

DISCHARGE SUMMARY

Name	: PRAVEEN S N	Attending Consultant	: Dr.GURUPRASAD H
Age/Sex	: 44 / MALE	Referrals	: hospitalist team
MRN	: 0000139297	Department	: Neurology
Date Of Admission	: 21/09/2010		
Date of Discharge	: 25/09/2010		

Presenting Complaints & History of Present illness :

cervical pain with paresthasae in both ULs since last few days
occasional clumsiness in the hands
no weakness in the LLs
no unsteadiness of gait
diagnosed to have CVA in 2006; MRI brain showed right thalamic infarct
recovered well except for residual left hemisensory symptoms
on medications
recent mri brain - normal

Past Medical History :

diagnosed to have CVA in 2006; MRI brain showed right thalamic infarct
non HT/DM

Allergies :

nil

Social / Family History :

not contributory

Physical Examination at Admission :

o/e no motor weakness
KJ brisk
rhomberts positive

Course in Hospital

a) Ventilator days

nil

b) Days on Antibiotics with Names :

nil

c) Other relevant information :

patient diagnosed to have cervical cord demyelinating lesions with clinically recent onset mild cervical myelopathy was admitted for iv methylprednisolone injections. His blood sugar were elevated requiring insulin inj according to sliding scale probably related to steroids. he tolerated the steroids well. LP was done, routine CSF analysis was normal. He was stable and was discharged.

Diagnosis

a) Primary Diagnosis :

Multiple sclerosis, relapsing remitting type; present relapse - mild cervical myelopathy

b) Secondary Diagnosis :

steroid induced hyperglycemia

Condition on Discharge :

stable

Reports to be enclosed :

CSF report, CBC, blood sugar, HbA1c

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DISCHARGE SUMMARY

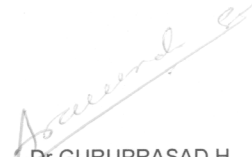
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Discharge Medication :

T.Wysolone 40mg 1 at 8am for 3 days, followed by
30mg 1 at 8am for 3 days, followed by
20mg 1 at 8am for 3 days, followed by
10mg 1 at 8am for 3 days and stop
T.pantocid 40mg 1 before breakfast for 15 days
T.gabantin 100mg 1 - 1 for 15 days
T. Amaryl 1mg 1-0-0 X till on steroids
Diabetic diet

Follow up/Advice /Appointment :

review in neurology OPD after 5 days with FBS report


Dr.GURUPRASAD H

Signature

In case of Emergency kindly contact Ph 080-41791504

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RADIOLOGY REPORT

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Malleshwaram West, Bangalore-560055.
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RADIOLOGY REPORT

Patient's Name : PRAVEEN S N
MRN : YESH-0000071643
Visit Number : V000000001-YESH
Date of Birth : 29.05.1966
Age : 044Y
Sex : MALE
Blood Group :

Report Date / Time : 18.09.2010 15:54:23

Speciality : NEUROLOGY

Ref Doctor : GURUPRASAD H

PROCEDURE

FINDINGS

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.

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RADIOLOGY REPORT

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Age : 044Y
Sex : MALE
Blood Group :

The uncovertebral joints are unremarkable.

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.

The visualized brainstem and cerebellum are normal.

Two Focal plaque like hyperintensities are seen in the cervical cord at level of bodies of C2 and C4 spinal cord are normal.
Post Contrast sequences did not show enhancement.

SCREENING OF BRAIN: Normal.

VISUALIZED NECK: The visualized thyroid, trachea, esophagus, carotid arteries and internal jugular veins are normal.

SCREENING OF THE THORACIC AND LUMBAR SPINE:

There is no significant indentation on the thecal sac or obvious spinal cord abnormality in the thoracic or upper lumbar regions, as visualized on screening sagittal T2 images.
The conus medullaris is at T12- L1 level.
The visualized vertebral bodies show normal stature, alignment and marrow signal characteristics.

IMPRESSION

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44 year old male with neck pain radiating to right upper limb and numbness of right upper limb.
MRI Cervical spine shows:

1. C6 C7 diffuse disc bulge with moderate compromise of bilateral neural foramina L> R probably impinging on corresponding exiting nerve roots.
2. Prominent uncovertebral joints at same level.
3. Non enhancing hyperintense plaques in cervical cord - suggestive of demyelination.
4. Normal post contrast screening brain single sequence.

Recommend clinical correlation and further evaluation.

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44 year old male with neck pain radiating to right upper limb and numbness of right upper limb.
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REPORTED BY

Dr.Sunita Gopalan
Consultant Radiologist

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