Lata Mangeshkar Medical Foundation's
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H-2019-0663
Since Sep 24, 2019

Printed Date:20/01/2025 20:28:13

Patient Name: Mr. GANDHI VILAS CHANDANMAL
MRD#: 1377751
Date of Birth: 01/05/1949
Sex: Male
Visit Code: IP0003
Age : 75Y 8M 20D
Bed No : 4 A - 404
Consultant : Dr. KULKARNI VIHITA VINAY
Date of Admission : 14/01/2025
Discharge Status : FOLLOW UP DISCHARGE
Date of Discharge : 20/01/2025

DIAGNOSIS :
Admitted with syncope
bilateral parietal sulcal Subarachnoid hemorrahege
Osteo-arthritis of right knee
Known diabetes mellitus
Hypertension

HISTORY OF PRESENT ILLNESS :
A 75-year-old male patient with a history of diabetes mellitus (DM) and hypertension (HTN) was brought to the emergency room (ER) on January 14, 2025, after an unwitnessed fall at home. The patient had no history of prior headache or chest pain, and no history suggestive of seizure. However, he was given sorbitrate by his relatives.

CLINICAL EXAMINATION ON ADMISSION:
Upon arrival the patient was conscious, oriented, and had a Glasgow Coma Scale (GCS) score of 15/15. His vital signs were stable, with a blood pressure of 120/80 mmHg, a pulse rate of 72/min, and an oxygen saturation of 98% on room air. He was moving all four limbs, and his speech was normal, with no neurodeficits noted at the time.

RELEVANT INVESTIGATIONS :
Date of Procedure: 15/01/2025
2D-ECHO / CARDIAC DOPPLER REPORT
M MODE 2D ECHOCARDIOGRAPHIC MEASUREMENTS
LVIDd: 47 mmAO: 29 mmIVS: 12 mm
LVIDs: 34 mmLA: 30 mmPW: 12 mm
LVEF: 60%TR: 2.2 m/s 19 mmHg
FINDINGS
. - Normal size LV
- Mild concentric LVH
- No regional wall motion abnormality / scar
- Normal LV systolic function, EF : 60%
- Left ventricular diastolic dysfunction, Grade I
- Trivial mitral regurgitation
- Sclerosed AV with trivial aortic regurgitation, no aortic stenosis
- Normal RA / RV size and function
- Trivial tricuspid regurgitation, no pulmonary hypertension
- No intra cavitory clot / vegetation
- No pericardial effusion
- Normal size and functioning IVC

USG A P

IMPRESSION: - Fatty changes in liver.
- Cholelithiasis. No sonographic signs of cholecystitis.
- Large left renal cortical cyst.
- Mildly thickened urinary bladder walls.
- Enlarged prostate with median lobe hypertrophy indenting the bladder neck.

COURSE IN THE HOSPITAL AND DISCUSSION :
Patient admitted with above mentioned complaints. Thourough examination was done all relevant investigations sent . A computed tomography (CT) scan of the brain revealed subarachnoid hemorrhage along the bilateral temporo-parietal convexities, right sylvian fissure, and along the bilateral frontal and parietal parafalcine region. The CT scan also showed comminuted fractures of the anterior and lateral wall of the left maxillary sinus and the lateral wall of the right maxillary sinus with hemosinus within, as well as a fracture of the lateral wall of the left orbit. A CT angiogram was also performed, which did not show any aneurysm. The patient's electrocardiogram (ECG) did not show any fresh or acute ST-T changes. His blood sugar level was 118 mg/dl,
The patient was referred to neurologist Dr Rahul Kulkarni and neurosurgereon Dr Borde , and a reference was given to Dr. Shaunak Sule , plastic surgery.

Over the next few days, the patient's condition improved, and he became more alert and oriented. He was able to ambulate and had no focal neurodeficits. The patient's sodium levels improved, and his blood sugar levels were controlled.
As patinet was conscious, oriented, and hemodynamically stable , shifted to wards. Initially he was slightly drowsy and preferring to sleep , but metabolic paramertes within normal limits. Review with neurology and neurosurgery was done. Holter monitoring was started for 7 days to look for Arrythemias. His mentation gradually improved. Opinion of Dr Barve was sought for right knee pain , Xray were done. Gross osteoarthritis of right knee The patient was continued on his medications and was planned for discharge.

PLAN ON DISCHARGE :
Investigations to be done before coming to the follow-up:
SERUM ELECTROLYTES

HAEMOGRAM

EEG

MRI Brain

Submit HOLTER MONITOR on 24th in 2nd Floor SS Building Cardiology OPD and collect Reports

Follow Up:
with Dr.Vihita Kulkarni after 2 weeks , with prior appointment in Medicine OPD, Old building, Ground Floor, D wing.

DISCHARGE MEDICATIONS:

Medicine	Frequency	Duration	Instruction
TAB LEVIPIL 500Mg	1-0-1	Till next follow up	DO NOT STOP WITHOUT CONSULTATION WITH PHYSICIAN
TAB JANUMET 50/500	1-0-1	Till next follow up	Before breakfast and dinner
TAB STAMLO 2.5MG	1-0-1	Till next follow up	
TAB COLLACIUM D3	1-0-0	30 days	
TAB CARTIGLOW	1-0-0	30 days	

CONTACT DETAILS :

*** OPD Appointment: 020-40151100 between 9.00 a.m. to 6:30 p.m. (Sunday Closed)**

*** Medicine OPD Reception: 020-40151072 (9 a.m. to 6 p.m.)**

*** DMH reception 020- 40151000/49153000**

IN CASE OF EMERGENCY :

If you have following symptoms :

Blurring of vision giddiness severe headache vomiting

Refer to DMH-Emergency Room-1 which is available 24 x 7 for 365 days. Phone 020-40151027/1065

Ambulance No. 020-40151540/108

SPECIAL NEEDS :

HYPOGLYCEMIA AWARENESS :
56548285

PREPARED BY : DR.APHALE SHUBHANKAR JAYDEEP

APPROVED BY : Dr. KULKARNI VIHITA VINAY