COLUMBIA ASIA

Address : KIRLOSKAR BUSINESS PARK,BELLARY ROAD,HEBBAL,BANGALORE,KARNATAKA, INDIA.PIN-560024.

Tel : 41791000,41791000
Fax : 41791002

DISCHARGE SUMMARY

Patient Name : PRAVEEN S N

Passport No. :
MRN : HEBL-0000009600
Visit No. : A0000000001-HEBL
Date Of Birth : 29/05/1966
Age : 45 Years 9 Months 3 Days
Sex : MALE
Blood Group :
Ward /Rm /Bed No. : OB04 / 121 / 1211

Admitting Consultant : DR GURUPRASAD H

Department : NEUROLOGY

Admitting Group :

Admission Date : 03/03/2012
Discharge Date : 07/03/2012
Discharge Type : DISCHARGED - DOCTOR ADVICE

Admission diagnosis :

Acute relapse of multiple sclerosis; dorsal cord demyelination with right > left LL pyramidal weakness with sensory loss

Discharge diagnosis :

Acute relapse of multiple sclerosis; dorsal cord demyelination with right > left LL pyramidal weakness with sensory loss

Consultants involved :

DR. GURUPRASAD.H
DR. ANURADHA.HK
DR. RAGHUNATH Anesthisia
DR. ARAVINDA.SN

Brief history and physical on admission :

46yrs old gentleman

h/o weakness in the right > left Ll with ocassional buckling in the knee since last 3 days
paresthasae in the right > Left Ll.
difficulty in climbing stairs
no bladder symptoms
previously had cervical demyelination with right UL paresthasae; received iv solumedrol
had recovered well
right thalamic demyelinating lesion in 2006, completely recovered
non HT/DM

o/e weakness in the LLs with brisk reflexes
planters extensor
gait - spastic

Course in the hospital :

patient admitted with acute relapse in the form of LL weakness and sensory symptoms, MRI dorsal spine showing fresh enhanci lesion in the cord at d8-d9 level s/o demyelinating plaque, received 5 days of iv solumedrol 1gm/day. he showed improvement the LL weakness and paresthasae and tolerated the steroid injections well. LP done for CSF study was normal and oligoclonal band report is awaited. He was stable and was discharged. Plan is start on interferon after the oral steroid dose is completed.

Surgeries Performed :

nil

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Sex	:	MALE
Blood Group	:	
Ward /Rm /Bed No.	:	OB04 / 121 / 1211

Investigations :

COMPLETE BLOOD COUNT | KIDNEY FUNCTION TEST* SODIUM*POTASSIUM*CHLORIDE* CREATININE*BLOOD UREA* URICACID* | GLUCOSE, RANDOM (R) | CEREBRO SPINAL FLUID ANALYSIS | CSF PROTEIN ELECTROPHORESIS / OLIGOCLONAL BANDS | COAGULATION PROFILE, PLATELET COUNT, PROTHROMBIN TIME, APTT

Condition at discharge :

stable
mild right LL weakness

Discharge Medication and advice :

t.medrol 16mg 2 tabs at 8am for 5 days, followed by
1 tab at 8am for 5 days, followed by
4mg 2 tabs at 8am for 5 days, followed by
1 tab at 8am for 5 days, and stop
T.sompraz 20mg 1 tab before breakfast for 20 days and stop
T.gabantin 100mg 1 - 1 at 8am - 8pm for 20 days
blood sugar monitoring

Follow up /appointment :

review in neurology OPD after 3 weeks

Discharge Instructions / When to Obtain Urgent Care :

"Please contact the hospital(080-41791000) if symptoms reocur or patient is in distress"

Signature

DR ARVINDA SN
MBBS, MD, INTERNAL MEDICINE

Consultant - HOSPITALIST
Regn No. : KMC-65872

For and Behalf Of :

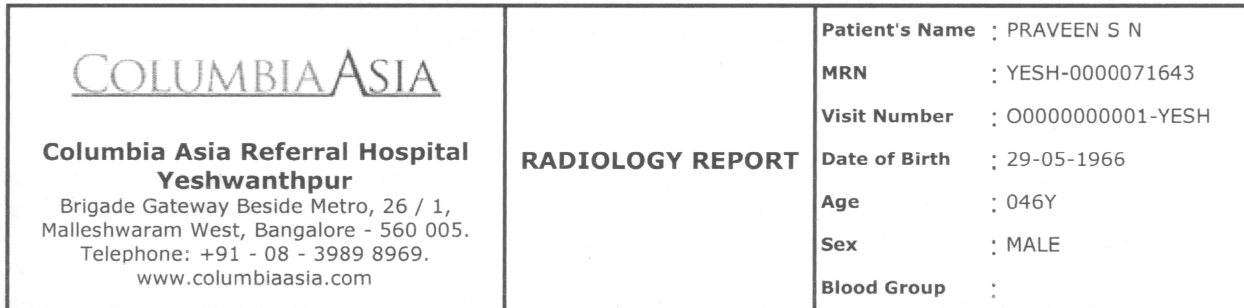
DR GURUPRASAD H

Consultant - NEUROLOGY
Regn No. :

In case of Emergency/Questions, please contact - 080-41791000

COLUMBIA ASIA

RADIOLOGY REPORT



Columbia Asia Referral Hospital Yeshwanthpur Brigade Gateway Beside Metro, 26 / 1, Malleshwaram West, Bangalore - 560 005. Telephone: +91 - 08 - 3989 8969. www.columbiaasia.com	RADIOLOGY REPORT	Patient's Name : PRAVEEN S N MRN : YESH-0000071643 Visit Number : O0000000001-YESH Date of Birth : 29-05-1966 Age : 046Y Sex : MALE Blood Group :

Report Date / Time : 01/03/2012 20:02:43
Clinic :
Ref Doctor : DR GURU PRASAD H

PROCEDURE
MRI WHOLE SPINE

FINDINGS

Contrast MRI of the Whole Spine:

MRI of the Cervical Spine:

CV junction:
The CV junction is normal.
There is no significant spinal canal stenosis.

C2 - C3:
The vertebral body and posterior elements are normal.
The disc height and hydration are well maintained.
The disc contour is normal.
There is no significant spinal canal or neural foraminal stenosis.
The uncovertebral joints are unremarkable.

C3 ??? C4:
The vertebral body and posterior elements are normal.
The disc height and hydration are well maintained.
The disc contour is normal.
There is no significant spinal canal or neural foraminal stenosis.
The uncovertebral joints are unremarkable.

C4 ??? C5:
The vertebral body and posterior elements are normal.
The disc height and hydration are well maintained.
The disc contour is normal.
There is no significant spinal canal or neural foraminal stenosis.
The uncovertebral joints are unremarkable.

RADIOLOGY REPORT

C5 ??? C6:
The vertebral body and posterior elements are normal.
The disc height and hydration are well maintained.
The disc contour is normal.
There is no significant spinal canal or neural foraminal stenosis.
The uncovertebral joints are unremarkable.

C6 ??? C7:
The vertebral body and posterior elements are normal.
The disc height and hydration are well maintained.
There is diffuse disc bulge with moderate compromise of bilateral neural foramina L> R probably impinging on corresponding exiting nerve roots.
There is no significant spinal canal stenosis.
The uncovertebral joints are prominent.

T1 ??? T12:
- The vertebral body and posterior elements are normal.
- The disc heights and hydration are well maintained.
- The disc contours are normal.
- There is no significant spinal canal or neural foraminal stenosis.
- The facet joints are unremarkable.
- The thecal sac and spinal cord are normal.

L1-L5 and sacrum:
- The disc height and hydration are well maintained.
- The disc contour is normal.
- There is no significant spinal canal / neural foraminal stenosis.
- The facet joints are unremarkable.

The visualized brainstem and cerebellum are normal.
Two Focal plaque like hyperintensities seen in the cervical cord at level of bodies of C2 and C4 spinal cord in the previous imaging dated 18-09-2010, show mild reduction in the size with no significant enhancment.
There is a central T2W hyperintese lesion along the length of the cord showing significant enhancment at T7-T8 level.
There is a The conus medullaris is at T12- L1 level.

IMPRESSION

44 year old male known case of Multiple sclerosis, now complains of right lower limb weakness, Contrast MRI whole spine study shows :
1. C6 ??? C7 diffuse disc bulge with moderate compromise of bilateral neural foramina L> R probably impinging on corresponding exiting nerve roots.
2. Mild regression in the hyperintense plaques in cervical cord at C2 and C4 levels.
3. Central T2W hyperintese lesion along the length of the cord showing significant enhancment at T7-T8 level- Suggestive of active demyelination.

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COLUMBIA ASIA

RADIOLOGY REPORT

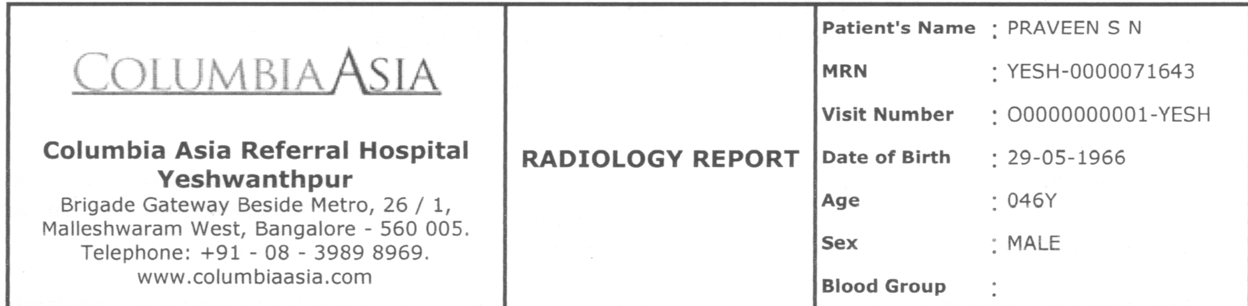
Dr. Shailender Singh MD
Consultant Radiologist

Printed By
User

Print Date and Time
02-03-2012 09:58:24

COLUMBIA ASIA

RADIOLOGY REPORT



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Report Date / Time : 01/03/2012 19:31:39
Clinic :
Ref Doctor : DR GURU PRASAD H

PROCEDURE

MRI BRAIN WITH GADOLINIUM

FINDINGS

MRI of the Brain following intravenous gadolinium:

TECHNIQUE: Multiplanar T1, T2, FLAIR, ADC, DWI and post Gadolinium T1 weighted scans of the brain were performed.

CEREBRAL PARENCHYMA: There is a non specific T2W and FLAIR white matter hyperintensity in the left high pareital region. No enhancemen ton contrast is seen.
BASAL GANGLIA, THALAMI: Normal.
INTERNAL CAPSULE: Normal.
VENTRICLES: Normal.
SULCI and BASAL CISTERNS: Normal.
MIDLINE SHIFT / MASS EFFECT: nil
CEREBELLUM: Normal.
MIDBRAIN, PONS, MEDULLA: Normal.
CV JUNCTION: Normal.
SELLA: Normal.
ORBITS: Normal.
CAVERNOUS SINUSES: Normal.
PARANASAL SINUSES and MASTOID AIR CELLS: Normal.
BONES: Normal.

IMPRESSION

45 year male with history of right Lower Limb weakness and buckling, Contrast MRI study of the brain shows :

- Non specific T2W and FLAIR white matter hyperintensity in the left high pareital region.

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This report is subject to the terms and conditions mentioned overleaf

COLUMBIA ASIA

RADIOLOGY REPORT

N. [signature]

Dr. Shailender Singh MD
Consultant Radiologist

Printed By
User

Print Date and Time
02-03-2012 09:58:49

This report is subject to the terms and conditions mentioned overleaf

COLUMBIA ASIA	**PATIENT ADVICE**	Patient Name : PRAVEEN S N
Address : 26/1, BRIGADE GATEWAY,,BESIDE METRO,,MALLESWARAM WEST,,BENGALURU,KARNATAKA,INDIA.PIN-560055.		Passport No.: :
		MRN : YESH-0000071643
		Visit No. : V0000000003-YESH
		Date Of Birth : 29/05/1966
		Age : 45 Years 9 Months 0 Days
		Sex : MALE
		Blood Group :
		Ward /Rm /Bed No. :
Tel : 080-39898969,080-39898969		
Fax : 080-30925454		

Date : 29/02/2012

Advice :

46yrs old gentleman

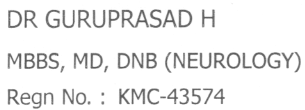
remitting relapsing type of MS
relapses in 2006 and 2010
previously received iv solumedrol in 2010
right LL weakness and buckling since last few days
more so since today morning
also feels change in temperature sensation in the right LL

o/e no weakness
KJ brisk
gait - normal

acute relapse of MS; mostly cervicodorsal cord demyelination

advice;
MRI whole spine with sos contrast
MRI brain focus study
will review

Signature :



DR GURUPRASAD H
MBBS, MD, DNB (NEUROLOGY)
Regn No. : KMC-43574

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