

Patient Name	: Mrs. Pushpa Saini	Patient UHID	: MM02532373
Age	: 46Y	Gender	: Female
Admission Date	: 09/05/2023 19:11	Discharge Date	:
Encounter Type	: Inpatient	Encounter ID	: 20039710
Consultant Incharge	: Dr Vinay Goyal & Team	Specialty	: Neurology
Location	: 6th Floor A2A3	Bed No	: 5610

Discharge Summary -Neuro

Patients Address	:	FLAT NO N101 JAWAHAR NAGAR ,GURUGRAM ,Gurgaon H.O,GURGAON,India,122001
Date of Discharge	:	<u>11/05/2023 12:26</u>
Name of Consultant	:	<u>Dr Vinay Goyal & Team</u>
Bed No	:	<u>5610</u>
Discharge Status	:	Discharged to home (routine discharge)
Reason for admissions	:	Medical Management **
Primary Diagnosis	:	Recurrent Transient Ischemic Attack (TIA) Severe Iron Deficiency Anaemia
Primary Diag ICD Code	:	.
Co-morbidities	:	Uncontrolled diabetes Dyslipidemia
Risk Factors & Others	:	
Diabetes mellitus -YES		
Hypertension -NO		
Dyslipidemia -YES		
Homocysteinemia -NO		
Atrial fibrillation -NO		
Valvular heart disease -NO		
Coronary artery disease -NO		
Obesity -NO		
Sedentary lifestyle -NO		
Alcoholic -NO		
Smoker -NO		

Medical History & Presenting Complaints :

Mrs. Pushpa Saini, 46 years female, known case of type 2 diabetes mellitus for 8 years, initially was on insulin and OHA, now on Ayurveda treatment for 4 months, presented here with complaints of sudden onset right hemiparesis with slurring of speech on 09/05/2023 at 5:15am which recovered in almost 40-45 minutes and 2nd similar episode occurred at 6:30pm which recovered in 5-7 minutes. Hence she was admitted here for further work up.

Physical & Systemic Examination :

Blood pressure: 110/70 Millimeter of Mercury (mmHg)
Pulse : 80/minute
Respiratory Rate: 22/minute
Chest : Bilateral clear
Cardiovascular System: S1, S2 normal

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5/11/2023



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Per Abdomen: Soft, Non-tender
Central Nervous System:

Conscious, oriented
Extra-ocular muscles (EOM) normal
Higher mental function (HMF) normal
Cranial nerves : Normal

Allergies :
Not known

Investigation

Laboratory :
Attached

Radiology :

MRI BRAIN PLAIN (09/05/2023): The cerebral parenchyma has normal appearance and signal intensity. Bilateral basal ganglia and thalami are normal. No diffusion restriction is seen to suggest presence of acute infarct. No abnormal blooming artifact is seen within brain parenchyma on SWI to suggest presence of hemorrhage or calcified granuloma. Brainstem and cerebellum are normal. CP angle cisterns are clear. Ventricles are normal in size, shape and position. Basal cisterns, cortical sulci and fissures are normal. A well-defined round 3 mm size T1 hypointense, T2 hyperintense area noted in the anterior lobe of the pituitary gland in midline. Optic chiasm is normal. No subdural hematoma is seen. Major intracranial flow voids are preserved. Cranio-vertebral junction is unremarkable. No tonsillar herniation is seen.

CT ANGIOGRAPHY OF BRAIN & NECK VESSELS (10/05/2023): ANGIOGRAPHY OF NECK VESSELS: Arch of aorta and origin of major neck vessels are normal. No significant vascular stenosis is seen. Bilateral common carotid arteries are normal in course and caliber. Carotid bulb on either side appears unremarkable. Bilateral internal and external carotid arteries are normal at origin and along their course in the neck with normal caliber. Left vertebral artery is normal in course and outline. Right vertebral artery is normal in course and attenuation with reduced caliber.

ANGIOGRAPHY OF BRAIN VESSELS: Intrapetrous, intracavernous and supraclinoid segments of both internal carotid arteries are normal in course and caliber. No significant vascular stenosis is seen. A1 segment of right ACA is hypoplastic. Rest segments of bilateral anterior cerebral arteries are normal in course and caliber. No significant vascular stenosis / aneurysm seen. Bilateral middle cerebral arteries and their branches show normal outlines, course and caliber. M1, M2, M3 segments of bilateral MCA are normal in course and caliber. The intracranial segments of the left vertebral arteries and basilar arteries are normal. Hypoplastic right vertebral artery. Bilateral posterior cerebral artery is normal. No aneurysm seen at circle of Willis.

Others :

2D echocardiograph was done on 10/05/2023 which revealed no left ventricular regional wall motion abnormality, left ventricular ejection fraction - 55%. Normal right ventricular systolic function. Cardiac chamber dimension - normal. Trace mitral regurgitation, trace tricuspid regurgitation, pulmonary arterial systolic pressure (PASP) - 22 mmHg. No aortic stenosis / aortic regurgitation. Mitral inflow pattern - normal, left ventricular end-diastolic pressure (LVEDP) - normal. Inferior vena cava - normal, central venous pressure (CVP) - 3 mmHg. No intracranial clot / vegetation / pericardial effusion.

Course in Hospital

:

Patient was admitted with above mentioned complaints under Neurology care with possibility of TIA. Hence her MRI (Magnetic Resonance Imaging) Brain Plain was done on 09/05/2023 which revealed no acute infarct / bleed. CT (Computed Tomography) Angiography of Brain & Neck vessels was done on 10/05/2023 which revealed A1 segment of

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right ACA and right vertebral artery are hypoplastic. No significant vascular stenosis in major neck and intracranial arteries. No aneurysm seen at circle of Willis.

2D echocardiograph was done on 10/05/2023 which revealed no left ventricular regional wall motion abnormality, left ventricular ejection fraction - 55%.

A 24-hour Holter Monitoring was done on 10/05/2023 [report awaited].

Endocrinology consultation was taken in view of uncontrolled diabetes and advice followed.

During hospital stay, patient was managed with dual antiplatelet, statins, dietary supplements and other supportive treatment measures. Now, patient is being discharged in stable condition with following medications and advice.

Significant Medication Given

Injection OPTINEURON, Tablet PREVA AS, Tablet ISTAMET

Condition at Discharge

Afebrile, Vitals stable.

Diet

As advised

Advice on Discharge

Discharge medication

Drug Name	Route	Frequency	Time	Duration
Tablet PREVA AS 75/75mg	oral	once at night	9pm	to continue till follow up
Tablet ATORLIP F 145/10mg	oral	once at night	9pm	to continue till follow up
Tablet ISTAMET 50/500mg	oral	twice daily	9am[after breakfast]-9pm [after dinner]	to continue till follow up
Tablet PANTOP 40mg	oral	once before breakfast	7am	to continue till follow up
Syrup HAEM UP 10ml	oral	twice daily	9am-9pm	to continue till follow up

Diabetic advice (If any)

Diabetic treatment as advised by Endocrinologist

Follow up at Endocrinology & Diabetes clinic at 5th floor with prior appointment. In case of any diabetes related emergency please call at-Endocrinology on call-08800494231.

Discharge Instruction

Review with Holter report.

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5/11/2023

Dr. Meenu SaharanMD Medicine (U.K),
Associate Consultant (Internal Medicine & Geriatrics)
HMC Regd. No - 6329
eclinic@medanta.org

Name: Mrs. Pushpa Saini

Age/sex: 46/F

Date: 9/5/23

UHID: NN402532373

BP: 101/74 mmHg
Pulse: 100/min
Weight: 100 kg
Temp:
Spo2:C/o Rt sided
weakness - sudden
at homeADU

? TIA

1. Shift to Emergency - Neurology Review

Meenu

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Medical Certificate

Patient Name	: Mrs. Pushpa Saini	Patient UHID	: MM02532373
Age	: 46Y	Gender	: Female
Practitioner	: Emergency Team	Specialty	: Emergency and Trauma Services

Emergency Certificate Admission

This is to certify that Mrs. Pushpa Saini S/D/W/O Mr/Mrs mukesh saini Age 46Y Female UHID No MM02532373 attended the Emergency department of Medanta hospital on 09/05/2023 and was admitted at 09/05/2023 14:40 with complaints of one sided weakness with slurring speech & facial deviation for 30 minutes and was advised for admission as an emergency case under neurology with diagnosis of Acute TIA .

Admitting Consultant - Dr Vinay goyal

Signature -

Date - 09/05/2023

Authorized By	: Emergency Team	Signature	
Last Modified By	: Emergency Team	Signature	
Print Date / Time	: 09/05/2023 18:47	Logged User	

Signature

Signature

Logged User

Dr. Vivekanshu Verma

Associate Consultant

Department of Emergency & Trauma
 Medanta-Gurugram

Sector-38, Gurugram -122 001, Haryana
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09-05-2023