

MEDICAL GROUP PRESENTATION

BIODATA

Name:EG

Age:45 years

Gender:Female

Contact:0723.....

Marital Status:Married

Residence:Igoji

Religion:Christian

Ethnicity:Ameru

Nationality:Kenyan

Occupation: peasant farmer

Nearest school:Karigo primary school

Area chief:Mbae

Next of kin: Husband, Morris Kaburu

Date of admission:28 Feb 2023

Date of history taking:13 March 2023

Duration of stay:14 days

Ward:3

Cube:1

Bed no:9

CHIEF COMPLAINTS

Headache 2/52

HISTORY OF PRESENTING ILLNESS

The patient was well until two weeks prior admission where she presented with complains of headache on the frontal part of the head. It was gradual on onset, throbbing in nature and non-radiating. It was aggravated by bending and not relieved by over the counter drugs (mara moja). It mostly occurs during the day. On a scale of 1-10 the patient graded the pain at 6. The headache was associated with dizziness and blurring of vision.

The patient also presented with easy fatigability one-week prior admission which was gradual on onset. It was associated with joint pains, inability to walk for a long distance and on steep areas. During that period, she also reports to get tired easily on doing her daily chores. There is history of fast breathing and awareness of heartbeat.

There is hx of craving for ice and soil.

No hx of trauma to the head. No hx of loss of consciousness no hx of fainting no hx of convulsions.

No hx of chest pains, no hx of swelling of limbs, no hx of difficulty in breathing while lying flat.

No hx of bleeding tendencies, no hx of deworming no hx of travel to malaria endemic areas.

The patient normally takes one meal per day due to low finance. Her daily diet includes; githeri, rice.

REVIEW OF SYSTEMS

RESPIRATORY SYSTEM

No history of cough

No hx of musical sounds while breathing

No history of night sweats

GASTROINTESTINAL SYSTEM

There is history of constipation

No hx of loss of appetite

No hx of difficulty in swallowing

No history of vomiting blood

No history of dark stool

No hx of pain while swallowing

No hx of early satiety

No history diarrhea

No hx of blood in stool

GENITOURINARY SYSTEM

No hx of pain while urinating

No hx of genital ulcers

No hx of itchiness during urination

No history of increased urine frequency

No hx of urine incontinence

No hx of urine dribbling

No hx of dyspareunia

No hx of reduced urine output

MUSCULOSKELETAL SYSTEM

There is hx of joint pains

No hx of joint stiffness

No hx of muscle spasms

No hx of muscle swelling

No hx of numbness and tingling sensation

ENDOCRINE SYSTEM

No hx of heat intolerance

No hx of cold intolerance

No hx of muscle twitching

No hx of increased salivation

No hx of lid lag and corneal irritation

No hx of excessive hair growth or hair loss

INTEGUMENTARY SYSTEM

No hx of skin peeling

No hx of change in skin colour

No hx of skin itchiness

No hx of dry skin

No hx of skin rashes

GYNAECOLOGICAL HISTORY

She started menarche at 14

Has a regular cycle of 28 days. Duration of five day and uses 3 pads a day.

LMP 26/02/2023

She is using oral combined pills.

No hx of painful menstruation, no hx intermenstrual bleeding, no hx of cervical cancer screening, no hx of multiple sexual partners.

PAST MEDICAL AND SURGICAL HISTORY

This is an index admission. No known food and drug allergies. No hx of radiological exposure. No hx of blood transfusion

PERSONAL SOCIAL ECONOMIC HISTORY

The patient is a class 8 graduate. She is married to one husband with 3 children all alive and well. She lives in a semi-permanent house with 2 rooms, 2 windows and 2 doors.

She uses tap water for domestic use and does not boil water for drinking. She uses a pit latrine located 30m away from the house and disposes household waste 20m away from the house.

She likes singing and praying. She does not take alcohol nor smoke cigarette or chew khat

She is a small scale farmer of maize and beans for subsistence use.

She is not covered by NHIF

FAMILY HISTORY

She is a firstborn in a family of 5(3 men and 2 females). All are alive and well.

Her parents are alive and well. There is no hx of chronic illnesses in the family like DM, HTN, Asthma, malignancies etc.

SUMMARY

This is the hx of EG,45yrs old female who presented with headache for 2 weeks and easy fatigability for 1 week.

Full hemogram was done and the results were; HB 4.3(11.5-16.5), MCHC-38.5(31-38), MCV 73.5(75-100), Hct 11(35-55)

She was transfused with 2 pints of whole fresh blood and is currently on Ranferon.She was given IV PCM 1gm TDS for 3 days.

Symptoms have subsided and currently the patient is doing well.

PHYSICAL EXAMINATION

GENERAL EXAMINATION

EG is in a fair general condition, lying supine on the bed, well groomed, with a green branulla on the dorsum part of the left hand.

PARAMETERS

There is dehydration +

There is pallor++

No lymphadenopathy

No oral thrush

No finger clubbing

No cyanosis

VITAL SIGNS

PARAMETER	DATE OF ADMISSION	DATE OF HX TAKING	NORMALS
BLOOD PRESSURE		120/81	90-140/60-90
PULSE RATE	98	81	60-100
RESPIRATION RATE	20	15	14-20
TEMPERATURE	36.3	36.8	36.5-37.5
SPO2	94%	97%	>95%

SYSTEMATIC EXAMINATION

RESPIRATORY SYSTEM

INSPECTION

Chest wall is symmetrical

Symmetrical chest movement

No hypo /hyperpigmentation

No cosmetic /therapeutic scars

No obvious masses

0No chest deformity

PALPATION

normal local temperature

Trachea is centrally placed

No tenderness

No palpable masses

Normal tactile fremitus

PERCUSSION

Resonant sound appreciated

Dullness over pericardium region

AUSCULTATION

Vesicular breath sounds heard

No crackles

CARDIOVASCULAR SYSTEM

INSPECTION

No distended neck veins

No Visible pulsation

There is no hyperactivity over the pericardium

No Osler's nodes, Janeway lesions, splinter hemorrhages

PALPATION

No heaves

No thrills

No palpable masses

Apex beat appreciated at 5th intercostal space, 9cm from the midsternum

AUSCULTATION

S1 and S2 heard

No murmurs

No added sounds

NEUROLOGICAL EXAM

HIGHER CENTERS

She is alert, well oriented with time, place and person but with reduced concentration. The speech is coherent. Short term and long-term memories are intact as patient could remember what she ate in the morning and the year she did her KCPE respectively. Her intellectual ability is intact as she could subtract 10 from 100.

Cranial Nerves

CN1: Olfactory nerve

Intact as the patient can differentiate between different smells introduced to her i.e. spirit, orange

CN2: Optic nerve

Intact as patient could read letters from a Snellen's chart placed 6 meters away

CN 3, 4 and 6 Oculomotor, Trochlear and Abducens

Intact as a pupillary reaction to light is normal; the pupil constricts when a ray of pen torch is introduced, and she could follow pen torch light moved in all directions.

CN 5: Trigeminal

Is intact since the patient could clench her teeth and differentiate the sensation of cloth and pen lid passed on the sides of the face.

CN 7: Facial nerve

Intact as the patient could smile, blink eyes, frown, and raise eyebrows.

CN 8: Vestibulocochlear

Intact as the patient could perceive words whispered at a distance and perceive sounds from both sides

Whisper test

Riner's test

Weber's test

CN 9 and 10 Glossopharyngeal and Vagus nerve

Intact as the patient gagged when she tried to place her fingers over the soft palate and was also able to swallow a small slice of orange.

CN 11: Accessory

Intact as the patient could turn her neck against resistance and shrug her shoulders against resistance

CN 12: Hypoglossal

Intact as the patient could move her tongue out of the mouth and roll in all directions.

Signs of meningeal irritation

Neck is soft

Kernig negative

Brudzinski negative

MOTOR ASSESSMENT

INSPECTION

Muscle wasting

PALPATION

Normotonic

MUSCLE POWER

Right and left upper limb 5/5

Right and left lower limb 5/5

SENSORY ASSESSMENT

Fine touch-perceives the touch of cotton and could localize area of stimulation.

Pain-on application of gentle pressure patient perceives pain

Temperature-could feel different temperatures (cold and warm)

Graphesthesia-normal as patient could recognize writing on skin purely by the sense of touch

REFLEXES

Brachial reflex present

Triceps reflex present

Biceps reflex present

Knee jerk present

Ankle jerk present

Plantar reflex present-Babinski

IMPRESSION

Anemia secondary to malnutrition

DIFFERENTIAL DIAGNOSIS

Malaria

Meningitis

Leukaemia

Cardiovascular accident

MANAGEMENT

INVESTIGATIONS

Blood for full hemogram

Blood for grouping and cross matching;

Blood for malaria parasite

Stool for occult blood.

Stool for ova and cyst.

Renal function tests

Liver function tests

Coagulation cascade

Bone marrow aspirate.

SUPPORTIVE

Admit the patient in female medical ward

Bed rest

Fix large bowel cannula

Give IV fluids-Normal saline

Give hematinic; ranferon

Advice on nutrition

DEFINITIVE

Transfusion with 2 pints of fresh whole blood

Refer for nutritional review

Deworm the patient with Albendazole 400mg Stat