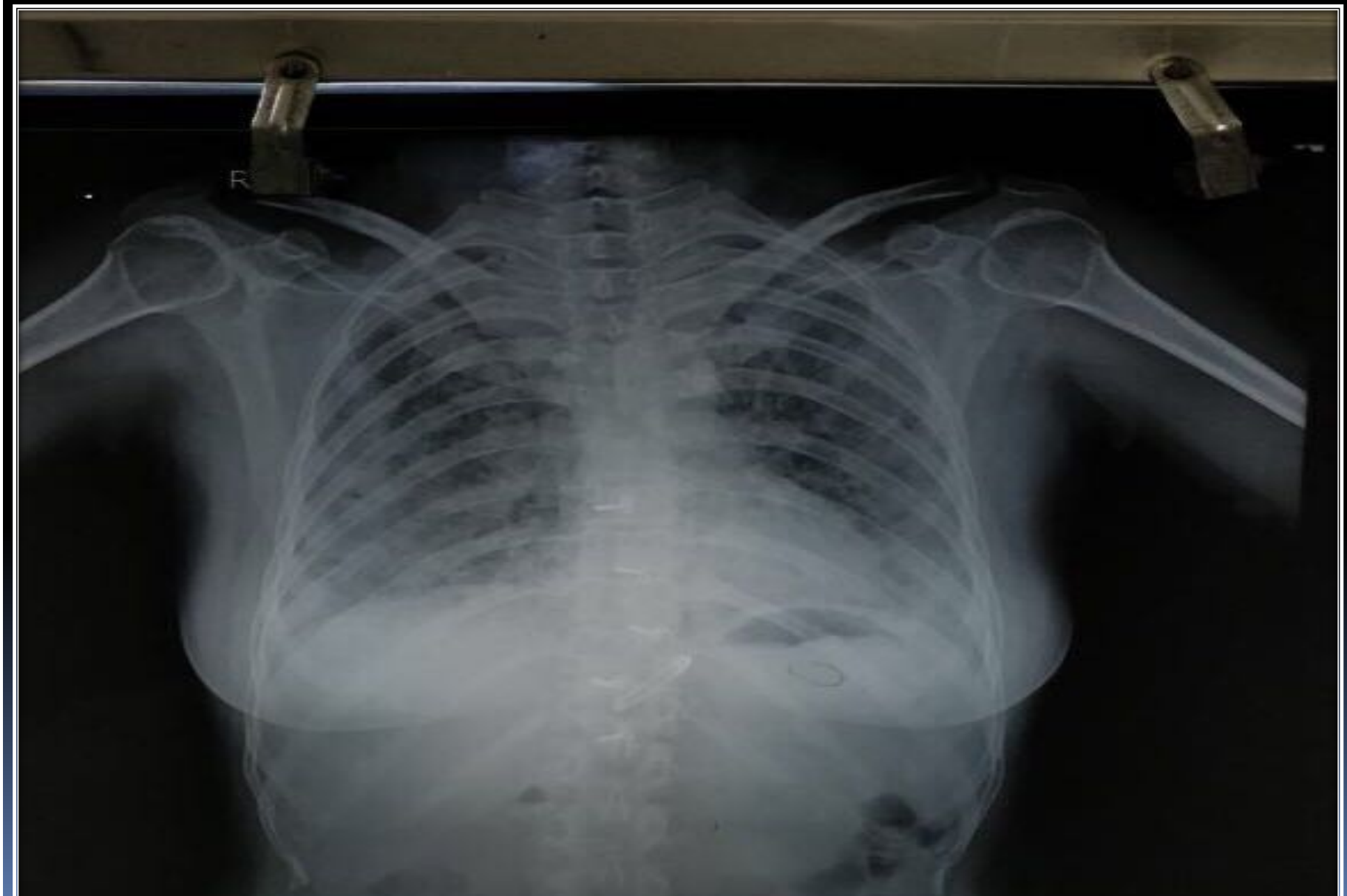
TOTAL PROTEINS-6.6 mg/dl

ALBUMIN-3.6 mg/dl

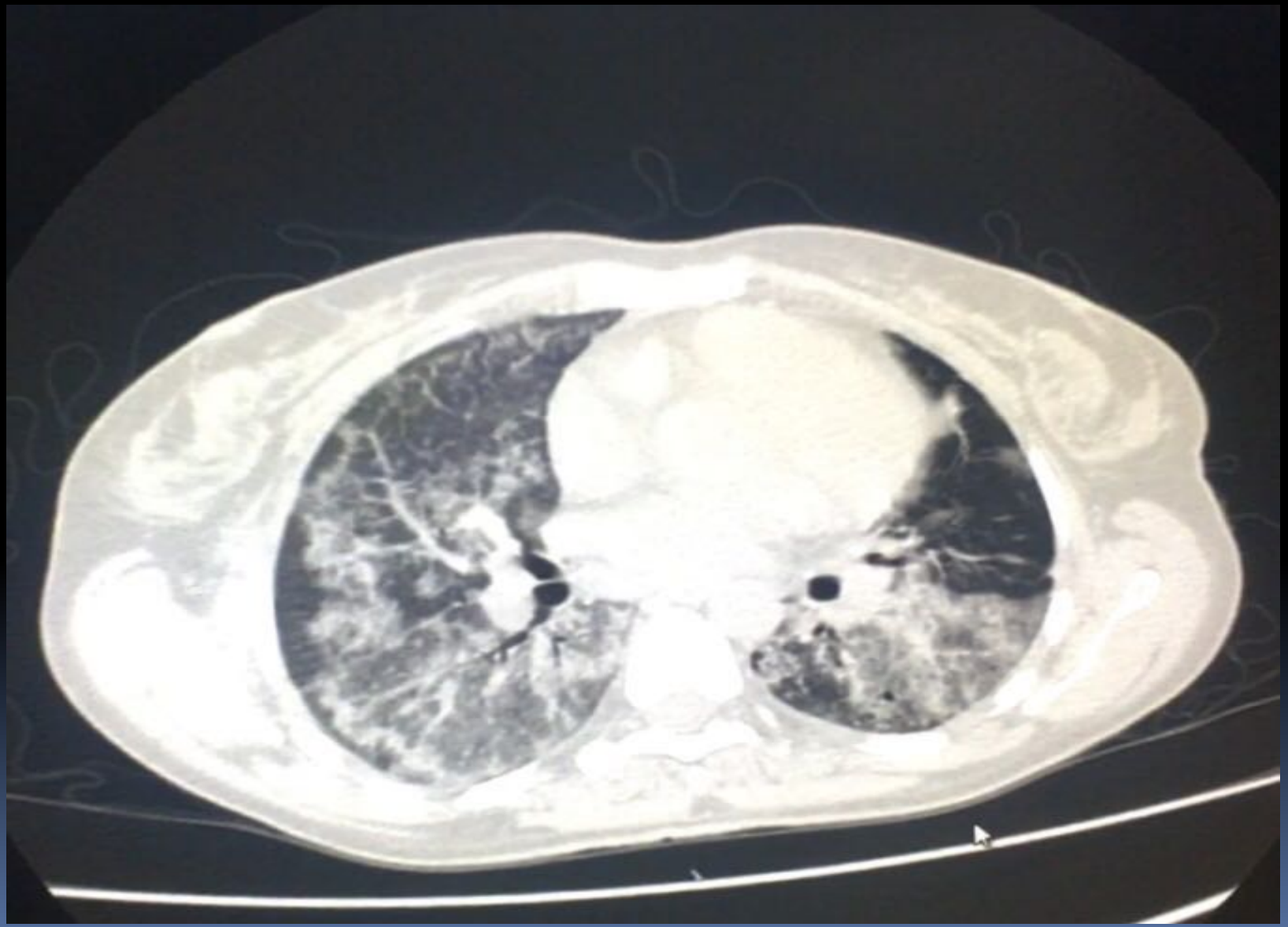
USG Abdomen – Normal Study

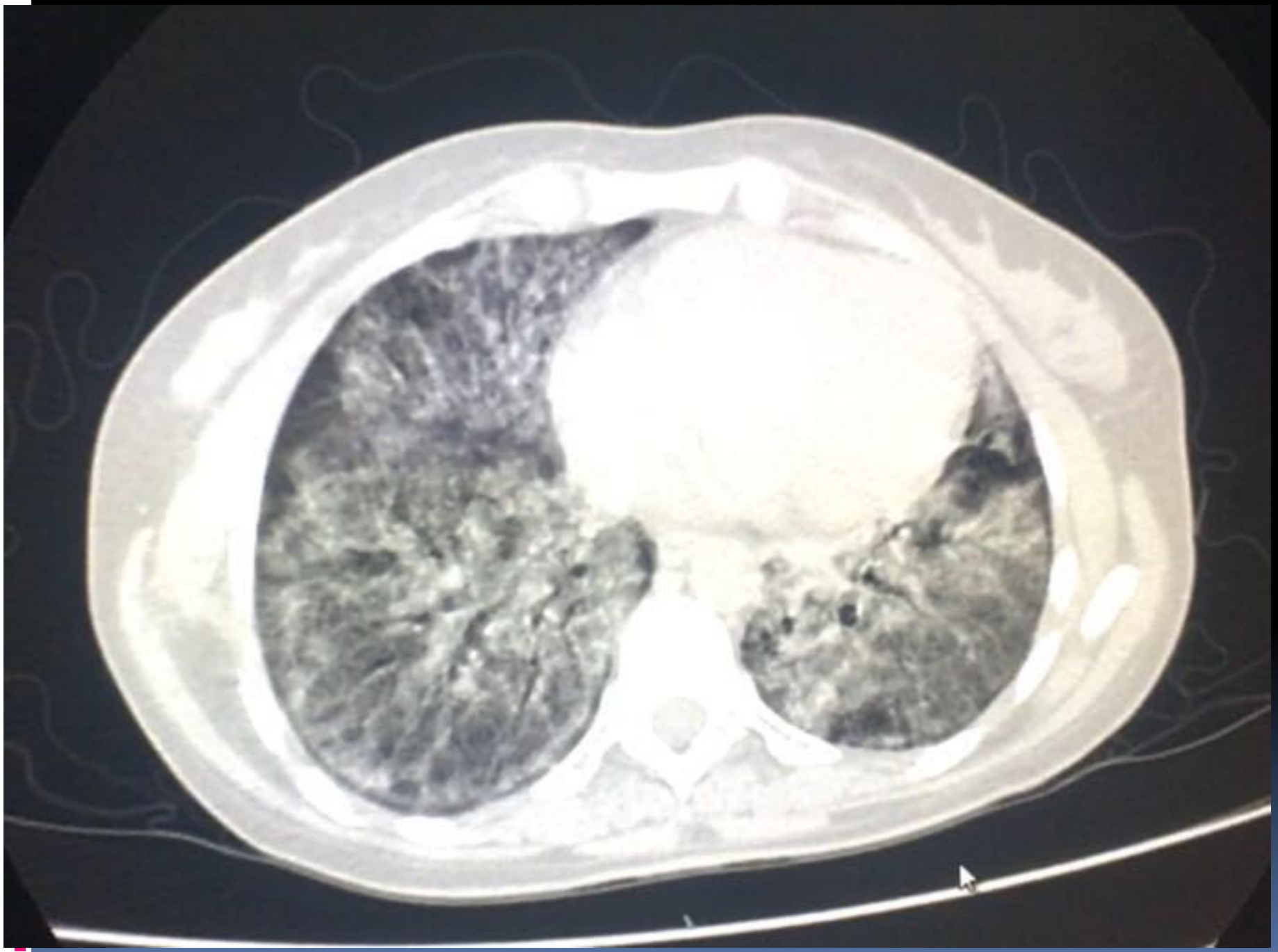
Sputum for afb - negative

CHEST X RAY



CT CHEST





- Bilateral Lung Fields show diffuse reticular shadows and super imposed ground glass opacities with e/o peripheral / sub pleural spacing.

FINAL DIAGNOSIS

- Pulmonary Alveolar Proteinosis with K/C/O Diabetes Mellitus Type-2

THANK YOU