From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 16/04/2024 07:53 AM
Subject: Invitation for CGR

Greetings from AIIMS, Rishikesh !!

The next student CGR will be held on the **16th April , 2024** in **CPD Hall**, AIIMS Rishikesh from **8:00 AM to 9:00 AM**. You can join online through the following link:

Meeting link:

https://aiimsrishikesh.webex.com/aiimsrishikesh/j.php?MTID=mc8c93fd93f3f682ded8b3f6c3f4a6a4e

Meeting number:

2513 748 2553

Meeting password:

160424

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

Thanks & Regards

Regional Resource Centre

Dept of Telemedicine

AIIMS Rishikesh

Clinical Grand Rounds

Division of Pain Medicine

(Department of Anaesthesiology)

Patient Name: Rinku Singh	**Age/Sex:** 38 years / F	**Clinician in charge:** Prof. Dr. Ajit Kumar
Residence: Haridwar	**UHID-** 20220142825	**Clinical discussant (resident):** Dr. Baibhav Bhandari **Presenter:** Dr. Baibhav Bhandari
Ward: Pain Medicine		**Date of admission**: 01/01/2024 **Date of surgery:** 03/01/2024 **Date of discharge:** 06/01/2024

Informant – self

Patient came to the hospital with complaints of –

- Low back pain for past 1 year
- Pain radiating to left leg for the past one year

History of present illness: Patient was apparently asymptomatic 1 year back when he started experiencing pain radiating to left leg associated with numbness and tingling. The pain was gradual in onset and progressed over a period of one year increasing in intensity since last 4 months.

This pain started from lower back along the belt area, and radiating to the buttock and lateral side of thigh followed by lateral side of leg and foot . It was severe in intensity , sharp shooting in nature , and was sometimes also associated with tingling. Pain aggravated on walking < 200m but got relieved on sitting and lying down on bed. There was no aggravation of pain on bending forwards and backwards or lateral rotation.

There was no antecedent history of trauma. No history of diurnal variation in pain iniensity or morning stiffness. No history of multiple joint pain, stiffness or skin changes. No history of fever, decreased appetite or unexplained significant weight loss. No history of discolouration of limb.

PAST MEDICAL HISTORY: not significant

FAMILY HISTORY: There was no history of any family history of similar complaints or any history of chronic illness in first degree relatives.

Treatment history: Patient tried course of physical therapy, NSAIDS and muscle relaxants with no noticeable improvement. Patient was then given left L3-L4 transforaminal epidural steroid injection which also resulted in no improvement of symptoms.

Personal history: Normal bowel/Bladder habits. No history of smoking or alcohol consumption.

General examination: (at the time of admission) :-

Patient is conscious, oriented to time, place, person, E4V5M6.

No Pallor, no cyanosis, clubbing, lymphadenopathy, oedema

Vitals: PR-78/min RR-24/min; BP- 108/72 mmHg

Systemic examination: No abnormality in CVS and RS

Abdominal Examination: Soft, Non Distended, non-tender, No lump palpable, no organomegaly.

Local examination:

Straight leg raise test: left side: 50 degree ; right side: 60 degree

FABER and FADIR negative,

Mc Kenzie test decentralisation of pain towards left lower limb, Motor power 5/5,

Sensory examination: slight decrease in sensation over left dorsal aspect of foot over L4-L5 dermatome,

reflexes were normal.

Pain score VAS 8/10

Oswestry disability index 45

<u>Investigations:</u>

X-ray lumbosacral spine AP, Lateral, Flexion, extension – Normal, no spondylolisthesis

MRI Lumbosacral spine: Disc protrusion L3-L4 with bilateral traversing nerve root compression, central canal diameter at L3-L4 7.5 mm

Complete blood count- Hb-12.4, TLC-8500 cells/mm3, Platelets- 1.2 lakhs/mm3

Viral markers- Nonreactive

PT/INR- WNL

IMPRESSION:

Prolapse intervertebral disc L3-L4

- **Course and management:-** In the latest admission, patient was admitted in pain medicine ward for endoscopic discectomy with posterolateral decompression on left side under **Local Anaesthesia.**

- **Post-op Course:** Patient was vitally stable during intra-op period and was mobilised 3 hours after the procedure. VAS was reduced significantly (3/10) and patient reported complete relief of radicular symptoms.

- **Outcome:** Patient relieved symptomatically, and was discharged on POD 3 on with a plan to follow up after 14 days for revaluation and assessment of the patient.

Attachments:

File: pain medicine CGR.docx	Size: 13k	Content Type: application/vnd.openxmlformats-officedocument.wordprocessingml.document