COLUMBIA ASIA
21st Century Healthcare

# 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
ocassional 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
rhombergs 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 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

COLUMBIA ASIA
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**RADIOLOGY REPORT**

| | | |
|---|---|---|
| Patient's Name | : | PRAVEEN S N |
| MRN | : | YESH-0000071643 |
| Visit Number | : | V0000000001-YESH |
| Date of Birth | : | 29.05.1966 |
| Age | : | 044Y |
| Sex | : | MALE |
| Blood Group | : | |

**Report Date / Time** : 18.09.2010 15:54:23
**Speciality** : NEUROLOGY
**f 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.
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.

RADIOLOGY REPORT

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|---|---|

The uncovertebral joints are unremarkable.

C5 C6:
The vertebral body and posterior elements are normal.
e 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.

UALIZED 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 responding 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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**REPORTED BY**

Dr.Sunita Gopalan
*Consultant Radiologist*





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