CASE PRESENTATION.
30/F WITH DIB

- BRIEF HISTORY.

  Name:BR

  Age: 30/F

  Address: Nankulabye

  Occupation: None

  PC: Cough x 5/7

  DIB X 1/7

- Known Asthmatic for unknown period was able to support herself to hospital;

  she presented with dry cough associated with difficulty in breathing and wheezing that worsened prior to admission.

  Pt reported some general body weakness however no fever

Hx Cont'd

- Pt had run out of drugs and Inhalers 2 days prior to admission.

- She has had several admissions because of the same complaints; atleast once a month. Last admission was a month ago.

- Triggers: No drugs

  Stays alone, Poor social support

Primary Survey

- Airway.

  In moderate respiratory distress, however able to talk.

- Breathing.

  RR-20bpm SPO2-90% RA Bilateral wide spread rhonchi

- Circulation.

  Warm peripheries, No pallor BP:167/129mmHg PR:140bpm

- Disability.

  GCS: 14/15 some confusion with visual hallucinations

DIAGNOSIS AND PLAN.

DX: Acute Asthma Exacerbation.
? Bipolar

1. Immediate plan.
   Nebulized salbutamol 5mg + 3mls of NS
   IV Hydrocortisone 200mg

2. Follow up plan.
   IV Amoxclav
   Montelukast tablets, Salbutamol Inhaler,Ascoril syrup, Prednisolone
   Involve social worker, D/C through Psychiatry clinic.

Post Treatment

- Day 1

  still has bilateral rhonchi. SPO2:96% RA BP:98/64mmHg

Plan: Nebulised salbutamol, Amoxclav, Montelukast

- Day 2. Generalised rhonchi.

Plan: Nebulised salbutamol, other Rx

- Day 3: Marked improvement; Rhonchi in Lt mammary Area.

Plan: Allow home