

MARYADA

(डा० राकेश चन्द्र अग्रवाल)

Dr. R. C. AGARWAL

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Reg. No. 22952 (LKO)

CONSULTANT PHYSICIAN, PULMONOLOGIST
AND CLINICAL CARDIOLOGIST

Ex - SENIOR MEDICAL OFFICER, STATE BANK OF INDIA
Ex - PROF. & HEAD, DEPTT. OF MEDICINE, KOTHIWAL
DENTAL COLLEGE & RESEARCH CENTRE, MORADABAD

विशेष इलाज

हृदय रोग

फेफड़े के रोग

डायबिटीज

ब्लड प्रेशर

खून में चर्बी

CLINIC AND RESIDENCE

AM-7, DEEN DAYAL NAGAR-1

OPP. MADHUBANI PARK

SAI MANDIR ROAD,

MORADABAD - 244 001

Phone : 0591-2453595

Mobile : 80576 - 74244

DATED 11 / 01 / 22

mk R.D. Choudhary

75 yrs male KRM

allergic rhinitis

1. dyspnea
cough sputum] 2 days

R mucoker. SITR-m

nasal lav. 1000 1/2 mg
4 9

Mupenta D 100
a B B U E L

Telmed 20 100
a 4 4 4 4 4 4

Be ezem e 400 100
e 21)

P-201-1
BA 156/8447
Temp 99.4 F

STU 2 257

BVBS BL

Amiwayn 100 100

समय प्रातः 10.00 - 2.00 सायं 7.00 - 9.00
रविवार प्रातः 10.00 - 2.00

अनुकाश शनिवार पूरा दिन एवम् रविवार सायंकाल
VISIT AND CONSULTATION BY APPOINTMENT

MARYADA

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विशेष इलाज

- हृदय रोग
- फेफड़े के रोग
- हायपरिटीव
- ब्लड प्रेशर
- मृत में पत्नी

CLINIC AND RESIDENCE
AM-7, DEENDAYAL NAGAR-1
OPP. MADHUBATI PARK
SAI MANDIR ROAD,
MORADABAD-244 091
Phone: 0591-2453595
Mobile: 80576 - 74244

DATED 10.4.22

MR. R. D. CHANDHU

epigott fullness 75 yrs male KRH

anxiety
p. 21 22 temporary over

P. 64/m mf
RA 150/80/mf

- o Pantocid D 1mg
- o Biphlec 1mg
- o Becozinc c forte 1mg

△ en. oligos
bromides

Boyer's tonic
3 tablets

Duphyeln R 150 mg

समय प्रातः 10.00 - 2.00 सायं 7.00 - 9.00
शनिवार प्रातः 11.00 - 1.00

74.67

अवकाश शनिवार एवं रविवार सायंकाल
VISIT AND CONSULTATION BY APPOINTMENT

समय प्रातः 10.00 - 2.00 सायं 7.00 - 9.00
रविवार प्रातः 10.00 - 2.00

75.57

अवकाश शनिवार पूरा दिन एवम् रविवार सायंकाल
VISIT AND CONSULTATION BY APPOINTMENT



HDFC ERGO TPA CLAIM NO. - RC-HS21-12679105
DISCHARGE SUMMARY

31 years *Female*.

Name Mrs. Meena
Consultant in Charge Dr. Umesh Varma
Address- 26/78, Gali No. - 11, Vishwas Nagar Shahdara Delhi - 110032.
Date of Admission 23.10.2021
Time of Admission 12.29 PM
ICD Code:

Date of Discharge 02.11.2021
Time of Discharge 12:30 PM
MLC No. 0

UHID NO-5256
IPD NO. 1319/21
Tel No. 9811336695
Room No. 301/ICU/304
No of Days 10*

PROVISIONAL DIAGNOSIS: ACUTE FEBRILE ILLNESS - DENGUE NS1 POSITIVE WITH G2 P1 L1 AT 14 WEEKS 4 DAYS + ANEMIA.

FINAL DIAGNOSIS: ACUTE FEBRILE ILLNESS WITH THROMBOCYTOPENIA WITH TRANSAMINITIS, POLYSEROSITIS ASCITES B/L PLEURAL EFFUSION, DENGUE NS1 POSITIVE, THALASSEMIA MINOR, G2 P1 L1 AT 14 WEEKS + IUD, SEPSIS MULTIPLE ORGAN DYSFUNCTION IMPROVED, BPV - SEVERE ANEMIA HB 5.3, HYPOALBUMINEMIA, ACALCULUS CHOLECYSTITIS.

PROCEDURE: - 1. D & C DONE ON 30.10.2021.
2. 2 UNIT PRBC GIVEN.

PRESENTING COMPLAINTS WITH DURATION AND REASON FOR ADMISSION:

1. High Grade Fever
2. Body ache
3. Headache x 3 days

SUMMARY OF PRESENTING ILLNESS: A 31 year's old Female patient admitted with complaints of High Grade Fever Body ache headache x 3 days with G2 P1 L1 at 14 weeks 4 days. No H/o - DM / HTN / TB / COPD. LMP 13/7/21. Available reports HB 8.0 TLC 4900 P 80 L 16 PLC 1.79 Malaria Antigen Negative. TD Negative Dengue NS1 Positive IgG / IgM Negative. Urine R/m 1-2.

KEY FINDINGS, ON PHYSICAL EXAMINATION AT THE TIME OF ADMISSION:

BP- 100/60 mm/hg, Pulse 112/mint, Temp 98.4 F, SPO2 97%, RR 20/mint, Pallor - Icterus - Cyanosis - Clubbing - JVP - LNP - Pedal edema
Chest B/L air entry +, CVS S1 S2 Normal, P/A bowel sound +, CNS conscious/oriented.

COURSE IN THE HOSPITAL, INCLUDING COMPLICATION INVESTIGATION DURING HOSPITALIZATION:

Patient admitted with above complaints & managed conservatively. Started Inj Augmentin + Pantop + Emset + Pidimol + and other supportive care. Gynecologist review done and order followed. Patient had low serum albumin level and Increase SGOT / SGPT added Inj. Human albumin + inj. Maxiliv in view of hypotension and SOB patient shifted to the ICU propped up + O2 inhalation + Catheterization done. Serial PLC PCV Monitoring done. Post stabilization patient shifted to ward. Patient spontaneously aborted IUD fetus at 50 gm on 30/10/2021 at 1.45 Pm vaginally check curettage done. Old macerated IUD +. NO GCA seen externally. BPV more than normal. D & C done under Inj. Synto / 25 units / Inj. Trenamic acid (1gm) in 100 ml NS, Inj Methergin. Tab. Mesoprost (P/R) and T. Justin P/R given Inj. Augmentin (1.2 gm) I/V given. USG to be done (USG lower abdomen).

INVESTIGATIONS SHOWS: HB 7.7 TLC 2500 DLC N 78 L 17 PLC 1.27 ESR 90 SGOT 297.4 SGPT 165.8 Total Protein 5.5 Gamma GT 68.8 Urea 20 Creatinine 0.45 NA + 140 K 4.15 CRP 32.2 PLC 1.28 PCV 22.6 Blood Group 'A' Positive Blood C/S done Sterile. PT 14.2 INR 1.05. ABG pH 7.57 PCO2 23.60 PO2 68.00 ECF -1.0 TCO2 22.0 Lac 2.70. **USG WA DONE** S/o - USG Abdomen reveals mild pericholecystic edema - Platelet correction. **USG OBSTETRICS 1ST TRIMESTER DONE** S/o - Single intrauterine pregnancy corresponding to 12 weeks and 2 days with absent cardiac activity - S/o - intrauterine fetal demise. **CXR PA DONE** S/o - Bilateral loculated pleural effusion seen with likely underlying collapse. Rest of the lung fields are clear. USG chest correlation. Serial PLC PCV Done. HB 5.3 2 Unit PRBC Done. Repeat Investigation showed HB 8.5 TLC 9600 DLC N 65 L 28 RDW 23.0 RBC 3.44 Bili Total 1.25 Bili Direct 0.55 Bili Indirect 0.70 SGOT 37.3 SGPT 51.0 GAMMA GT 70.9 CRP 97.4 Na+ 133.0 K+ 3.71. Physiotherapy done. Patient showed symptomatic improvement at the time of discharge.



Triage Priority: 1 2 3

Name: Meena Age: 30 Sex: Female
UHID No. 9811336695 Date: 25/03/20
TIME IN: 6:15 PM TIME OUT: 6:50 PM

Wherever options are provided please [] mark against the correct information.

1. Presentation to ED
 Walking
 Stretcher
 Wheelchair
 Other
 Brought by: Mr. Nidhi (Husband)

2. Medico-legal Status
 MLC
 Non MLC
 MLC No. _____

3. Vitals on arrival to ED
 HR: 80
 BP: 120/70
 RES: 18
 SPO₂/RR: 99.1-99.5
 Temperature: Afebrile
 GCS: 15/15

4. Follow up of _____

5. Drug Allergy: [] Nil Known [] Unknown [] Known

Summary of ED Treatment

9/6 -
Councils started

1/0 -
Pain in paravertebral region
(L) lumbar region
- 3-4 days

1/0 -
slowly increased
1/0 -
irregular bowel movements
1/0 -
constipation
1/0 -
leg cramps yesterday

1/0 -
No h/o fever, loose stool,
Passing dark stool

1/0 -
Pain abdomen ↓ evaluation

Investigations Advised:

Panstop IV ✓
Tramadol 100mg ✓
Coax IV ✓
CBC, CRP, USG (WIA) ✓
Urine R/M ✓

8. Nutritional Screening:
 Pallor / Oedema / Koilonychia

9. Pain Score:
 No Pain Mild Pain Moderate Pain Severe Pain

Advised Admission: [] ICU [] Ward [] NICU [] Labour Room [] Day Care
 Condition on discharge: Stable [] Serious [] Critical [] LAMA [] Refer to Other Centre [] End of life

Medications on discharge:

T. Oxidol 500mg
T. Gabapentin 300mg
T. Pantoprazole 40mg
T. Ultracel-Tab 1300
T. Pylorflush 100mg

14. Vitals on discharge from ED

HR: 80 SPO₂/RR: 99.1-99.5
 BP: 120/70 Temperature: Afebrile
 RBS: _____ GCS: 15/15
 Date/Time: 25/03/20

Up/Review: _____ Doctor/Department: Dr. Anshu Sharma Date/Time: _____