# MINUTES OF THE MORTALITY MEETING
## HELD ON 19TH SEPTEMBER 2014 AT 2.00P.M.

Chairperson : 1. Dr. C. R. Patnaik
Co-chairperson : 2. Dr. N. Gopal Reddy

**Case. No 1**
**Medical unit-1**
Bhramma chary 57 years Male. DOA-04-08-14, DOD: 03-09-14
Admitted for 1.H/O vomiting-5days
2. Pain abdomen, breathlessness, loose motions-1day.
3. H/O Chronic alcoholism - 10 years
4. H/O pulmonary koch's -taken treatment one and half years back.

**On admission:**
Breathlessness- grade -2 on the day of admission, altered sensorium, hypotension, breath sound decreased on left side.
Patient was irritable with irrelevant talk from the day of admission
Decreased urine output since 2 days.
There was no history of fever, pain abdomen, hemoptysis, haematemesis

**Past history:**
Not a known case of diabetes, asthma, hypertension, epilepsy or any cardiac illness.

**Family history:**
No similar history in any of his family members

**Personal history:**
Pt was a chronic alcoholic since 15 years. Not a known smoker. Patient had decreased appetite since 1 week and decreased urine output since two days.

**OE:**
Pt was obese, Irritable and incoherent, Afebrile.

**Vitals:**
Blood pressure:90/70 mm Hg. Pulse: 100/min,normal in volume and regular in rhythm.
GRBS: 200 mg/dl

Systemic examination: CVS: S1 & S2 heard, no murmurs, RESP SYST: absent air entry left side, occasional crepts on the right side.

ABDOMEN: mild distention was present. No tenderness and rigidity. Bowel sounds heard hepatomegaly was present.

CNS: Pt was irritable, no response to verbal commands with incoherent speech, no focal neurological deficit, pupils were normal in size and reacting to light.

**Investigations:**Hb:9 gm/dl.Total count: 9000/cu.mm,Plt count: 80000 cells.

SGOT: 716 IU/L, SGPT: 282 IU/L.Total protein: 6gm/dl,Albumin: 3.5 gm/dl.

ECG: WNL,CT BRAIN was normal

USG ABDOMEN showed hepatomegaly with fatty changes.

HIV and HbsAg were negative. Metabolic acidosis was present

**Provisional diagnosis:**

List of problems: Alcohol abuse, Alcoholic hepatitis, Acute pancreatitis, Acute kidney injury with encephalopathy. Chronic cause: left lung fibrosis secondary to old tuberculosis?

**Day 2 events**

Patient had no urine output for 24 hrs after admission.

Pt conscious level did not improve, Blood pressure was about 100/60 mmhg with inotropic support. Central line catheterization has been done. No complaints of vomiting and diarrhea after admission.

**Treatment**: TAB. shelcal 500 mg OD,INJ.SODA BICARB was administered as per requirement to correct acidosis[pH:7.01 bicarb:11].Complete blood picture ,blood urea and serum creatinine have been repeated. Approval for dialysis has been taken.

Urea was about 278 mg/dl and creatinine was 7.7 mg/dl

on day 3. Patients blood pressure has been stabilised and was taken for haemodialysis. Platelet count dropped to 55000, 1 pint SDP has been transfused. Prothrombin and activated partial thromboplastin time were raised. Inj. vitamin. k 1 cc iv/od was administered. Ryles tube aspiration was done. There was no evidence of any upper GI bleeding.

**Events from day 4 to 10**

Pt was afebrile, there was no response to oral commands, Pt was maintaining saturation of 100%, 3 cycles of haemodialysis each about 4 hrs was done, total counts raised to about 26000,There was a fall in haemoglobin level to 4.6mg/dl., Blood pressure was about 130/90 on an average. Total bilirubin was 5 IU/l and direct bilirubin was 2.9 mg/dl. There was hypoproteinaemia and hypoalbuminaemia. AST and ALT were 499 and 121 IU/L repectively. Urine output was around 150 ml.

**Treatment**: Inj. Imipenam/0.5 gm/iv/bd,Inj. Metrogyl 100 ml/iv/tid,Inj.hepamerz 1 ampule in 100 ml NS iv/bd.Inj. Pantop 40 mg/iv/od,Syp.duphulac 10 ml H/s2 pints PCV tranfusion,Inj.lasix 40 mg/iv/od. Milk through ryles tube.

**Events from 11 to 20 days**

Patient was conscious and there was response to verbal commands, Pt was afebrile, Urine output again reduced to 25 ml, About 3 cycles of haemo dialysis of 4 hours each was done, Total counts were 16000, Platelets improved to 2.5 lakhs. Blood pressure was 110/70 mm Hg.

**Events from 21 days till death**

Pt on mechanical ventilator for about 17 days

Pt was conscious and responding to verbal commands in initial days of intubation.

4 more cycles of haemodialysis was done of 4 hours each

Haemoglobin was 6.9mg/dl after 3 units of PCV transfusion

Platelets again reduced to 32000 cells.Melena was present.

pH came down to 7.2 with bicarb value of 18

Blood pressure was 110/70.

On 2/9/14 pts Hb further reduced to 5 gm/dl and platelets came down to 20000 cells.

Blood urea was 95 mg/dl and serum creatinine was 4.5mg/dl after 10 cycles of hemodialyses Pt suddenly developed hypotension, cardiac arrest, resuscitation measures not successful.

**QUESTION&ANSWERS**

What were the causes for death?

Renal failure followed by multi-organ failure.

Why do you say it also may be due to acute pancreatitis?

Raised serum amylase

What ionotropes you have used at the resuscitation time ?.

Dopamine drip,&adrenaline..

**Case-2**

Pitchi reddy male 50 years

**ADMITTED WITH:** A history of Organophosphate poisoning on 26-08-14.

Pt was hemodynamically stable at time of admission. Shifted to AMC after giving initial treatment in causality.

Pt has developed sudden fall of saturations, went into cardiac arrest on 29-08-14 at 12 am midnight. Intubated with 7mm T Tube and CPR done as per the protocol but could not revive hence declared dead at 12.55 on29-08-14.

Investigations: CBP, RFT, RES, AGB,-WNL

PSEUDOCHOLINE ESTERASE 860 UNITS (N.5400-13,200),

QUESTION 7ANSWERS:

What was cause for sudden collapse?

Due to respiratory failure

What are the different types OPS available classify them?

diethyl, dimethyl, carbamide.

What is the role of atropine, dose of atropine?

Controls CNS, ANS symptoms

Role of Mgso4, Stabilizes neuromuscular junction, heart muscle

Role of clonidine. Prevents hypertension, tachycardia.

Criteria for Ventilatory treatment?

Respiratory failure -falling $O_2$ level.