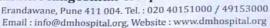


Lata Mangeshkar Medical Foundation's

Deenanath Mangeshkar Hospital & Research Center





MEDICAL DISCHARGE SUMMARY

Patient Name: Mr. DESHPANDE VISHNU

HARI

Date Of Birth: 13/10/1939

Visit Code: IP0004

Created Date: 08/11/2024

Ward/Bed No: SS13D - 4352 Date of Admission: 04/11/2024

Date of Discharge: 09/11/2024

Age: 85Y 0M 27D

MRD#: 841541

Sex: Male

Speciality: MEDICINE

Consultant: Dr. TAMANE SANDEEP

Blood Group: B+

Discharging Status: FOLLOW UP DISCHARGE

SUMMARY

DIAGNOSIS:

Urinary Tract Infection, Oral Candidiasis in known case of Hypertension

HISTORY OF PRESENT ILLNESS:

Known HT, Severe LV dysfunction.

Admission with Septic shock in September.

RT feeding.

Patient has no specific symptoms.

But urine cs abnormal.

Problems with RT and Foley's.

CLINICAL EXAMINATION:

On Examination,

Mentation normal.

No fever.

Hd stable.

No specific signs.

Using Diapers.

COURSE IN THE HOSPITAL AND DISCUSSION:

The patient, a known case of hypertension with severe left ventricular dysfunction, was admitted following septic shock in September. Initially, they had been receiving RT feeding due to swallowing difficulties, compounded by oral candidiasis and challenges with Foley catheter placement. Despite these issues, the patient was afebrile, mentally alert, hemodynamically stable, and voiding urine with the assistance of diapers. Blood investigations indicated an abnormal urine culture - proteus mirabilis sensitive to meropenem, leading to its administration. Early in the admission, a referral was made to ENT for scopy-guided RT insertion due to complications, with ENT noting the presence of mobile vocal cords and no aspiration risk, allowing a gradual introduction of thick liquids and pureed consistencies orally. By Day 5, the patient showed progress with increased ambulation in the corridor with walker support, LThe RT was eventually removed as the patient transitioned to accepting a semi-soft diet orally in small amounts. Medically, the patient remained vitally stable with no fever and improved oral intake. Patient is hemodynamically stable and can be discharged

PLAN ON DISCHARGE:

MRD No:841541

Name:Mr. DESHPANDE VISHNU HARI

1/2

F/u with dr tamane Sandeep Medicine opd with CBC, urine-r, RFT after 1 week

DISCHARGE PRESCRIPTION:

B-L-D Inj meropenem, 1gm, 1-1-1, in 100 ml NS, for 4 days

Tab Concor 2.5, 1-0-0, till further follow up Tab stamlo 5, 1-0-0, till further follow up Cap A to Z, 0-1-0 for 1 month Tab zocon 50, 1-0-0 for 3 days Cap pan D, 1-0-0, for 10 days

ADVICE ON DISCHARGE:

In case of emergency like abdominal pain, chest pain, please come to DMH ER 1 (Emergency Room). It is open 24 hours a day. Phone no.: 020-4015-1027 / 1065.

Special needs:

SIGNED BY: Dr. TAMANE SANDEEP

APPROVED BY: DR.MENDPARA ISHIT VINODBHAI

MRD No:841541

Name: Mr. DESHPANDE VISHNU HARI