Discharge Summary

Dept. of ORTHOPAEDICS

None

General Information

UHID	APD1.0011702204	**Patient Identifier**	DELIP475485
Ward/Bed No	6th Floor Tower-II , 6th Floor T2 ward,Bed no:3612		
Name	Mrs. SUMAN YADAV		
Age	58Yr 3Mth 21Days	**Sex**	Female
Address	SEC 62,NOIDA,Noida,Uttar Pradesh		
Primary Consultant	Dr. H. TANDON, ORTHOPAEDICS		
Admission Date	17-Apr-2024		
Discharge Date	22-Apr-2024		
Allergies	No known allergy		
Diagnosis	..		

Advanced arthritis right knee

Surgery/Procedure
After pre anaesthesia check up, physician clearance from Dr. S Chatterjee (Sr. Consultant, Internal Medicine) and well informed written consent patient was taken up for the procedure -

Total knee arthroplasty right side done on 18.04.2024 by Dr. H Tandon and team under CSE

Anaesthesia - Dr. V Gogia
Implant details: Stryker orthopaedics
Triathlon femoral component (PS) - size 3
Triathlon tibial base plate - size 2
Triathlon tibia bearing insert PS - size 2
thickness - 9mm

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thickness - 9mm

Present Illness

History of **Present Illness**

Mrs. SUMAN YADAV, A 58 years old female patient presented with history of pain over right knee. It was insidious in onset and gradually progressive. Pain was increasing on walking and standing for long time and subsided on taking rest. Now came to Indraprastha Apollo Hospital for further evaluation and management.

Clinical Examination

On **Examination**

Conscious, oriented
Afebrile
Pulse Rate: 80/minute
Blood Pressure: 120/80 mm Hg
Respiratory Rate: 20/minute
Chest: Bilateral clear
Cardiovascular Deficit : S1, S2 Normal/ No murmur/ rub/ gallop
Per Abdomen : Soft, No tenderness, No distension
Central Nervous System : No focal neurological deficit

LOCAL EXAMINATION

Skin : Normal.
Swelling present.
Tenderness present
ROM : 10°-100°
Distal pulses palpable
No distal neurovascular deficit

Course In The Hospital & Discussion

Patient was admitted, evaluated. After all routine investigation, Physician clearance by Dr. S Chatterjee (Sr. Consultant Internal Medicine), pre anaesthetic check up, written and informed consent, patient was taken up for the procedure. Patient and attendants were explained in detail about procedure, its advantages and complications in detail such as bleeding, neurovascular injury, infection, iatrogenic fracture, periprosthetic fracture, implant failure, joint stiffness, deep vein thrombosis, pulmonary embolism residual pain, need for further procedure etc. They were also explained about rehabilitation and need of physiotherapy in detail.

PROCEDURE:
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SURGICAL STEPS:
Patient positioned supine.
Under all aseptic precautions part prepared and drapped.
Through anterior midline 15 cm long skin incision and medial parapatellar approach arthrotomy done.
Osteophytes removed.
Using zig guides, femoral and tibia cuts prepared.
Soft tissue balancing done.
Trial component fixed. ROM and stability checked.
Cemented femoral and tibial component of same size implanted.
ROM and stability checked and found satisfactory.
Patellar tracking satisfactory.
Haemostasis achieved.
Wound washed and closed in layers.
Antiseptic dressing done.

Post operative course :
Patient shifted to recovery room, vitals monitoring done and then shifted to ward.
DVT prophylaxis given with calf pumps and Inj. Clexane, early mobilisation and above knee stockings.
Physiotherapy started. Patient was mobilized using walker. Dressing done on post-operative day 2 and 4. Stitch line was healthy and dry.
Toilet training given. In bed hamstring and quadriceps exercises were taught.
Patient is now being discharged in stable condition with following medical advice.

ADVICE ON DISCHARGE

Diet	As advised
Physical Activity	Local ice packs Quadriceps and hamstring exercises Mobilize with walker under supervision Do not sit on less than 18 inches height Continue above knee stockings. Full weight bearing Do not squat / sit cross legged

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	Dressing care as advised Use toilet extender (6 inch)
Discharge Medication	Tab. Ceftum 500 mg per orally twice a day for 5 days. Tab. Voveran SR 75 mg per orally twice daily for 5 days Cap. Becosule Z 1cap per orally once daily for 4 weeks Tab. Ultracet per orally as and when required for pain Tab. Pantocid 40 mg per orally once a day before breakfast for 7 days. Tab. Dolo 650 mg 1 tab per orally thrice a day for 7 days then as and when required. Cap. Tayo 60 K 1 cap per orally once weekly for 8 weeks Tab. Shelcal HD tab per orally once daily for 8 weeks Tab. Ecosprin 75 mg per orally once daily for 6 weeks Suture removal 14th post operative. Physician Input: Tab. Thyronorm 75mcg per orally once daily empty stomach in the morning. To continue depression medication under supervision/monitoring.
Follow Up	Review with Dr. H Tandon in Physician Office with prior appointment. Kindly confirm your appointment on 011-26925858/26925801/29871280/1281. Review with Free, CBC, ESR and CRP reports in physician office.
Pending Reports	Kindly bring a copy of your bill to collect the pending lab reports from Sample Collection reception and Radiology reports from Radiology Report collection reception at gate 7 on week days,Monday to Saturday(8am-8pm)and Sunday(8am-2pm). You can also download the reports from Apollo 24|7 app.To login, kindly use your registered mobile number.

IF you have any of following symptoms,Please contact your doctor or our Emergency Physician on +911126925888 /26825555 /29872001/ 2003.

1. Fever Of 101°F
2. Onset of new pain or worsening of previous pain.
3. Vomiting
4. Breathing difficulty
5. Altered level of consciousness
6. Discharge from the operative wound.

7. Worsening of any symptoms.

8. Other significant concerns.

Thank you for choosing Apollo Hospital for your healthcare needs.

DR. H. TANDON
ORTHOPAEDICS
Primary Consultant

Registrar/Resident

Please understand your discharge prescription from your doctor before using the medicines.
You can contact Emergency Room Physician, INDRAPRASTHA MEDICAL CORPORATION LIMITED at 26925858
Typed by 141244

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