CASE PRESENTATION

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- Patient name: xxx
- Sex: male
- Age: 42 years
- Address: athmakur, nalgonda district.
- Date of admission: 6-11-2015.

- CHIEF COMPLAINTS:

  - breathlessness since 20 days on and off

  - dry cough since 10 days

- H/O PRESENTING ILLNESS

  - patient was apparently normal 20 days back.

  Later he developed breathlessness of grade II.

  h/o orthopnea +

-dry cough since 10 days. Gradual in onset and progressive.

no h/o seasonal or diurnal variations

no h/o fever.

- PAST HISTORY:

  no h/o hypertension/ diabetes/bronchial asthma/tuberculosis/epilepsy.

- PERSONAL HISTORY:

  diet -mixed

  appetite- normal

  bowel and bladder habits-regular

  not a K/C/O smoker

  known alcoholic stopped 20 days back

- GENERAL PHYSICAL EXAMINATION:

  no pallor/no icterus/no cyanosis/no clubbing/no lymphadenopathy/no pedal edema

- VITALS:

  patient afebrile

  PR-86/min regular rhythm, normal volume

  BP-110/80mm of hg

  RR-32/min

SYSTEMIC EXAMINATION

- RESPIRATORY SYSTEM:

1. Inspection: shape of the chest elliptical

   trachea deviated to right side

   no crowding of ribs

   no kyphoscoliosis

   no scars/sinuses

   Palpation: inspectory findings confirmed

   decreased movement of the chest on right side.

Percussion: stony dull note on right infrascapular and infra axillary region.

Auscultation: decreased breath sounds on right infrascapular, infraaxillary areas.

- CARDIOVASCULAR SYSTEM:

  S1 and S2 heard

  no murmers

  jvp- not raised

INVESTIGATIONS

Complete blood picture: Hb-16gm%

total count-14,800/mm3

platelets-3.3lakhs/mm3

Complete urine examination: WNL

RFT: blood urea-34mg/dl

serum creatinine-0.7mg/dl

serum electrolytes- WNL

Blood group:O+

Bleeding time: 2 min 30 sec

Clotting time: 3 min 30 sec

Liver function test:

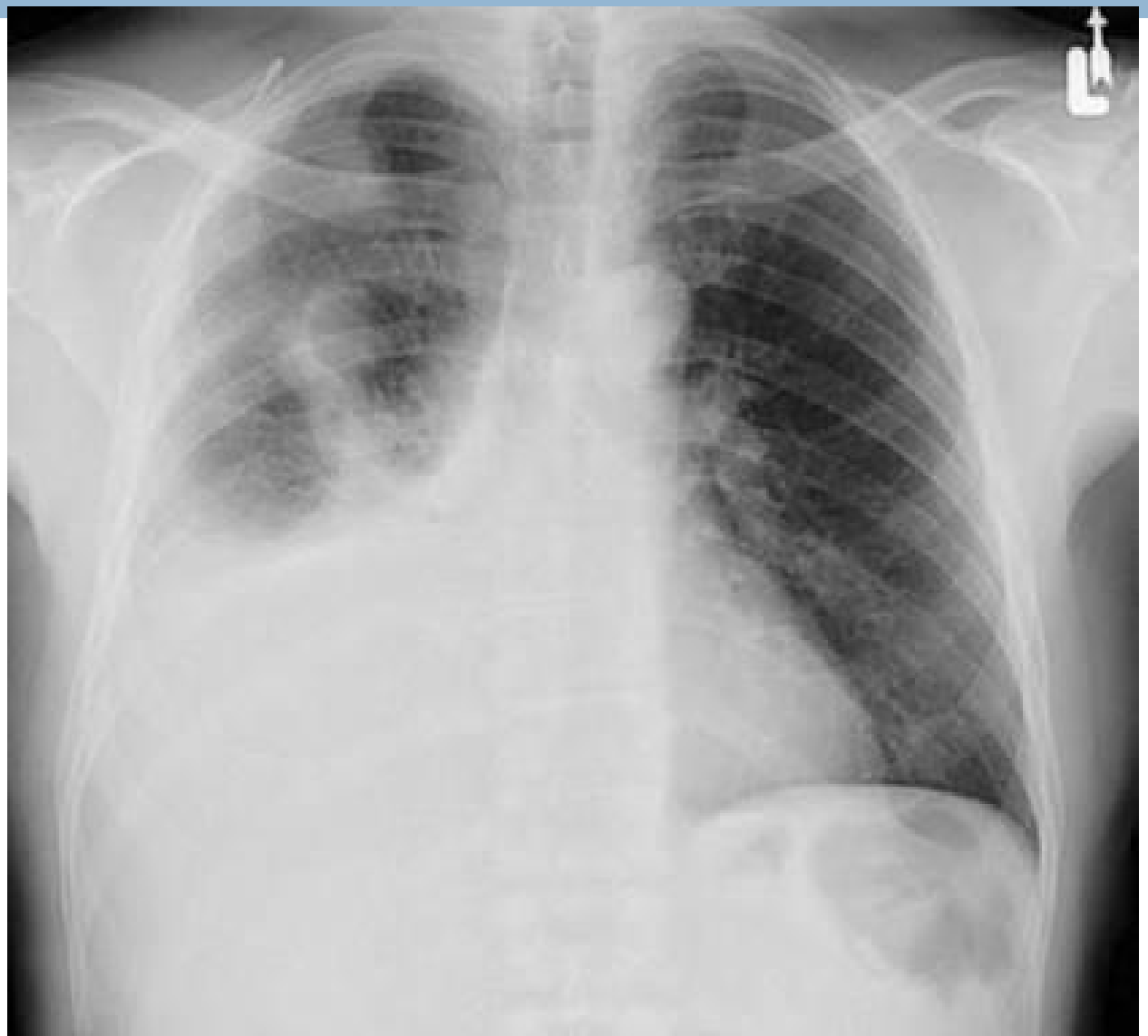
- total bilirubin-1.31mg/dl
- direct bilirubin-0.49mg/dl
- total protiens-5.4mg/dl
- albumin-2.9mg/dl

Serology: HIV, HBsAg- non reactive

chest Xray- right sided pleural effusion

ECG: WNL

Chest x-ray flim



- Thoracocentesis done and 150 ml of hemorrhagic pleural fluid was aspirated and sent for analysis

  pleural fluid: sugar-71mg/dl

  protein-5gm/dl

  LDH-630 IU/L

  Cell count- total count: 50 cells/mm3

  neutrophils:40%

  lymphocytes:60%

- Thoracostomy done and ICD tube inserted.
- Nearly 2800 ml of hemorrhagic pleural fluid was drained.

PROVISIONAL DIAGNOSIS

- Right sided massive hemorrhagic pleural effusion
- procedure planned- thoracoscopy.

- Preanaesthetic checkup:

  history - No comorbidities
  -no h/o anaesthetic exposure
  - non vysya
  - k/c/o alcoholic

- **Clinical examination:**

  moderately built

  hydration adequate

  trachea deviated to right side

  Temporomandibular joint movement adequate

  cervical spine movement adequate

  no short neck

  mouth opening adequate

  no loose /protruding teeth

  mallampati grade II

- Vitals: PR-90/min
  BP-130/90mmHg
  RR-25/min
- Ausculation: decreased breath sounds on right side

- Preanesthetic checkup was clear and posted for thoracoscopy under general anesthesia.
  -informed and written high risk consent for anaesthesia and surgery was taken
  -nill by mouth from midnight.

- on the day of surgery patient was shifted to operation theater and connected to multi paramonitor , baseline vitals PR, NIBP,Spo2 & etco2 were recorded.
- An 18 gauge iv line was secured on right hand and iv fluid started.
- Preoxygenation was done with 100%oxygen for 3 minutes.
- Premedication: inj.glycopyrolate 0.2mg iv
  inj.ondensetron 4mg iv
  inj.fentanyl 100mcg iv
- Induction: inj.propofol 100mg iv
  inj.scoline 100mg iv

- intubation: intubated with left sided double lumen tube of 39 fr.

  B/L air entry checked and confirmed. Both bronchial and tracheal cuffs were inflated. Ventilator was connected to the bronchial lumen so that only left lung was ventilated.

- Maintanence: oxygen and nitrous oxide 50:50

  vecuronium 4mg+1mg+1mg

  halothane 0.2-0.4 MAC

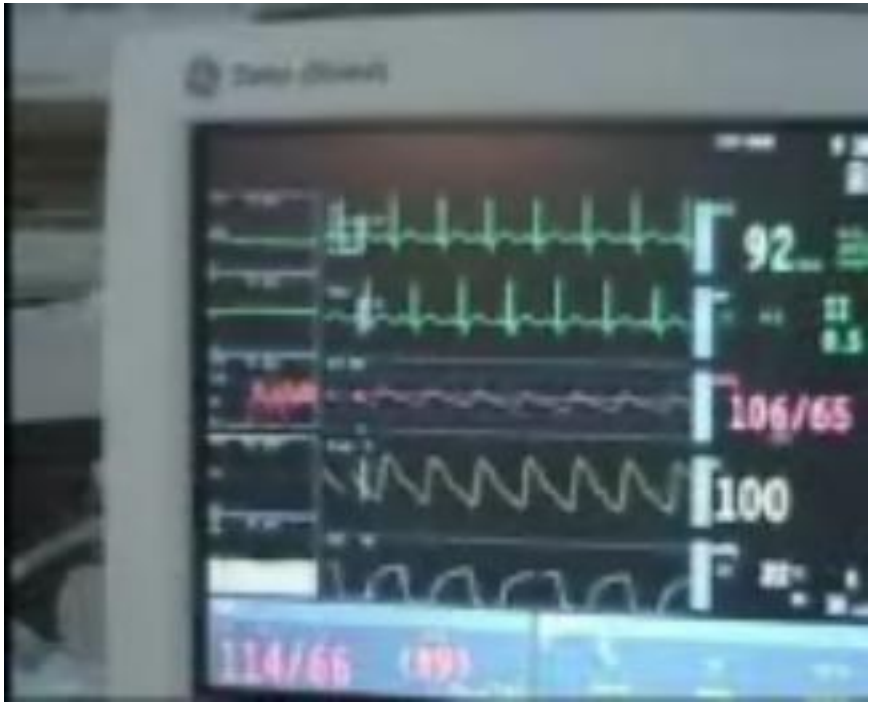
  ventilator settings- tidal volume:500 ml

  frequency:14/min

  peep: 5cmH2o

- Intraoperative monitoring:

  pulse rate, non invasive blood pressure, spo2, etco2,ecg was continuously monitored. All vitals are stable through out the procedure.



- Extubation: after completion of the procedure, the ventilator was connected to both the lumens so that both lungs were ventilated. Vitals were stable. After attaining spontaneous respiratory attempts, Patient was planned to extubate.

  inj. Glycopyrolate 0.6mg IV

  inj. Neostigmine 3mg IV was given.

After attaining good muscle power and adequate tidal volume. Patient was extubated.

vitals after recovery: PR- 86/min

BP-130/90mmofhg

spo2-99%on room air

RR- 23/min

- Postoperative status : patient shifted to postoperative ward and connected to monitor and vitals were recorded.

  nbm for next 6hrs.

  o2 inhalation with 6lit of o2 with face mask.

  Inj.tramadol 50mg im BD.

  propped up position 30.

THANK YOU