Ministry of Health
Emergency Medical Services ECHO
Case Presentation Form

Date: 11/2/2022 **Presenter'sname:** NATUKUNDA FERGUSON

Presenter's location, MULAGO NRH ☐

Patient Initials, S.R Patient type: ☐ ☒ New case **Age:** 18years **Sex:** Male **Diagnosis (if known):** Basal skull fracture with cranial 6,7 and 8 palsy.

What is your presenting Complaint?

Headache for 4 days
Bloody discharge from right ear for 4 days

History of presenting complaint- Duration and Progress

The patient is a referral from Masaka RRH where he had been admitted for 2 days. Prior to that admission, he was involved in a RTA when he was riding a motorcycle and collided with another riding motorcyclist losing consciousness for about 1 hour. After regaining his consciousness he developed a headache that was generalized, throbbing in nature and aggravated by sitting from a supine position. He also started noticing discharge of blood from the right ear which was not quantified. Currently, he is able to sit by himself but has generalized body weakness and is unable to walk.
However, he reported no history of convulsions, fever, dizziness, memory loss, loss of sensations or vomiting.

Systems review of the illness:

system	Symptoms
GIT	Loss of appetite. No abdominal pain no abdominal distension, no diarrhea, no constipation, no yellow eyes, no vomiting
RS	No cough, no chest pain, no difficulty in breathing, no wheezing,
CVS	No easy fatigability, no PND, no palpitations,
MSS	Painful and swollen wrist joint, no pain in other joints, bones or muscles
GUT	No pain on urination, no urgency, incontinence or discharge

Significant Medical/Surgical history

This is his index admission, no known chronic illnesses,food or drug allergies
No history of prior surgery,blood transfusions or burns

Social history and pertinent family history

Workstatus:	Occupation: student_____
Education: s3 at rakai sec school	Socio-economic class:
Marital status: ☐	Lifestyle habits: no alcohol consumption or smoking
Relevant health conditions in the close family members?	

Examination Findings
Airway
intact

Breathing

No central or peripheral cyanosis
Bronchovesicular breath sounds, resonant percussion note
Trachea central

Circulation

Radial pulse, brachial pulse, carotid pulse, dorsalis pedis were also palpable on both sides

Disability

Exposure

Vital Signs;
Blood Pressure, ___124/86 mmhg_____ Pulse rate, _____104_____ SPO2, ___98_____
Temperature, _____36.8____ Respiratory rate, __18_____ Weight, _____ Height, _____

Relevant Systemic Examination
Central Nervous System
On examination of the head, he had a stitched right occipital laceration, obvious left supra-orbital depression and bruises, blood clots in the right ear.
On CNS examination, he was alert, appropriate speech in volume and frequency.
GCS 14/15, V4, not well oriented in place, time and person.
PEARL, however he had right cranial nerve 6,7, and 8 palsy.
Cranial 6 failed lateral deviation of the eye,
Cranial 7 loss of the right nasolabial fold,

Cranial 8 reduced hearing in the right ear and nystagmus of the right eye
Examination from other cranial nerves was unremarkable.
Motor exam was normal in all limbs however has swelling and tenderness at the left wrist joint and could not extend and flex at that joint.
Normal sensory exam findings

The rest of cerebellar examination was unremarkable. The neck was normal.

Cardiovascular System
UR

Per Abdomen

UR

Musculoskeletal

Left wrist joint was tender and swollen

Case Summary
SR an18 yr old male, a referral from MRRH presented with a 4 days history of generalized throbbing headache and a 4 days history of blood discharge from the right ear, failure of lateral deviation of the right eye, loss of the right nasolabial fold, reduced hearing in the right ear and nystagmus of the right eye and GCS of 14/15 with V4.

Focused investigation *(list and attach pertinent labs)*

Current Labs			
Test	Result	Reference range	Comments/Interpretation
electrolytes	Potassium 3.12 l Creatinine 1.04 h	3.50 5.50 0.2 0.8	
CBC	HCT 36.5 MCV 76.4 MCH 25.1	37.0 54.0 80 100 27.0 34.0	
For e.g. IGRA			
For e.g. TSH			

Imaging/ Special investigations	
Test	Salient findings
CT scan	Comminuted fracture of the left frontal orbital bone with extension into the frontal sinus with ethmoid, sphenoid and maxillary effusions.
	Right temporal mastoid fracture, pneumocranium on both left and right sides.
	Left frontal contusions extending down to the base, subarachnoid hemorrhage into the inter-hemispheric fissure. No midline shift and sulcial spaces can be seen.

Management Plan
Do CBC, LFTs, RFTs and serum electrolytes, blood grouping and cross matching
IV PCM 1g tds for 3 days
IV ceftriaxone 2gs once a day for 5 days
IV phenytoin 250mg twice a day for 7 days.