arogya Hospital
merly Known as
ditya Varma Medical Centre

Chitra Vihar, Vikas Marg, Delhi-92
Tel.: +91-11-22448008, 22043839
Fax: +91-11-42440108
E-mail: avhrc@rediffmail.com

HDFC ERGO TPA CLAIM NO. – RC-HS21-12679105

DISCHARGE SUMMARY

Name **Mrs. Meena** 31 years Female.
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 – SEVER 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 FORADMISSION:

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.

AAROGYA HOSPITAL
Multi Speciality Hospitals & IVF Centre
Chitra Vihar, Vikas Marg, Delhi-110092
Tel.: 011-22448008, 22043839

043

ER INITIAL ASSESSMENT FORM

AH/ER/F-61

Name: Meena Age: 30y Sex: F
UHID No. .... Date: 25/03/20

TIME IN: 6:15PM TIME OUT: 6:50PM

9811336695

Triage Priority: 1 2 (3)

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% - on RA
Temperature: Afebrile
GCS: 15/15

4. Follow up of ....

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

6. Summary of ED Treatment

O/E -
Conscious
oriented
Chest - B/L AE (+)
CVS - S1 (+) S2 (+)
P/A - Soft, Non-tender
BS (+)

C/O -
Pain in paraumbilical region
(L) lumbar region - 3-4 days
a/w nausea
H/O irregular bowel movement
H/O vomiting 1 episode yesterday
No h/o fever, loose stool,
Passing flatus

(P) Pain abdomen for evaluation
(?) Colitis

7. Investigations Advised:
Pantop IV
Tramadol IM
Emset IV
CBC, CRP, USG (W/A)
S/I - 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. Omidaz 500mg BD
- T. Glox 200mg BD
- T. Pantop DSR 1 tab OD
- T. Ulkacel - 1 tab BD
- T. Pyloflush 1 tab OD

14. Vitals on discharge from ED

HR	80	SPO₂/RR	99% - on RA
BP	120/80	Temperature	Afebrile
RBS		GCS	15/15
Date/Time	25/03/20		

Follow up/Review: .... Doctor/Department: Dr. Umeshwar .... Date / Time: ASAP

I explained current condition management, alternative and prognosis. All my questions have been answered satisfactorily. I have understood