



DISCHARGE SUMMARY

Patient Name :	Mrs. SARINDRI DEVI	Room No :	11B1119-T2
Address :	ETERNIA 551, MAHAGUN MODERN A SEC-78, NOIDA	Hosp No :	196756
Contact No :	9667300769	IP No :	NE232411948
Consultant :	Dr. PUNEET GUPTA	Age/Sex :	67 Yrs. /F
Qualification :	MBBS,MD,FIB CHEST PHYSI.	Admission Date :	30/10/2023 11:50
Department :	PULMONARY MED	Discharge date :	01/11/2023 12:35:00

FINAL DIAGNOSIS - HAEMOPTYSIS UNDER EVALUATION
MEDIASTINAL LYMPHADENOPATHY
STATUS: FOB + BAL + EBUS DONE ON 31.10.23

PRESENTING COMPLAINTS & FINDINGS - A - 67 year-old female patient admitted with c/o fever since 5 days, cough with Hemoptysis.

PHYSICAL EXAMINATION -
 BP- 110/80mmHg
 PR-86/min
 Temp-98.4F
 RR-18/min
 Spo2-98% on room air
 Chest -B/L Air Entry +, Crepts +
 CVS-S1S2+
 CNS-Conscious and Oriented
 PA-Soft, Non -Tender

PRE-MORBID CONDITIONS - K/C/O RA

DRUG ALLERGIES/ADDICTIONS - None

SIGNIFICANT PAST HISTORY - None

COURSE IN HOSPITAL - Patient was admitted with above mentioned complaints. All relevant investigations sent. Hb-10.5, TLC-6260, PLT-2.47, Urea-28.0, Creat-0.6, Na+/K+ -140/4.0, Bilirubin total -0.2, SGOT/SGPT-25.0/20.0, Albumin - 4.5, viral marker - non reactive, patient was managed conservatively with i/v antibiotics, PPI, antiemetics, antipyretics and other supportive treatment. Patient is referred back to ESI Hospital.

PROCEDURE/OPERATIONS (IF ANY WITH DATE) - None

CONDITION ON DISCHARGE - Stable

- ADVISE ON DISCHARGE** -
- b. Cefocil - C 325mg twice daily for 7 days
 - b. Tranexa 500mg SOS (if blood in sputum)
 - b. Pantotab 40mg once daily (before breakfast)
 - b. Immutide forte once daily (After Breakfast)
 - I Foracort 200 1cap twice daily & SOS (Inhalation with lupihaler device)

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