MORTALITY REVIEW MEET

DEPARTMENT OF GENERAL MEDICINE

17/12/2021

- **27 years old, Male patient**
- **Kodavalur, Nellore**
- **Date of admission – 17/10/2021, 12:15 PM**
- **Date of death – 27/10/2021, 4:40 PM**
- **Duration of hospital stay – 11 days**

HISTORY OF PRESENT ILLNESS:

- Alleged consumption of unknown quantity of MONOCHROTOPHOS (organophosphate insecticide) at around 6:30 AM at his residence at Kodavalur,
- Patient was taken to local hospital, gastric lavage was done, and atropine (5 ampoules) was given.
- h/o 5-6 episodes of vomitings
- h/o 2 – 3 episodes of loose stools
- Later patient was referred to higher center for further management.

- No h/o involuntary micturition / defecation / excessive salivation
- No h/o loss of consciousness / seizures

PAST HISTORY :

- Not k/c/o epilepsy / diabetes mellitus / thyroid disorders / hypertension

PERSONAL HISTORY :

- Consumes mixed diet
- Normal sleep and appetite
- Normal bowel and bladder habits
- Non-smoker, alcoholic

ON EXAMINATION:

- Patient was conscious, coherent, oriented
- No pallor/icterus/clubbing/ generalised lymphadenopathy / pedal edema

VITALS :

Pulse rate – 110/min

BP – 110/70 mmHg

RR- 24 cycles/minute

SpO2 – 97% on room air

Temperature – 100 F

CBG – 138 mg/dL

- SYSTEMIC EXAMINATION :

CVS – tachycardia present,

S1, S2 Heard, no murmurs

RS – Normal vesicular breath sounds heard

no added sounds

P/A – soft, non-tender, no organomegaly

CNS – conscious, coherent, oriented

no focal neurologic deficit

pupils – bilateral 3 mm, sluggishly reacting to light.

- Gastric lavage was done, and Patient was given activated charcoal (1 gm/kg) through RT.
- Inj ATROPINE 2 mg IV was given stat, patient started on 2ml/hr IV infusion
- Inj PAM 2 gm IV STAT
- Patient shifted to ICU for further management.

INVESTIGATIONS
At Admission

- Hb – 13.6 gm/dl
  TLC – 18,400/mm
  N/L/M/E/B – 86/09/05/00/00
  Platelet – 2,86,000/mm

- Serum urea – 20 mg/dl
  creatinine – 1.18 mg/dl

- Serum electrolytes – Na/K/Cl – 139/4.3/99 mEq/L

PH	7.39
pCO2	34 mmHg
pO2	87 mmHg
HCO3- LACTATE	20.6 mmol/L 3.6 mmol/L


Status: ACCEPTED
17/10/2021 12:49:36
Sample Type:
Arterial
Sample No.: 98
Patient:
Name:
Sex:
Instrument:
Model: GEM 3500
S/N: 19091663

Measured (37.0C)

pH	7.39	
#pCO2	34	mmHg
pO2	87	mmHg
Na+	145	mmol/L
#K+	3.1	mmol/L
!Ca++	2.93	mg/dL
#Glu	181	mg/dL
#Lac	3.6	mmol/L
Hct	41	%

Derived Parameters

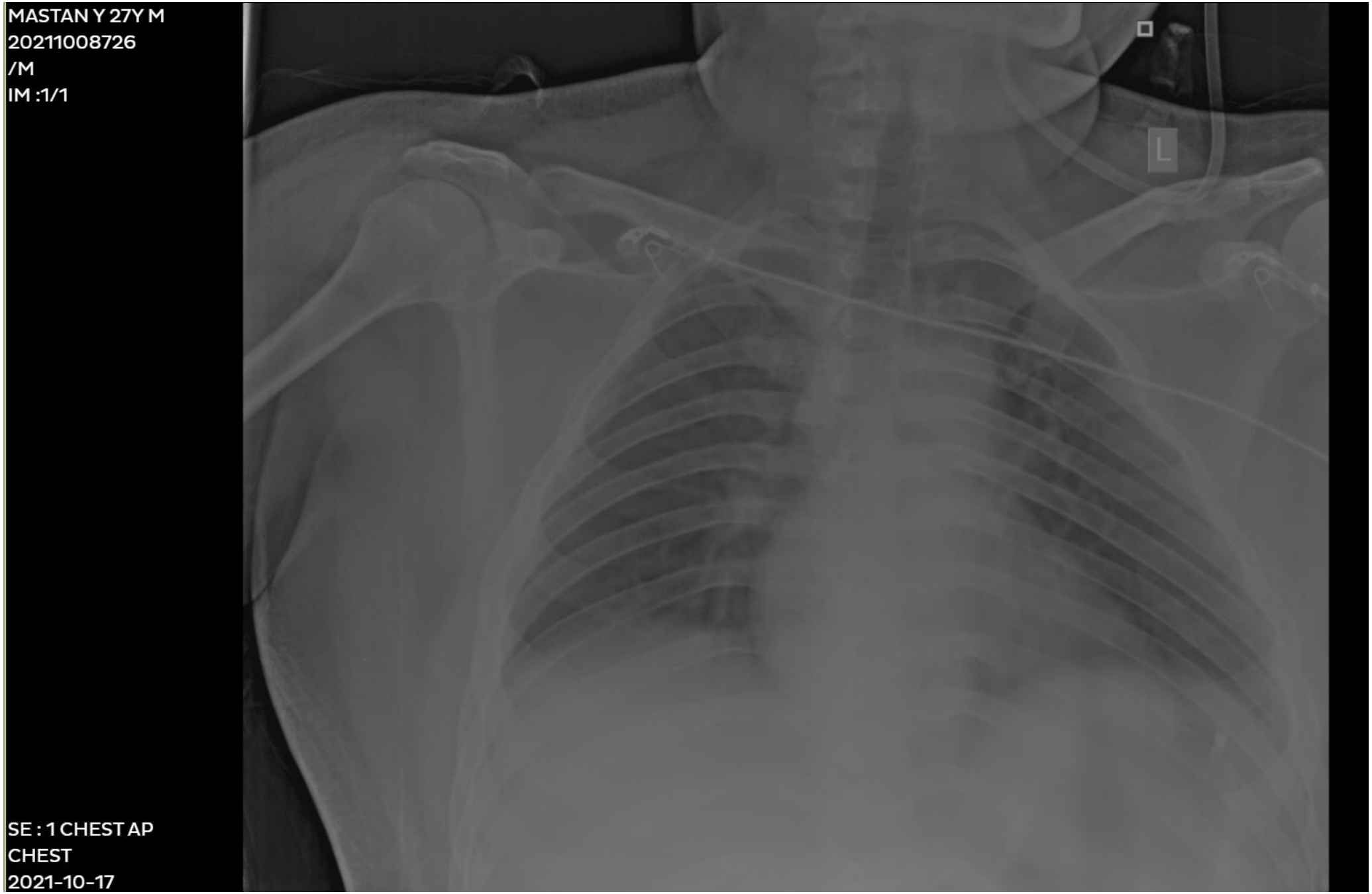
Ca++(7.4)	2.93	mg/dL
#HCO3-	20.6	mmol/L
HCO3std	22.0	mmol/L
#TCO2	21.6	mmol/L
#BE(ecf)	-4.4	mmol/L
#BE(B)	-3.7	mmol/L
SO2c	97	%
#THbc	12.7	g/dL

!=Outside critical limit
#=Outside ref. range

- ESR – 25 mm/hr, CRP - 9 mg/dl
- serum Calcium – 9.0 mg/dl
- Serum Magnesium – 2.1 mg/dl
- Serum cholinesterase – 885 mg/dl
- LFT – Serum total bilirubin – 0.47 mg/dl , Direct – 0.28 mg/dl
  SGOT – 33 U/L, SGPT – 67 U/L, ALP – 181 U/L,
  Total protein – 6.5 gm/dl,
  Serum albumin – 4.4 gm/dl, Globulin – 2.1 gm/dl

- CUE – pus cells – 2-4/ HPF , Bacteria – nil, sugar – nil, albumin – trace, ketone bodies – negative

- ECHO – tachycardia present, normal LV function, EF – 58% trivial MR no LA/LV clot, no PE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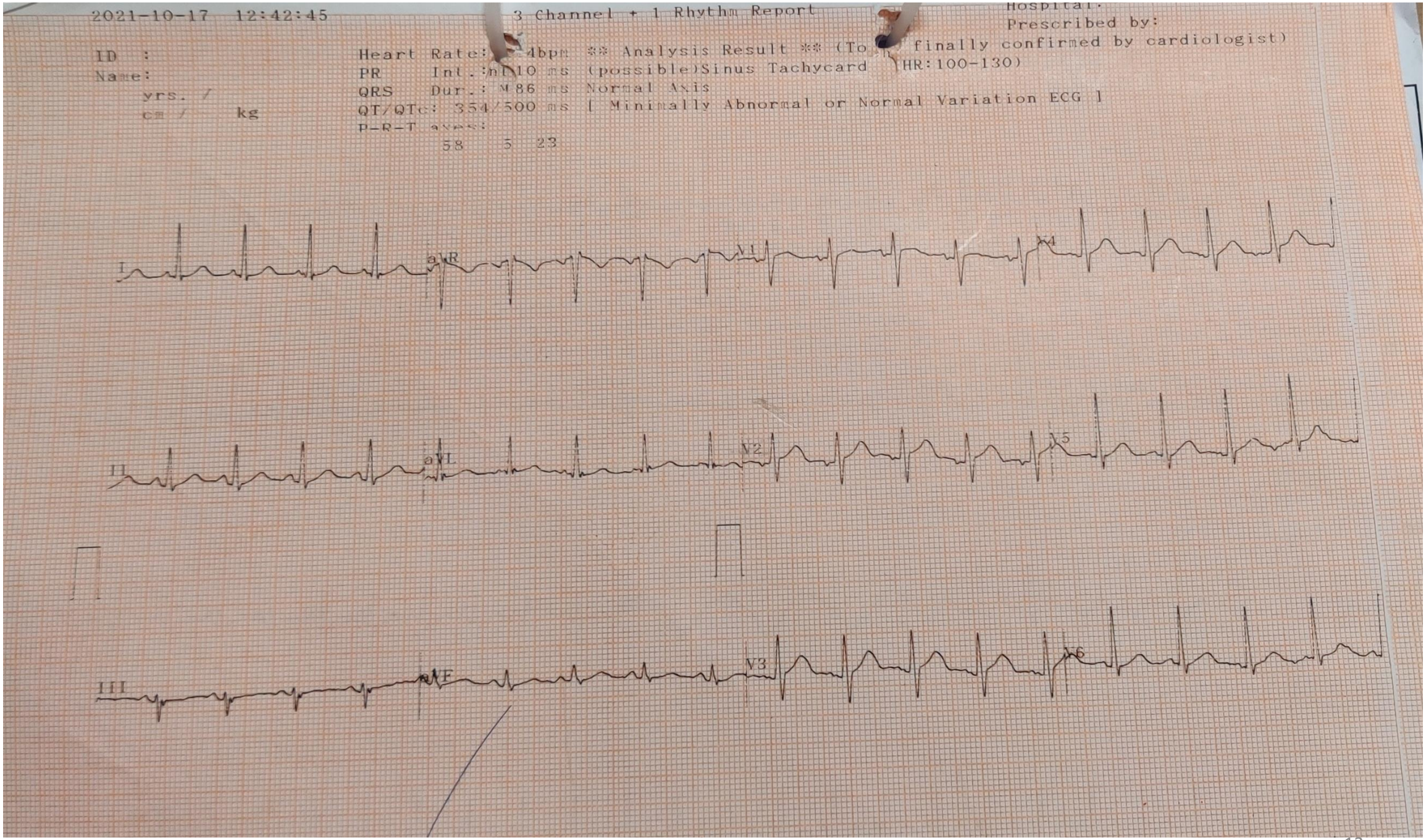

2021-10-17 12:42:45
3 Channel + 1 Rhythm Report
Hospital:
Prescribed by:
ID :
Name:
yrs. /
cm / kg
Heart Rate: 4bpm ** Analysis Result ** (To be finally confirmed by cardiologist)
PR Int.: 110 ms (possible)Sinus Tachycard (HR:100-130)
QRS Dur.: 86 ms Normal Axis
QT/QTc: 354/500 ms [Minimally Abnormal or Normal Variation ECG]
P-R-T axes:
58 5 23
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6

1. IV fluids @ 75 ml/hr with 1 amp OPTINEURON IV OD 1-0-0
2. Inj ATROPINE IV infusion @ 2ml/hr
3. Inj PAM 1 gm IV BD 1-0-1
4. INJ PIPERACILLIN + TAZOBACTUM 4.5 gm IV TID 1-1-1
5. Inj PANTOP 40mg IV 0D 1-0-0
6. Inj EMESET 4 mg IV BD 1-0-1
7. Inj DOLO 1gm IV SOS(if temp >101 F)
8. TAB DOLO 650MG RT TID 1-1-1
9. Syp SUCRAFIL 10ml RT TID

DAY 1 HOSPITAL STAY (17/10/2021):

- 6:00 PM : Patient was conscious, coherent, oriented to time, place and person.

  Inj Atropine IV Infusion @ 2 ml/hr

VITALS	SYSTEMIC EXAMINATION
PULSE – 106/min, Regular	CVS – S1,S2 heard , no murmurs
BP – 110/90 mmHg	RS – normal breath sounds , no added sounds
RR – 18 cycles/minute SpO2 – 99% on room air	P/A – soft, non-tender
Temperature – 98 F CBG - 123 mg/dl	CNS – E4V5M6, pupils – B/L, 3 mm, sluggishly reacting to light

- 10:00 PM

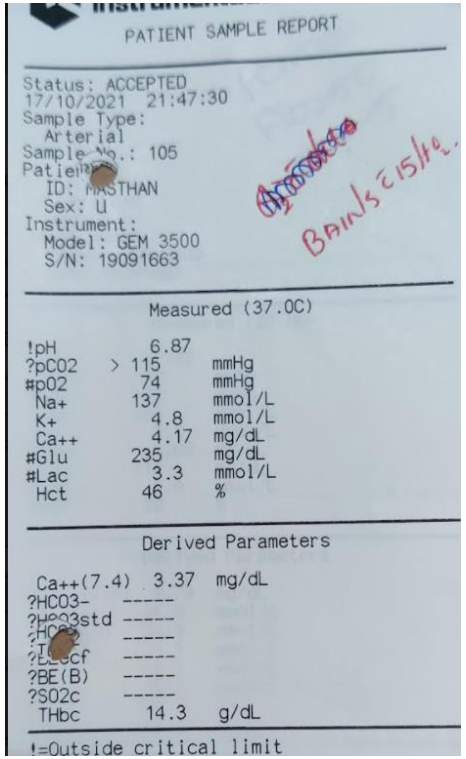
Patient was desaturating (spo2 – 40 – 60 %) and had decreased responsiveness, i/v/o this and for airway protection, patient was intubated and connected to mechanical ventilator

(PRVC mode, FiO2 – 100%, PEEP – 5 cm H20)

- ABG –

On Bains

pH	6.87
PCO2	> 115 mmHg
PO2	74 mmHg
LACTATE	3.3 mmol/L
HCO3-	Non-recordable


PATIENT SAMPLE REPORT

Status: ACCEPTED
17/10/2021 21:47:30
Sample Type:
Arterial
Sample No.: 105
Patient
ID: MASTHAN
Sex: U
Instrument:
Model: GEM 3500
S/N: 19091663

Measured (37.0C)

!pH	6.87	
?pCO2	> 115	mmHg
#pO2	74	mmHg
Na+	137	mmol/L
K+	4.8	mmol/L
Ca++	4.17	mg/dL
#Glu	235	mg/dL
#Lac	3.3	mmol/L
Hct	46	%

Derived Parameters

Ca++(7.4)	3.37	mg/dL
?HCO3-	-----	
?HCO3std	-----	
?TCO2	-----	
?ctHbcf	-----	
?BE(B)	-----	
?SO2c	-----	
THbc	14.3	g/dL

!=Outside critical limit

- Post – intubation vitals –

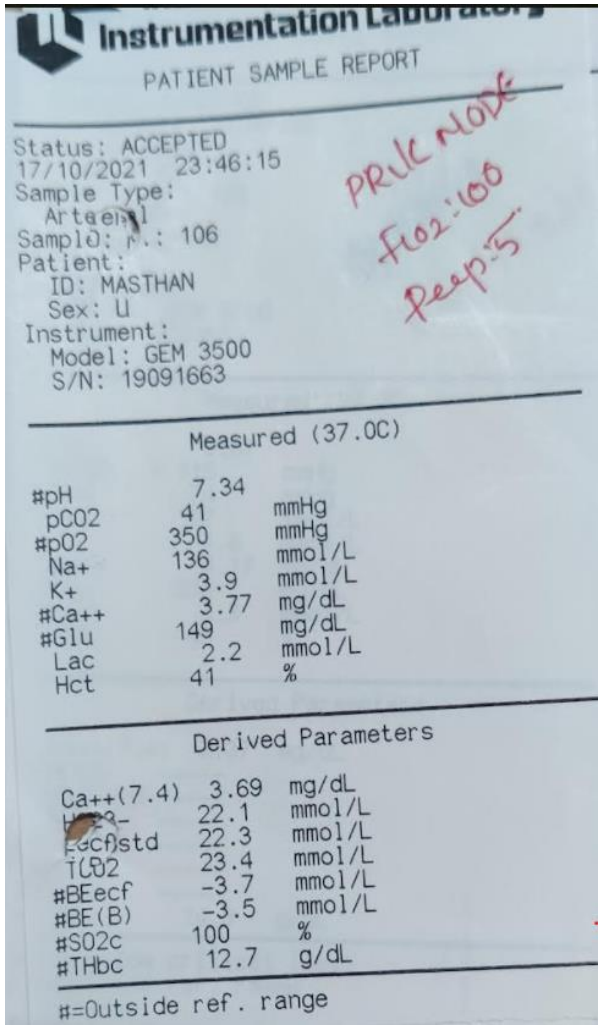
Pulse – 130/ min

Bp – 150/80 mmHg

Spo2 – 100%

CBG – 130 mg/dl

- Injection ATROPINE IV infusion gradually increased to 15 mg/hr.



Instrumentation Laboratory

PATIENT SAMPLE REPORT

PRVC MODE
FiO2: 100
Peep: 5

Status: ACCEPTED
17/10/2021 23:46:15
Sample Type:
Arterial
Sample #.: 106
Patient:
ID: MASTHAN
Sex: U
Instrument:
Model: GEM 3500
S/N: 19091663

Measured (37.0C)

#pH	7.34	
pCO2	41	mmHg
#pO2	350	mmHg
Na+	136	mmol/L
K+	3.9	mmol/L
#Ca++	3.77	mg/dL
#Glu	149	mg/dL
Lac	2.2	mmol/L
Hct	41	%

Derived Parameters

Ca++(7.4)	3.69	mg/dL
[illegible]	22.1	mmol/L
[illegible]std	22.3	mmol/L
TCO2	23.4	mmol/L
#BEecf	-3.7	mmol/L
#BE(B)	-3.5	mmol/L
#SO2c	100	%
#THbc	12.7	g/dL

#=Outside ref. range

DAY 2 (18/10/2021)

- Patient is on mechanical ventilator, PC mode, FiO2- 50%, PEEP – 5 cm H2O,
- Patient is sedated, on MIDAZOLAM + FENTANYL @ 3 ml/hr IV infusion.
- On inj ATROPINE 15ml/hr IV infusion.
- Fever spike present

VITALS	SYSTEMIC EXAMINATION
PULSE – 102/min, Regular	CVS – S1,S2 heard , no murmurs
BP – 130/90 mmHg	RS – normal breath sounds , no added sounds
RR – 28 cycles/minute SpO2 – 100% on MV	P/A – soft, non-tender, bowel sounds+
Temperature – 100.3 F	CNS – E3VtM6, pupils – B/L pinpoint pupils

INVESTIGATIONS:

- Hb – 13.5 gm/dl

TLC – 14,200/mm

N/L/M/E/B – 87/08/05/00/00

Platelet – 2,61,000/mm

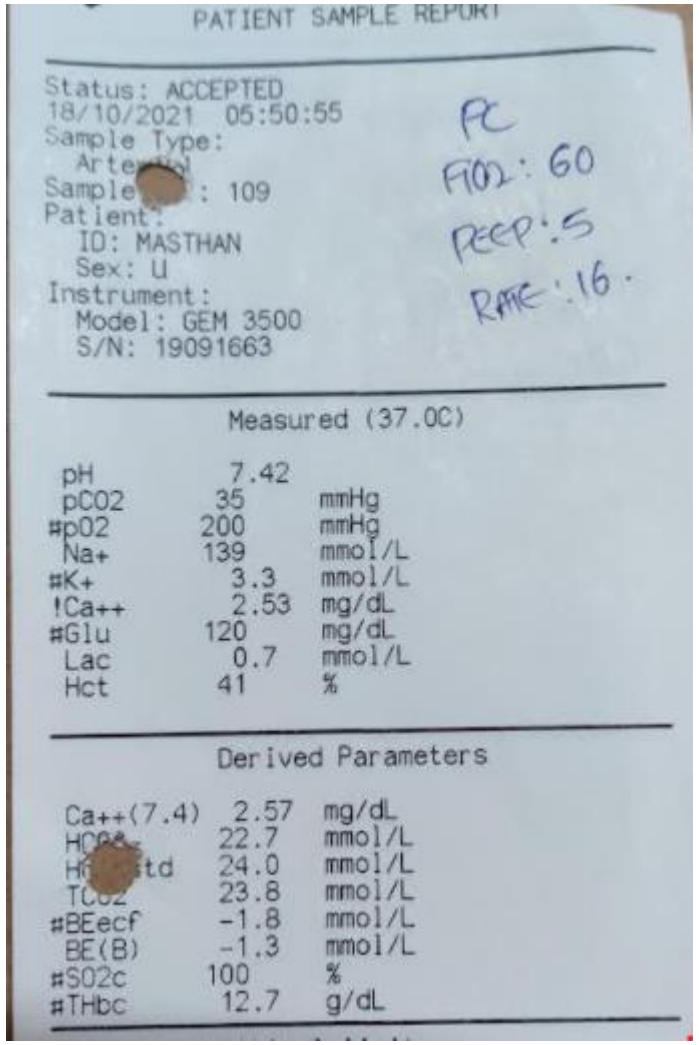
- Serum urea – 21.5 mg/dl

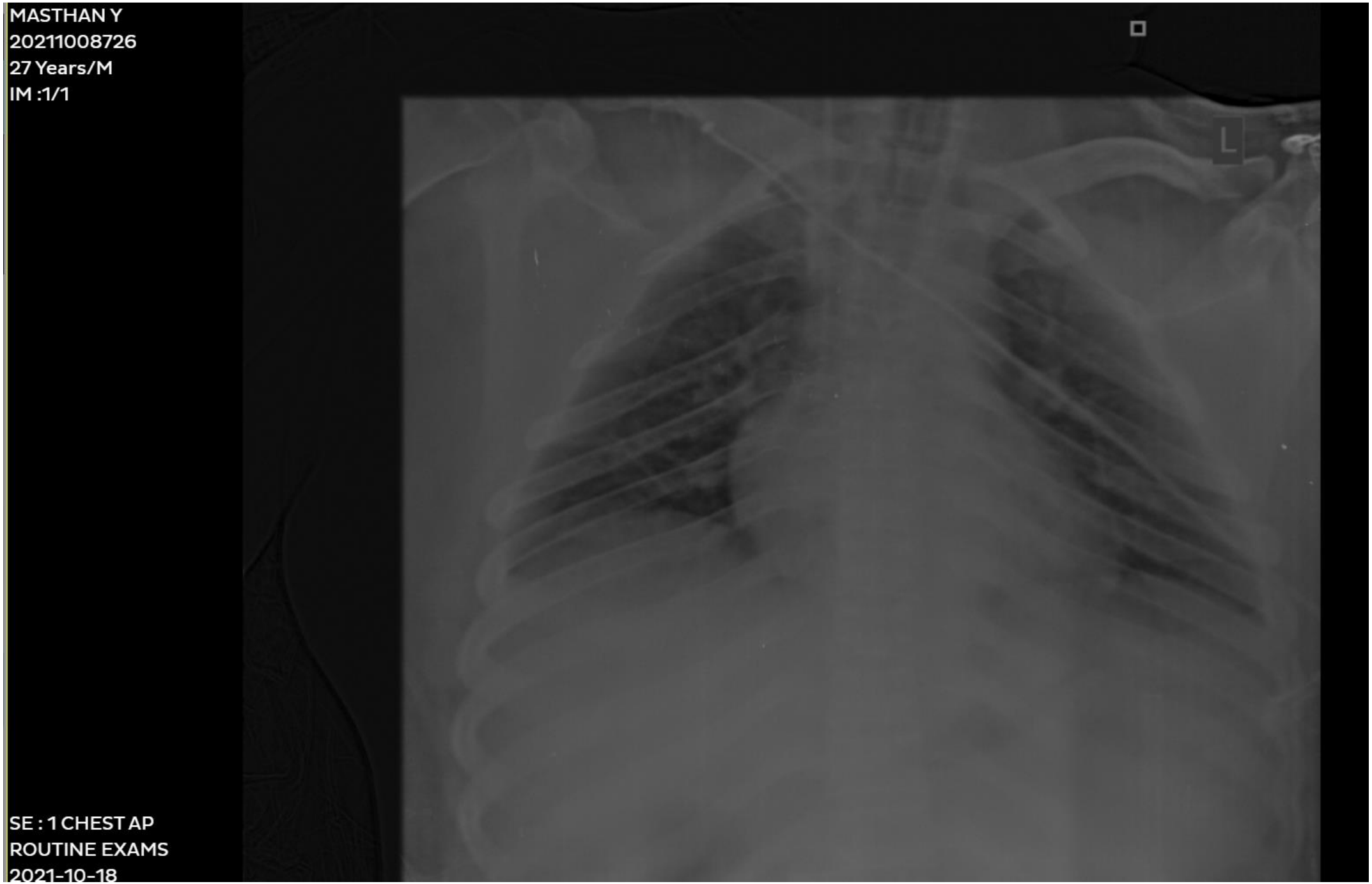
  creatinine – 0.89 mg/dl

- Serum electrolytes – Na/K/Cl – 137/4.3/98 mEq/L
- RTPCR for COVID19 – NEGATIVE

- LDH – 266 U/L
- CK-NAC – 218 IU/L
- ABG –

pH	7.42
PCO2	35 mmHg
HCO3-	24 mmol/L
LACTATE	0.7 mmol/L

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27 Years/M
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ROUTINE EXAMS
2021-10-18

TREATMENT:

- INJ ATROPINE IV infusion @ 15 ml/hr
- Rest of the treatment continued

DAY 3 (19/10/2021)

- Patient is on mechanical ventilator, PC mode , FiO2 – 50%
- Fever spikes present

VITALS	SYSTEMIC EXAMINATION
PULSE – 94/min, Regular	CVS – S1,S2 heard , no murmurs
BP – 110/80 mmHg	RS – normal breath sounds , no added sounds
RR – 16 cycles/minute SpO2 – 100% on MV	P/A – soft, non-tender, bowel sounds+
Temperature – 99.8 F	CNS – E2VtM1, pupils – B/L pinpoint pupils

- Hb – 13.0 gm/dl

TLC – 10,500/mm

N/L/M/E/B – 76/18/06/00/00

Platelet – 2,30,000/mm

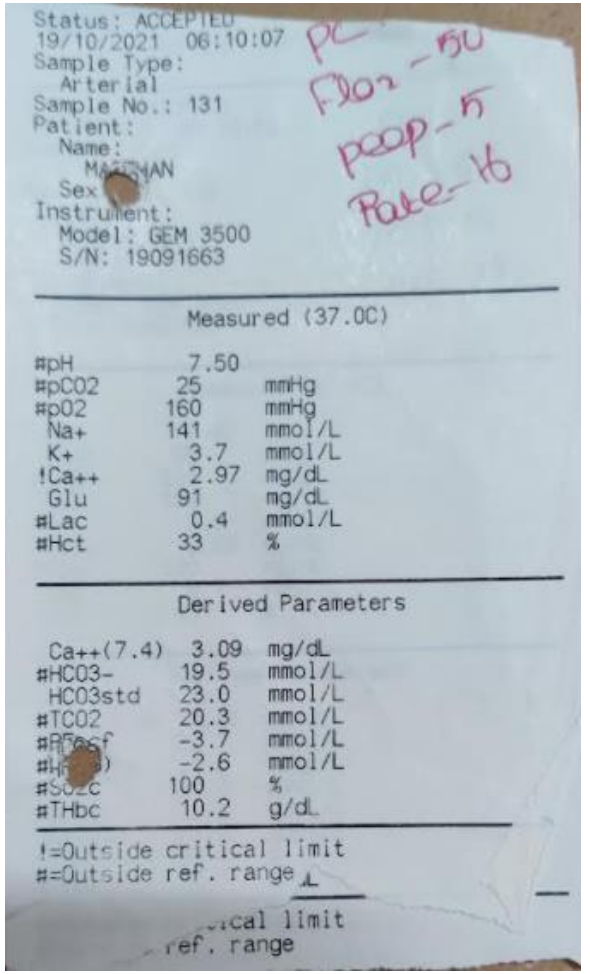
- Serum urea – 27.5 mg/dl

  creatinine – 0.7 mg/dl

- Serum electrolytes – Na/K/Cl – 139/3.5/100 mEq/L

- SERUM CHOLINESTERASE – 744 U/L
- ABG –

pH	7.5
PCO2	25 mmHg
PO2	160 mmHg
HCO3-	19.5 mmol/L
LACTATE	0.4 mmol/L



TREATMENT:

- INJ ATROPINE IV infusion @ 25 ml/hr
- Rest of the treatment continued

- 1:00 PM

pulse rate – 94/min

Pupils – B/L 1 mm with 25 ml/hr ATROPINE iv infusion

INJ ATROPINE 50mg IV bolus given

DAY 4 (20/10/2021)

- Patient is on mechanical ventilator, PC mode, FiO2 – 50%, PEEP – 5cm H2O
- Continuous fever spikes present

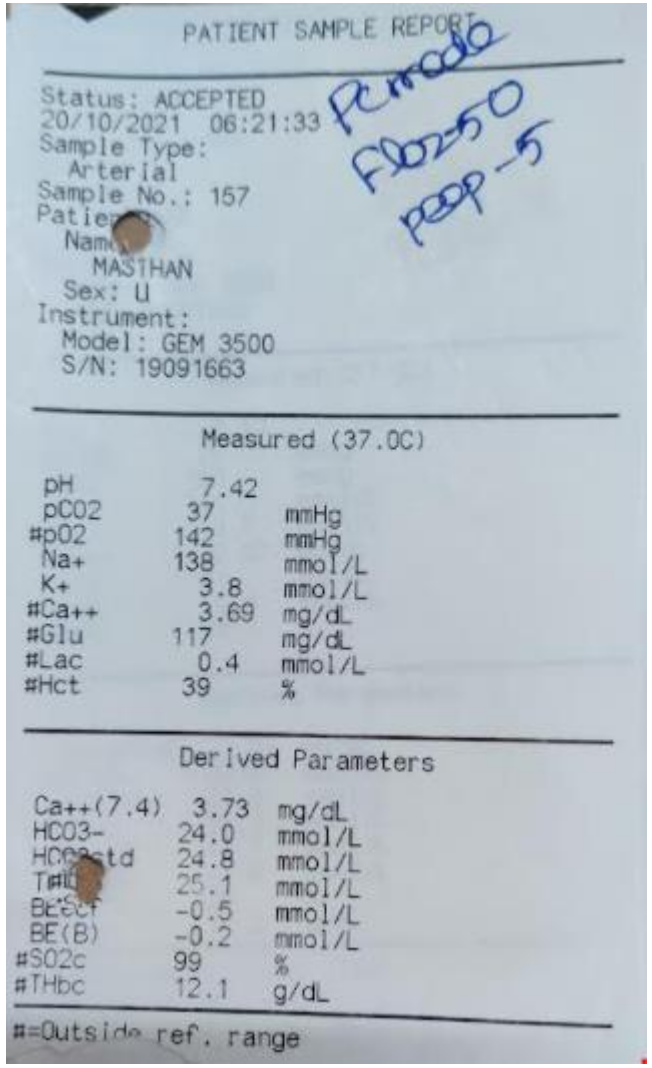
VITALS	SYSTEMIC EXAMINATION
PULSE – 98/min, Regular	CVS – S1,S2 heard , no murmurs
BP – 150/90 mmHg	RS – normal breath sounds , no added sounds
RR – 16 cycles/minute SpO2 – 100% on MV	P/A – soft, bowel sounds+
Temperature – 99.8 F	CNS – E2VtM4, pupils – B/L 4 mm NRL

- Hb – 12.4 gm/dl
  TLC – 10,100/mm
N/L/M/E/B – 77/17/06/00/00
Platelet – 2,05,000/mm

- Serum urea – 13.0 mg/dl
  creatinine – 0.74 mg/dl

- Serum electrolytes – Na/K/Cl – 140/3.4/101 mEq/L

pH	7.42
PCO2	37 mmHg
HCO3-	24.8 mmol/L
LACTATE	0.4 mmol/L


PATIENT SAMPLE REPORT

Status: ACCEPTED
20/10/2021 06:21:33
Sample Type:
Arterial
Sample No.: 157
Patie
Nam
MASTHAN
Sex: U
Instrument:
Model: GEM 3500
S/N: 19091663

PC mode
FIO2 50
PEEP -5

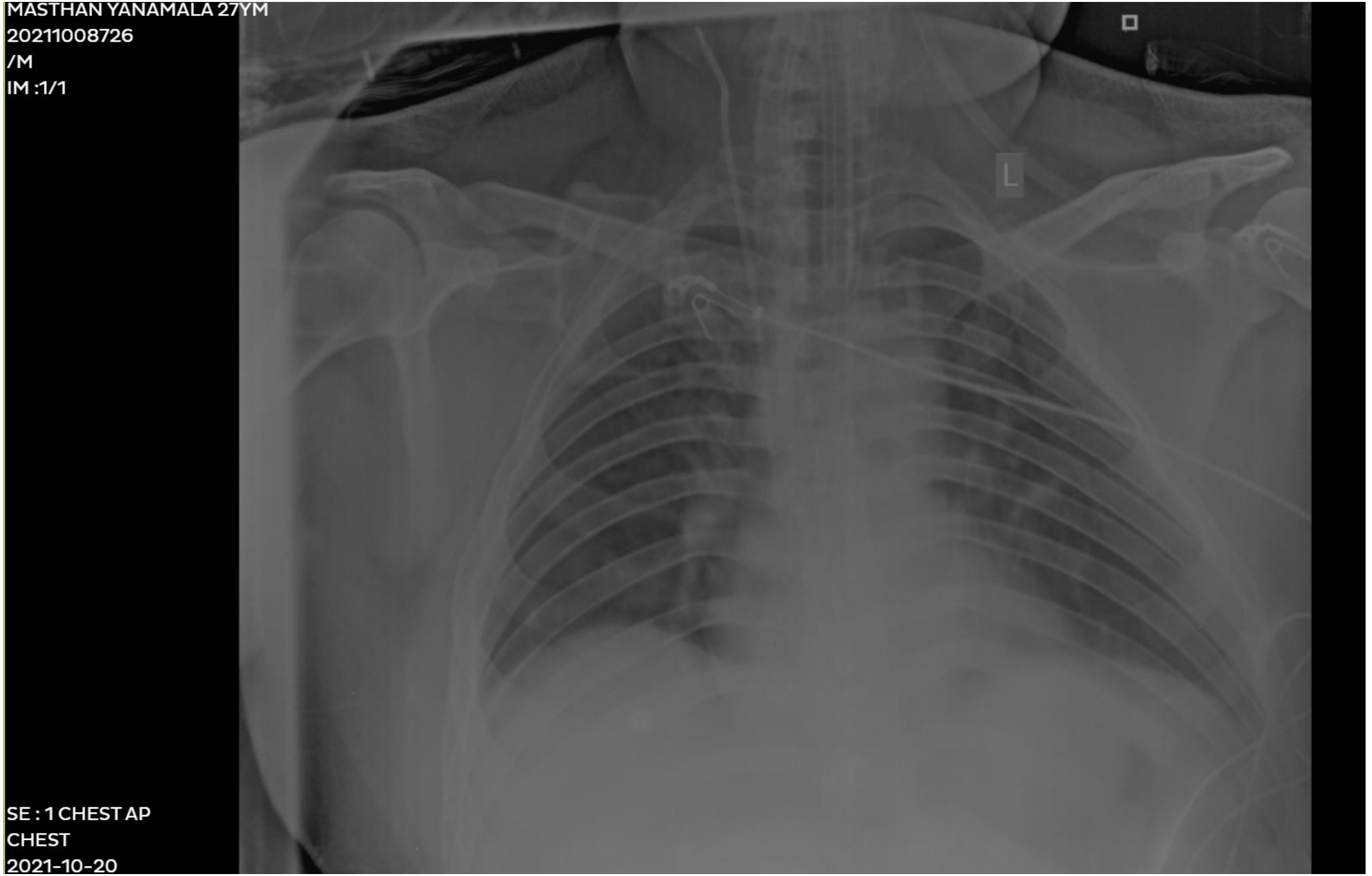
Measured (37.0C)

pH	7.42	
pCO2	37	mmHg
#pO2	142	mmHg
Na+	138	mmol/L
K+	3.8	mmol/L
#Ca++	3.69	mg/dL
#Glu	117	mg/dL
#Lac	0.4	mmol/L
#Hct	39	%

Derived Parameters

Ca++(7.4)	3.73	mg/dL
HCO3-	24.0	mmol/L
HC std	24.8	mmol/L
T	25.1	mmol/L
BE ecf	-0.5	mmol/L
BE(B)	-0.2	mmol/L
#SO2c	99	%
#THbc	12.1	g/dL

#=Outside ref. range


MASTHAN YANAMALA 27YM
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CHEST
2021-10-20

TREATMENT

- Inj ATROPINE IV infusion @ 10ml/hr
- Inj KCL IV infusion(60 mEq) @ 5 ml/hr
- Inj LMWX 60 mg SC OD 1-0-1
- Rest of the treatment continued

DAY 5 (21/10/2021)

- On mechanical ventilator, PC mode, FiO2- 60%
- Fever spikes present

VITALS	SYSTEMIC EXAMINATION
PULSE – 108 /min	CVS – S1 S2 heard, no murmurs
BP – 150/90 mmHg	RS – bilateral airentry present, Normal breath sounds, no added sounds
RR - 28/min SpO2 – 96% on MV	P/A – soft
TEMP – 101 F	CNS – E3VtM5 Pupils – B/L, 4 mm NRL

- Hb – 13.8 gm/dl
  TLC – 8,100/mm
N/L/M/E/B – 76/16/06/02/00
Platelet – 2,35,000/mm

- Serum urea – 18 mg/dl
  creatinine – 0.9 mg/dl

- Serum electrolytes – Na/K/Cl – 143/3.9/103 mEq/L

pH	7.36
PCO2	45 mmHg
HCO3-	24.6 mmol/L
LACTATE	0.6 mmol/L


PATIENT SAMPLE REPORT

Status: ACCEPTED
21/10/2021 07:04:01
Sample Type:
Arterial
Sample No.: 192
Name:
MASTHAN
Sex: U
Instrument:
Model: GEM 3500
S/N: 19091663

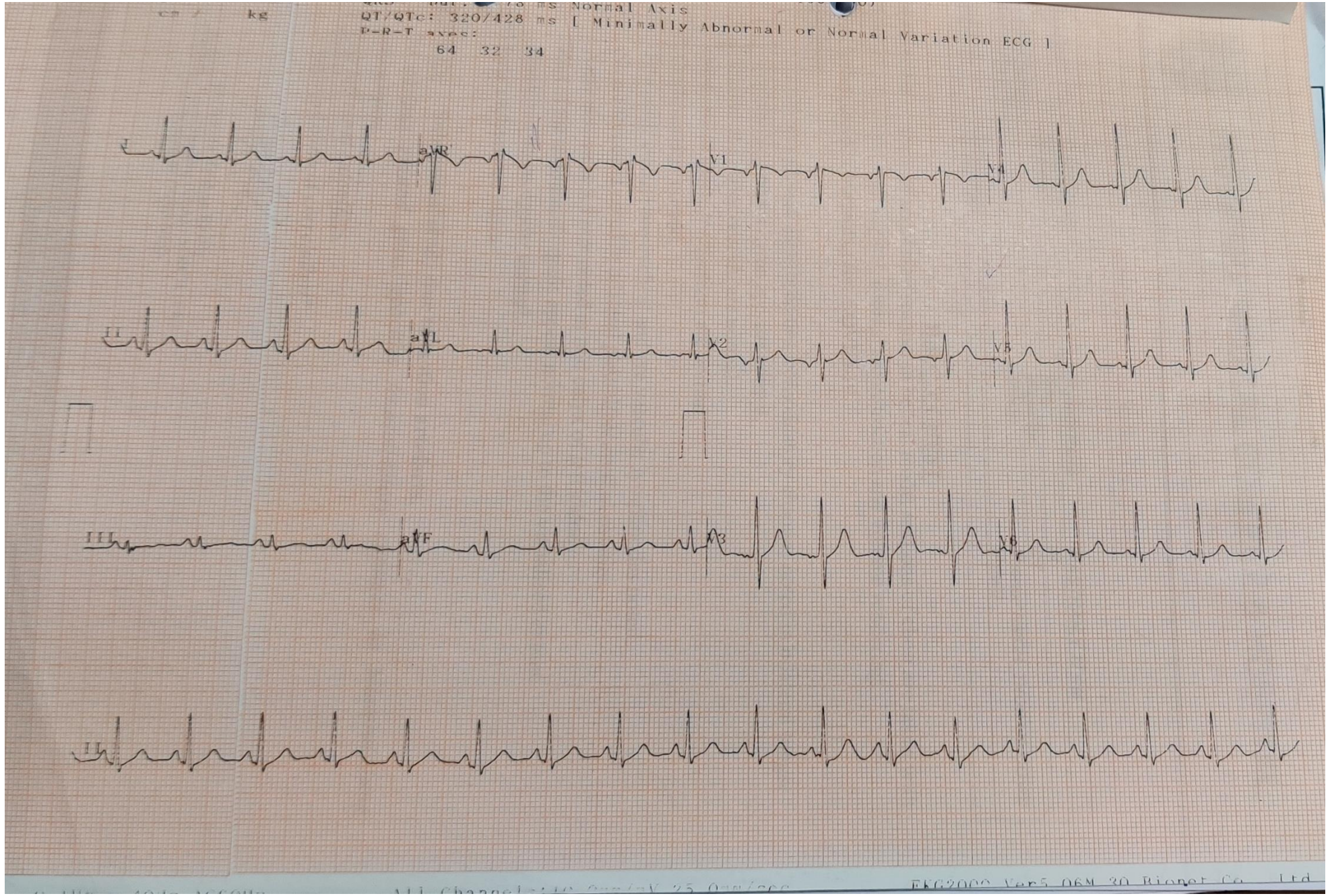
Measured (37.0C)

pH	7.36	
pCO2	45	mmHg
#pO2	143	mmHg
Na+	141	mmol/L
K+	3.5	mmol/L
?Ca++	Drift Error	
#Glu	134	mg/dL
Lac	0.6	mmol/L
#Hct	57	%

Derived Parameters

?Ca++(7.4)	-----	
HCO3-	25.4	mmol/L
#tCO2	24.6	mmol/L
pCO2	26.8	mmol/L
BEecf	-0.0	mmol/L
BE(B)	-0.5	mmol/L
#SO2c	99	%
THbc	17.7	g/dL

#=Outside ref. range
?=Review


kg
QT/QTc: 320/428 ms [Minimally Abnormal or Normal Variation ECG]
P-R-T axes:
64 32 34
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
FX2000 Ver5 OBM 3D Bionet Co., Ltd

1. RT feeds @ 60 ml/hr
2. IV fluids @ 75 ml/hr with 1 amp OPTINEURON IV OD 1-0-0
3. Inj ATROPINE IV infusion @ 5ml/hr
4. Inj PAM 1 gm IV BD 1-0-1
5. INJ PIPERACILLIN + TAZOBACTUM 4.5 gm IV TID 1-1-1
6. Inj PANTOP 40mg IV 0D 1-0-0
7. Inj EMESET 4 mg IV BD 1-0-1
8. Inj DOLO 1gm IV SOS(if temp >101 F)
9. Inj LMWX 40mg SC OD
10. Inj PERINORM 10mg IV BD 1-0-1
11. TAB DOLO 650MG RT TID 1-1-1
12. Syp SUCRAFIL 10ml RT TID
13. Nebulisation – BUDECORT BD

- 6 PM – patient on MV, PC mode, FiO2- 40%

  ATROPINE IV infusion decreased to 3 ml/hr,

  heart rate – 112/min

  pupils – B/L, 4 mm, not reactive to light

DAY 6 (22/10/2021)

- Patient is on Mechanical ventilator , SIMV mode , FiO2 – 40%, PEEP – 5 cm H2O
- Inj ATROPINE IV infusion @ 0.5 ml/hr

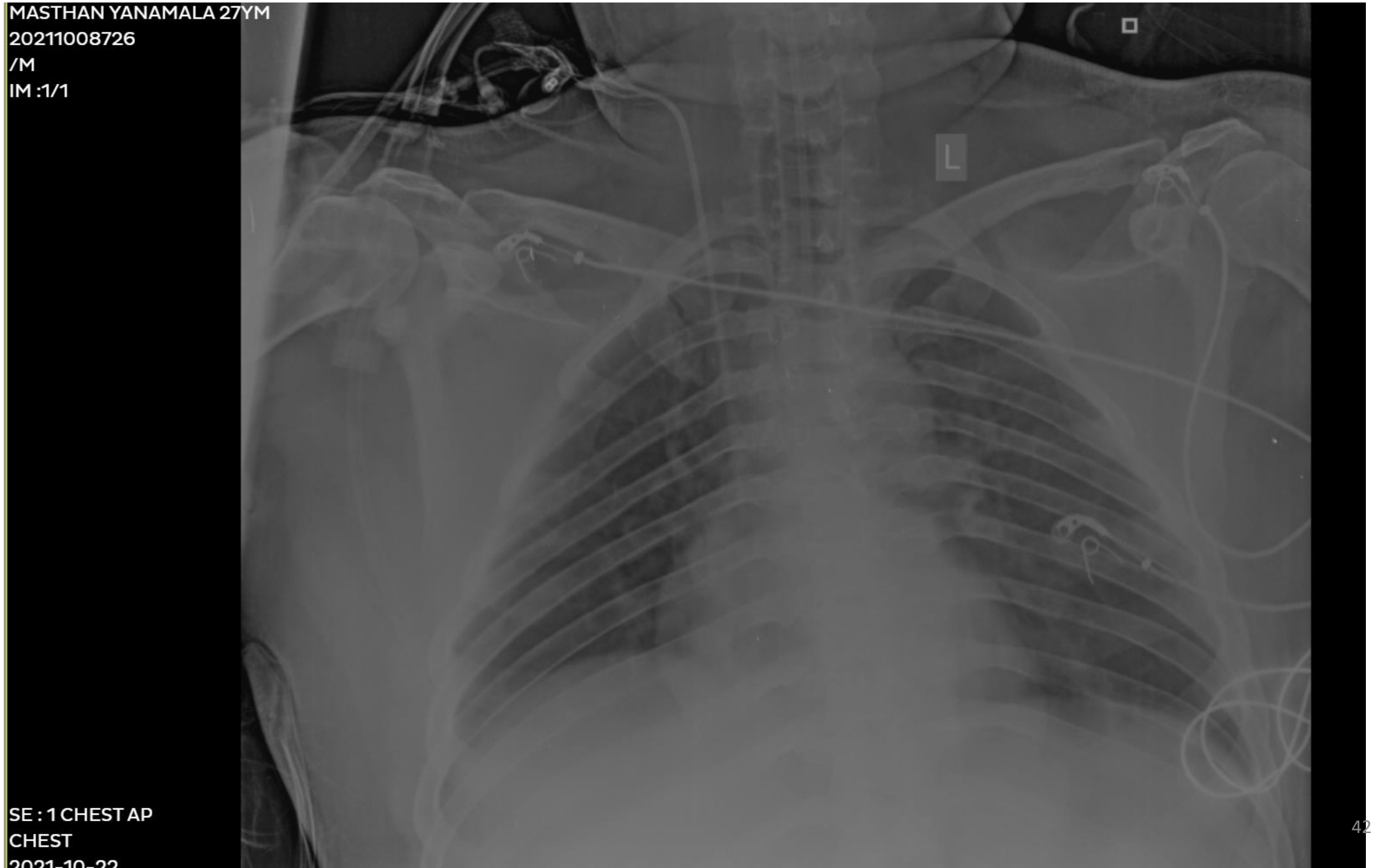
VITALS	SYSTEMIC EXAMINATION
PULSE – 100/min	CVS – S1 S2 heard, no murmur
BP – 130/80 mmHg	RS – normal breath sounds, no added sounds
RR – 22 cycles/min SPO2 – 98% on MV	P/A - soft
TEMP – 100.5 F	CNS – E4VtM6 Pupils – 4-5 mm, NRL

- Hb – 13.8 gm/dl
  TLC – 7,500/mm
N/L/M/E/B – 74/15/08/03/00
Platelet – 2,26,000/mm

- Serum urea – 33.9 mg/dl
  creatinine – 0.79 mg/dl

- Serum electrolytes – Na/K/Cl – 141/3.8/98 mEq/L

pH	7.43
PCO2	43 mmHg
HCO3-	28.5 mmol/L
LACTATE	0.5 mmol/L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DAY 7 (23/10/2021)

- Patient is on mechanical ventilator, SIMV mode , Fio2 – 40%, PEEP – 5 cm H20
- On Inj ATROPINE @ 2.5 ml/hr

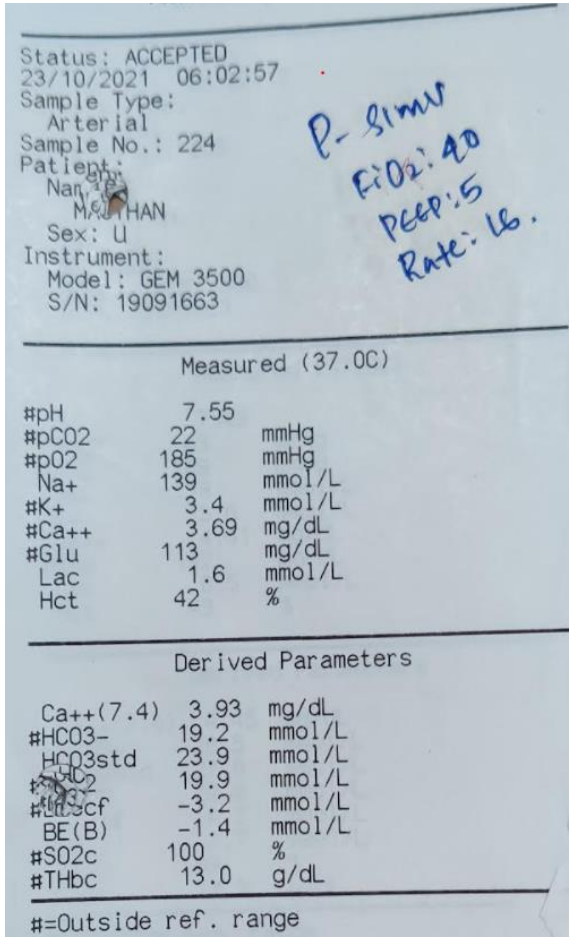
VITALS	SYSTEMIC EXAMINATION
PULSE – 120/min	CVS – Tachycardia +, S1 S2 heard
BP – 130/70 mmHg	RS – normal breath sounds no added sounds
RR – 16/min SpO2 – 100% with MV	P/A – soft, non-tender
TEMP – 100 F	CNS – E4VtM6 PUPILS – B/L 4 mm , sluggishly reactive

- Hb – 14.6 gm/dl
  TLC – 11,100/mm
N/L/M/E/B – 78/12/08/02/00
Platelet – 2,65,000/mm, PCV – 46%

- Serum urea – 18.5 mg/dl
  creatinine – 0.88 mg/dl

- Serum electrolytes – Na/K/Cl – 139/4.0/100 mEq/L

PH	7.55
PCO2	22 mmHg
PO2	185 mmol/L
HCO3-	19.2 mmol/L
LACTATE	1.6 mmol/L



- ET ASPIRATE FOR GRAM STAIN – plenty of pus cells, gram positive cocci arranged in pairs and clusters.

5:00 PM

- Patient is on MV
- Continuous fever spikes present
- Copious oral , ET secretions present
- Inj ATROPINE IV infusion gradually decreased to 1 ml/hr
- Inj GLYCOPYRROLATE 0.2 mg QID added
- Inj LINEZOLID 600mg IV BD added
- Rest of the treatment continued

DAY 8 (24/10/2021)

- Patient is on MV, SIMV mode, FiO2 – 40%, PEEP – 5 cm H20,
- Fever spikes present

VITALS	SYSTEMIC EXAMINATION
PULSE – 131/min	CVS – Tachycardia +, S1 S1 heard
BP – 150/90 mmHg	RS – Normal breath sounds, Right basal crepitations heard
RR – 18/min SpO2 – 96% on MV	P/A – soft, bowel sounds +
TEMP – 102 F	CNS – E4VtM6, Puipils – 4-5 mm, sluggishly reactive

- Hb – 15.9 gm/dl

TLC – 12,900/mm

N/L/M/E/B – 75/10/06/09/00

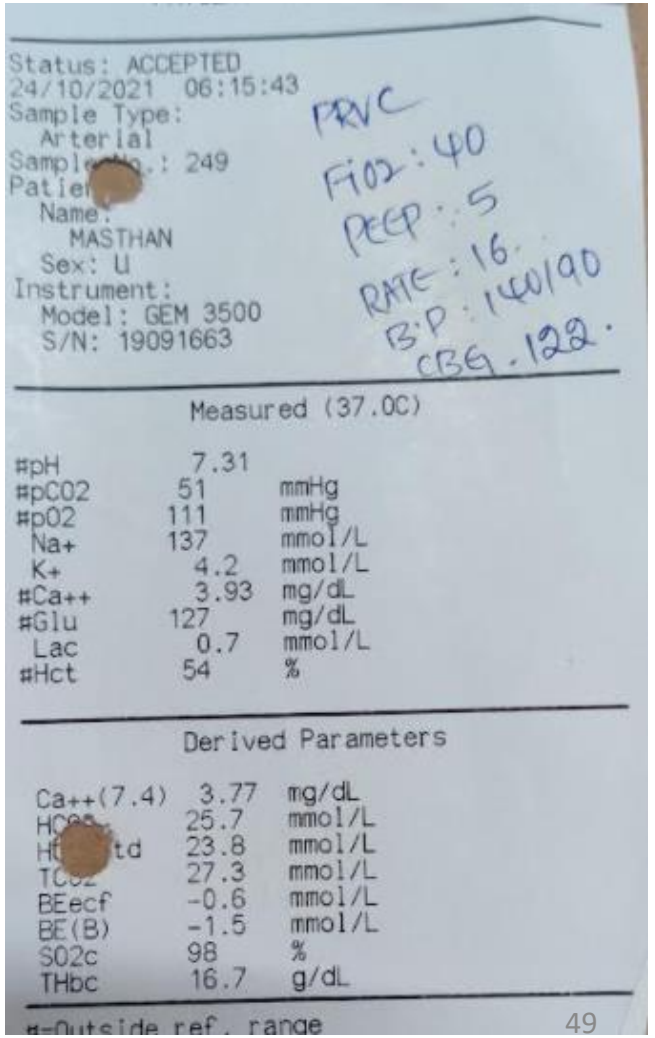
Platelet – 2,54,000/mm,

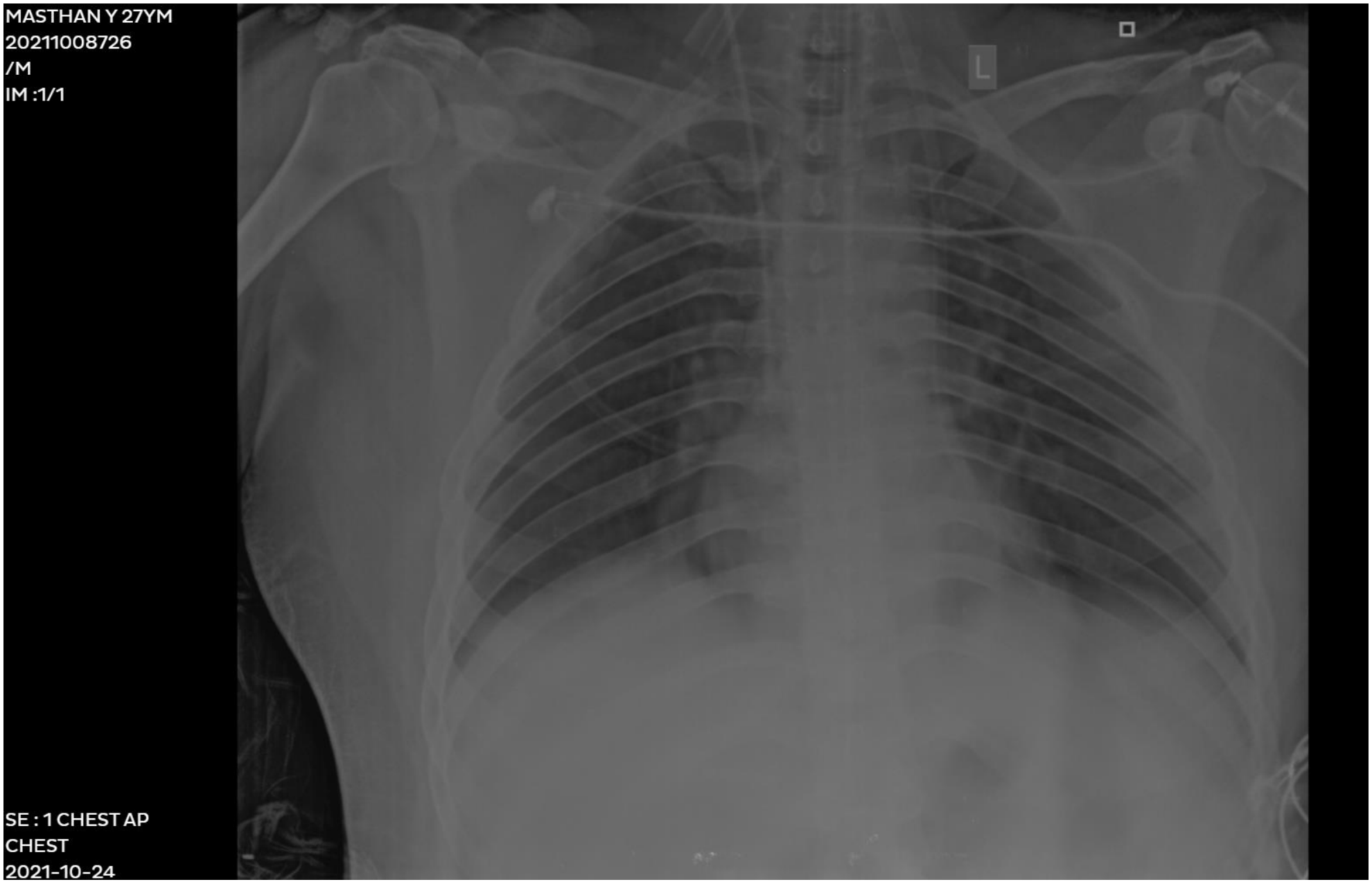
- Serum urea – 25.0 mg/dl

creatinine – 1.09mg/dl

pH	7.31
PCO2	51 mmHg
HCO3-	25.7 mmol/L

- Serum electrolytes – Na/K/Cl – 139/4.8/97 mEq/L

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/M
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SE : 1 CHEST AP
CHEST
2021-10-24

TREATMENT:

- Inj ATROPINE IV infusion decreased to 0.5 ml/hr and stopped at 2:00 PM.
- INJ MEROPENEM 2gm IV STAT given and continued at 1 gm IV TID
- INJ LINEZOLID 600mg IV BD 1-01 continued
- Rest of the treatment continued.

DAY 9 (25/10/2021)

- Patient is on MV, SIMV mode, FiO2 – 70%, PEEP – 5 cm H20,
- Continuous Fever spikes present

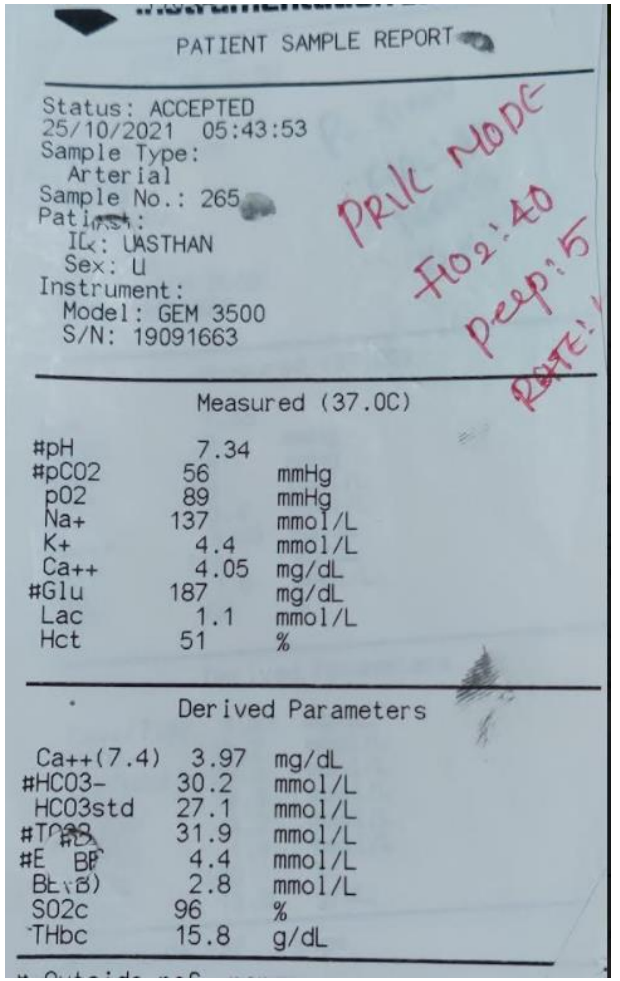
VITALS	SYSTEMIC EXAMINTION
PULSE – 142/min	CVS – Tachycardia +, S1 S1 heard
BP – 130/100 mmHg	RS – Normal breath sounds heard, no added sounds
RR – 30 cycles/minute SPO2- 97% on MV	P/A - soft
TEMP – 99 F	CNS – E4VtM6 Pupils – B/L 5mm, NRL

- Hb – 15.7 gm/dl
  TLC – 16,400/mm
N/L/M/E/B – 85/07/08/00/00
Platelet – 2,50,000/mm

- Serum urea – 30.0 mg/dl
  creatinine – 0.98 mg/dl

- Serum electrolytes – Na/K/Cl – 139/4.3/97 mEq/L

pH	7.34
pCO2	56 mmHg
pO2	89 mmHg
HCO3-	30.2 mmol/L
LACTATE	1.1 mmol/L


PATIENT SAMPLE REPORT

Status: ACCEPTED
25/10/2021 05:43:53
Sample Type:
Arterial
Sample No.: 265
Patient:
ID: UASTHAN
Sex: U
Instrument:
Model: GEM 3500
S/N: 19091663

PRVC MODE
FIO2:40
PEEP:5

Measured (37.0C)

#pH	7.34	
#pCO2	56	mmHg
pO2	89	mmHg
Na+	137	mmol/L
K+	4.4	mmol/L
Ca++	4.05	mg/dL
#Glu	187	mg/dL
Lac	1.1	mmol/L
Hct	51	%

Derived Parameters

Ca++(7.4)	3.97	mg/dL
#HCO3-	30.2	mmol/L
HCO3std	27.1	mmol/L
#T[illegible]	31.9	mmol/L
#E [illegible]	4.4	mmol/L
BE(B)	2.8	mmol/L
SO2c	96	%
THbc	15.8	g/dL

- BLOOD CULTURE – No growth after 72 hours of aerobic incubation

- URINE CULTURE – No growth after 24 hours of aerobic incubation.
- LFT – Serum total bilirubin – 0.86 mg/dl , Direct – 0.5 mg/dl

  SGOT – 27 U/L, SGPT – 67 U/L, ALP – 292 U/L,

  Total protein – 7.6 gm/dl,

  Serum albumin – 3.7 gm/dl, Globulin – 3.9 gm/dl

- ET Culture showed ACINETOBACTER BAUMANNII

Sensitive to TIGECYCLINE,

Intermediate sensitivity to CEFOPERAZONE + SULBACTUM

DAY 10 (26/10/2021)

- Patient is on MV, SIMV mode, FiO2 – 70%, PEEP – 8 cm H20,
- Continuous Fever spikes present
- Patient had involuntary movements of head and limbs , multiple episodes per day, lasting 2-3 minutes
- Not moving limbs even to painful stimulus.

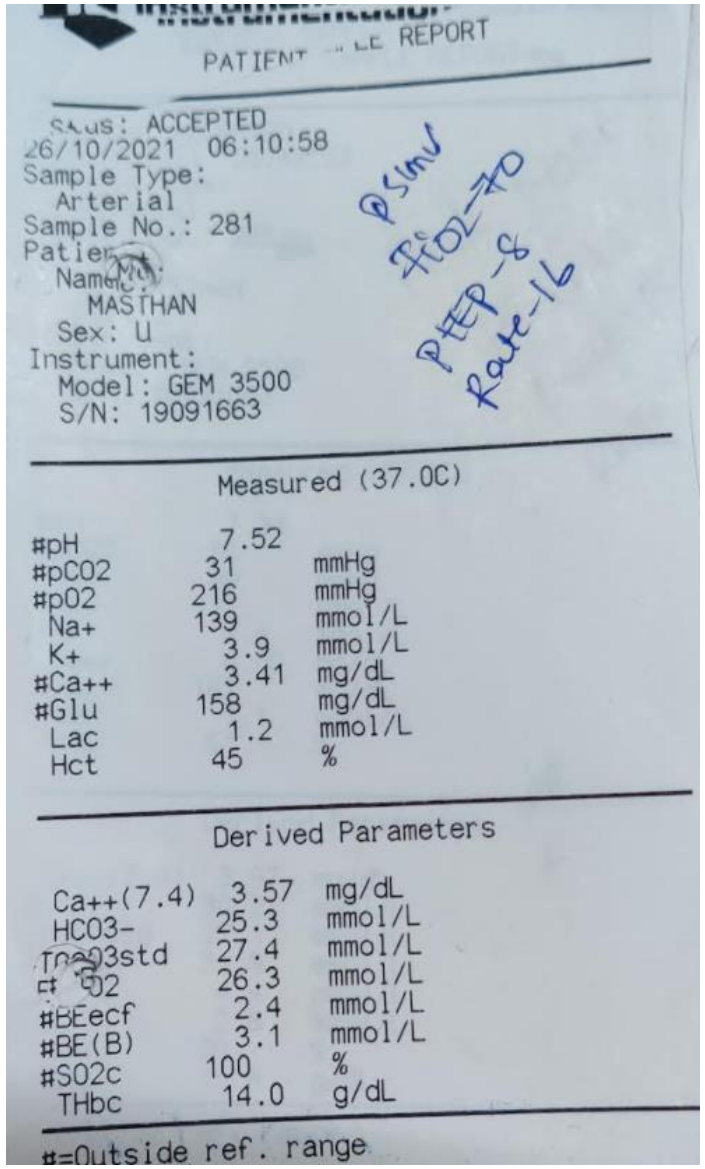
VITALS	SYSTEMIC EXAMINATION
PULSE – 140/min	CVS – tachycardia + S1 S2 heard
BP- 130/80 mmHg	RS – B/L air entry present, normal breath sounds, no added sounds
RR – 29 cycles/min SpO2 – 100% on MV	P/A – soft
TEMP – 102 F	CNS – E3VtM1 PUPILS - B/L 5 mm, NRL

- Hb – 14.4 gm/dl
  TLC – 13,800/mm
N/L/M/E/B – 78/14/08/00/00
Platelet – 2,72,000/mm

- Serum urea – 41.0 mg/dl
  creatinine – 0.80 mg/dl

- Serum electrolytes – Na/K/Cl – 140/4.6/99 mEq/L

PH	7.52
pCO2	31 mmHg
PO2	216 mmHg
HCO3-	25 mmol/L
LACTATE	1.2 mmol/L



TREATMENT:

- INJ CEFOPERAZONE/SULBACTUM 3 gm IV TID 1-1-1 added
- INJ LINEZOLID 600mg IV BD 1-0-1 continued
- Rest of the treatment continued

- Neurology consultation was taken
- ? INTERMEDIATE SYNROME
- Inj DIAZEPAM 1cc IV TID
- MRI brain full study

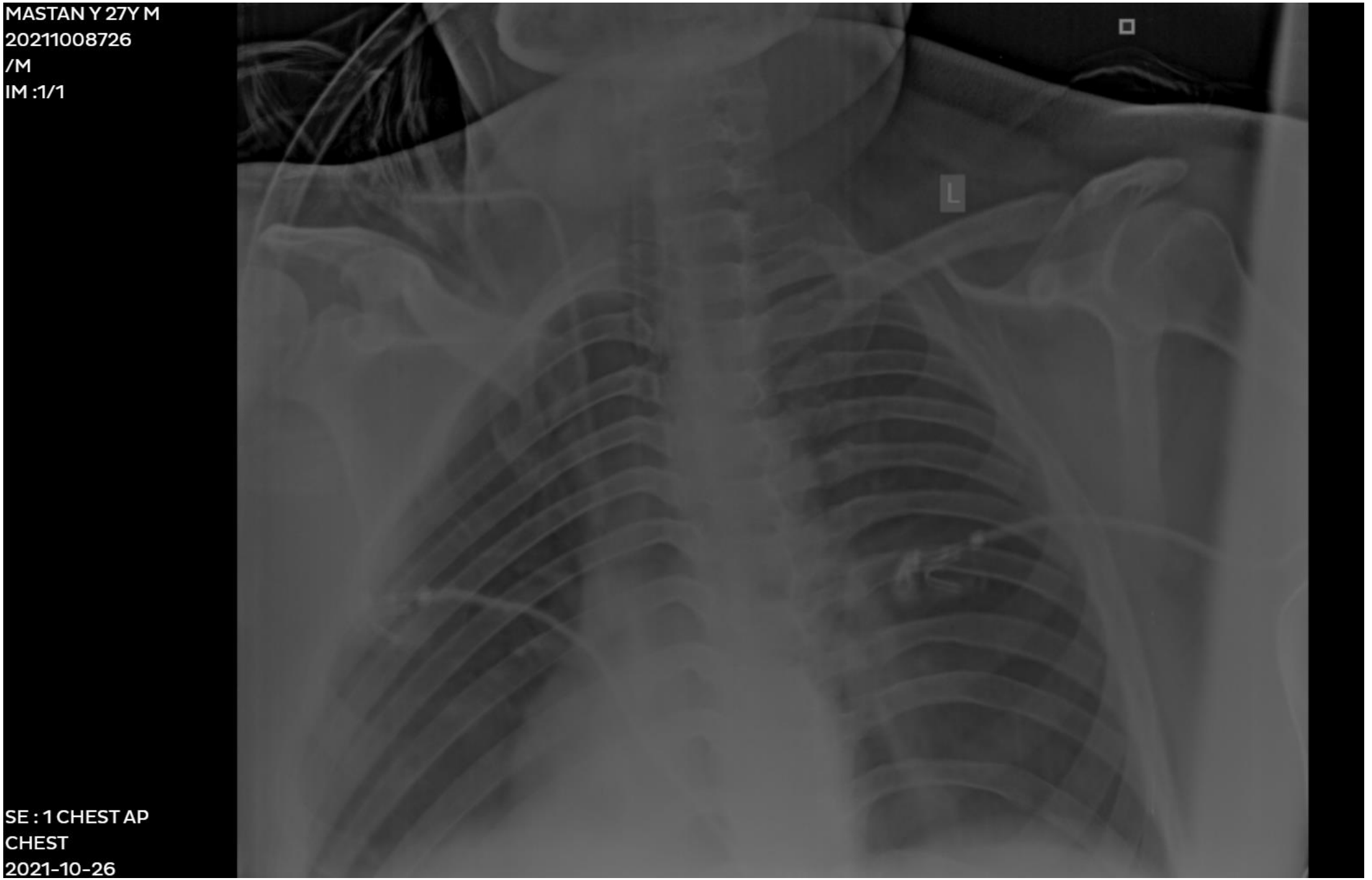
5:30 PM

Patient on MV, SIMV mode, FiO2 – 65%, PEEP – 8 cm H2O

Fever spikes present

Inj TIGECYCLINE 100mg IV STAT given.

Rest of the treatment continued.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CHEST
2021-10-26
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DAY 11 (27/10/2021)

- Patietnt is on mechanical ventilator, SIMV mode, FiO2- 65%, PEEP – 8 cm H2O,
- Continuous fever spikes present

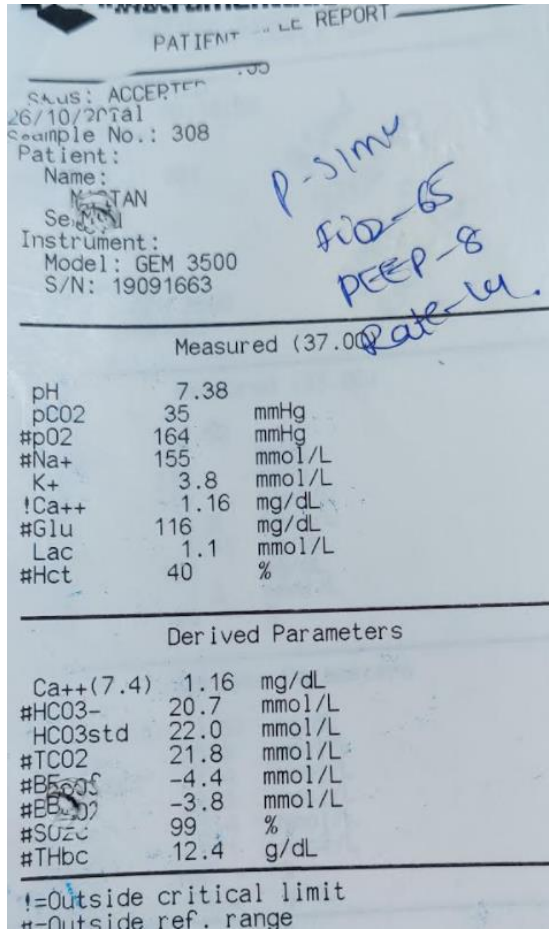
VITALS	SYSTEMIC EXAMINATION
PULSE – 148/min	CVS – Tachycardia present, S1, S2 heard
BP – 100/60 mmHg	RS – Normal breath sounds, no added sounds
RR – 26 cycles/minute SPO2- 96% ON MV	P/A - Soft
TEMPERATURE – 105 F	CNS – E4VtM1 PUPILS – B/L 5 mm, NRL

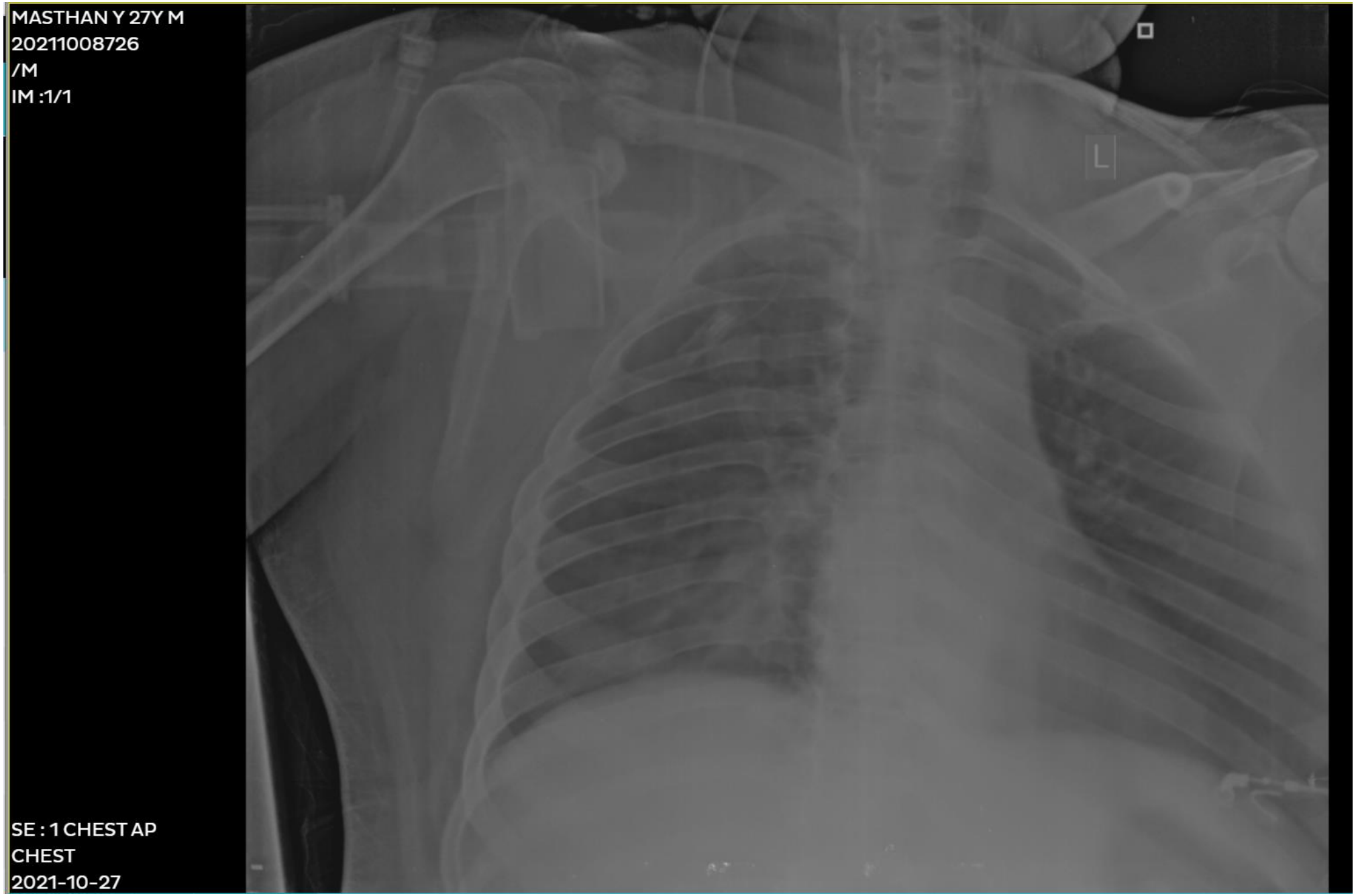
- Hb – 14.7 gm/dl
  TLC – 24,600/mm
N/L/M/E/B – 88/06/06/00/00
Platelet – 3,17,000/mm, PCV – 50%

- Serum urea – 54.0 mg/dl
  creatinine – 0.97 mg/dl

- Serum electrolytes – Na/K/Cl – 141/5.0/100 mEq/L

PH	7.38
PCO2	35 mmHg
PO2	164 mmHg
HCO3-	22 mmol/L




MASTHAN Y 27Y M
20211008726
/M
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SE : 1 CHEST AP
CHEST
2021-10-27
L

TREATMENT:

1. RT Feeds @ 60ml/hr ,
2. IV fluids @ 50 ml/hr with 1 amp OPTINEURON IV OD 1-0-0
3. Inj TIGECYCLINE 50 mg IV BD 1-0-1
4. Inj RANTAC 50 mg IV BD 1-0-1
5. Inj EMESET 4 mg IV SOS
6. Inj DOLO 1gm IV TID 1-1-1 (if temp >101 F)
7. Inj GLYCOPYRROLATE 0.2 mg IV QID 1-1-1-1
8. INJ DIAZEPAM 1 CC IV TID 1-1-1
9. TAB DOLO 650MG RT TID 1-1-1
10. Syp SUCRAFIL 10ml RT TID
11. NEB – BUDECORT BD
12. NEB – MUCOMIX TID

27/10/2021, 2:30 PM

- Patient had bradycardia, carotid pulse absent (PEA)
- CPR initiated as per ACLS PROTOCOL,
- ROSC attained after 2 cycles of CPR,
- Post cardiac arrest vitals:

Pulse – 168/min,

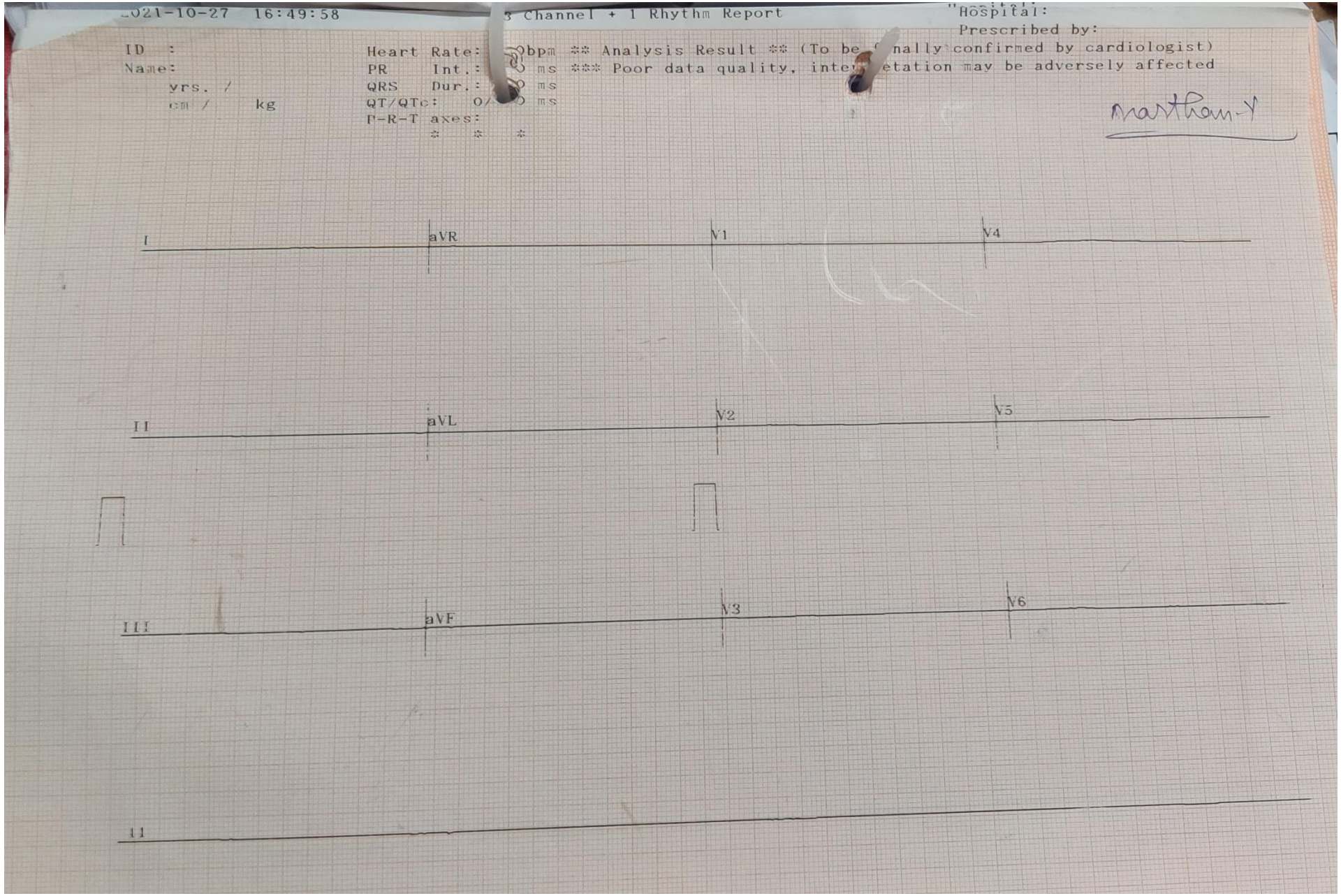
BP – not recordable

SpO2 – 90%n on MV

IN J NORADRENALINE IV infusion started at 0.2 microgm/kg/min

27/10/2021 4:00 PM

- Monitor showing heart rate < 30 beats/min
- Carotid pulse – absent (PEA)
- CPR initiated according to ACLS protocol
- Despite resuscitative efforts, patient could not be revived and declared dead at 4:40 PM


-021-10-27 16:49:58
3 Channel + 1 Rhythm Report
Hospital:
Prescribed by:
ID :
Name:
yrs. /
cm / kg
Heart Rate: bpm ** Analysis Result ** (To be finally confirmed by cardiologist)
PR Int.: ms *** Poor data quality, interpretation may be adversely affected
QRS Dur.: ms
QT/QTc: / ms
P-R-T axes:
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II

CAUSE OF DEATH :

IMMEDIATE CAUSE – CARDIAC DYSRHYTHMIA LEADING TO CARDIAC ARREST

ANTECEDENT CAUSE _

SEPSIS

INTERMEDIATE SYNDROME

ORGANOPHOSPHORUS COMPOUND POISONING (MONOCHROTOPHOS)

THANK YOU

2nd case

Case For Mortality Meet
Department of General Surgery,
NMCH

Presenter- Dr.Shaik Ashik Ilahee,
Final Yr Pg.

Moderator- Dr.V.Mahidhar Reddy,

- A 48yr old male Pt named Venkateswarlu was brought to NMCH ER [at 2pm on 7-10-2021] with
- Chief complaints of pain in abdomen since 15 days.
- c/o loose stools 10 days back.
- c/o vomiting since 1 day.
- c/o shortness of breath since 1 day.

Vitals

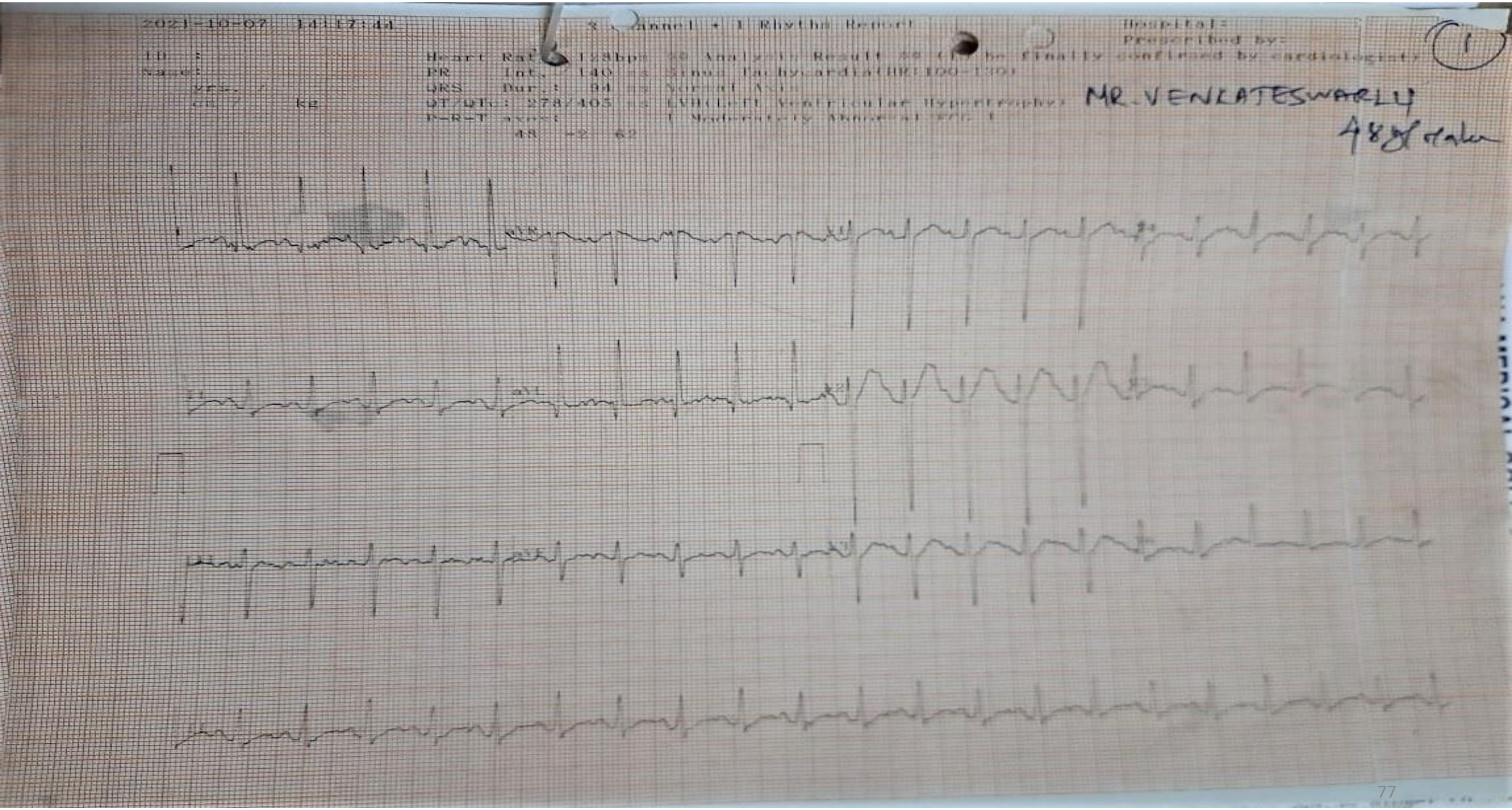
Afebrile

HR-144/min

BP-120/80 mm of hg

RR-40cy/min

SPO2-100% on NRBM 8 lit of 02


2021-10-02 14:12:44
Heart Rate 128bpm
PR Int. 140 ms
QRS Dur. 84 ms
QT/QTc 278/405 ms
P-R-T axes 48 42 62
Sinus tachycardia(HR:100-130)
Normal ECG
LVH(Left Ventricular Hypertrophy)
MR.VENKATESWARLU
48 yrs male

Patient was initially seen by Duty General Physician.

(8) I.P. DOCTOR'S ORDERS (7)

Patient Name Mr. Venkateshwarlu Age 48/M Sex M Ward ER Hosp. No 2021091641G

Date	History, Examination, Investigation, Treatment and Progress
7/10/21 5-5opm.	C/B/Segment - IV Dr. Kavya (PG) Dr. Nikhil (PG) & Dr. Nakesh SR Patient named Venkateshwarlu aged 48yrs male farmer by occupation from Nellore is c/o pain Abdomen --10days HOPI; patient was apparently alright 10 days back then he developed pain Abdomen which gradually progressive; continuous type; Relieved on taking medication; severe intensity pain H/o vomiting ⊕ ; 2 episode ; watery H/o loose stools 4-5 episodes ⊕ days back ~~[redacted]~~ No H/o cold / cough / chest pain / orthopnea / palpitations. No H/o fever. No H/o Burning micturition

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CHINTHAREDDYPALEM, NELLORE - 524 003 A.P., INDIA PH : 0861-2317963, 2317964

I.P. DOCTOR'S ORDERS

Patient Name: Mr. Venkateswarlu Age: 48y Sex: M Ward: 12 Hosp No: 2201091644 15

Date	History, Examination, Investigation, Treatment and Progress
11/02/21	**Past History:** Not K/C/O DM/HTN/ Asthma/ epilepsy/ TB/ CVA No similar history in the past **Personal History:** Mixed diet Sleep = adequate Appetite = decreased Bladder = Regular Bowel = Irregular; decreased No known addictions. **Drug History:** Not significant **General examination:** Patient is Conscious, oriented Cooperative well oriented to time, place and person P I C C L E BP = 118/76 mm. Pr = 130/80 mmHg. RR = 28 cpm. Temp = 99°F SpO2 = 100% @ 6 lit O2 via

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NARAYANA MEDICAL COLLEGE AND HOSPITAL

CHINTHAREDDYPALEM, NELLORE - 524 003. A.P., INDIA. PH: 0861-2317963, 2317964

10 I.P. DOCTOR'S ORDERS

2021 0916419

Patient Name: Mr. Venkateswarlu Age: 48 Sex: M Ward: ER Hosp. No:

Date	History, Examination, Investigation, Treatment and Progress
11/10/21	SLE c CVS:- S1S2 (+); No murmurs. Pitchy Cardiac (+) RS:- B/L AVBS (+); No added sounds. P/A:- Soft; No Tenderness. No palpable organomegaly. CNS:- E4V5M6 NFND.
Adv - CRP - LFT - Streelectrolytes - BCG - UCG Abdomen. - CUE - LFT.	1.) ? Small bowel obstruction
Refer to General Surgery	Adv 1.) No Active Medical Intervention

11/10/21.

The Case was given to general surgery around 6 pm i/v/o ? Bowel obstruction.

Vitals of the patient when referred to us

- Temp-99 F
- PR-113bpm,normal volume and rhythm
- BP -130/90 mmof hg
- RR -24cy/min
- SpO2-93% at 4 lit of 02.

H/O PRESENT ILLNESS:

Patient was apparently normal 15 days back then he developed loose stools for which he took medication from local quack after which loose stools subsided but developed pain abdomen which was insidious in onset gradually increased to colicky type,then became continuous type for which he was hospitalized in a local hosapital 10 days back.

- Patient started having vomiting soon after having food,non projectile,non bilious, 1-2 episodes /day since 1day .
- H/o of abdomen distension since 1 day.
- H/o decreased appetite since 15days.
- Pt passed stools yesterday from then he has not passed flatus and stools.
- No h/o trauma ,fever, micturition difficulties, dyspepsia , weight loss, yellowish discolouration of eyes, passing of black tarry stools, difficulty in breathing and chest pain.

Past History

- No H/O similar complaints in past.
- No H/O HTN,DM,TB, COPD, Bronchial asthma, Epilepsy,CAD,CKD
- No H/o Previous surgeries in past,blood transfusion.

Personal History:

- Pt takes mixed diet.
- Bowel habits are irregular and bladder habits are regular.
- Sleep cycles are regular, decreased appetite.
- No H/o substance abuse.

Family history:

No h/o similar complaints in family members.

General examination

- Pt is conscious, coherent and oriented. Moderately built and nourished.
- No pallor, icterus, cyanosis, clubbing, oedema and Generalized lymphadenopathy.

- **Vitals**

  Temp -99.6 f

  PR -113bpm,regular rhythm and volume.

  Bp -120/80 mm of Hg in right arm supine position.

  RR-24 cyc/min

  Spo2-93% with 4 lit of o2

Examination of Abdomen-Inspection

- Abdomen mildly distended.
- Umbilicus is in midline,inverted and centrally placed.
- All quadrants are moving equally with respiration.
- No visible peristalsis, engorged veins, sinuses and scars.
- Hernial Orifices appear to be normal.
- External genitalia appear to be normal.

Palpation

- Abdomen is soft, Non-tender and distended.
- No Guarding,rigidity and palpable organomegaly.
- Hernial orifices and external genitalia are normal.

- **Percussion** :
  - Resonant note heard all over abdomen.
  - No fluid thrill, shifting dullness.

- **Auscultaion :**
  - Bowel sounds are absent.

- **Per rectal examination:**
  - Normal.

Systemic examination:

- CVS : S1,S2 +, no murmurs are heard.
- RS:B/L air entry present. No added sounds heard.
- CNS: No focal neurological defect.

Provisional Diagnosis-

Acute Intestinal Obstruction.

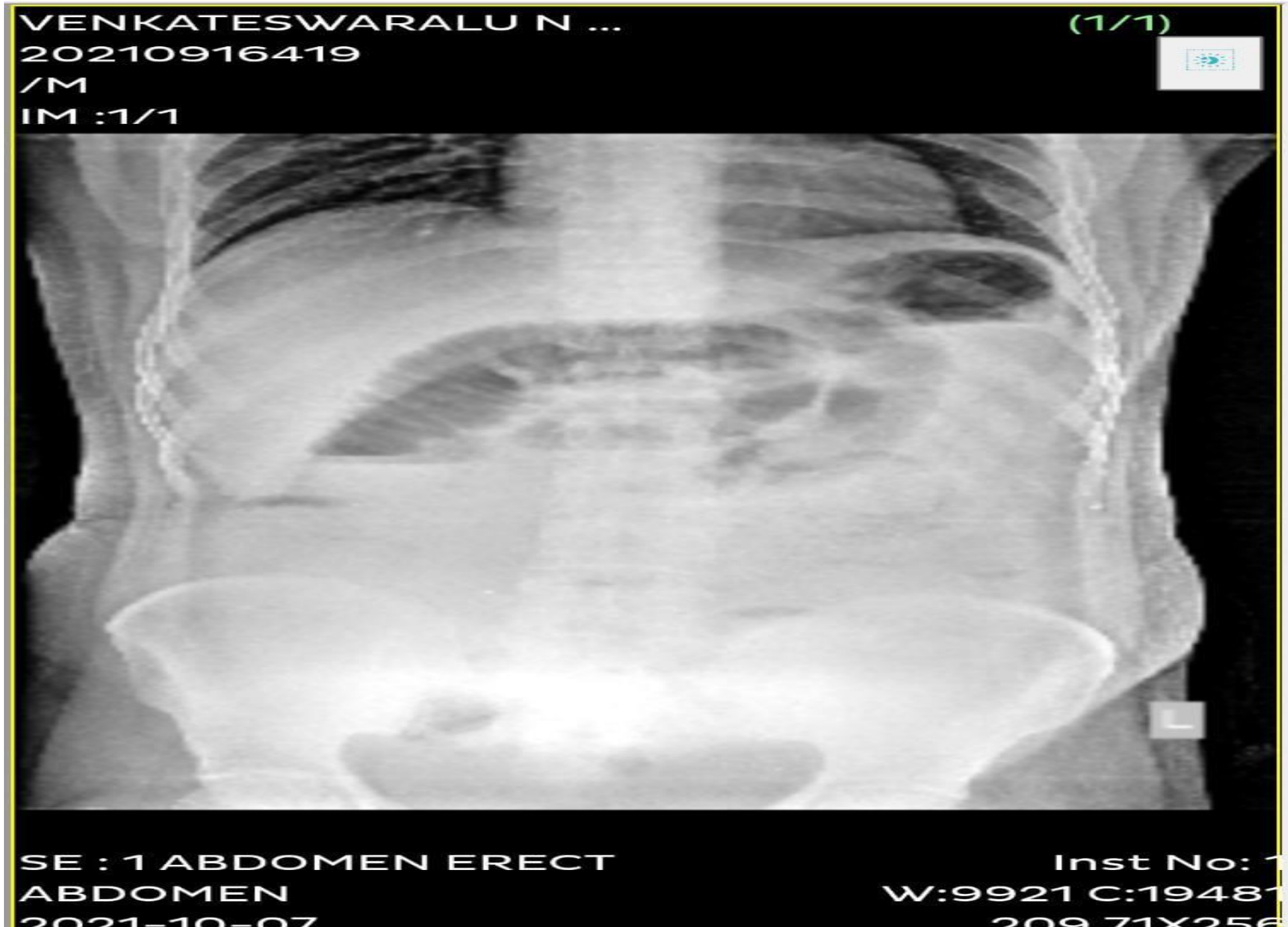
Investigations advised:

X-ray erect abdomen

Usg abdomen

CECT abdomen

CBP, RFT, Serum Electrolytes.


VENKATESWARALU N ...
(1/1)
20210916419
/M
IM :1/1
SE : 1 ABDOMEN ERECT
Inst No: 1
ABDOMEN
W:9921 C:19481
2021-10-07

USG abdomen :

- Visualised small bowel loops appear dilated of maximum calibre 4 cm with few showing sluggish peristalsis and few showing to and fro peristalsis.
- Features suggestive of small bowel obstruction
- Suggested CECT abdomen for further evaluation.

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Chintharedypalem, Nellore - 524 002.

DEPARTMENT OF RADIOLOGY & IMAGING

ULTRASONOGRAPHY - ABDOMEN & PELVIS

NAME ..... N. Venkateswarlu ..... AGE/SEX ..... 48 yrs/M .....

OP NO. / IP NO. ..... RADIO - RG. NO. ..... DATE ..... 27/10/21 .....

		NORMAL	INCREASE	DECREASE
LIVER SIZE	12.6 cm	✓		

No focal lesions
No IHBRD

	NORMAL	INCREASE
	✓	

ECHO TEXTURE :

PV : NORMAL ✓

CBD : NORMAL ✓

GALL BLADER : NORMAL ✓ partially distended

PANCREAS : poor window

SPLEEN 10.7 cm : Normal

KIDNEYS 9.9 × 5.2 cms : RIGHT : } (N) size, echotexture
11.2 × 5.7 cm : LEFT : } pcs compact. CMD maintained

URINARY BLADDER : partially distended. Foley's bulb noted inside. Few internal echoes noted [? Correlate with CUE]

PROSTATE : poor window

OTHERS : No free fluid noted in peritoneal cavity

PELVIS :

Visualised small bowel loops appears dilated of maximum calibre 4 cms with few shaving sluggish peristalsis ... few shaving ... to & fro peristalsis

UTERUS :

ENDOMETRIUM :

OVARIES : RIGHT :

LEFT :

PDO :

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IMPRESSION :- Dilated small bowel loops as described features suggest possibility of small bowel obstruction
Suggested CECT Abdomen for further evaluation

Dr. Madhu(Gen)
RADIOLOGIST
for AP

HRCT CHEST

- No obvious ground glass opacities/consolidatory changes in bilateral lung parenchyma.
- Visualised bowel loops appear dilated with multiple airfluid levels.

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Chinthareddypalem, NELLORE - 524 003, A.P., India.
Ph : 0861-2317963, 2317964

Department of Radio Diagnosis

Patient Name:	VENKATESWARLU NOSINA 48Y/M	Patient ID:	20210916419
Age:	48 Years	Sex:	M
Modality:	CT	Study Date:	7-Oct-2021

H.R.C.T CHEST

TECHNIQUE: On a 16 serial slice scanner in helical mode, sections of chest are taken with 1.25mm slice thickness with sagittal, coronal reconstruction and volume rendering.
Clinical background: Screening for COVID-19.

FINDINGS:

- No obvious ground glass opacities /consolidatory changes noted in bilateral lungs.
- Bilateral lung parenchyma appears normal.
- Trachea and major bronchi are normal.
- Mediastinal vascular structures are normal.
- Cardia appears normal.
- Few small volume pre tracheal and pre vascular lymphnodes noted.
- No e/o free fluid noted in bilateral pleural/pericardial cavities.
- Visualised small bowel loops appears dilated with multiple air fluid levels..
- Rest of the Abdominal organs appear normal up to the visualised extent.
- Degenerative changes noted in the form of bridging and marginal osteophytes in the visualised bones.

IMPRESSION-

- ***No obvious ground glass opacities /consolidatory changes in bilateral lung parenchyma.***
- ***Visualised small bowel loops appears dilated with multiple air fluid levels.***
  ****Suggested clinical correlation and further evaluation to rule small bowel obstruction****

ASKR

Dr. Sravan Krishna Reddy.
MDRD., NeuroImaging (USA)., MRCR (UK).
Asst. Professor (Radiology).

Patient ID:	*20210916419*	*Patient Name:*	*VENKATESWARLU NOSINA*
Age:	*48 Years*	*Sex:*	*M*
Accession Number:	*182411*	*Modality:*	*CT*
Referring Physician:	*ACCIDENT AND EMERGENCY*	*Study:*	*CT CONTRAST(ABDOMEN)*
Study Date:	*7-Oct-2021*		

CECT Abdomen (IV CONTRAST)

TECHNIQUE: On a 128 serial slice scanner in helical mode, sections of abdomen are taken after giving IV contrast. Sections of abdomen are taken and multi planar reconstructions done.

Clinical Profile – C/O abdominal pain since today.

FINDINGS:-

- Dilatation of jejunal and proximal ileal loops, max calibre meas 6cm, with possible transition points at distal jejunal and proximal ileal loops
  - Possibly closed loop obstruction.

  Few of the ileal loops are faecal filled.

  Rest of the small bowel loops and colon are collapsed.
- Few small volume mesenteric lymph nodes noted.
- **Liver**: Normal in size & attenuation. No focal lesions and IHBRD
- **Portal vein**: normal.
- **Gall bladder:** Partially distended.
- **CBD:** Normal
- **Pancreas:** Normal
- **Spleen:** Normal in size and attenuation.
- **Right kidney:** 10.8 x 5.7cmNormal in size and attenuation
  PCS and ureter normal
- **Left kidney:** 11.3 x 5.7cmNormal in size and attenuation
  PCS and ureter normal.
  An ill defined non-enhancing hypodense area noted in interpolar region
  -possibly infarct
- Bilateral adrenals appear normal.
- **Urinary bladder:** Minimally distended. Foleys bulb noted insitu
  Prostate: Normal
- Origin of celiac axis, SMA, IMA appears normal.

Patient ID:	*20210916419*	*Patient Name:*	*VENKATESWARLU NOSINA*
Age:	*48 Years*	*Sex:*	*M*
Accession Number:	*182411*	*Modality:*	*CT*
Referring Physician:	*ACCIDENT AND EMERGENCY*	*Study:*	*CT CONTRAST(ABDOMEN)*
Study Date:	*7-Oct-2021*		

- Appendix - normal.
- Few thin sub pleural fibrotic bands noted in right lower lobe. Rest of the bilateral visualised lung fields appear normal
- No free fluid in peritoneal / pleural cavities.
- Visualised bones appear normal.

IMPRESSION:-

- ***Features suggest the possibility of acute small bowel obstruction.***
  - Possibly closed loop obstruction secondary to adhesions.

****Suggested clinical correlation and follow up****

- Rapid antigen test for covid 19 is NEGATIVE
- BGT – B positive
- Hb 14gm% (13.6-17.2)
- TC -11200 cells/mm3 (4000-11000)
- N-81 %
- L-10%
- E-O1%
- M-08%
- PLATELETS- 3,64000/mm3

- Na -134 meq/l (130-143)
- K -3.5 meq/l (3.5-5)
- Cl-94 meq/l (93-110)
- S.amylase- 152 U/l (220)
- S.lipase- 42 U/l (13-60)
- S.urea -24.5 mg/dl (10-50)
- S.Creatinine- 0.7 mg/dl (0.7-1.3)

- T.bilirubin- 0.71 mg/dl
- Direct bilirubin- 0.5mg/dl
- S.albumin -2.9 g/dl
- S.Globulin- 2.5 g/dl
- T.protein- 5.45 g/dl
- ALP- 164 u/l
- SGOT -24U/L
- SGPT -36U/L

- PT -20.9 Sec (11-16)sec
- APTT- 36.2 (25-39)sec
- INR- 1.75 (<2.0)

Treatment adviced:

NBM till further orders,2nd hrly ryles aspiration.

- Iv fluids-DNS ,RL @ 120ml /hr
- Inj cefperazone+sulbactum 1.5 iv b.d
- Inj Metrogyl 100ml iv tid
- Inj Pantop 40mg iv od
- Inj Cylopam 10mg im sos
- Inj Emset 4mg iv bd
- Inj Dolo 1gm iv sos
- Abdomen girth monitoring chart 2nd hrly,TPR chart,monitor vitals, i/o chart.
- Continue 02 inhalation.

- Pt’s condition was explained to pt attenders as Acute intestinal obstruction according to usg abdomen , x-ray erect abdomen and cect abdomen reports.
- Pt attenders were explained about need for emergency surgery exploratory laparotomy , high risk and complications of surgery and anaesthesia.
- Informed and written High risk consent for surgery and anaesthesia was taken.

Patient vitals at the time of shifting to OT

- PR : 142 bpm
- RR : 29 cy/min
- BP : 130/70 mm of Hg
- TEMP : 100.2 F
- SPo2: 97% at room air

ANAESTHESIA CHART

NAME Venkateshwarlu ANAESTHESIOLOGIST Dr Shiny

PROCEDURE/SURGERY Exploratory Laparotomy DATE 08/10/24

PRIMARY SURGEON Dr. Mahidhar Reddy NURESE

PREMEDICATION (in Holding Area) ANAESTHESIA-G.A / S.A./E.A./I.V. SEDATION / MAC

ANAESTHESIA ASSESSMENT BEFORE INDUCTION (not earlier than 15 mins before induction)

H.R.: 130 bpm B.P.: 130/80 mmHg SPO_2: 98% on RA R.R.: 20 Cycles/min

Machine / Equipment check done - Yes / No

REGIONAL ANAESTHESIA - Technique - EA / SA / CSE / Nerve Block Approach

Needle Space Drug

Point of Action Sensory Level Motor Level

GENERAL ANAESTHESIA - Preoxygenation for 5 min with 100% O2

Induction By Glycopyrrolate 2mg, By midazolam 1mg IV, By Lidocaine 3mg, By Fentanyl 125mcg By Thiopentone 250mg By Scholine

Greade of laryngoscopy I / II / III Eyes - Covered Yes / No Pressure points - Padded Yes / No Throat pack - Yes / No

Intubation - Nasal / Oral Size 8.0 Type of ETT Cuffed Cuff Inflated Attempts 1

Ventilation Controlled / Spontaneous, Circuit closed

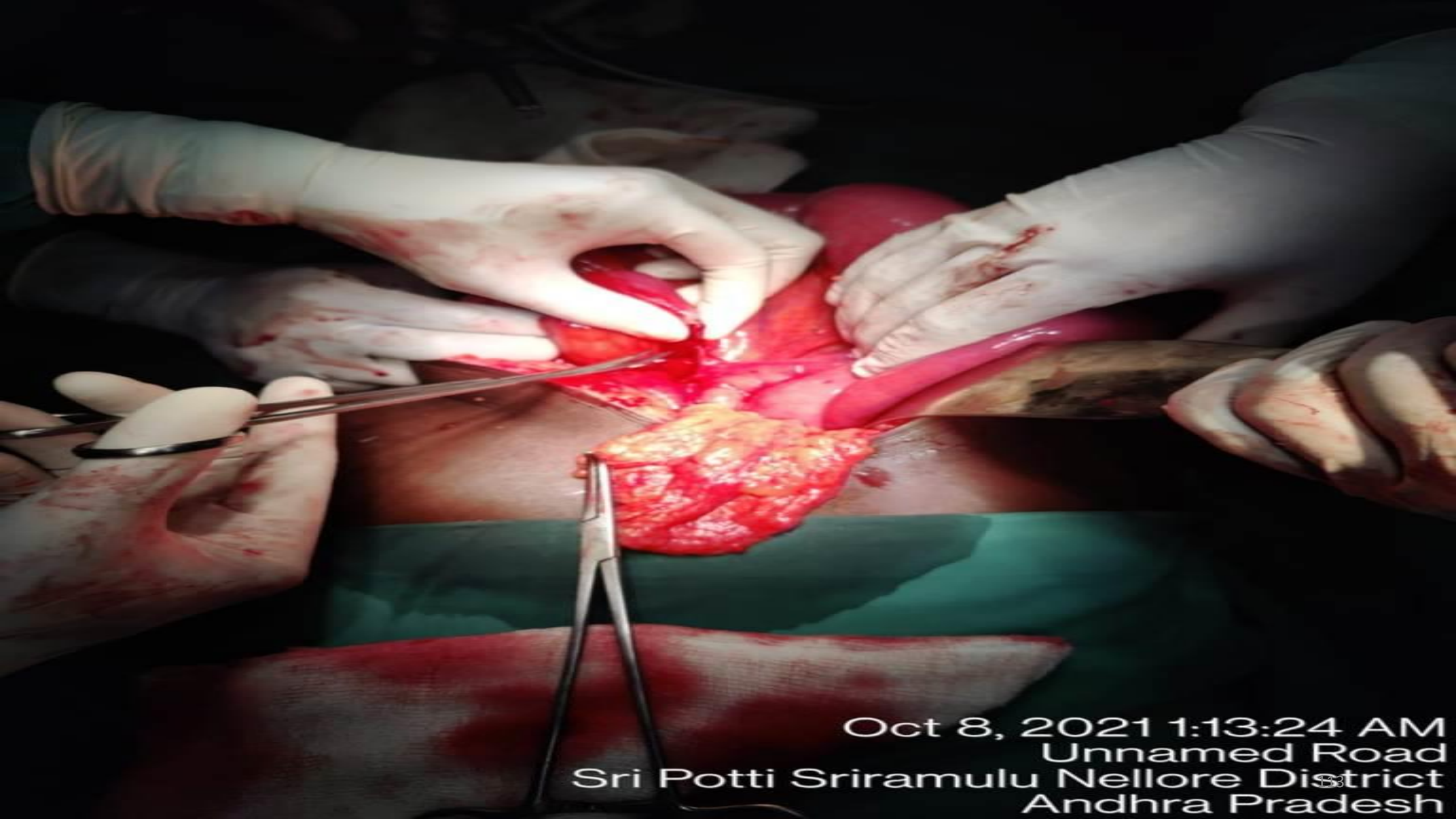
Ventilator - MV RR 14 TDV 450 I : E Ratio 1:2

TOURNIQUET - Applied at Removed at

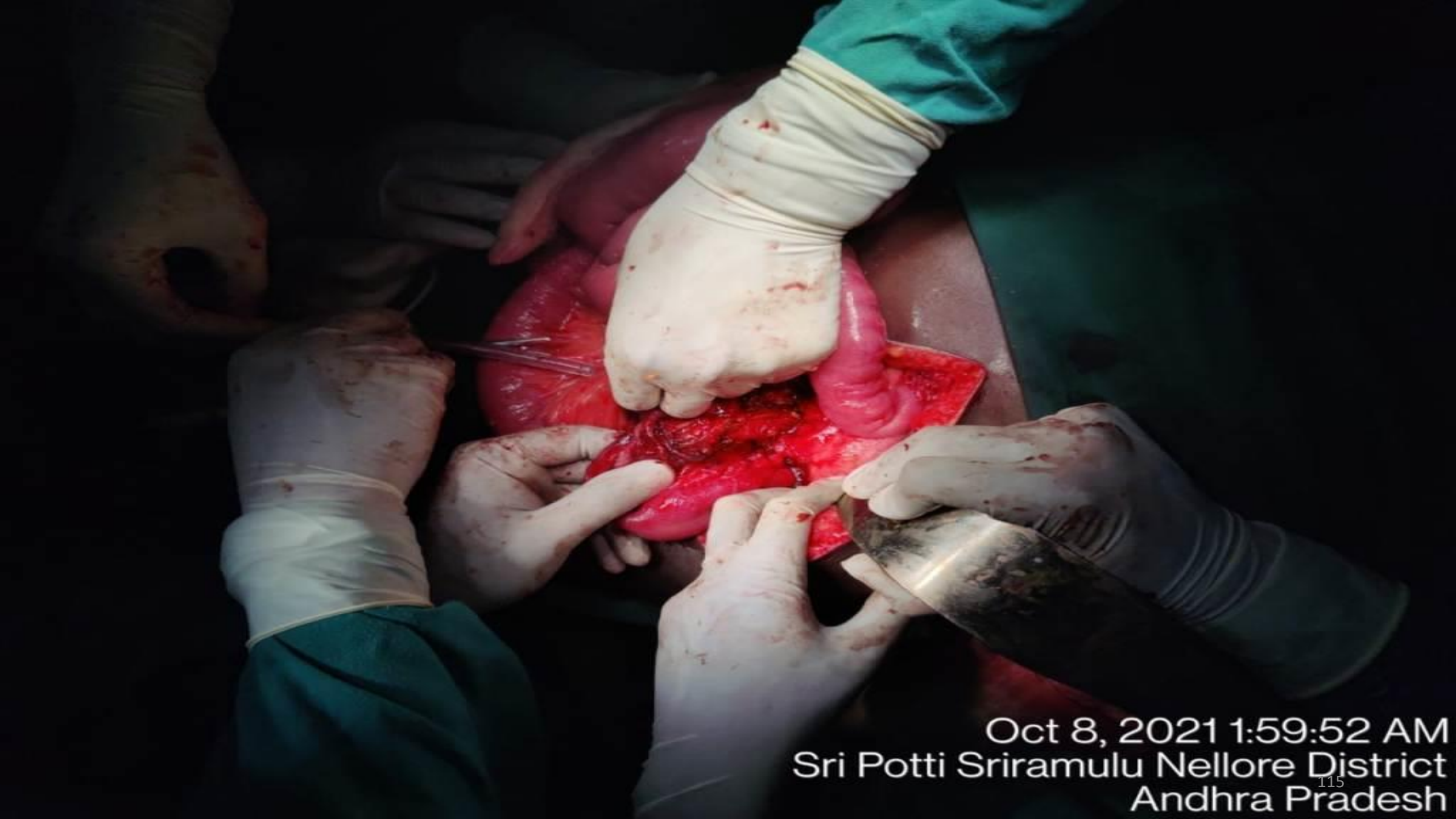
Procedure done:- Under GA, Exploratory Laparotomy + ileostomy was done on 8-10-2021 (12.55 AM- 4.30 AM).

Intra operative findings are :

- Nearly 300ml feculent fluid was drained.
- Multiple bowel adhesions between bowel and omentum are noted.
- A perforation of size 0.5 x 0.5cm seen at 170 cm from duodenojejunal junction.
- About 20cm of gangrenous bowel was noted on either side of perforation, gangrenous segment was resected.
- Ileostomy was done.


Oct 8, 2021 1:13:24 AM
Unnamed Road
Sri Potti Sriramulu Nellore District
Andhra Pradesh


Oct 8, 2021 1:42:35 AM
Sri Potti Sriramulu Nellore District
Andhra Pradesh


Oct 8, 2021 1:59:52 AM
Sri Potti Sriramulu Nellore District
Andhra Pradesh


Oct 8, 2021 1:59:55 AM
Sri Potti Sriramulu Nellore District
Andhra Pradesh

- Pt was not extubated and shifted to icu i/v/o acidosis with ET tube insitu at 6:05 am on 8/10/21

ABG report (intra operative)

- Ph- 7.23
- Pco2- 46 mmHg
- Po2- 271 mmHg
- HCO3- 19.3mmol/L
- BE -8.3 mmol/L
- Na -126 mmol/L
- K- 3.1 mmol/L
- Ca-1.44 mg/dl
- Lactate -1.1 mmol/L

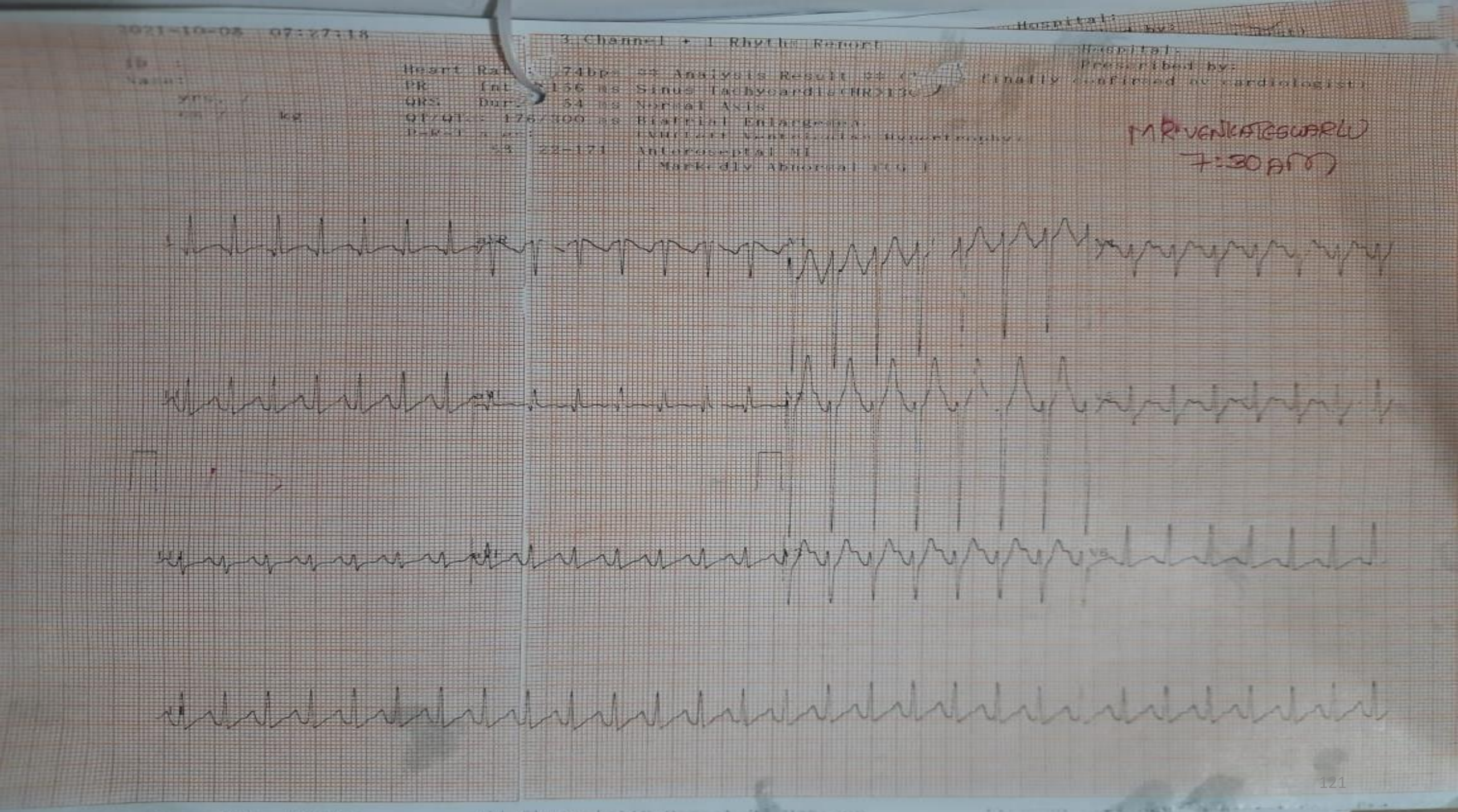
Vitals on arrival at ICU

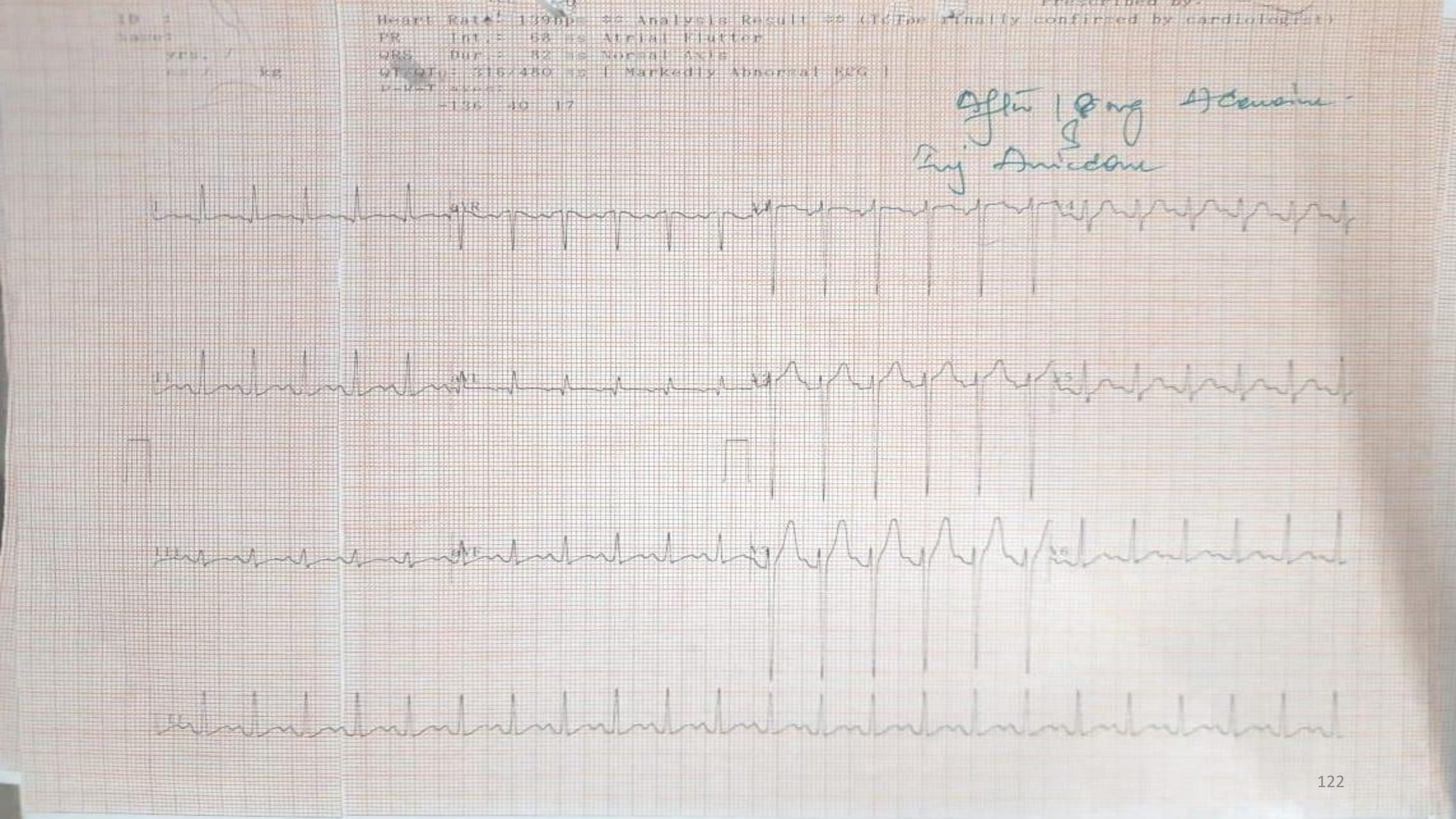
- BP 150/80 mm of Hg
- HR 140 /MIN
- SP02 99% on bains circuit
- Patient is shifted to ventilator prvc mode
- Fio 2 - 50%
- PEEP 5cm of water
- RR 16/MIN
- TV 400ML
- CBG-181mgldl
- Patient was sedated

Patient Condition and vitals on 8/10/21, 7am (Pod-0)

- Patient is on mechanical ventilator PRVC Mode
- FiO2 50%
- PEEP 6 cms of water
- RR 15 cycles/min
- PR 164 BPM
- BP 170/90 mm of Hg
- Temp 102 f
- Abdomen- Soft, Non-rigid, flat and absent Bowel Sounds.
- Drain- 150 ml of serous fluid.
- Stoma- Functioning, 20ml serous fluid.
- Urine Output- 50ml in 1 hr.

- In ICU, patient developed supraventricular tachycardia at around 7:30 am for which vagal manoeuvre was done and planned for chemical cardioversion, informed and written consent taken from Pt attenders .
- Chemical Cardioversion started with inj. Adenosine 6mg iv bolus followed by 12mg iv bolus .


2021-10-08 07:27:18
3 Channel + 1 Rhythm Report
Hospital:
Prescribed by:
Finally confirmed by cardiologist
Heart Rat 74bpm
PR Int 156 ms
QRS Dur 94 ms
QT/QTc 176/200 ms
P-R-T axes
22-171
Sinus tachycardia(HR>130)
Normal Axis
Biatrial Enlargement
Anteroseptal MI
Markedly Abnormal ECG
MR VENKATESWARLU
7:30 AM


Heart Rate: 139bpm
PR Int.: 68 ms
QRS Dur.: 82 ms
QT/QTc: 316/480 ms
P-R-T axes:
-136 40 17
Analysis Result
Atrial Flutter
Normal Axis
Markedly Abnormal ECG
Inj Amiodarone

- Pt had refractory SVT.

- Inj Amiodarone 150mg bolus f/b infusion of 1mg/min was started .

Name:

yrs. /

cm / kg

Prescribed by:

Heart Rate : 141bpm ** Analysis Result ** (To be finally confirmed by cardiologist)

PR Int. : 140 ms Sinus Tachycardia(HR>130)

QRS Dur. : 80 ms Normal Axis

QT/QTc: 292/446 ms LAE(Left Atrial Enlargement)

P-R-T axes: [Moderately Abnormal ECG]

65 41 54

6

Afdil 12 mg

Adenosine

150mg Amiodarone @ 6 ml/hr

I

aVR

II

aVL

III

aVF

V1

- Cardiology referral was done i/v/o refractory SVT and their advice to continue amiodarone infusion was followed.

NARAYANA MEDICAL COLLEGE HOSPITAL
CHINTHAREDDYPALEM, NELLORE - 524 003. A.P., INDIA. PH : 0861-2317963, 2317964

NARAYANA MEDICAL COLLEGE AND HOSPITAL

I.P. DOCTOR'S ORDERS

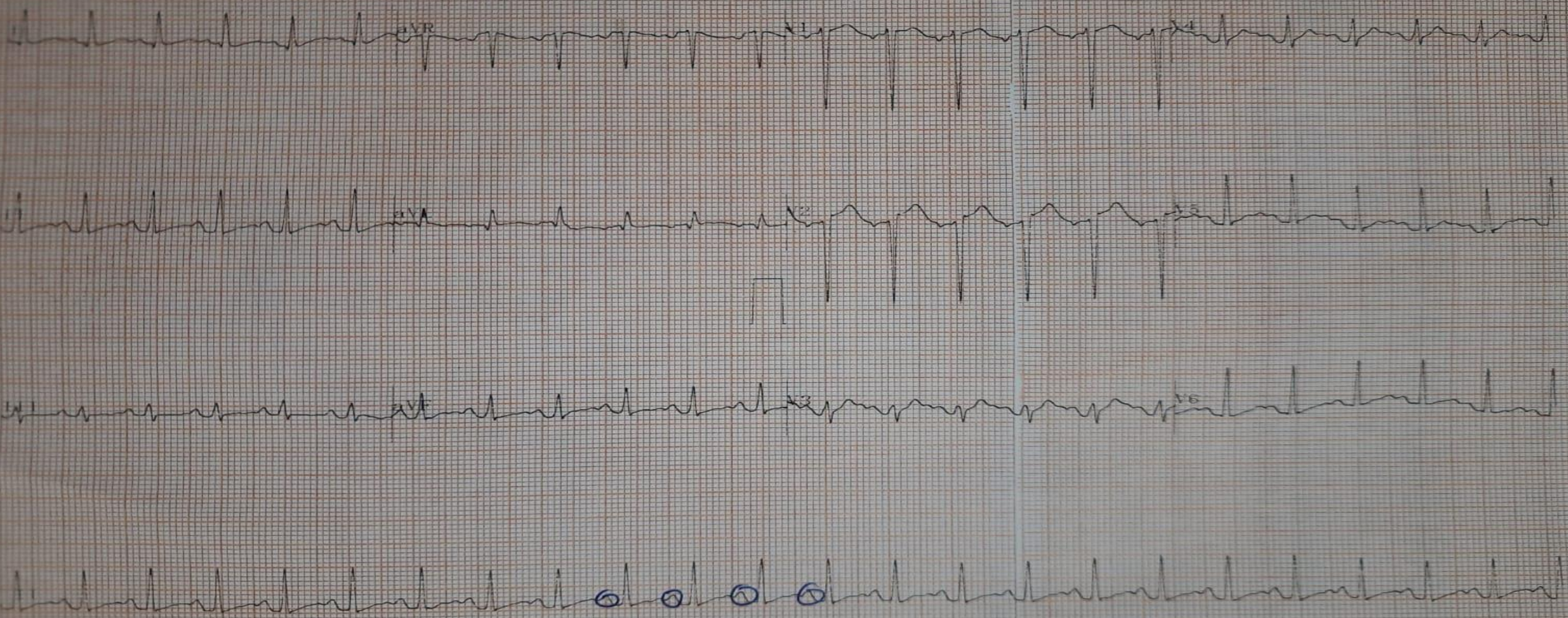
Patient Name Mr. Venkateswarlu Age 41 SY Sex M Ward GICU Hosp. No 210027160

Date	History, Examination, Investigation, Treatment and Progress
8/10/21	C/S/B Cardiology Resident 3rd visit [Thanks for referral] case of, small bowel obstruction Referred c/o/v/o High BP. O/E BP- 18 bpm BP: 100/60 mmHg SPO2: 100% @ RA VC mode ECG: BWT * S/E CVS: S1S2 (+) RS BAE (+) Rp ② LASIX 10mg stat ① TAB CARVEDILOL 12.5mg stat ③ continue amiodarone infusion @ titrate accordingly

3 Channel + 1 Rhythm Report

Hospital:
Prescribed by:

Heart Rate: 140bpm ** Analysis Result ** (Please finally confirmed by cardiologist)
PR Int: 138 ms Sinus Tachycardia(HR>130)
QRS Dur.: 78 ms Normal Axis
QT/QTc: 286/436 ms | Moderately Abnormal ECG |
P-R-T axes:
64 41 48



- Patient developed pulseless electrical activity on **9/10/21at 5:00 am**
- CPR intiated according to 2020 ACLS protocol and ROSC attained after 3 cycles of CPR

VITALS Post ROSC

- BP: 70/50 mm of Hg on inj.noradrenaline 10ml/hr.
- HR :140 /min
- RR : 25 Cycle/min
- TEMP 103 F

Investigations

- ABG showed metabolic acidosis
- S.urea -84.3 mg/dl
- Creatinine -1.66 mg/dl
- CRP- 153 mg/L

- Patient was started on inj.vasopressin 2.4 ml/hr

Patient Condition and Vitals on 9/10/21 at 8:00 am (Pod-1)

PR-143 beats/minute.

BP- 160/40 mm of Hg.

RR-38 cycles/minute.

Temp-103 F

Pt Febrile, Stoma Functioning-30 ml serous

Abdomen- Soft, Non-rigid, Bowel sounds absent.

Drain-200ml serous fluid.

Urine Output- 1615 ml (input-3613 ml)

- At around **4:OO pm** patient BP was not recordable
- PR 145 BPM
- SPO2 96% with Fio2 100% on prvc mode
- Inj.adrenaline @ 3ml/hr started.
- At around **5:15 pm** monitor showed pulseless electrical activity
- 3 cycles of CPR done along with inj. Adrenaline 1mg bolus for every 3 minutes .
- Monitor showed asystole
- Inspite of above resuscitation measures patient could not be revived and declared death at **6:15 pm.**

3rd case

Mortality meet obstetrics & gynaecology 17/12/2021

COURSE OF EVENTS:

ON 5/10/21:

- A 47 year old patient came to Gynec OPD with c/o lower abdominal pain since 2 months on & off.
- No c/o burning micturition.
- No c/o increased frequency of micturition.
- No c/o WDPV / bleeding PV.
- No c/o cough / cold/ fever / other respiratory symptoms.

- **<u>GENERAL EXAMINATION:</u>**
- Patient was apparently normal, conscious & coherent.
- No pallor / icterus/ cyanosis/clubbing/lymphadenopathy/ pedal edema.
- TEMPERATURE- 96.8F.
- PULSE RATE: 90 beats/min.
- BLOOD PRESSURE: 110/70mm Hg.

- CVS: normal heart sounds heard, no murmur.
- RS: normal vesicular breath sounds heard, no added sounds.
- CNS: no focal neurological deficit seen.
- P/A: A mass of 24weeks size felt
- P/S: cervix – hypertrophied,
  vagina – healthy.
- P/V: uterus size could not be made out,
  cervix- hypertrophied,
  right forniceal fullness +.
- Patient was advised CBP,USG abd& pelvis, CUE, TSH, RBS.
- CECT abdomen ,CA125, CA 19-9 were advised to rule out malignancy.

- CECT abdomen – probably mucinous cystadenocarcinoma.
- CA-125 – 29.7U/ml (normal - < 35U/ml).
- CA 19-9 – 18.4 U/ml(normal - <37U/ml).

- **<u>On 7/10/21:</u>**

- Patient came to Gynec OPD with c/o fever since night
- c/o pain abdomen since night.
- C/O increased frequency of micturition.
- No c/o burning micturition
- No c/o WDPV.
- No c/o vomiting / loose stools.
- No c/o cough / cold.

- Patient was referred to General Medicine OPD i/v/o fever& back pain since night.
- They had advised CUE which was showing pus cells 10-15.
- Patient was given symptomatic treatment.
- She was advised for admission on 16/10/21 for laparotomy and proceed.

- **<u>ON 11/10/21:</u>**

- Patient came to Gynec OPD with c/o pain abdomen since night.
- No h/o fever or headache.
- No c/o WDPV or burning micturition.
- No c/o cough or cold or fever.
- No h/o contact with COVID-19 patient / travel history.
- Patient appeared normal , vitals were stable.

- All systems were normal.
- P/A: A mass of size corresponding to 26-28wks,
  - soft to firm in consistency, non tender,
  - no guarding,
  - no rigidity.
- The patient was given the option of getting admitted, but they wanted to go home & come later for admission.

- **<u>ON 15/10/21:</u>**

- Patient came to labour ward with c/o pain abdomen since night.
- No h/o fever or headache.
- No c/o WDPV or burning micturition.
- No c/o cough or cold or fever.
- No h/o contact with COVID-19 patient / travel history.

- Patient appeared normal , all systems were normal.
- P/A: A mass of size corresponding to 24 wks size felt at the right side of abdomen, non tender.
- The patient was given symptomatic treatment.
- They were advised to get admitted, but they wanted to go home & come after the festival.

- **<u>on 16/10/21:</u>**

- At 12:20pm the patient with K/C/O ? Mucinous cyst adeno carcinoma/ ? Cystadenoma (CECT abdomen) came to labour ward with c/o pain abdomen & breathlessness since morning.
- c/o 1 episode of vomiting at home at morning.
- No h/o fever or headache.
- No c/o WDPV or burning micturition.
- No c/o cough or cold or fever.
- No h/o contact with COVID-19 patient / travel history.

- **GENERAL EXAMINATION:**
- Patient was conscious with severe respiratory distress.
- TEMPERATURE: 96.4F
- PULSE RATE: feeble, not palpable.
- BLOOD PRESSURE: not recordable, cold extremities.
- RESPIRATORY RATE: rate & depth were inadequate (gasping).
- SPO2: 80% on room air.

- CVS- normal heart sounds heard, no murmur.
- RS: decreased vesicular breath sounds heard on both sides lower lobe.
- CNS: no focal neurological deficit seen.
- P/A: abdominal distention +, guarding+ , rigidity+.
- Later anaesthetist & ER team have been called for help.

On arrival to LR

- c/o pain abdomen & breathlessness since morning.

- On examination Pulse rate was feeble & not palpable, BP was not recordable manually , abdominal distention +

- Later bed side ultrasonography was done by radiologist & gave the report as – **RUPTURED MUCINOUS CYST ADENOCARCINOMA (12X11CMS) WITH ASCITES WITH GROSS AMOUNT OF FREE FLUID IN PERITONEAL CAVITY WITH FEW INTERNAL SEPTATIONS.**

- Cold peripheries with collapsed veins were observed , SPO2 was found to be 80% with 15L of oxygen

↓

- Immediately anaesthetist & ER team had been called for help.

↓

- Anaesthetist started secured the IV line , fluid resuscitation started, after that her BP was 60/40mm Hg, PR 40bpm(low volume pulse),SPO2- 50% with 15L of O2 @ 12:35pm.

↓

- Suddenly patient had 1 episode of seizure, later ABG sample was taken , it revealed severe metabolic acidosis.

↓

- Pt was intubated i/v/o desaturation & hemodynamically unstable@12:50pm

↓

- Inj. Atropine 0.2mg IV given following fluid bolus + Inj. Adrenaline 1mg given

↓

- Monitor showed pulseless electrical activity(PEA), BP not recordable , then 1st cycle of CPR started @1:00pm.

↓

- Chest compressions were given@ 120/min + Inj. Adrenaline 1mg given

- After 2 min , monitor shows PEA, then 2nd cycle CPR started @ 1:30pm

- Chest compressions were given @ 120/min + Inj. Adrenaline 1mg given, later carotid pulse felt , in monitor BP was recorded 160/50mm Hg , PR- 170bpm, SPO2- 70% with 15L of O2.

- Inj. Noradrenaline infusion started & kept @ 10ml/hr after 5min.

- Later carotid pulse not felt, the started CPR again (6 cycles) was done followed by Inj. Adrenaline 1mg given

↓

- CPR continued, monitor shows PEA, Inj. Adrenaline 1mg given.

↓

- Again feeble carotid pulse felt , but peripheral pulses were not felt, pupils non reactive & cold peripheries noted.

↓

- After 5 min , monitor shows asystole, pt was resuscitated as per ACLS protocol

↓

- In spite of above resuscitation methods (ACLS guidelines) , patient could not be revived

  - ECG showed flat line & declared death at 3:29pm on 16/10/21.

CAUSE OF DEATH:

- Ruptured ovarian cyst
- MODS
- Cardiac arrest.

THANK YOU

4^{th} case

MORTALITY MEET

DEPARTMENT OF PAEDIATRICS

- 3 Months old
- Female baby
- Date of admission : 26-11-2021 at 8 pm
- Date of death : 27-11-2021 at 1.49 am
- Duration of hospital stay : 6 hours

PRESENTATION

- A 3 month old female child was brought to Paediatric ER on 26-11-21 at around 8 pm
- Baby was intubated at Govt. General Hospital in view of poor sensorium , low GCS and gasping respirations
- Baby was referred to NMC-H for further management

- At presentation , baby had low GCS , gasping respiration and bloody secretions in the ET Tube
- Baby was connected to mechanical ventilator with settings :

PCV Mode – 25/7 X 100% X 40X 0.3 sec

- Baby had H/O of cold , cough and restlessness for 2 days
- Baby had increased work of breathing since afternoon
- Baby had altered sensorium and was gasping 4 hrs prior to presentation to NMC-H and was hence taken to GGH.
- H/O of inconsolable cry for around 1 hr before being taken to GGH

VITALS AT PRESENTATION

- Temp : 99 ^{o} F
- HR : 170/min
- RR : gasping respirations
- BP : Non recordable
- SPO_2 : 90 % with ET insitu and ambu
- GRBS : 20 mg/dl

O/E :

- Central pulses were feeble & Peripheral pulses were not palpable
- Baby was floppy
- Peripheries were cold and cyanosed
- CRT ~ prolonged (> 5 Sec)

S.E :

- CVS : S1S2 + , No murmurs
- RS : BAE + , Conducting sounds +
- P/A : Soft , No organomegaly
- CNS: B/L pupils - sluggish reaction to light

GCS – E1 VT M1

At 8.15 PM

- There were multiple pricks on all possible vein sites
- Hence , intraosseous line was secured & 2 Bolus of 20ml/kg NS was given
- Inj Vitamin K of 1 mg was given

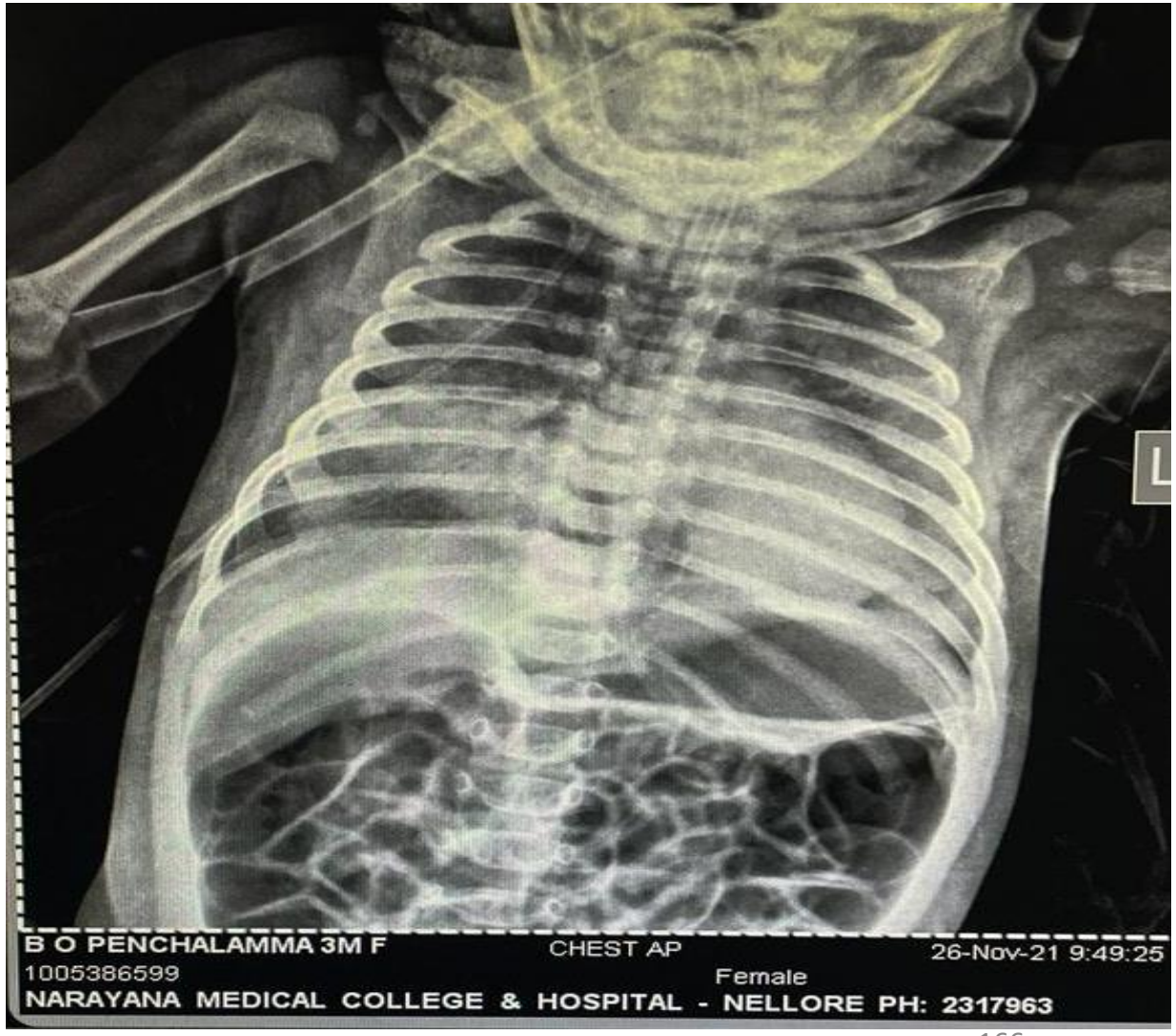
- In view of low GRBS , 10%D given at 4ml/kg was given
- GRBS checked after 30 mins => GRBS improved – 68 mg/dl
- Baby started on 1 and ½ maintainance fluids and IV antibiotics were started
- Baby was catharized . No urine output noted

- Rapid test for covid – done and it was negative
- Blood and urine

Investigations couldn’t be done

- chest X-ray was done
- Showing non homogenous

Opacities



At 10PM

- Baby had sudden desaturation with bradycardia while connected to ventilator.
- CPR was started with chest compressions and bag and tube ventilation.
- 1st dose of Injection adrenaline was given at 0.1ml/kg (1:10,000)
- HR improved to > 100/min

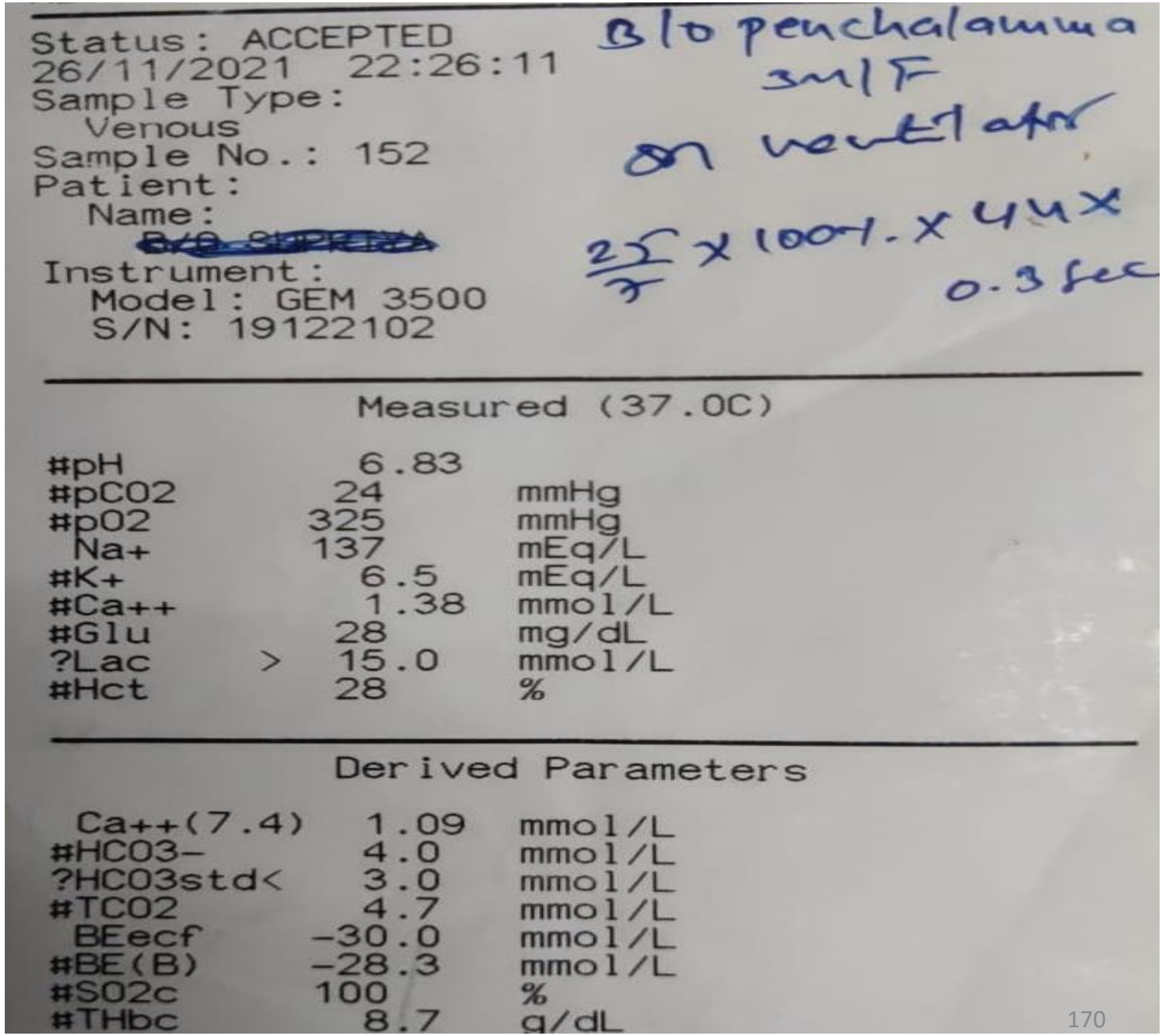
At 10.10 PM

- Baby had another episode of desaturation with bradycardia
- Chest compressions continued with bag and tube ventilation.
- Second dose of adrenaline injection was given

At 10.15 PM

- Third dose of adrenaline injection was given as baby was still having bradycardia
- Heart rate improved,Saturation:92%
- Then baby was connected to mechanical ventilator with PCV mode.
- Adrenaline infusion started at 0.2 mic/kg/min
- Despite fluid and inotrope , BP was not recordable

- VBG was done



Status: ACCEPTED
26/11/2021 22:26:11
Sample Type:
Venous
Sample No.: 152
Patient:
Name:
[redacted]
Instrument:
Model: GEM 3500
S/N: 19122102

B/o penchalamma
3m/F
on ventilator
25/7 x 1004. x 44x
0.3 sec

Measured (37.0C)

#pH		6.83	
#pCO2		24	mmHg
#pO2		325	mmHg
Na+		137	mEq/L
#K+		6.5	mEq/L
#Ca++		1.38	mmol/L
#Glu		28	mg/dL
?Lac	>	15.0	mmol/L
#Hct		28	%

Derived Parameters

Ca++(7.4)		1.09	mmol/L
#HCO3-		4.0	mmol/L
?HCO3std	<	3.0	mmol/L
#TCO2		4.7	mmol/L
BEecf		-30.0	mmol/L
#BE(B)		-28.3	mmol/L
#SO2c		100	%
#THbc		8.7	g/dL

- In view of severe metabolic acidosis , PH < 7 Bicarbonate correction was started

At 11PM:

- Baby was shifted to PICU for further management.
- In PICU connected to mechanical ventilator with the PCV mode with settings: 25/7 X 100% X 44 X 0.3 sec
- Severe ET bleeds and OG bleeds noted

At 12 AM (27/11/21)

- Peripheries – Dusky , CRT – 4 sec , P.I – 0.3, Central and peripheral pulses were feeble
- Bolus was given at 10ml /kg over 30 mins
- Maintenance fluids and adrenaline infusion continued
- Baby showed no improvement
- No urine output was noted since admission

At 1.30 AM

- Sudden desaturation was observed
- Heart rate: 40/min
- Chest compressions started with bag and tube ventilation.
- 1st dose of Inj Adrenaline given

At 1.35 AM

- Second dose of Adrenaline given.
- Chest compressions continued with bag and tube ventilation.

At 1.40 AM

- Third dose of Adrenaline given.
- Chest compressions continued with bag and tube ventilation
- No improvement observed

At 1.49 AM

- Inspite of above resuscitation efforts , Baby could not be revived and declared dead at 1.49 AM on 27/11/21.

- Cause of death : Severe metabolic acidosis with fluid and inotrope refractory shock secondary to - ? Sepsis or ? IEM

Thank you