From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 09/09/2024 08:21 AM
Subject: Student CPC

Greetings from AIIMS, Rishikesh !!

The next student CPC is scheduled on **Sept 9, 2024** in **CPD Hall**, AIIMS Rishikesh from **8:00 AM to 9:00 AM**.

You can also join online through the following Webex link:

Meeting link:

https://aiimsrishikesh.webex.com/aiimsrishikesh/j.php?MTID=m5aa5bca6169be75db73b35e7ce844b0c

Monday, Sept 9, 2024, 8:00 AM | (UTC+05:30) Chennai, Kolkata, Mumbai, New Delhi

Meeting number: 2513 212 4124

Meeting password: 090924

The Clinical handout of the case to be discussed is attached herewith.

Thanks & Regards

Regional Resource Centre
Dept of Telemedicine
AIIMS Rishikesh

CPC Clinical Summary (9 September 2024)

Pt. Age/sex: 67/F	Clinician-in-Charge: Dr. Sanjay Agrawal Dr. Ankit Agarwal and Dr. Gaurav Jain	Discussant: Dr. Mayuri Gupta
Dept : Anaesthesia	Followed in OPD	Radiology discussant: Dr. Shrikant Shukla

Chief Complaints:

- Pain in the left hip and inability to bear weight, after sustaining an injury due to fall from height.

History of present illness:

67 yr old female, non-smoker , no known comorbidities , patient was apparently well 2 days back when she fell from stairs at home leading to pain in the left hip. Pain was insidious in onset, sharp in nature, relieved on taking analgesics and aggravated with movement of that limb.

Past medical history: No previous significant medical history

Past surgical History: No previous surgical history

Family history: No significant family history

Personal history: homemaker, non-smoker, non-alcoholic, vegetarian and regular sleep pattren, no addiction or allergy

General examination: normal built, conscious, oriented,

PR- 105 bpm, regular, normovolemic, BP- 138/86 mm Hg, RR- 20/min, SpO2 99%RA, Temperature 38o C Pallor^{-}, Pedal edema^{-}, Icterus^{-}, Cyanosis^{-}, Clubbing^{-}, Lymphadenopathy^{-}

JVP not elevated

Systemic Examination:

- Chest- B/L NVBS present, no added sounds, CVS- S1S2 + No added sounds.
- CNS: E4V5M6, No motor or sensory deficit, reflexes normal
- PA: Soft, non-tender, no organomegaly, no shifting dullness, BS+

Investigations:

- Complete blood count: Hb-11.2 gm/dl, WBC- 5,600 cells/ cu mm, platelet count- 2.36 lakh/ cu mm
- Renal function test: S.creatinine-0.9 mg/dl, B, urea- 22 mg/dl, S. Na- 138 meq/L, S. K- 3.8 meq/L, S. uric acid – 2.4 mg/dl
- Liver function test: Total bilirubin- 0.8 mg/dl, T. protein -6.2 gm/dl, S. albumin- 3.8 gm/dl, SGOT- 25 U/L, SGPT- 22 U/L
- PT/ INR- 11/1.25, RBS 108 mg/dl
- Viral markers- Non- reactive

Baseline radiological work-up revealed-

- Garden III femoral neck fracture
- Chest X-ray- WNL
- ECG- WNL
- ECHO- WNL

Plan:

- Patient was admitted and advised surgical correction of fracture with left hip bipolar cemented hemiarthroplasty.

Preanesthetic work-up: WNL, considered fit for surgery

Course And Management:

Patient underwent a surgery under combined spinal-epidural anaesthesia. Total intra-operative (duration 2 h) was uneventful. Patient was shifted to orthopedics ward post-operatively. After the 1st post-operative hour, patient developed a sudden onset of respiratory distress, chest discomfort and restlessness. There were no signs of intracranial hypertension, cerebellar dysfunction or cranial nerve palsy.

- Patient was initiated on oxygen therapy through facemask along with fluid resuscitation of around 400 ml of ringer lactate in the ward. In view of the non-improving symptoms, patient was transferred to the CCU immediately.
- Patient was immediately intubated and initiated on mechanical ventilation via APCV mode due to worsening oxygenation and lower GCS.
- Vasopressor infusion was started for hypotension (noradrenaline: 0.2 µg/kg/min).
- In suspicion of PE, CT pulmonary angiography was performed which was suggestive of PAH. As per clinical presentation, patient was graded under moderate-to-high clinical probability (modified Geneva score: 8; moderate risk; Well's score: 9; high risk) for pulmonary embolism.
- Anticoagulation was started with low-molecular-weight heparin (60 mg subcutaneously twice a day).
- CT scan brain and Subsequent CT brain angiography confirmed the **presence of acute infarct in the left insular cortex and right centrum semi-ovale.**
- Gradually, her clinical condition stabilized with improved echocardiographic parameters and oxygenation.Vasopressor infusion was stopped by day **4th post-operative day**. Patient was extubated on the **10th post-operative day**. After extubation, she was lethargic, was non-communicative and had persistent motor weakness (bilateral UL: Grade 3/5, bilateral LL: grade 2/5) which improved gradually over a period of 2 weeks.
- Thereafter. patient was discharged to a step-down facility with no other complications

On clinical examination: (in ward) • Patient was drowsy with HR- 115 bpm, • BP- 82/50 (61) mmHg, • SpO2-82% on room air, • RR- 28 breaths per minute • Temp- afebrile • Motor power- 2/5 in the upper limbs and 1/5 in the lower limbs • Deep tendon reflexes (UL normal and LL non-assessable) and the sensory functions were normal	**On clinical examination: (in CCU)** • GCS- E3 V2 M4, PR- 130 bpm • BP- 80/47 (58) mm HR • RR- 28 breaths per minute with the use of accessory muscles • SpO2- 96% @ 8 L/min face mask • ABG- revealed Type 1 respiratory failure (pH: 7.46, **PO2: 44 mmHg,** PaCO2: 33.6 mmHg, and HCO3: 23.2 mEq/L). • ECG revealed an inverted T-wave in the chest lead V4 and V5. • CXR was normal.
Bedside POCUS: • Lungs- confluent B lines in the lower lung zone bilaterally • Echocardiography: moderately dilated right ventricle (RV), an interventricular septal shift towards the left chamber and PAH, but no cardiac thrombus or shunts. • IVC- 1.3 cm with <50% variability • The LL Doppler was normal, although pelvic veins could not be assessed.	**Vitals after 15 min:** • GCS- could not be assessed (sedated) • HR- 108 bpm • BP- 112/74 mm Hg • SpO2- 100% on FiO2-0.6
CT-pulmonary angiography- RV dilatation, and PAH (main pulmonary trunk: 34 mm). No focal filling defect in the pulmonary vessels	**CT scan brain** -ill-defined hypodensity in the right corona radiata and centrum semi-ovale, and few lacunar infarcts in the bilateral ganglio-capsular region and pons.

	CT brain angiography -confirmed the presence of acute infarct in the left insular cortex and right centrum semi-ovale.

Unit's Differentiall Diagnosis:

- Post-operative ischemic stroke with pulmonary embolization.
- Peri-operative MIs
-

Attachments:

File: CPC 9 sept 2024.docx	Size: 32k	Content Type: application/vnd.openxmlformats-officedocument.wordprocessingml.document