CASE PRESENTATION

DR N.BHANU TEJA
DEPT OF PULMONARY MEDICINE

CASE PRESENTATION

- NAME : X

- AGE/SEX : 35/M
- ADDRESS : DHAMARCHARLA, Nalgonda

- DOA : 04/09/15

- DOD : 19/09/15

- IP NO:201526793

CHIEF COMPLAINTS AND PRESENTING HISTORY

- Cough -20 days
- Fever -20 days
- Breathlessness -15 days

Presenting complaints

- The patient was apparently normal 20 days ago, then he developed fever,continuous, high grade , associated with chills ,headache and generalized body pains ,aggravated during night,not associated with any rash,vomitings and diarrhea.
- .COUGH with sputum since 20 days, with scanty whitish non foul smelling sputum;associated with chest pain. No h/o postural & diurnal variation, no h/o hemoptysis.

- Breathlessness-since 15 days, with sudden worsening to grade4(mMRC) at the time of admission ,no h/o wheezing ,seasonal & diurnal variation,no h/o orthopnea,PND..

PAST HISTORY

k/c/o SERO +ve-on ART since 2005

No history of similar complaints in the past

No h/o HTN/DM/EPLIPESY/ASTHMA/COPD

PAST history of pulmonary kochs 10 years back –underwent ATT for 6 months .

PERSONAL HISTORY

Married,farmer by occupation

Mixed diet

h/o weight loss +

Decreased sleep and appetite,

Normal bowel and bladder habits,

Chronic alcoholic since 15 years

Smoker-occasionally

FAMILY HISTORY

Not significant

DRUG HISTORY

Previously used ATT for 6 months for pulmonary kochs 10 yrs back

On ART ;Efavirenz600mg, lamivudine300mg,

Tenofovir300mg.

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 : 102F

Pulse : 120/min,regular, normal in volume and character

Blood pressure : 130/80 mm Hg , left arm supine position

Respiratory rate : 28/min, abdomino thoracic type

SpO_2 : 88% at room air

JVP : Not raised

CVS : S1S2 +, no murmurs

RESPIRATORY EXAMINATION

URT-

- Poor oral hygiene.
- Tongue-coated,whitish in colorwith ulceration of buccal mucosa.

LRT:

INSPECTION-

- Shape of the chest:Asymmetrical .
- Trachea appears to be shifted to right.
- Apex beat not visible. .
- Drooping of rt shoulder present .
- Movements appear to be decreased on rt side
- Intercostal retraction +,use of accessory muscles+
- Spinoscapular distance decreased on rt side
- No visible scars, dilated veins or sinuses .

- **Palpation** :
- All inspection findings confirmed.
- Trachea deviated towards rt side
- Apex beat palpable in the left 5th intercostal space, medial to midclavicular line.
- Chest expansion- decreased on right side.

- **Percussion** :
- Impaired note in rt ICA,MA
- Normal resonant note in all other areas. Liver dullness percussed in the Rt. 6^{th} ICS.
- Traube‘’s area -tympanic
- **Auscultation** :
- Cavernous breath sounds over rt ICA,MA.
- NVBS over all other areas.
- Fine inspiratory crepts present over Rt-MA, AA,IAA INTERSCAPULAR AREA and over Lt-MA
- Vocal resonance- increased over rt ICA, IMA
- No whispering pectoriloquy

OTHER SYSTEMS

- NAD

Provisional diagnosis

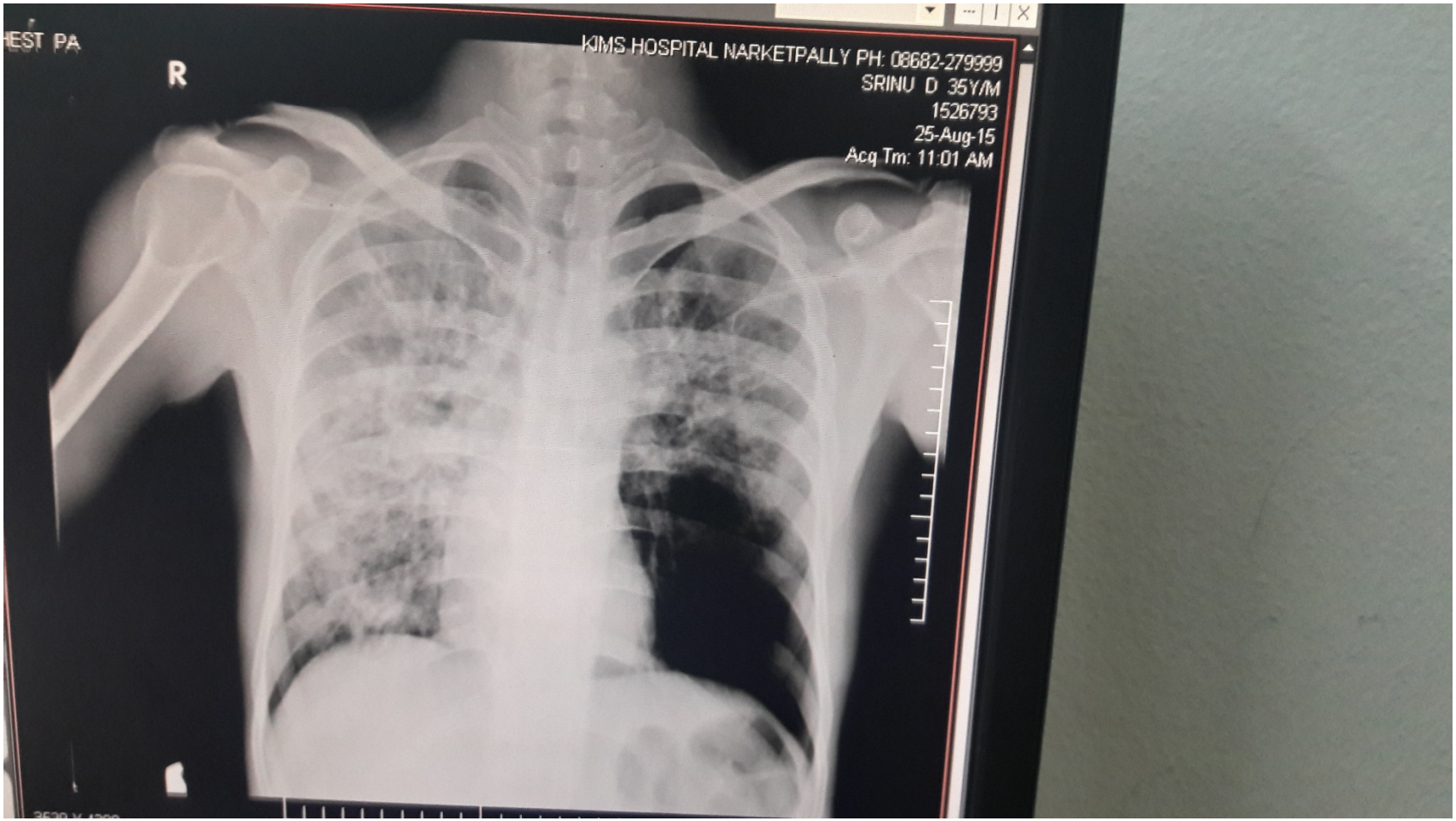
Right upperlobe fibrocavernous lesions secondary to pulmonary kochs with consolidation secondary to???TB/BACTERIAL/FUNGAL/VIRAL/PCP withRVDwith oral candidiasis.

INVESTIGATIONS

CBP(24/8/15)
Hb : 8.8 gm%
TC :11800/cu.mm
N-80%,L-15%,E-3%,M-2%,B-0
Platelet count : 1.77 lakhs/cu.mm
ESR:55 mm
LFT (24/8/2015)
TP : 6.9 gm/dl, albumin-3.9gm/dl, TB : 0.99, DB : 0.18, AST :30, ALT : 20, ALP : 120.
RFT
urea : 27 mg%
Creatinine : 1 mg/dl
Na : 130 mmol/L
K : 4.2 mmol/L
Cl : 95 mmol/L
CUE : sugar nil;albumin- nil
Sputum for AFB : negative in 2 samples
HIV –reactive;HbsAg- NR

Investigations contd

- ABG:
- Ph-7.49
- pco2-25.9
- po2-57.1
- Hco3-19.9
- spo2-88.8
- ECG- sinus tachycardia
- 2D ECHO- no RMWA,mild AR, trvial TR/MR, good LV systole function,EF:65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25-Aug-15
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INVESTIGATONS contd..

Sputum for gram stain and fungal elements- negative.

Sputum for c/s- no growth

CD4 count – 190cells/cu.cm

Treatment

.Oxygen inhalation @4 lt/min with nasal cannula

.Inj.augmentin 1.2 gm/ iv /bd

Tab.septran ds /2-1-2

.Inj.pantop 40 mg iv OD

.Syp.Ambrox-AB 2tsp TID

.Tab.Paracetamol 500 mg TID

. Tab Prednisolone 40mg bd

Treatment contd….

T.Fluconazole 150 mg/od

Betadine mouth gargling

T.vit.c /od

IVF-1 NS &2 DNS @75 ml/hr

Protein powder in milk/bd

- ABG on 15/9:
- Ph:7.44
- Pco2:30mm hg
- Po2:78mm hg
- Hco3:24

FINAL DIAGNOSIS

- RT SIDE FIBROCAVENOUS LESIONS SECONDARY TO PULMONARY KOCHS, WITH TYPE I RESPIRATORY FAILURE WITH PNEUMOCYSTIC CARINII PNEUMONIA WITH ORAL CANDIDIASIS WITH RVD.

Thank you