MINUTES OF THE MORTALITY MEETING
HELD ON 17-10-2014, at 2.00pm

Attended by Faculty & PGs — Chairperson: Dr.(Col.)V.M Venugopalan

The following case was presented:

I.P. No. 201422620 V. Narsimha, Age 48 years/Male of Pulmonology Department. Admitted to hospital on 04-08-2014 with history of dry cough and fever, chest pain and burning micturition of 7 days duration and breathlessness of 3 days duration. Chills and rigors present with fever. Breathlessness sudden and progressive. No haemoptysis, wheeze or palpitation. No pain abdomen, vomiting or loose motions.

Past history of pulmonary TB 6 years ago (A T T 6 months) and diabetes mellitus type - 2 since 1 year, on irregular treatment with tab. Metformin. Chronic smoker and alcoholic since last 30 years on examination: Conscious and oriented. Dyspnoea present at rest, pallor +, pedal oedema +, No icterus or cyanosis. Pulse-120/mt. temp 99^0F J V P not raised. Resp. System: Decreased expansion of chest right side with decreased breath sounds Rt. Lower zone. Crepitations left lower zone. Heart :S1 & S2 normal. No murmurs.

INVESTIGATIONS:

Hb 13.8G%, TLC 5200/Cmm ESR 45mm fall in first hour, Platelets 1.7 Lakhs/cmm Blood urea --225mg%, Serum creatinine 4 mg%, Serum electrolytes WNL, GRBS 131mg% ,Sputum AFB - Negative. LFT - Total protein 4.9 G%, Allbumin 2.5G %, Enzymes - Normal.

Provisional Diagnosis - Rt. Hyrdropneumothrox with Type-2 Diabetes mellitus with Acute kidney injury with old pulmonary KOCH's .

Treatment - Inj. Cefperazone 1.2Gm IV BD, Inj. Metrolgyl 50mg ,IV tds, Inj. PAN 40mg, IV OD Human actrapid insulin sliding scale. Tube throacostamy right 5th intercostal space was done and 400ml , foul smelling pus removed. On 6/8/14 blood urea 1.78 mg %, serem creatinine 2.3mg. Inj. Piptaz 2.25 g IV l tds added on 7/8/14 Patient complained of chest pain and breathlesseness. CT Chest showed prenumothroax lt. ICD Lt.chest was done. On 8/8/14 culture of urine and sputum showed no growth. Blood urea 234 mg% and creatinine 2.8% On 13/8/14 inj. Streptokinase 2.5 L units in 20ml of normal saline 12 hourly 3 times through right side ICD Tube. On 18-08-2014 HRCT showed Rt. Hydropnemothorax with visceral pleural thickening - empyema and fibrous traction bronchiectasis right upper lobe. Lt. side minimal pleural effusion. Surgical emphysema on anterior chest and abdominal wall on the right side. Lt. side chest tube got displaced and removed. On 19-08-2014 Inj. Clidamycin 600 mg IV tds, instead of metrogyl. On 20-08-2014 DOTS cat 1 started. Urine culture showed Pseudomonas Aerogenosa and Inj.amilkacin 750 mg IV started.

Contd.2.

Blood urea 29mg%, and serum creatintine 1.1mg%. On 24-08-2014 Inj.Clindamycin stopped and On 27-08-2014 inj.piptaz stopped TLC 4000/Cmm Inj. Imipenam 1g in 100ml NS over 30 minutes QID . On 30-08-2014 Inj Enoxheparin 0.4ml. SC, OD started. On 03-09-2014 D Dimer was 200mg/dl. On 09-09-2014 night patient's condition started deteriorating. Became irritable and gasping. Pulse rate 40/.mt BP unrecordable. inspite of all resuscititave measures patient could not be revived. Declared dead at 12.15am on 10-09-2014.

Cause of death:

Immediate cause – Hypoxaemic respiratory failure.

Primary causes – Rt. Pyoneumothorax with broncho pleural fistula and trapped lung. Secondary causes -- Sepsis with acute kidney injury and pulmonary tuberculosis.

QUESTIONS AND ANSWERS

Comments by Dr. Venu, Prof. & HOD Pulmonology: H/o of breathlessness, chest pain with diminished air entry was suggestive of pneumothorax or pleural effusion. Fever was indicating pneumothorax. With the thickened plura and empyema the lung got trapped on right side and the lung could not expand. The cause of death in sepsis and MODS.

Dr. P.K. Murthy

Q1. How was broncho pleural fistula diagnosed?

A-1 Dr. Venu – Broncho pleural fistual here is clinical diagnosis. It can be confirmed Radiologically by injecting methylene blue or gastrografin dye.

Q2. What is the treatment for broncho pleural fistula?

A2. Dr. Venu - It is by open drainage of fistula. But it will take long time to close.
Surgical treatment is thoracotomy and excision of the fistula.

As these were no further questions or comments the session was declared closed.

CHAIRMAN
MORTALITY & MORBIDITY MEETING