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LAKESHORE HOSPITAL & RESEARCH CENTRE LTD., KOCHI - 682 040, INDIA
Phone : 91-484-2701033 E-mail : info@lakeshorehospital.com, Web : www.lakeshorehospital.com

DISCHARGE SUMMARY

DEPARTMENT OF NEURO SURGERY

Patient No	0000500197	Gender / Age	Male / 58 Years
Name	MR. BOSLAL K	Phone No	9061100395
Address	S/O Karunakaran	Date of Admission	12/06/2021
	Nivarthil House,Cmc 34, Cherthala Po	Date of Discharge	29/06/2021
Mobile No	8547269556	Surgery Date	13/06/2021

Dr.SUDISH KARUNAKARAN
HOD (Neuro Surgery)
Dr.ARUN OOMMAN
Sr.Consultant
Dr.AJAY KUMAR AJANVI
Consultant
Dr.ANIL C
Assosiate Consultant

Dr.FRANCIS MANAVALAN
Cheif Of Neuro Anaesthesia
Dr.ANU CHANDRAN
Assosiate Consultant
Dr.DHARAV KHERADIA
Sr.Consultant (Neuro Inter. Radiology)

Medical Officers
Dr.VANDANA DOMANIC
Dr.SHERIN MAJEED
Dr.POOJA RAJESH
Dr.ABIN JOSEPH SAMUAL

Diagnosis

SEVERE HEAD INJURY
GRADE 3 DIFFUSE AXONAL INJURY
SEDDON'S GRADE 2-3 RIGHT BRACHIAL PLEXUS INJURY
MULTIPLE RIB FRACTURES
MULTIPLE FACIAL BONE FRACTURE

History And Examination

Patient presented with alleged history of RTA at around 8:20pm near Cherthala Railway Station on 12-06-2021.

History of LOC +

No history of seizures/ vomiting / ENT bleed.

Initially taken to Cherthala Taluk Hospital and from there referred to VPS Lakeshore for further management.

Clinical Examination

On arrival:

RR- 20/min

Pulse – 82/min

BP- 140/90mmHg

On room air

GCS- E1 M5 V1

Pupils right 3.5mm +, left 2mm +

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Bilateral periorbital edema +

paucity of right upper and lower limb movements

RS- air entry bilaterally equal

CVS- S1 S2 normal

P/A- soft, non tender

CT brain 12-06-2021- Undisplaced fracture seen in the right frontal bone extending into the superior and lateral wall of right orbit. Undisplaced fracture greater wing of sphenoid on the left side with extension into lateral wall of left orbit, lateral wall maxillary sinus and temporal bone. Periorbital soft tissue hematoma seen on left side noted. Minimal hyperdense areas seen along the falx – small hematoma. Ill defined hyperdense area seen at the grey white matter junction in left temporal region - ? Hemorrhagic contusion.

Plain CT cervical and dorsolumbar spine 12-06-2021- Normal heights and alignment of vertebral bodies. Fracture 6th, 7th and 8th ribs noted on right side posterior aspect. Normal lung fields. No pneumoperitoneum or free fluid in the abdomen.

CT brain repeat 13-06-2021- Small hemorrhagic contusion noted in left posterior temporal lobe with mild perilesional edema. Mild increase in size compared to previous CT dated 12/06/2021. No midline shift or mass effect. No hydrocephalus. Prominent extracerebral CSF spaces bilateral frontal region. Periorbital soft tissue hematoma seen on left side. Fractures as described in previous scan. Mucosal thickening both ethmoid air cells and left maxillary sinus.

CT brain 15-06-2021- Small hemorrhagic contusion noted in left posterior temporal lobe with mild perilesional edema. Status quo as compared to the CT dated 13/06/2021. Left parafalcine hyperdensity in the high parietal region. Right parafalcine subdural hyperdensity , measuring 9x2mm. No parenchymal edema/ mass effect. No midline shift or mass effect. No hydrocephalus. Prominent extracerebral CSF spaces bilateral frontal region. Periorbital soft tissue hematoma seen on left side. Fractures as described in previous scan. Mucosal thickening both ethmoid air cells and left maxillary sinus.

MRI brain 20-06-2021- Multiple foci of blooming noted in right frontal corona radiata and bilateral temporal region and right posterolateral midbrain, at the grey – white matter junction - suggestive of hemorrhagic DAI – stage 3. Multiple foci of diffusion restriction noted in dorsolateral midbrain, periaqueductal region, left superior cerebellar peduncle. Multiple cortical based areas of

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diffusion restriction noted in right temporal lobe, left medial temporal lobe, left parietal region– not corresponding to blooming in SWI sequence – likely represent non hemorrhagic DAI. T2 FLAIR hyperintense area showing blooming and diffusion restriction noted in left posterior temporal lobe. –status quo as compared to previous CT dated 15/06/2021. Subacute subdural hematoma noted in bilateral parietooccipital region. FLAIR hyperintense SAH noted in bilateral occipital lobe. T2 hyperintense FLAIR hypointense subdural collection noted in both cerebral hemisphere, maximum thickness measuring 9.7 mm. - ? Subdural hygroma.

MRI brachial plexus and cervical spine 20-06-2021- Right brachial plexus root, trunk and division show mild thickening and T2 hyperintense signal. Rest of cord and terminal branches of right brachial plexus appear normal in morphology and signal intensity.No evidence of root avulsion or meningocele. Seddon classification of nerve injury – grade II-III. Nodular and serpiginous structure noted in left supraclavicular region , which show IR hyperintense signal – probably vascular malformation.

Surgical details

Surgery Date : 13/06/2021
Surgery Name : Right sided ICP transducer insertion + Scalp lacerated wound suturing
Description : Twist drill craniostomy done Codmann ICP transducer inserted Opening ICP - 5mmHg Closure done Frontal L/W sutured

Discussion

Patient was kept under strict neuro observation. Radiological evaluation in the form of CT brain on 12-06-2021 revealed hemorrhagic contusions over the left temporal region. Undisplaced fracture of right frontal bone. Undisplaced fracture of greater wing of sphenoid left side with extension in to lateral wall of maxillary sinus and temporal bone. Periorbital soft tissue hematoma+. CT whole spine revealed fracture 6th, 7th and 8th rib on the right posterior aspect. No pneumoperitoneum or free fluid. Serial radiological evaluation in the form of CT brain revealed mild increase in the hemorrhagic contusion. In view of radiological findings and neurological status patient was taken up for right sided ICP insertion and scalp wound suturing under GA on 13-06-2021. Post operatively patient was continued on ventilator under relaxants. He was treated with antibiotics, antiepileptics, antacids, analgesics, steroids and other supportive measures. Relaxants were stopped after 24 hours to assess neurological status. ICP was stable for 24 hours. In view of poor sensorium and for better tracheobronchial toileting patient underwent tracheostomy under GA on 15-06-2021 and was completely weaned off ventilator. Diabetology consultation (Dr. Jasim) was sought as patient is known

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case of diabetes and was managed as per their orders. Ophthalmology consultation (Dr. Haris) was sought in view of orbital wall fracture and was managed as per their orders. CTVS consultation was sought for multiple rib bone fracture. CTVS consultation (Dr. Sujith) was sought for multiple rib bone fracture and was managed as per their orders. OMFS consultation(Dr.Jojo) was sought for zygomatic and maxillary sinus fracture and was managed as per their orders. MRI brain with MRI cervical spine was done under GA on 28.6.21 which revealed grade 3 diffuse axonal injury. MRI CS spine with right brachial plexus was done on 20.6.21 which revealed seddon classification grade II-III nerve injury. During hospital stay patient had shown significant improvement in his symptoms. Tracheostomy stoma was closed. Patient tolerating oral feeds. Complete suture removal done. Surgical site noted to be clean and healed. Hence patient is being discharged with plan to review in NS OPD after one month with CT brain.

Condition on Discharge

Patient symptomatically better
Conscious, oriented
PEARL
Afebrile
Vitals stable
RIGHT Upper limb paucity +
Ambulated few steps
On condom catheter insitu
Surgical site clean and healed
On oral feeds

Advice on Discharge

Tab. Roxim	500mg	1-0-1 x 5 days
Tab. Pan	40mg	1-0-0 x 5 days
Tab. Lofecam	8mg	1-0-1 x 5 days
Tab. Nuhenz		1-0-0 x 1 month
Tab. Levigress	500mg	1-0-1 x 1 month
Tab. Colihenz	500mg	1-0-1 x 1 month
Tab. Benalgis		1-0-0 x 1 month
Zylopred eye drop		1-1-1 x 1 month

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Moistane eye drop — 6th hourly x 1 month

Soline eye drops — 1-1-1 x 1 month

Inj. Tresiba — 30 units s/c at 10:00pm to continue

Inj. Fiasp — 16----16---14 units s/c at 6:00am, 12:00pm, 6:00pm to continue

To follow Diabetology orders

To review in NS OPD after 1 month with CT brain

Urgent care- Review immediately in case of increasing headache, vomiting, drowsiness, limb weakness or any other significant complaints.

In case of any emergency contact: 7592022035

Prepared By:
Dr.VANDANA DOMINIC MBBS

Signed By:
Dr.AJAY KUMAR AJANVI MCh, DNB

Approved By:
Dr.SUDISH KARUNAKARAN MCH, MRCS(EDIN), FRCS NEURO SURGERY, PDF HOD NEURO SURGERY

For Any Emergency Please Contact : 0484 2772773 (Neuro OPD 9AM - 5PM) and 0484-2772464 (Neuro ICU)