MEDICAL GROUP PRESENTATION

BIODATA

Name: J K

Age : 73yrs

Gender: male

Occupation: Farmer

Tribe : Meru

Marital status: Widower

Contact: 0742****56

Residence: Ruiga

Religion: Christian

Next of kin: Lilian [daughter]….0766****78

Nearest land mark: Ruiga Girls sec sch

Location: Ruiga

Chief :Mutuma

Nationality: Kenyan

D O A : 5/10/2022

D O H : 7/10/2022

D O S : 2 DAYS

Ward : 6

Cube : B

Bed : 16

Chief complain

1. Chest pain *2/7

HISTORY OF PRESENTING ILLNESS

The patient was fairly well until two days prior admission when he presented at MeTRH with chest pain. However, the patient reports that one week earlier he had presented with the above complain at CHAARIA MISSION HOSPITAL where a chest x-ray was done, patient was admitted for three days and was managed with drugs unknown to him .he was later discharged on the following drugs; P.O Bacep II OD *10/7, PO Gastro plus 40mgOD*10/7 , PO Ascoril 10mls TDS , PO Azithromycin 500mg OD *3/7, PO Amoxyclav 625mg BD. He took the drugs for two days but there was no improvement and he opted to seek further treatment at MeTRH.

The chest pain was on the left side, gradual on onset, stabbing in nature, non-radiating, associated with difficulty in breathing which was insidious on onset , relieved by rest and exarcerbated by work, it was also associated with cough which was productive , had blood stained sputum, non-copius , mostly occurred in the evening, it was on and off for a period of three weeks , it had no exacerbating factors such as dust , pollen grains or perfume . Chest pain was worse at night, aggreviated by work i.e digging in the farm, it was relieved by rest and with a severity of 7/10.

There is history of drenching night sweats, history of hotness of the body that was mostly in the evening.There is history of weight loss since the clothes he used to wear couldn't fit him. There is history of Tb illness 23yrs ago where he was treated and the test results later were negative. there is no history of musical sounds when breathing out, no history of nose bleeding, no history of TB contact recently, no history of covid patient contact recently, no history of travel to malaria endemic areas.

No history of difficulty in breathing while lying flat, no history of awareness of heartbeat, no history of waking up at night to gasp for air, no history of easy fatigability, no history of lower limb swellings.

He reports to have smoked cigarette 4 to 5 sticks daily and used alcohol [muratina] approximately 2liters in a day but not frequently . He stopped using them 4 years ago after advice from his daughter who is a nurse.

REVIEW OF SYSTEMS

GASTROINTESTINAL SYSTEM

There is history difficulty of swallowing

No history of loss of appetite

No history of nausea

No history of vomiting

No history of constipation

No history of early satiety

No history of flatulence

No history of abdominal pain

No history heart burn

No history abdominal distension

GENITOURINARY SYSTEM

No history of change in urine color

No history of pain while urinating

No history of increased frequency of urination

No history of increased urgency to urinate

No history of dribbling of urine

No history of urine incontinence

No history of blood in urine

No history of burning sensation when urinating

CENTRAL NERVOUS SYSTEM

No history of headache

No history of dizziness

No history of double vision

No history blurred vision

No history of fainting

No history of hearing problems

No history of tingling sensation

MUSCULOSKELETAL SYSTEM

No history of joint pain

No history of joint swelling

No history of joint stiffness

No history of muscle weakness

No history of muscle wasting

No history of muscle tremors

No history of muscle pain

INTEGUMENTARY SYSTEM

No history of skin rashes

No history of hyper/hypopigmentation of the skin

No history of skin ulcers

No history of itchness of the skin

No history of peeling off of the skin

No history of dry skin

ENDOCRINE SYSTEM

No history of heat intolerance

No history of cold intolerance

No history of increased thirst

No history of increased salivation

No history of sleep difficulties

No history lacrimation

No history mood swing

No history of loss of hair

No history of hoarseness of the voice

PAST MEDICAL AND SURGICAL HISTORY

This is the 2nd admission

The 1st admission was at CHAARIA MISSION HOSPITAL due to chest pain on 29th sep 2022

There is history of exposure to radiation [CHEST X-RAY]

No history of blood transfusion

No history of surgical procedures

No known food and drug allergies

PERSONAL, SOCIAL AND ECONOMC HISTORY

Jk 73 yrs old male has never gone to school. He is a widower, his wife died of liver cancer three months ago, has six children , lives with the daughter . he lives in a permanent house with 4 rooms , 5 doors and 6 windows which he opens regularly. he uses electricity for lighting , uses tap water for domestic use and does not boil water for drinking .has a flashing toilet inside the house and pit

latrine 20meters from the house ,he disposes waste in a compost pit 50 meters away from the house . His diet consist of ugali, beans, Sukuma ,cabbage ,meat, banana ,oranges. He likes watching news and football. He stopped taking alcohol and smoking cigarette in 2018 after advice from his daughter. He is large scale farmer, he plants tomatoes, maize, coffee and beans.

FAMILY HISTORY

He is a third born in a family of 5 siblings 3males and 2 females .one sister died of a disease unknown to him, the rest are alive and well. Both parents died of unknown cause. No known chronic or genetic illnesses in the family e.g TB, asthma, diabetes hypertension and epilepsy .

SUMMARY

This is a history of JK 73YR Old male who presented with chest pain for two days at MeTRH .The chest pain was associated with difficulty in breathing and cough . there is history of drenching night sweats, history of hotness of the body, history of weight loss, history of TB illness 23yrs ago , history of smoking cigarette and alcohol intake . A chest x- ray was done which showed massive pleural effusion on the left side. fullhemogram , LFTs ,UECs were done and findings were within the normal ranges. Drainage of pleural fluid was done through under water seal drainage and currently the patient is on IV ceftriaxone 1gm bd *5/7, IV paracetamol 1gm tds *3 /7. Today is day 2 and the patient is doing well .

PHYSICAL EXAMINATION

The patient is in fair general condition, lying supine on the bed, well groomed and in fair nutritional status , has a pink canula on the right ante cubital fossa ,and has under water seal drainage inserted in the 4^{th} intercoastal space mid axillary line, the fluid is cloudy in colour and the amount is 0.8 liters.

PARAMETERS

No jaundice

No pallor

No lymphadenopathy

No dehydration

No oral thrush

No finger clubbing

No oedema

VITAL SIGNS

PARAMETERS	DOH TAKING	NORMALS
Blood pressure	120/73	90-140/60-90
Temperature	36.7	36.5-37.5
Pulse rate	86bpm	60-100bpm
Respiratory rate	15bpm	14-20bpm
Spo2	96%	95-100%

SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM

INSPECTION

Chest wall is assymetrical,

Reduced chest movement on the left

No flairing of alae nasae

No hypo/hyper pigmentation

No cosmetic scars

No obvious masses

Underwater seal drainage tube inserted at the 4th intercostal space mid axilliary line on the left[safe triangle]

PALPATION

No increase in local temperature

No palpable mass

There tenderness on the left side of the chest

The trachea is deviated to the right

Asymmetrical expansion of the chest(the left was not expanding)

Reduced tactile fremitus on the left side

PERCUSSION

There's resonance note appreciated on the right lung field

Stony dullness appreciated over the middle and lower left lung field

AUSCALTATION

Reduced vesicular breath sounds on the left

Reduced vocal fremitus on the left side

No inspiratory stridor

No crepitations

CARDIOVASCULAR SYSTEM

INSPECTION

No distended neck veins

No visible palpations

No hyper/hypo pigmentation

No hyperactivity the pericordium

No chest deformity

The chest is asymmetrical

PALPATION

No heaves

No thrills

No palpable masses

Apex beat appreciated on the 5^{th} intercostal space 9cm from the mid sternum

Tenderness at the site of incision

AUSCALTATION

S1 and S2 appreciated

No murmurs

No added sounds

ABDOMINAL EXAM

INSPECTION

Abdomen moves with respiration

No abdominal distention(scaphoid)

The abdomen is symmetrical

Umbilicus is centrally located and inverted

No hypo/hyper pigmentation

No therapeutic or cosmetic scars

Pubic hair is everted

No visible peristalsis

No visible distended veins

AUSCULTATION

Bowel sounds heard 8 sounds/min(Normal 6-12)

No vascular bruits

PALPATION

Light palpations

>No superficial mass

>No increase in local temp

>No tenderness

Deep palpation

>No organomegaly

>No tenderness

PERCUSSION

Tympanic note appreciated

Liver span 8cm (normal 6-12)

No fluid thrill

No shifting dullness

NEUROLOGICAL SYSTEM EXAMINATION

NEUROLOGICAL EXAMINATION

Higher centers

The patient is well well groomed , mood and affect are congruent.(The patient was happy)

The patient is conscious, well oriented with time, place, and person. The speech is coherent and his immediate, short-term and long-term memory is intact as he could remember what he ate the previous night, the date of inauguration of the fifth president of the republic of Kenya and when Kenya got her independence. His intellectual capacity is intact as he could carry out simple arithmetic operations. Abstract thinking present as the patient can interpret local proverbs(kidole kimoja hakivunji chawa).Attention/concentration present as the patient has the ability to substract serial 7 from 100

Cranial Nerves

CN1: Olfactory nerve

Intact as the patient can differentiate between the smell of an orange and alcohol swab.

CN2: Optic nerve

The patient could read letters and differentiate colors from a distance of six metres.

CN 3 ,4 and 6 Oculomotor, Trochlear and Abducens

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

CN 5: Trigeminal

Is intact since the patient could clench his teeth and differentiate the sensation of cotton 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-air conduction greater than bone conduction

Weber's test-

CN 9 and 10 Glossopharyngeal and Vagus nerve

Intact as the patient gagged when he tried to place his fingers over the soft palate and was also able to swallow.

CN 11: Accessory

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

CN 12: Hypoglossal

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

Signs of meningeal irritation

- Neck is soft
- Brudzinski sign negative
- Kerning sign negative

MOTOR ASSESSMENT

Inspection

The patient has normal muscle bulk.

Palpation

Muscle tone is normotonic

Muscle power: Right upper limb 5/5

Left upper limb 5/5

Right and left lower limbs 5/5

REFLEXES

- Brachial reflex present
- Triceps reflex present
- Biceps reflex present
- Plantar reflex negative
- Corneal reflex present

Sensory functions

- Superficial touch is normal
- Normal pain sensation
- Point sensation present

IMPRESSION

Pleural effusion secondary to PTB

DIFFERENTIAL DIAGNOSIS

Pneumonia

Bronchogenic carcinoma

Systemic lupus etrythromatus

Rheumatoid arthritis

Nephrotic syndrome

Cirrhosis

Cardiac failure

MANAGEMENT

Investigation

Lab work

FHG

BLOOD FOR CULTURE AND SENSITIVITY

SPUTUM FOR GENE EXPERT

URINE FOR TB LAM

PLEURAL BIOPSY

PLEURAL FLUID ANALYSIS

HIV TEST

IMAGING

CHEST X RAY

CT SCAN

MRI

SUPPORTIVE MANAGEMENT

ADMIT THE PATIENT IN MALE MEDICAL WARD

MONITOR VITAL SIGNS

IV PARACETAMOL 1GM TDS 3/7

IV CEFTRIAZONE 1GM BD 5/7

SPECIFIC MANAGEMENT

UNDERWATER SEAL DRAINAGE

MANAGEMENT OF TB

INITIAL PHASE[2 MONTHS]	*CONTINUTION PHASE[5MONTHS]*
*Rifampicin 150mg+isoniazide 75mg+pyrazinamide400mg+ethambutol 275mg QID+ pyridoxine 50mg*2/12*	*Rifampicin 150mg +isoniazide75mg+pyridoxine 50mg QID+ Ethambutol275 mgQID*5/12*

COMPLICATIONS

SEPSIS

THICKENNED PLEURAL

EMPYEMA THORACIS

SPREAD OF TB TO PERICODIUM OR PERITONEUM

PNEUMOTHORAX

TB LARGNGITIS

CARDIAC FAILURE TUBERCUOUS