SDM College Of Medical Sciences and Hospital
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Discharge Summary

Patient UHID : 000001540823 **Patient Visit No. :** IP/24/172287 **Admission Date & Time :** 09/07/2024 10:45 AM

Patient Name : VARAMALA GUNAGI | **Gender :** Female | **Age :** 53 Years | **Mobile No. :**8553214211

Consulting Doctor : Dr.NEPHROLOGY | **Doctor Department :** NEPHROLOGY | **Unit :** Unit I

Discharge Date & Time : 11-07-2024 12:23:00 PM
Department Name : NEPHROLOGY
Condition On Discharge : Improved

Final Diagnosis

ACCELERATED HYPERTENSION + FLUID OVERLOAD STATE
UNDER DIALYSIS
DIABETES MELLITUS
HYPERTENSION
IHD LVEF - 40%(REFUSED CAG+/- PTCA)
DR- VH+ RD
CKD VD
FAILED VASCULAR ACCESS (LEFT AVF)
? AVF STENOSIS
PRESENT ACCESS - RIGHT AVF
OGD SCOPY - ANTRAL GASTRITIS (HPE - NORMAL)
ANEMIA
CKD MBD
BLOOD GROUP - B POSITIVE
3 VIRAL MARKER NEGATIVE - IMMUNISATION COMPLETED
LVEF- 50%

CONDITION AT DISCHARGE
WIGHT :46KG UOP: 100ML LAST HD :11/7/2024

Surgery/Proc Performed

MEDICALLY MANAGED

Chief Complaints

BREATHLESSNESS

History of Chief Complaints

53 YEAR OLD LADY K/C/O CKD VD ON MHD
LAST HD ON 5/7/2024 – COULD NOT COMPLETE THE SESSION OF HD AS SHE HAD BLEEDING FROM AVF SITE
HAD COMPLAINTS OF BREATHLESSNESS SINCE 2 DAYS

Past History

CKD VD ON MHD
HYPERTENSION

Personal History

DIET – MIXED
SLEEP – NORMAL
APPETITE - NORMAL
BOWEL AND BLADDER-NORMAL AND REGULAR

Family History

NOTHING SIGNIFICANT

Examination

Treatment/Surgery

INJ PAN 80MG IV STAT F/B 1-0-0
INJ EMESET 4MG IV 1-0-1
INJ LASIX 40MG IV STAT
INJ 10 UNITS INSULIN ON 25% DEXTROSE IV STAT
INJ CA GLUCOMATE 10% OVER 10 MINUTES
SALBAIR NEB STAT
INJ NTG INFUSION AT 2.4ML/HR
TAB ARKAMINE 0.1MG 2-2-2
TAB ISOLAZINE 1-0-1
TAB ECOSPIRIN 75MG 0-1-0
TAB CLOPIDOGREL 75MG 0-1-0
TAB ATORVA 10MG 0-0-1
INJ INSUGEN R A/S/S

Course In Hospital

SHE HAS CKD V ON MHD TWICE WEEKLY ELSEWHERE, HAD SKIPPER HD ON 6/7/2024 SINCE SHE HAD BLEEDING FROM RIGHT AVF SITE. NOW SHE CAME WITH ACCELERATED HYPERTENSION WITH FLUID OVERLOAD STATE. SHE WAS STARTED ON INJ NTG INFUSION AND HER ORAL BP DRUGS WERE ESCALATED. SHE DIALYSED IN EMERGENCY DEPARTMENT AND SHIFTED TO NEPHROLOGY COMMON WARD. DOPPLER OF RIGHT AVF DONE AND SHOWED DIAMETER OF THE DRAINING VEIN 8 MM IN DIAMETER, 8 CM PROXIMAL TO AV FISTULA AND IS SEEN AT THE DEPTH OF 2MM FROM THE SKIN SURFACE WITH FLOW VOLUME AT THIS SITE IS 2500 CC/ MIN,PROMINENT TRIBUTARY DRAINING INTO THE CEPHALIC VEIN ON ITS MEDIAL ASPECT AT MIDARM 8 CM PROXIMAL TO FISTULA, NO EVIDENCE OF STENOSIS / ANEURYSM, BRACHIAL ARTERY SHOWS NORMAL FLOW, BRACHIAL VEINS ARE PATENT, A SMALL COLLECTION NOTED IN CUBITAL FOSSA MEASURING 1.0 X 0.5 CM------CHRONIC HEMATOMA NOT CAUSING ANY COMPRESSION OVER THE ADJACENT VESSELS.
THE NEED FOR THRICE WEEK HD ALONG WITH SALT AND RESTRICTION EXPLAINED
NEED FOR CAG+/- PTCA ALSO EXPLAINED
NOW SHE IS HEMODYNAMICALLY STABLE AND HENCE BEING DISCHARGED WITH BELOW ADVICE.

Condition at Discharge

STABLE

Advice on discharge

CONTINUE MHD THRICE WEEKLY
INJ CRESP 25MCG WEEKLY ONCE POST HD
INJ OPTINEURON 1AMP IV WEEKLY ONCE POST HD
INJ FCM 500MG ONCE IN A MONTH IV POST HD
DRY WEIGHT 45KG

TAB LASIX 40MG 2-2-0
TAB SHELCAL 500MG 1-0-1
CAP LUMIA 60,000 UNITS ONCE IN WEEK EVERY THURSDAY X 8 WEEKS
CAP ROCALTROL 0.25MG 1-0-0
TAB OROFER XT 0-1-0
TAB MEGAFOLIN 0-1-0
TAB NEXPRO RD 40/30MG 1-0-0

Diet

AS ADVICED

Verified By :

Consulting Doctor : Dr.NEPHROLOGY
Unit : Unit I
Signature & seal

Dr. Sanjay T. Patil
Associate Professor
Dept. of Nephrology
SDMCMS & H, Dharwad
KMC.Reg.No. 57991

PATIENT IS CONSCIOUS, CO- OPERATIVE , WELL ORIENTED TO TIME, PLACE PERSON
O/E
AFEBRILE
BP – 180/110MMHG
PR – 103BPM
RR- 30CPM
SPO2 – 98%RA
GRBS - 209
S/E
RS – B/L NVBS, B/L AIR ENTRY+
CVS - TACHYPNEA
CNS – CONSCIOUS, ORIENTED
PA – SOFT

Investigation

2D ECHO DONE ON 10/7/2024, LVEF- 50%, CONCENTRIC LVH, NO DEFINITE RWMA, ADEQUATE LV SYSTOLIC FUNCTION, MILD MR, TRIVIAL AR, GRADE I TR, MILD PAH, MILD RIGHT PLEURAL EFFUSION, NO VEG.CLOT SEEN

LAB Reports

CREATININE

Test (Method)	Result	Units	Ref. Range
Investigation Date : 09/07/2024			
Creatinine(Alkaline picrate-kinetic, IFCC-IDMS Standardized)	12.74	mg/dl	0.5 - 0.9

ELECTROLYTES (NA+, K+, CL-)

Test (Method)	Result	Units	Ref. Range
Investigation Date : 09/07/2024			
Potassium(ISE indirect)	6.96	mmol/l	3.5 - 5.1
Sodium(ISE indirect)	139	mmol/l	136 - 145
Chloride(ISE indirect)	101.8	mmol/l	98 - 108

UREA

Test (Method)	Result	Units	Ref. Range
Investigation Date : 09/07/2024			
Urea(Urease, UV)	221.4	mg/dl	16 - 49

ELECTROLYTES (NA+, K+, CL-)

Test (Method)	Result	Units	Ref. Range
Investigation Date : 10/07/2024			
Potassium(ISE indirect)	6.4	mmol/l	3.5 - 5.1
Sodium(ISE indirect)	138	mmol/l	136 - 145
Chloride(ISE indirect)	98.3	mmol/l	98 - 108

SCREENING HEMOGRAM

Test (Method)	Result	Units	Ref. Range
Investigation Date : 09/07/2024			
Eosinophils	4.4	%	1 - 6
Haemoglobin			
Haemoglobin	9.6	gm%	13.5 - 15.5
Lymphocytes	17.7	%	20 - 40
Monocytes	3.0	%	2 - 10
DLC-DIFFERENTIAL LEUCOCYTE COUNT			
Neutrophils	74.3	%	40 - 80
Packed cell volume			

...me/Haematocrit(HCT)	32.5	%	38 - 41
...count			
Platelet Count	3.43	lakhs/cmm	1.5 - 4.0
TOTAL LEUKOCYTE COUNT		Cell/cmm	
Total leucocyte Count (WBC)	12600	%	5000 - 10000
Basophils	0.6		1 - 2

HCV (RAPID TEST)

Test (Method)	Result	Units	Ref. Range
Investigation Date : 09/07/2024			
Hepatitis C Virus; HCV Rapid Screening Test(Immunochromatography assay)	Negative		

This is only Screening test. All reactive test samples should be confirmed by confirmatory test. Test result should be interpreted in conjunction with clinical findings.

HIV (RAPID TEST)

Test (Method)	Result	Units	Ref. Range
Investigation Date : 09/07/2024			
HIV RAPID TEST(Immunochromotography assay)	Non Reactive		

This is only a screening test. All reactive test samples should be confirmed by confirmatory test. Test result should be interpreted in conjunction with clinical findings.

HBsAg (RAPID TEST)

Test (Method)	Result	Units	Ref. Range
Investigation Date : 09/07/2024			
HEPATITIS B SURFACE ANTIGEN; HBsAg; AUSTRALIA ANTIGEN(Immunochromatography assay)	Negative		

This is only Screening test. All reactive test samples should be confirmed by confirmatory test. Test result should be interpreted in conjunction with clinical findings.