A 43year old man presented with cough and breathlessness

Presented by
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PARTICULARS OF THE PATIENT:

- **Patients name : Mr. Md. Ismail ,43 years .**
- **Address : Chittagong .**
- **Marital status : Married**
- **Occupation : Computer programmer .**
- **Date of admission : 04/12/2005(through OPD)**
- **Date of examination : On the day of admission**

***The presenting complaint* :**

- Breathlessness for 4 months .
- Cough for same duration .

The H/O the present Illness:

- ***Breathlessness for 4 months***
  - Initially on moderate to severe exertion gradually progressive and relieved by rest .
  - No chest pain ,wheeze, diurnal or postural variation
  - No history of paroxysmal nocturnal dyspnoea or orthopnoea .

The H/O the present Illness (cont..):

- ***Cough for same duration***
  - Non productive ,persistent and irritant .
  - Aggravated by cold exposure
  - Not associated anorexia, haemoptysis, hoarseness of voice .
  - No history of weight loss

H/O Past Illness:

- Bilateral pleural effusion-9 months back
- Complete heart block with IHD and LVF 1 ½ years back
- No history of Diabetes mellitus ,HTN, Bronchial asthma .

Treatment History:

- For cough tab Amoxycalv for 2 weeks 1o months back.
- For pleural effusion 4FDC for 3 months and 2FDC for 4½ months
- PPM was inserted 1½ years back .
- Anti anginal ,anti platelet drugs for 1½ years

Family History:

- Father died from Stroke 4years back.
- Mother suffering from DM,HTN,Stroke.
- Brother treated with PPM due to heart block
- Other members of the family are in good health

Personal History:

- EX-Smoker.
- No history of contact with bird .

Socioeconomic Status:

- middle class family

H/O Immunization:

- A scar mark for vaccination is present at left arm

H/O Allergy:

- No history of allergy to any food, drug or environmental allergen.

General Examination :

- **Appearance**- Anxious
- **Co-operative**
- **Built**- Average
- **Nutritional status-**well nourished
- **Decubitus**- on choice
- **Anaemia**- absent
- **Jaundice**- absent
- **Cyanosis**- absent
- **Dehydration**- absent
- **Oedema**- absent
- **Leuconychia**-absent
- **Clubbing**- present
- **Koilonychia**- absent

- **Pulse**- 84/min
- **BP**- 110/80 mm of Hg
- **Respiration**- 32/min
- **Temperature**- 98°F

- **Thyroid gland-** not enlarged
- **Lymph node-** not enlarged
- **Neck vein-** not engorged

Respiratory System Examinations:

- Shape-Normal .(permanent pace maker in situ on left upper chest)
- Movement – bilateral symmetrically reduced.
- No intercostal or suprasternal recession
- Mediastinum – central.
- Chest expansibility – 2 cm
- Percussion note – Impaired in lower zone of both lung fields.
- Breath sound – vesicular but diminished in both lower zone
- Both inspiratory and expiratory coarse creps in both lower lung fields .

Cardiovascular System:

- Pulse – 84/min, regular, low volume
  Peripheral pulses intact.
- JVP – Not raised
- Precordium
  - Apex beat – Left 5th intercostal space,
    9 cm from midline
  - Gallop rhythm present

Alimentary System Examinations:

- **Mouth and oral cavity**

  -Normal

- **Abdomen proper**

  - No organomegaly or ascites

Other Systems:

Normal

Summary of Clinical Features:

Mr. Ismail, 43year-old, married, Non diabetic ,non hypertensive ,non asthmatic ex-smoker computer programmer hailing from chittagong was admitted into DMCH with complains of breathlessness and cough for 4 months . His shortness of breath was initially following on moderate to severe exertion which is progressive and now is unable to walk more than 50 yards. NO history of chest pain , wheeze ,diurnal and postural variation and no history of paroxysmal nocturnal dyspnoea .His cough is persistent, non productive, irritant aggravated by cold exposure .Not associated with anorexia ,haemoptysis. He had bilateral pleural effusion 9 months back and treated with anti-TB drug for 7 ½ months. He has permanent pace maker inserted 11/2 years back for complete heart block with IHD and LVF

Cont..

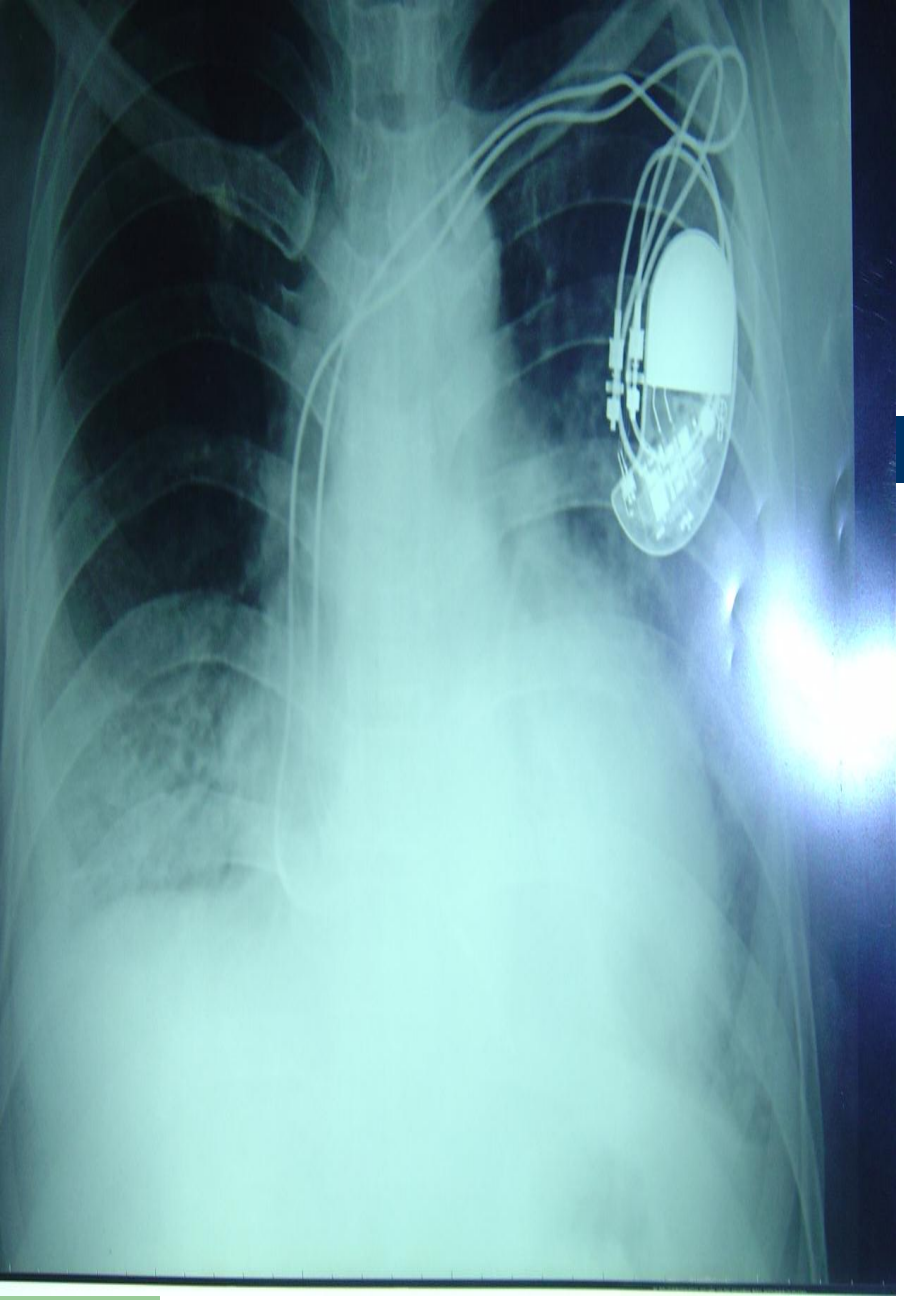
He has strong family history of IHD ,Stroke, DM .He is anxious looking ,well build ,not anaemic not cyanotic but early sign of clubbing is present .He has no lymphadenopathy, or organomegaly no engorged vein. His pulse is 84/min , BP 110/80 mm of Hg, Resp rate -32/min,temp-98^{o}F.on respiratory system examination chest movement is symmetrically reduced, mediastinum is central ,chest expansibility 2cm,percussion note is impaired in lower zone ,breath sound is vesicular with diminished intensity and inspiratory and expiratory coarse creps is present in both lower zone .On cardiovascular system examination pulse rate is 84/min low volume all peripheral pulses are present no radio femoral delay. apex beat in 5th intercostal space 9cm from midline .Gallop rhythm is present in all vulvular area .other systems examination reveal no abnormality.

Differential Diagnosis:

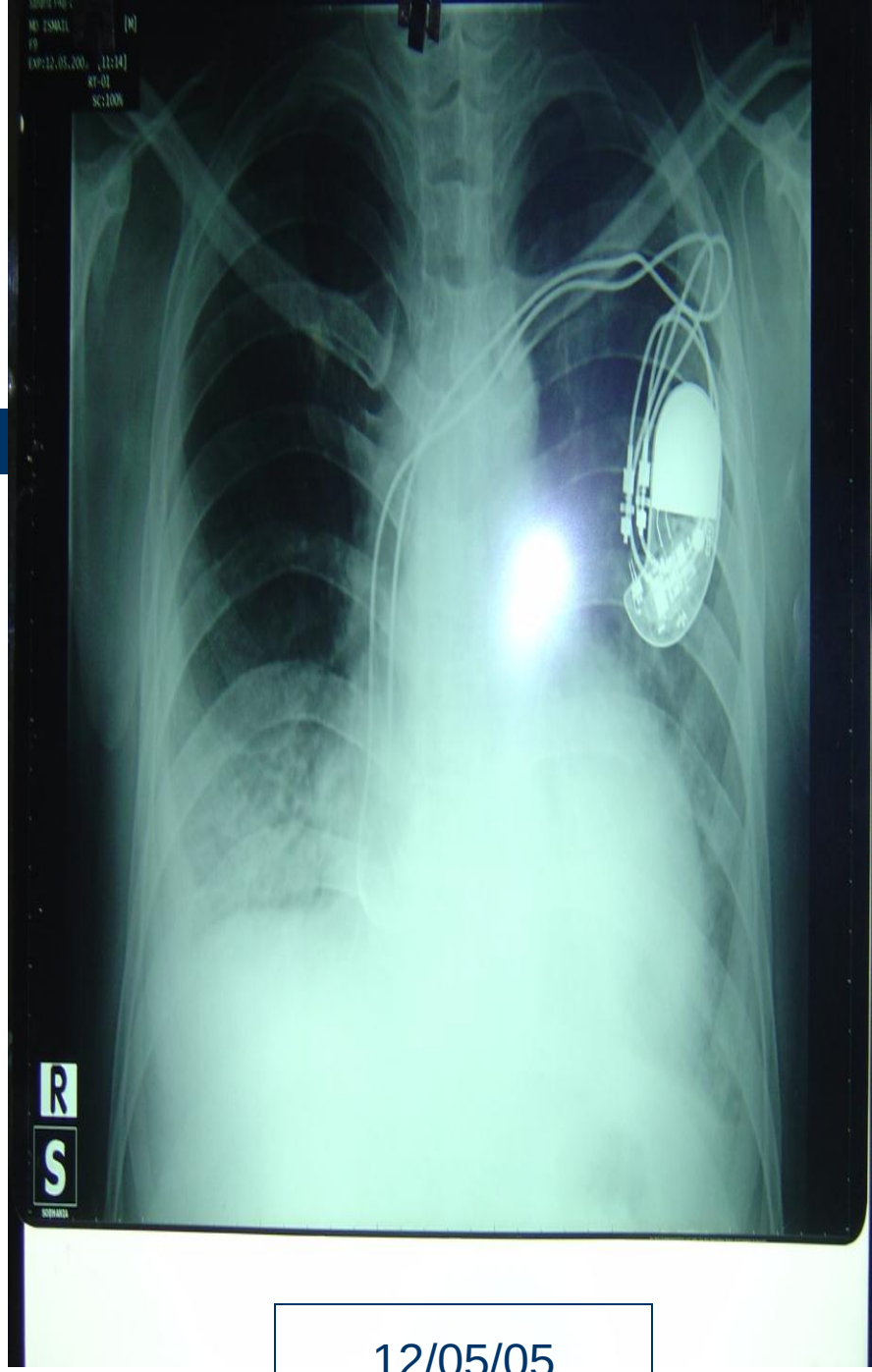
- Interstitial lung disease with bilateral pleural effusion with LVF.
- Pulmonary fibrosis with bilateral pleural effusion with LVF.
- Drug resistant Pulmonary tuberculosis with bilateral pleural effusion with LVF

Investigations:

Date	HB (gm/dl)	ESR(mm in 1st hr)	TLC(/cmm)
05/03/05	12.0	75	9000 Pn-60% L-26%
21/05/05	11.21	66	9000 Pn-58% L-26%
22/09/05	11.6	46	9200 Pn-58% L-34%
04/12/05	13.2	14	4800 Pn-56% L-37%



17/03/05



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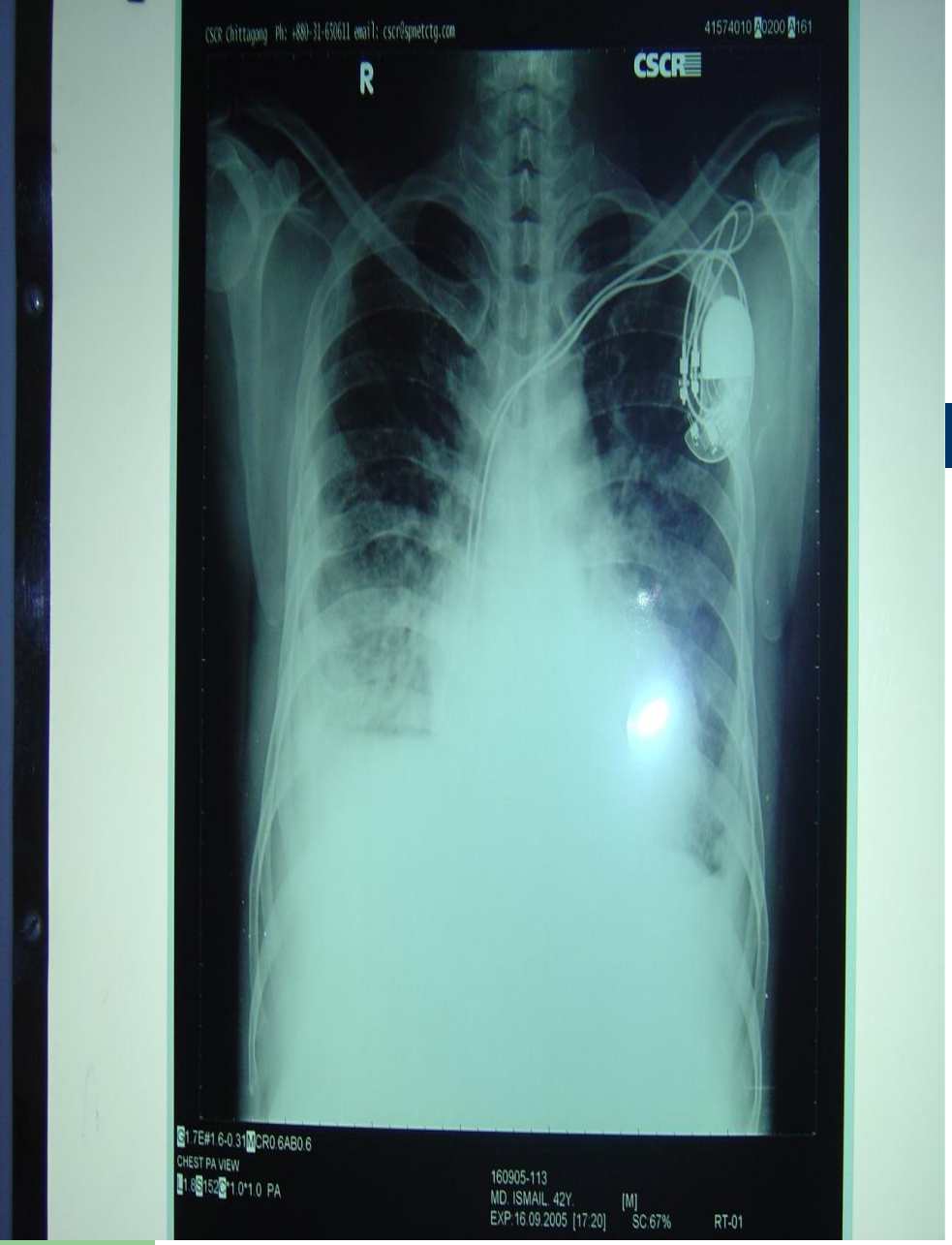

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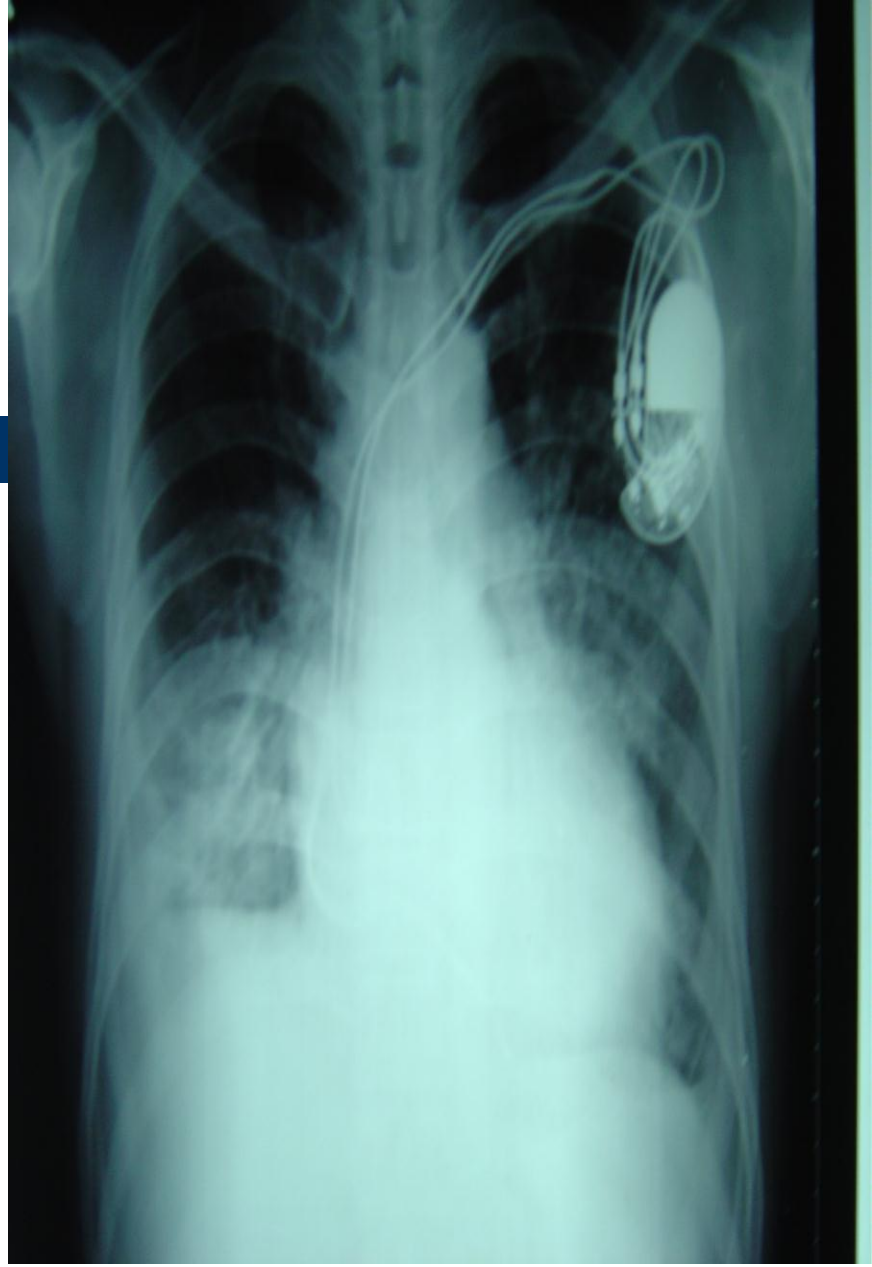

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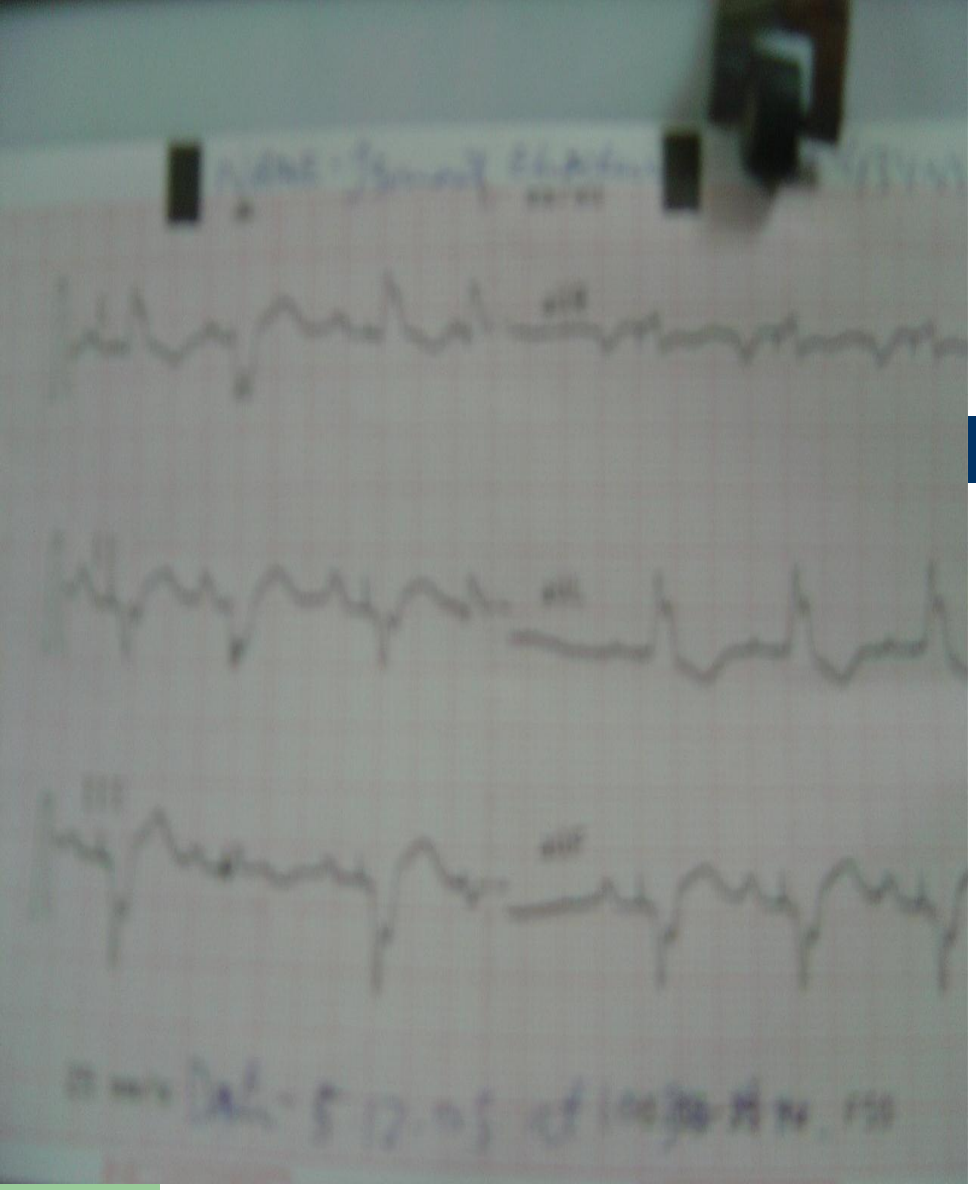
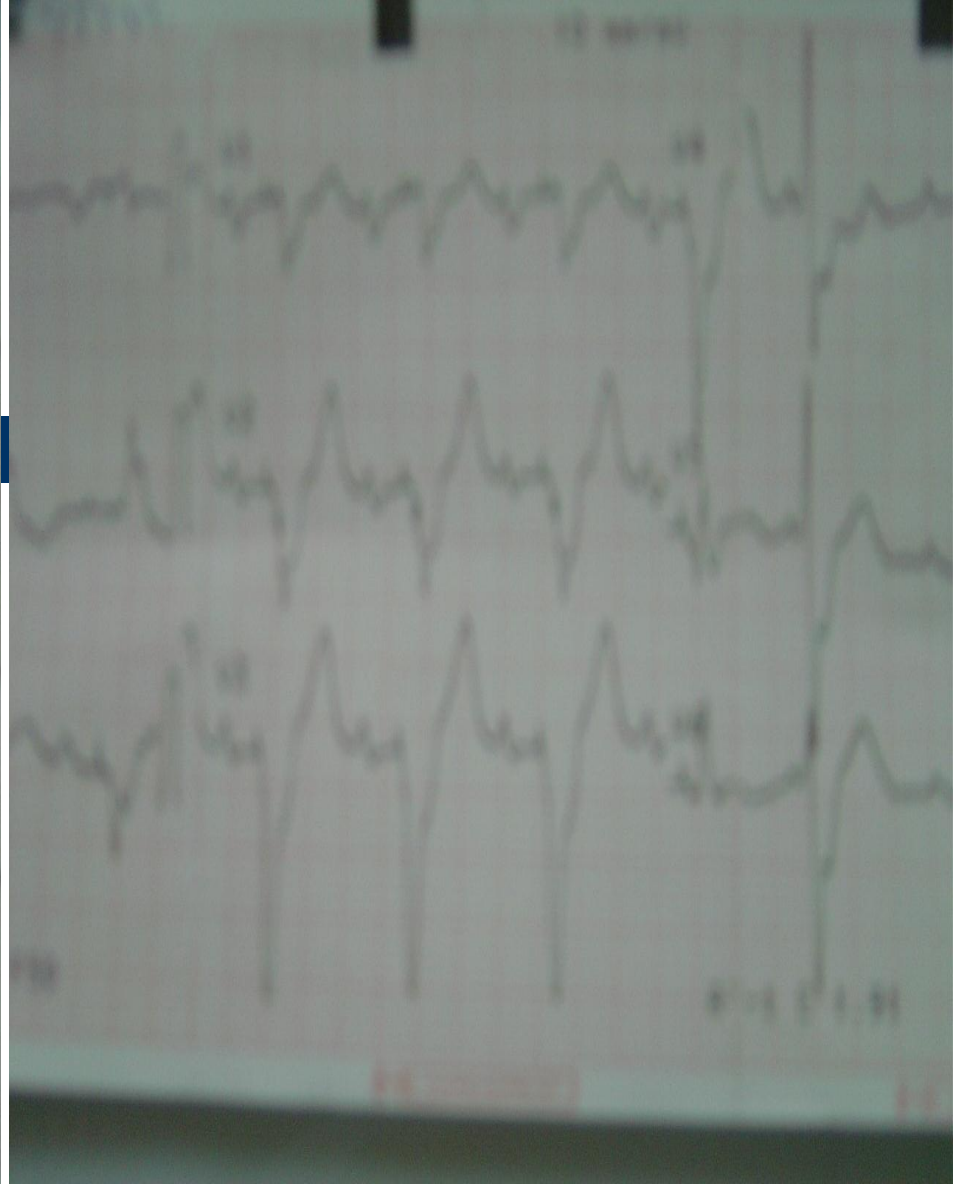


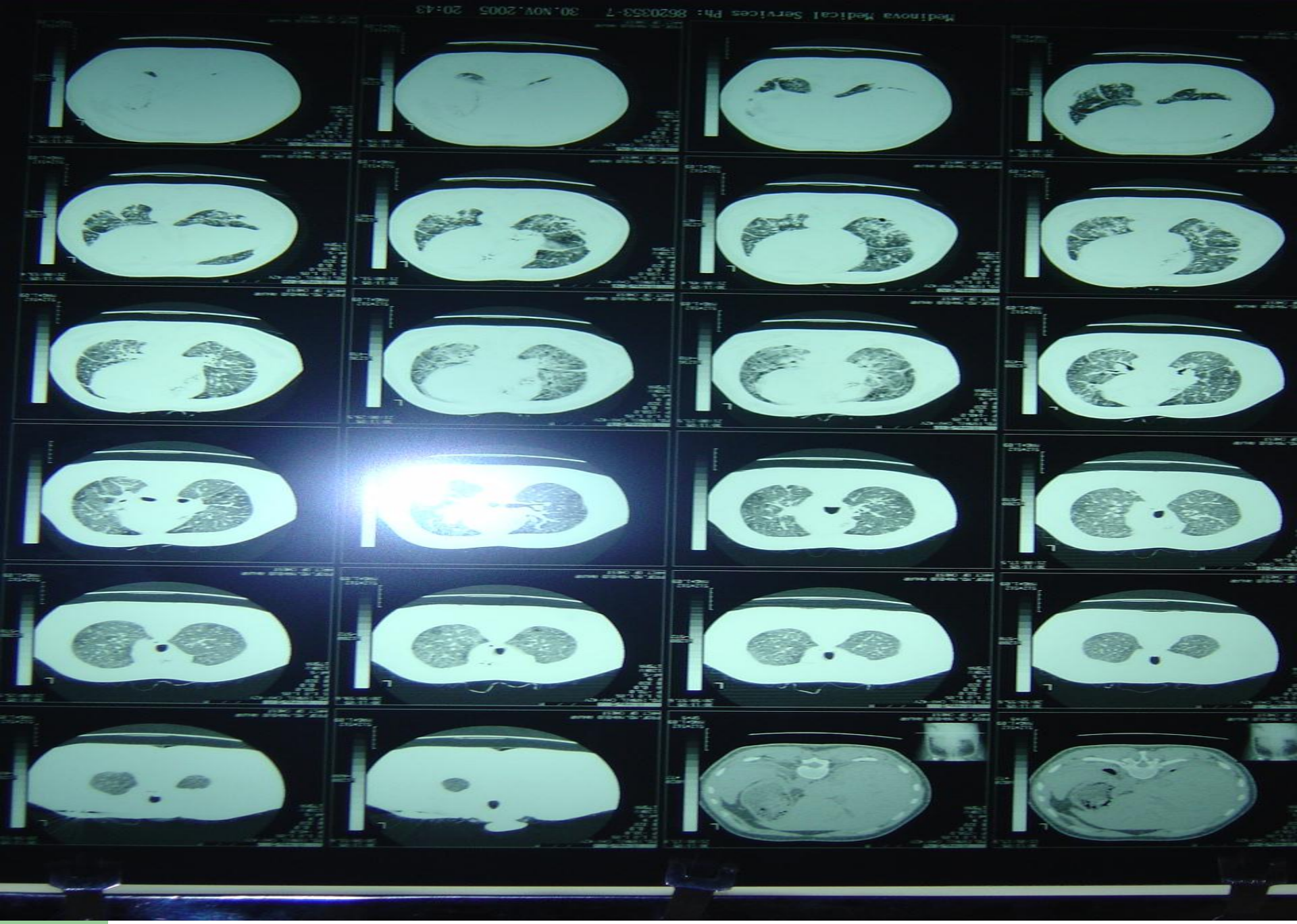


05/12/05

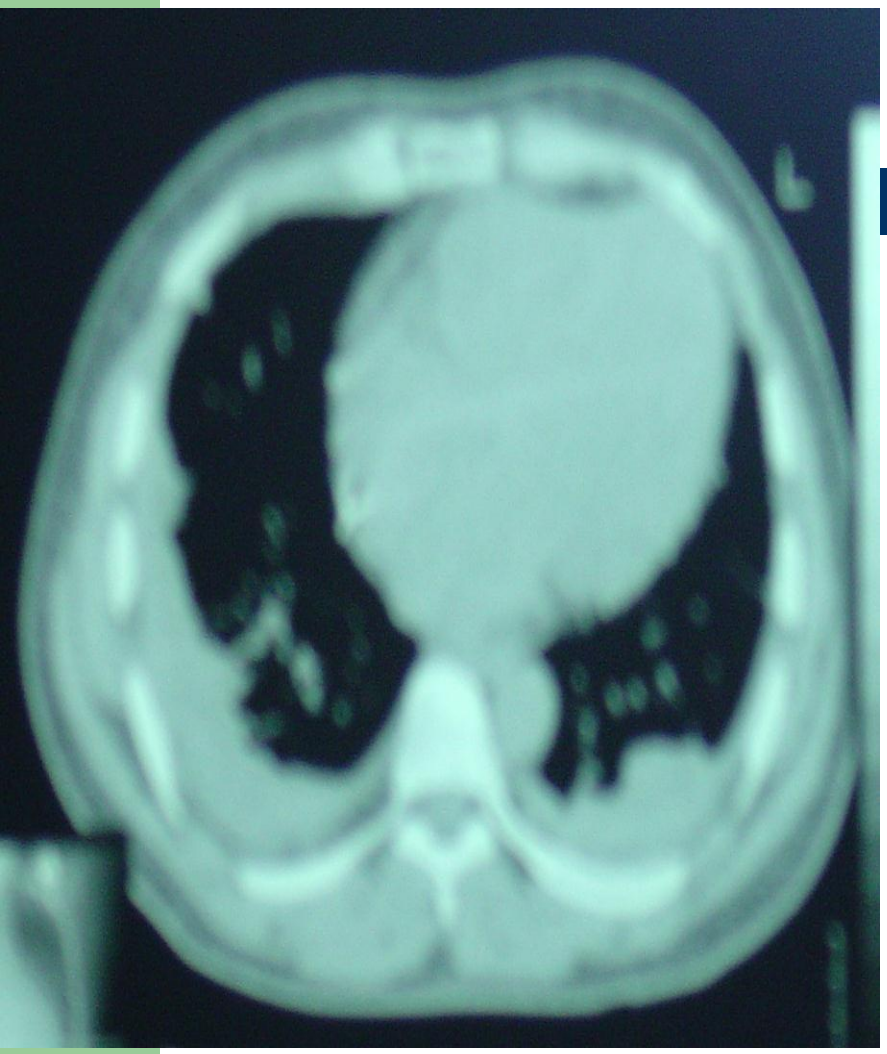
Investigations (cont…)

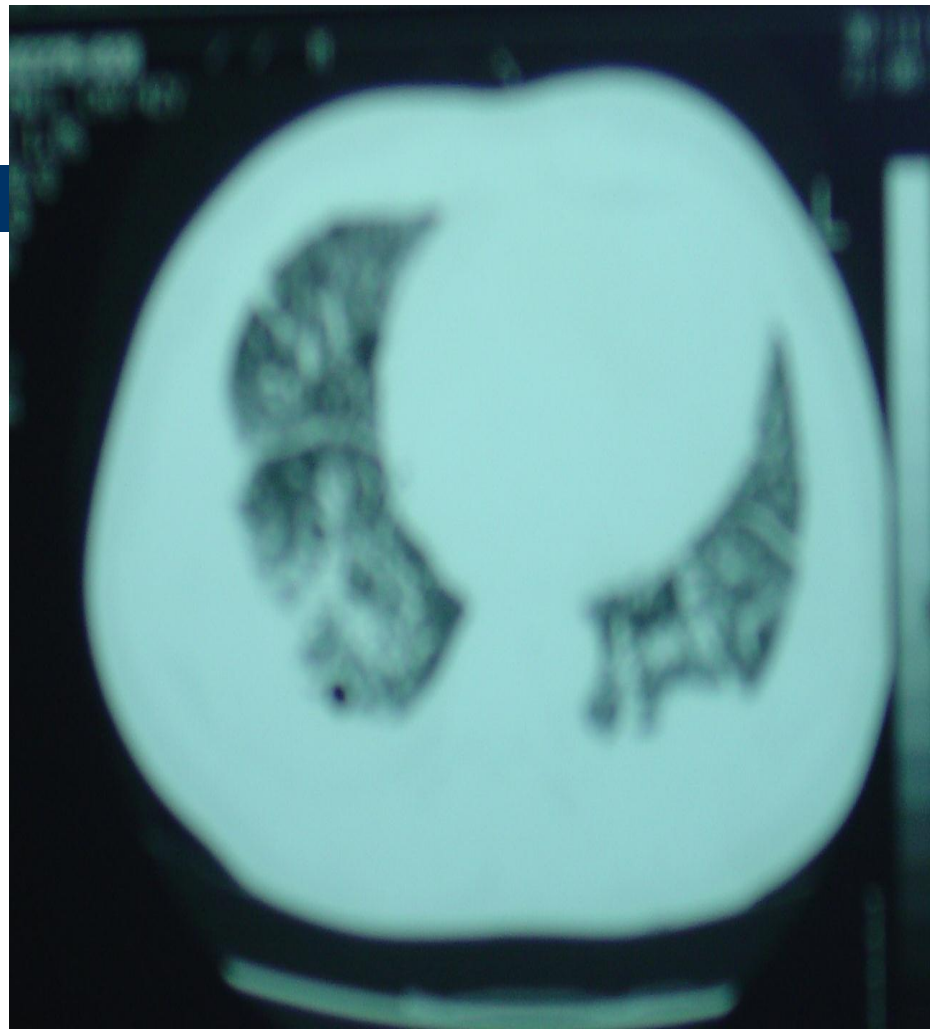
- RBS-7.94mg/dl.
- S.Bilirubin-1.9mg/dl.
- SGPT32.6u/l
- Pleural fluid study –Sugar-77mg/dl.protein-5.7mg/dl. RBC-70,000/cc .WBC-16,000/cc (19/03/05)
- Spirometry –severe restriction . (30/11/05)
- ANF-(+ve) (04/12/05)
- Anti DS DNA-(-ve)

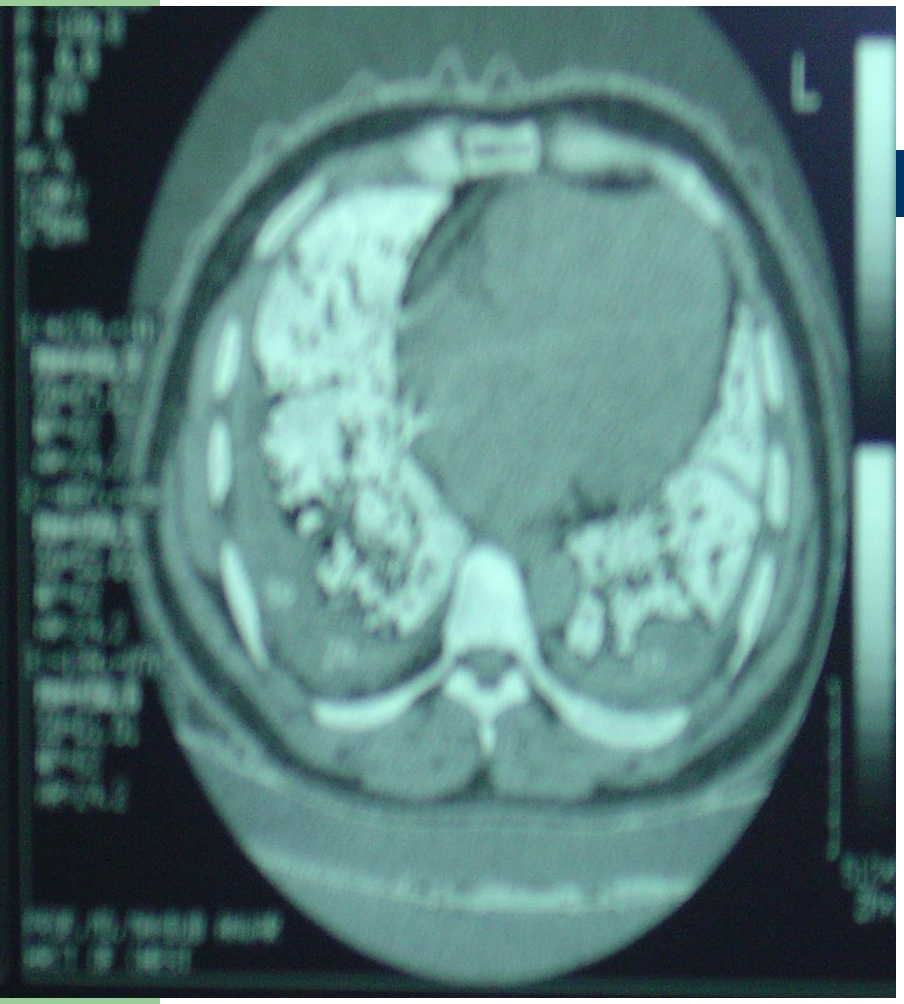
ECHO –Concentric hypertrophy LV with mild pericardial effusion

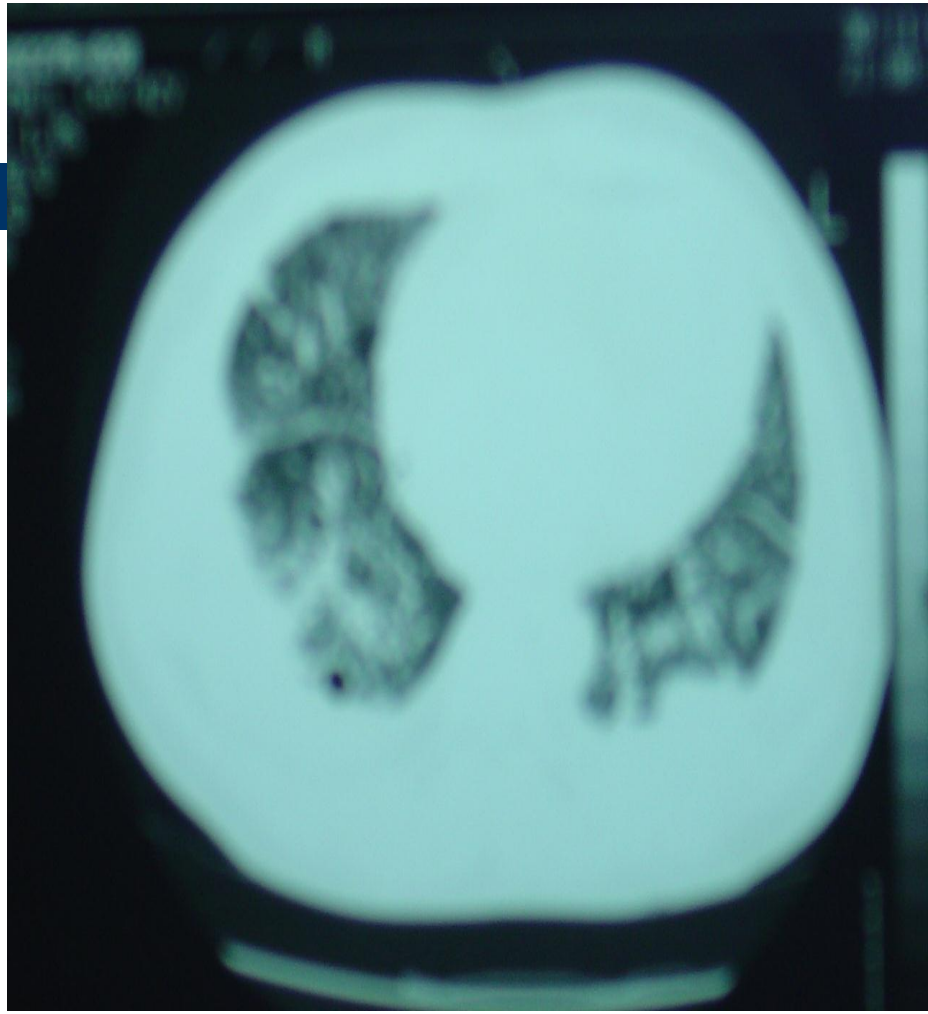


30/11/05









Final Diagnosis :

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