CASE PRESENTATION

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DEPT OF PULMONARY MEDICINE

CASE PRESENTATION

- NAME : X
- AGE/SEX : 67/F
- ADDRESS : Chitur, Nalgonda
- DOA : 11/12/15
- DOD : 21/12/15
- IP NO:201601352

CHIEF COMPLAINTS AND PRESENTING HISTORY

- Cough with expectoration - 1 yr
- Fever - 3 days
- Haemoptysis - 3 days

Presenting complaints

- The patient was apparently asymptomatic 1 year ago, then she developed Cough with expectoration , insidious in onset , no postural and diurnal variation , no seasonal variation with no aggravating or relieving factors , with scanty , mucoid whitish initially and now associated with foul smelling sputum since 20 days.
- Haemoptysis since 3 days , frank blood of 2 - 3 episodes approx. 60 ml per episode. No h/o of trauma , breathlessness , wheeze or chest pain.
- Fever since 3 days ,sudden in onset, intermittent , low grade , not associated with chills and rigor, subsided by the use of medication ,headache and generalized body pains ,aggravated during night,not associated with any rash,vomitings and diarrhea.

PAST HISTORY

pt had cough with expectoration 4yrs back diagnosed as pulmonary tuberculosis and used ATT completely for 6 months.

k/c/o T_2DM since 10 years on oral hypoglycemics since then.

No h/o HTN/seizures/Bronchial asthma/COPD.

PERSONAL HISTORY

Married,Daily labour

Attained menopause 20 yrs back,

Mixed diet,

Decreased appetite , no significant wt. loss

Normal bowel and bladder habits,

Non-Smoker , occasionally consumes alcohol.

FAMILY HISTORY

Not significant

DRUG HISTORY

4 yrs back used ATT completely for 6 months .

On oral hypoglycemics Tab.metformin 500mg BD for T_2DM since 10 yrs.

No specific allergic history to drugs.

GENERAL EXAMINATION

- The patient was conscious, oriented to time, place and person.
- moderately built and moderately nourished.
- Pallor+ , icterus-, cyanosis-, clubbing+, lymphadenopathy-, pedal edema- .

VITALS

Temperature : 99.6 F

Pulse : 110/min,regular, normal in volume and character, no radio-femoral delay.

Blood pressure : 100/70 mm Hg , left arm supine position

Respiratory rate : 20/min, regular, thoraco-abdominal type

SpO_2 : 99% at room air

JVP : Not raised

CVS : S1S2 +, no murmurs

RESPIRATORY EXAMINATION

URT-

- Oral hygiene normal

LRT:

INSPECTION-

- Chest Asymmetrical .
- Trachea appears to be shifted to the LF. Trails sign +.
- Apical impulse not visible.
- Drooping of shoulders present on Lf side.
- Movements appear to be decreased on Lf side
- No visible scars, dilated veins or sinuses .

- **Palpation** :
- All inspectatory findings are confirmed.
- Apex beat not palpable.
- TVF: LF>RT @ LF ICA, SSA,AA
- Chest expansion- decreased on the Lf side.
- Lf hemi-thorax: 32cm ; Rt hemi-thorax:35cm.
- Crowding of the ribs present on the LF side.

- **Percussion** :
- Dull note in Lf ICA,MA,INTER.SA and Rt ICA,MA **.**
- Normal resonant note in all other areas. Liver dullness percussed in the Rt. 6th ICS.
- Traube‘’s area -tympanic
- **Auscultation** :
- Bronchial breath sounds over LF ICA, MA,SSA,INTER.SA.
- NVBS over all other areas.
- Fine crepts present over Rt-ICA,MA .
- Vocal resonance- increased over Lt ICA, MA, INTER.SA and Rt ICA.
- Whispering pectoriloquy present at Rt ICA , MA.

OTHER SYSTEMS

- NAD

Provisional diagnosis

Right upper lobe and middle lobe consolidation with left upper lobe fibrosis secondary to ?pul. kochs.

Treatment

. Inj.Augmentin 1.2 gm/ IV/BD

. Inj. Metrogyl 100ml /IV/BD

. Inj. pan 40mg IV/OD

. Inj tranexa 1 amp in 100 ml NS over 30 mins /IV Stat

. T. ethamsylate 250mg/TID

. SYP. linctus codeine 2tsp / TID

. Tab. pcm 500mg/TID

. IVF 2 units NS @ 75ml/hr

. GRBS 8th hrly

. Inj. Human Actrapid insulin s/c acc. to sliding scale

. o_2 inhalation (sos)

INVESTIGATIONS

CBP(11/12/15)

Hb : 8.4 gm%

TC :14,700/cu.mm

N-80%,L-16%,E-2%,M-2%,B-0

Platelet count : 2.5 lakhs/cu.mm

ESR:25 mm

LFT (11/12/2015)

WNL

RFT

urea : 81 mg%

Creatinine : 2.1mg/dl

uric acid : 5mg/dl

contin...

Na : 133 mmol/L

K : 3.4 mmol/L

Cl : 99 mmol/L

CUE : sugar nil;albumin- nil

Sputum for AFB : negative in 2 samples, sputum for c/s no organism grown

Sputum for fungal elements : negative

GRBS : 285mg/dl

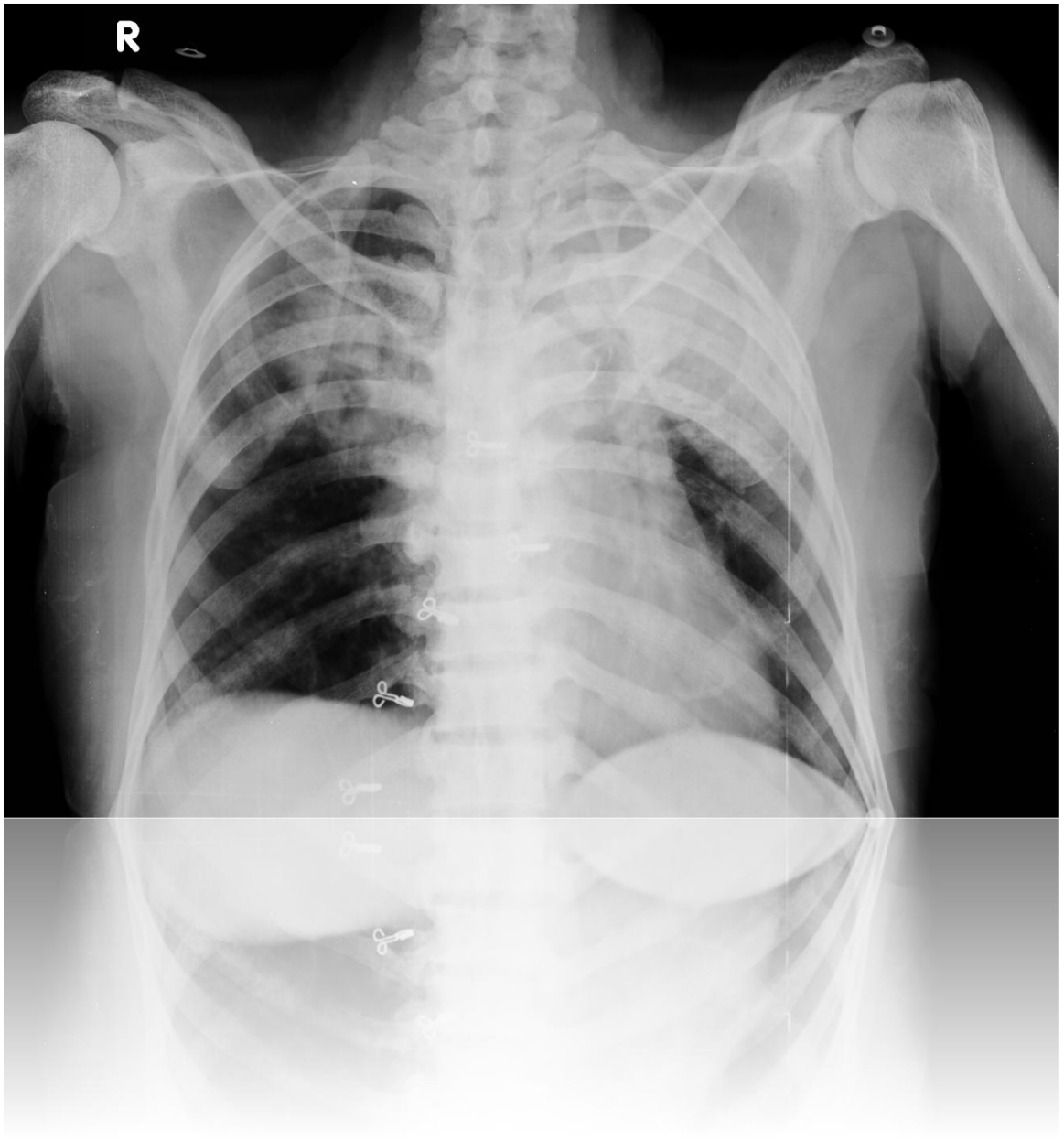
HIV –NR ;HbsAg- NR

ABG : WNL

ECG: N ; 2D ECHO : N

USG ABD : RPD grade 2

FBS : 211 mg/dl , PLBS : 385 , HBA1c: 8.4%(13/12/15)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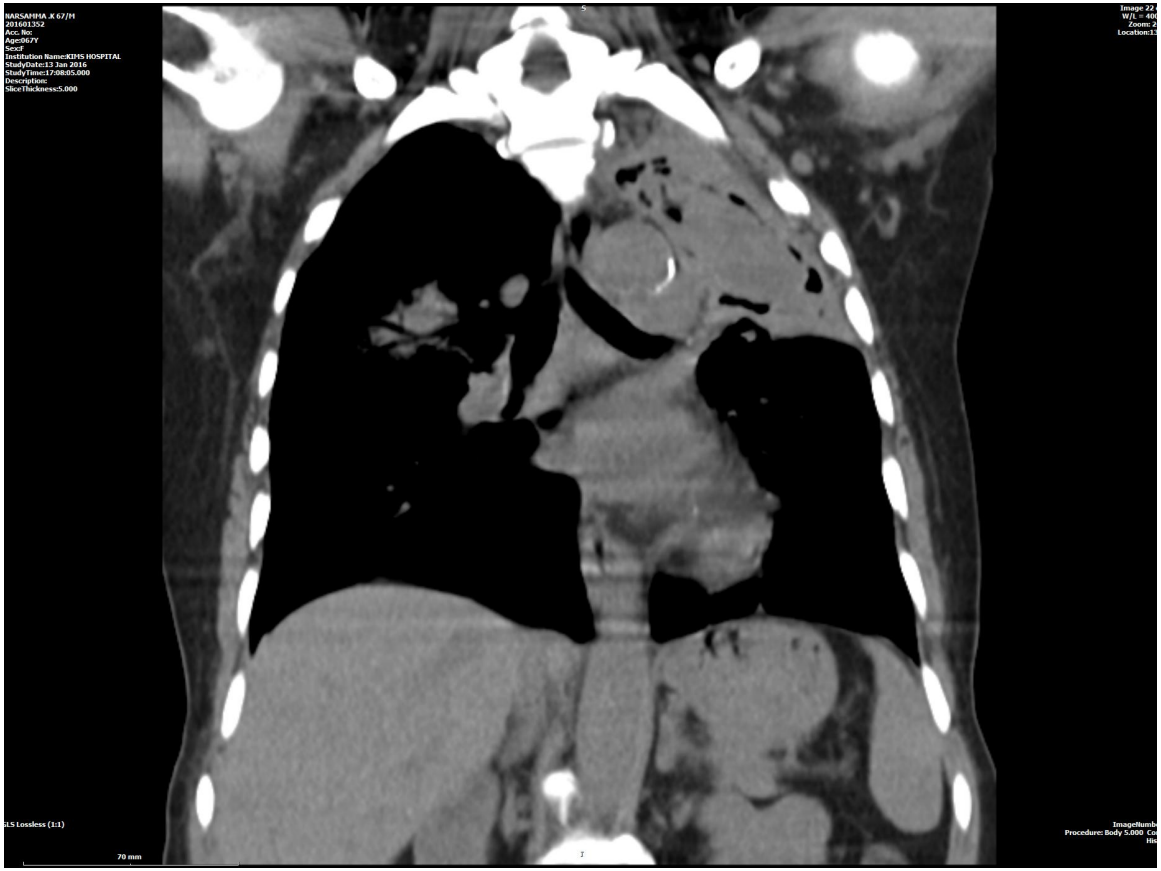
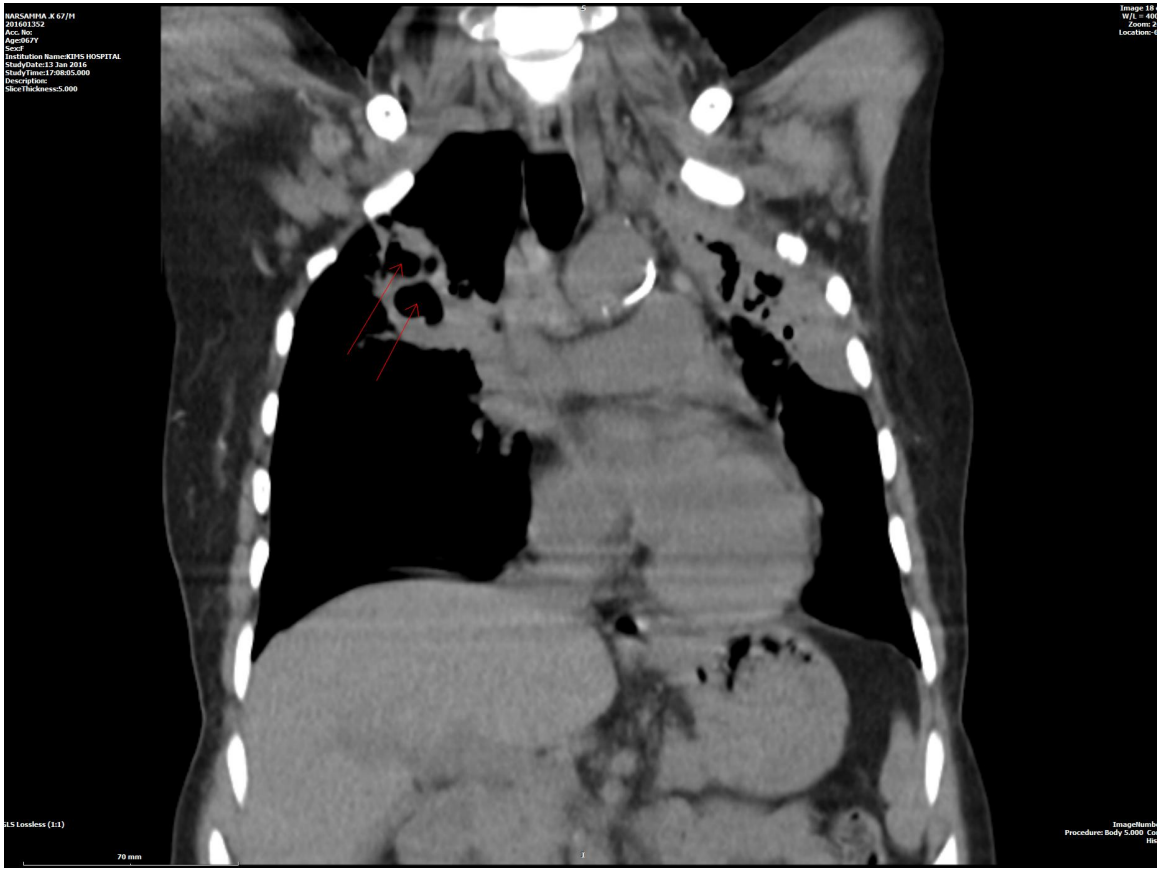
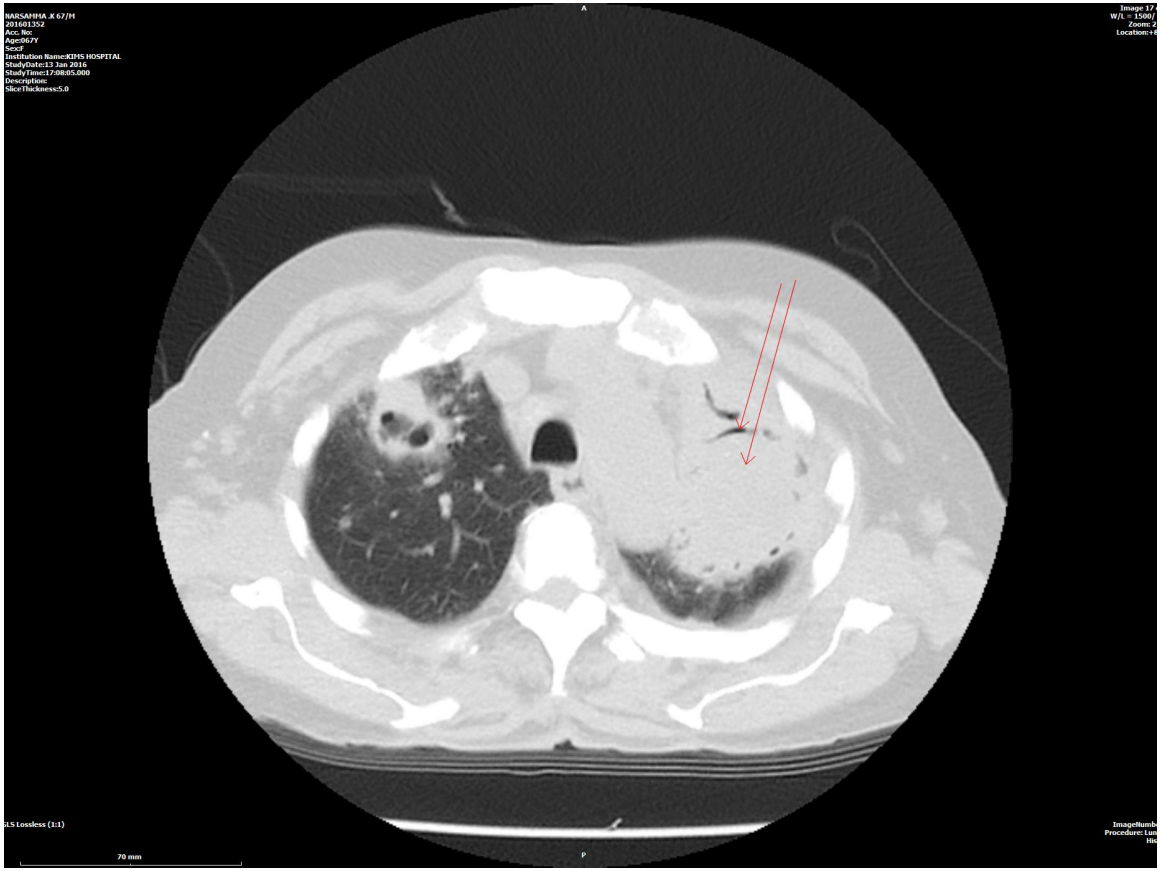


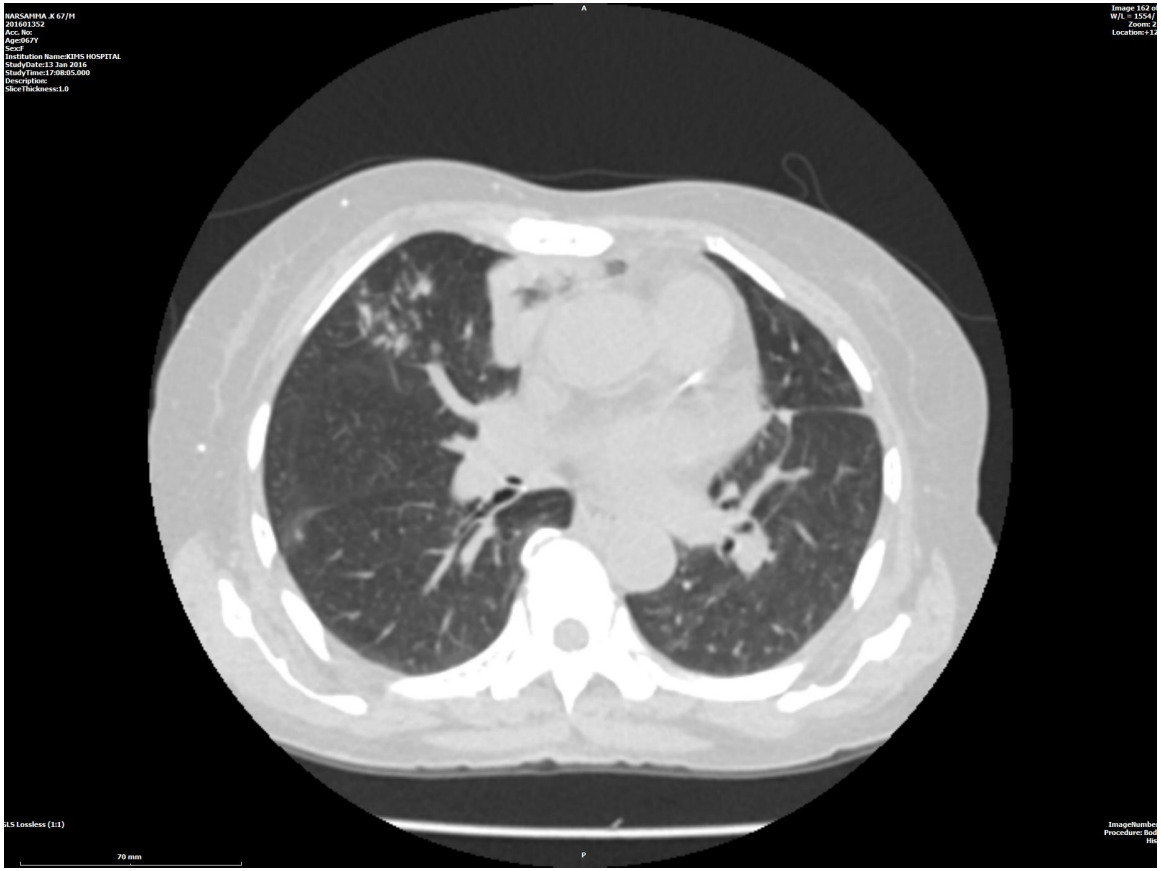
LF UL CAVITY , VOLUME LOSS SINGS IN LF UL WITH CROWDING OF RIBS , ENLARGED AXILLARY LYMPH NODES



CS SHOWING CAVITIES IN RT UL AND ML



AIR CRECENT SIGN WITH SOFT TISSUE MASS IN THE CAVITY IN LF UL



RT MIDDLE LOBE

- Gen. med. referral for uncontrolled T2DM and in the view of RPD on 14/12/15.
- HAI acc. to sliding scale with GRBS 1/2 hrly monitoring.
- Tab. Itraconazole 200 mg OD added

FINAL DIAGNOSIS

- B/L UL WITH RT. ML CONSOLIDATION WITH CAVITIES SECONDARY TO PUL. KOCHS WITH LT UL CAVITY WITH FUNGAL BALL WITH TYPE 2 DM

Thank you