Ministry of Health
Emergency Medical Services ECHO
Case Presentation Form

Date: 11th February 2022

Presenter's name: Dr. Atimango Lucille

Presenter's location: Mubende RRH, Mubende

Patient Initials: NN **T.O.A:** 6:00hrs

Age: 30

Sex: Female

Diagnosis:

30yrs old female with moderate head injury secondary to assault

Presenting complaint
Convulsions x 4hrs

History of presenting complaint- Duration and Progress

NM. a 30yrs/F self-referred from home with a one day history of having been hit on the head with a stool by her partner, with complaints of Convulsions, that was generalised tonic clonic, brief episodes, with slight loss of consciousness without foam formation, no faecal and urine incontinence, however associated with nose bleeding and vomiting blood.

Systems review of the illness:

Unrevealing

Significant Medical/Surgical history

She is HIV seronegative

No known history of any known chronic illnesses such as hypertension, Diabetes, heart diseases, SCD or any psychiatric illness.

Social history and pertinent family history

Work status: Unemployed	**Occupation**: House wife
Education: illiterate	**Socio-economic class**: Low income
Marital status: Married	**Lifestyle habits**: Non
Relevant health conditions in the close family members	
Reports no any Known Familial Illnesses	

Examination Findings

Airway

Air way was patent and she could easily talk.

No secretions or foreign objects.

Breathing

Breathing was spontaneous with visible normal chest movements. No use of accessory muscles of respiration. No signs of chest or neck trauma.

RR 28bpm SPO2 was 92-95% on RA.

Bilateral equal air entry on both sides with Broncho vesicular breath sounds, no added abnormal sounds.

Circulation

Warm extremities, Capillary refill 2s

Pulse Tachycardic, regular PR-132b/m .

No cyanosis, no distended neck veins

BP-150/127 mmHg

Normoactive precordium, Heart Sounds I and II heard and normal without any added abnormal sounds.

Disability

Patient was disoriented in place time and person, talkative with inappropriate words with, GCS 10/15 on admission, then GCS 12/15 at dispatch E-4,V-3,M-5

E-2 V-3 M-5

PEARL, No neck trauma or tenderness

No focal deficits

Blood glucose level not done

Exposure

Patient's clothing's were soiled with bloodstains from the nose bleeding that had stopped.

Vital Signs
Blood Pressure: 123/80mmHg **Pulse rate:** 123 bpm **SPO2:** 95% on RA
Temperature: 37.0˚C **Respiratory rate:** 28bpm

Relevant Systemic Examination
General Exam
Sick looking young woman, afebrile T 37.0˚C not in respiratory distress, no pallor, no jaundice, no limb oedema and no cyanosis.
HENT Examination
Scalp was covered by heep of hair with some swellings and minor bruises
She had minor conjunctival heamorrages without periobital swellings and no raccoon eye signs
No Rhinorea and no otorhea
Central Nervous System
Active convulsions, disoriented in place time and person, very talkative with inappropriate words
GCS 12/15 E-4 M-5V-3,
PEARL, No Neck Stiffness, Negative Kerning
No neurological deficits
Cardiovascular System
Warm extremities, Capillary refill 2s
Pulse tachycardic, regular, PR-123bpm.
No cyanosis, no distended neck veins
BP-123/80 mmHg
Normative precordium, Heart Sounds I and II heard and normal without any added abnormal sounds.
Per Abdomen
Normal fullness, moving well with respiration.
No tenderness on palpation
Resonant percussion note

Musculoskeletal
No deformities
No abnormal movements
Normal muscle tone, bulk and power.

Case Summary
NM a 30yr/F self-referred from home, presented with a history of being hit on the head by partner, with complaints of brief convulsion, generalised tonic clonic associated with slight loss of consciousness, nose bleeding, and vomiting blood. However, it was not associated with dizziness, blurring of vision.
Imp:
30yr F with moderate head injury 2˚ Assault.

Focused investigation *(list and attach pertinent labs)*

Current Labs			
Test	Result	Reference range	Comments/Interpretation
CBC Blood grouping and Matching X-ray of the skull			

Management Plan

i) Patients head was elevated to 30^0
ii) Do CBC Blood grouping and Matching, Transfuse with 1 Unit of WB if Hb less than 5g/dl.
iii) IV mannitol 40g stat since the team could not ascertain whether patient had brain oedema or not.
iv) IV phenytoin 1g loading dose, 500mg maintenance to control convulsions.
v) IV ceftriaxone 2g stat was prescribed but patient received IV Ampiclox 1g stat for prophylaxis since ceftriaxone was not available at that time
vi) IV Paracetamol 1g prescribed but patient received IV Dynapar 75mg stat as pain management.
vii) Insert urine Catheter to monitor urine output.
viii) Referred patient to Mulago NRH in an EMS ambulance for Brain CT scan and for further management.

However, patient was discharged on 31st of January 2022 with a diagnosis of haemorrhagic contusion (Mild Traumatic brain injury) without attached Brain CT scan results.