OPHTHALMOLOGY: CASE RECORD

(1)

CASE SHEET NUMBER:

DATE: REG.NO.:

NAME : Sudhi Gange

AGE: 56 yrs. SEX: M/F✓

ADDRESS: Nagarnaar

OCCUPATION : House wife RELIGION: Hindu

CHIEF COMPLAINTS:

Diminision of vision in right eye – Since 1 year

HISTORY OF PRESENTING COMPLAIN:

Gradual, progressive, painless loss of vision in right eye since 1 year.
She also complained of glare & lacrimation.
There is no associated symptom.

PAST ILLNESS:

Not significant

PERSONAL HISTORY:

No History of Diabetes, hypertension, asthma or Trauma

FAMILY HISTORY:

Not significant

DRUG HISTORY:

Not relevant

(2)

GENERAL EXAMINATION:

Patient is conscious & oriented with time, place & person.
Vitals are normal.
No pallor
No icterus
No cyanosis
No lymphadenopathy
No clubbing

SYSTEMIC EXAMINATION:

CVS, CNS, RS, ABDOMEN — Normal

LOCAL EXAMINATION:

FACIAL SYMMETRY, HEAD POSTURE, FOREHEAD — Normal

OCULAR EXAMINATION

	RIGHT EYE	LEFT EYE
VISUAL ACUITY	CF +nt	6/36
EYEBROWS	Normal	Normal
EYELASHES	Normal	Normal
EYELID	Lid creases +nt	lid creases +nt
EYEBALL- POSITION, SIZE, MOVEMENT	Normal	Normal
CONJUNCTIVA-BULBAR	No congestion	Scar is +nt
PALPEBRAL	No scar	

	RIGHT EYE	LEFT EYE
CORNEA	Normal	Normal
ANTERIOR CHAMBER	Normal in depth	Normal in depth
IRIS-	Normal in colour & pattern	Normal in colou & pattern
PUPIL -	Dilated due to mydriatics Not reactive	Round, regular & reactive
LENS -	Greyish White opacity Iris shadow +nt	Pseudophakia shimmering reflex +nt
LACRIMAL APPARATUS:	Regurgitation test negative	negative

INVESTIGATIONS:
Fundoscopy, slit lamp, Tonometry, Keratometry
Routine Investigations

PROVISIONAL DIAGNOSIS:
Immature senile cataract (cortical) in right eye

FINAL DIAGNOSIS:
Immature senile cortical cataract in right eye

TREATMENT:
SICS (Small Incision Cataract Surgery)

CASE SHEET NUMBER: 2

DATE: REG.NO.:

NAME : Roshlai Tertu

AGE: 24 yrs. SEX: M/F

ADDRESS: Narayanpur

OCCUPATION : farmer RELIGION: Hindu

CHIEF COMPLAINTS:
Diminision of vision - Since 6 yrs.
Lacrimation - Since 1 yr.

HISTORY OF PRESENTING COMPLAIN:
Gradual, progressive, painless loss of vision
No itching
No trauma

PAST ILLNESS:
Not relevant

PERSONAL HISTORY:
No hypertension
No Diabetes
No addiction

FAMILY HISTORY:
Not relevant

DRUG HISTORY:
Not relevant

GENERAL EXAMINATION:

Pt. is conscious & well oriented
No cyanosis, No icterus, No clubbing, No pallor,
No lymphadenopathy.

Vitals = Normal

SYSTEMIC EXAMINATION:

CVS
CNS
RS
ABDOMEN
} Normal

LOCAL EXAMINATION:

FACIAL SYMMETRY:
HEAD POSTURE:
FOREHEAD
} Normal

OCULAR EXAMINATION

	RIGHT EYE	LEFT EYE
VISUAL ACUITY	CF from 1 feet	HM tnt
EYEBROWS	Normal	Normal
EYELASHES	Normal	Normal
EYELID	Normal	Normal
EYEBALL- POSITION	Normal	
SIZE		Normal
MOVEMENT		
CONJUNCTIVA-BULBAR	Normal	
PALPEBRAL		Normal

	RIGHT EYE	LEFT EYE
CORNEA	Transparent	Transparent
ANTERIOR CHAMBER	(N) depth	(N) depth
IRIS-	(N) in colour & pattern	(N) in colour & pattern
PUPIL	Round, Regular, Reactive	Dilated
LENS	Pearly white opacification in post. pole	Pearly white opacification in post. pole
LACRIMAL APPARATUS:	Iris shadow +nt	Iris shadow -nt
	RT - ve	RT - ve

INVESTIGATIONS:
Routine investigation
fundoscopy, Slit lamp, Tonometry, Keratometry

PROVISIONAL DIAGNOSIS:
Post. polar cataract in both the eye.

FINAL DIAGNOSIS:
Post. polar cataract in both the eye

TREATMENT:
SICS

(1)

CASE SHEET NUMBER: (3)

DATE: REG.NO.:

NAME : Chakradatiri Yadav

AGE: 64 yrs. SEX: M/F

ADDRESS: Nayamunda

OCCUPATION : — RELIGION: Hindu

CHIEF COMPLAINTS:

Diminision of vision since 6 months.

HISTORY OF PRESENTING COMPLAIN:

Gradual progressive painless loss of vision since 6 months
No itching
No trauma

PAST ILLNESS:

Not relevant

PERSONAL HISTORY:

-Alcohol addicted
No hypertension, No diabetes

FAMILY HISTORY:

Not relevant

DRUG HISTORY:

Not relevant

(2)

GENERAL EXAMINATION:

Patient is conscious & oriented with time, place, person.
Vitals are Normal
No cyanosis, No icterus, No pallor, No clubbing
No lymphadenopathy

SYSTEMIC EXAMINATION:

CVS, CNS, RS, ABDOMEN — Normal

LOCAL EXAMINATION:

FACIAL SYMMETRY, HEAD POSTURE, FOREHEAD — Normal

OCULAR EXAMINATION

	RIGHT EYE	LEFT EYE
VISUAL ACUITY	HM tnt	HM tnt
EYEBROWS	Normal	Normal
EYELASHES	Normal	Normal
EYELID	Normal	Normal
EYEBALL- POSITION	Normal	Normal
SIZE		
MOVEMENT		
CONJUNCTIVA-BULBAR	Normal	Normal
PALPEBRAL		

	RIGHT EYE	LEFT EYE
CORNEA	Transparent	Transparent
ANTERIOR CHAMBER	Normal	Normal
IRIS-	(N) in colour & pattern	(N) in colour & pattern
PUPIL	Round, Regular, Reactive	Dilated
LENS	Greyish white opacity	Milky white opacity
LACRIMAL APPARATUS:	RT -ve	-ve

INVESTIGATIONS:
Routine
fundoscopy, Tonometry, Keratometry, Slit lamp

PROVISIONAL DIAGNOSIS:
Hypermature Senile cortical cataract in left eye
Immature Senile cortical cataract in right eye

FINAL DIAGNOSIS:
Hypermature Senile cortical cataract in left eye
Immature Senile cortical cataract in right eye

TREATMENT:
SICS

(1)

CASE SHEET NUMBER: (4)

DATE: REG.NO.:

NAME : Sunita Das

AGE: 70 yrs. SEX: M/F

ADDRESS: Narayanpur

OCCUPATION : Housewife RELIGION: Hindu

CHIEF COMPLAINTS:
1) Diminision of vision in left eye since 1yr.
2) Burning & Itching
3) Pain

HISTORY OF PRESENTING COMPLAIN: There was foreign body sensation in left eye with burning sensation & itching since 1 year.
Diminision of vision
Sometimes lacrimation present.

PAST ILLNESS:
Cataract surgery 5 year back (left eye)

PERSONAL HISTORY:
Diabetic
Mixed diet

FAMILY HISTORY:
Not relevant

DRUG HISTORY:
Not relevant

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GENERAL EXAMINATION:

Pt. is conscious, well oriented with time & place, person.

No cyanosis No icterus No clubbing
No pallor No lymphadenopathy

Vitals = Normal

SYSTEMIC EXAMINATION:

CVS, CNS, RS, ABDOMEN — Normal

LOCAL EXAMINATION:

FACIAL SYMMETRY:
HEAD POSTURE: — Normal
FOREHEAD

OCULAR EXAMINATION

	RIGHT EYE	LEFT EYE
VISUAL ACUITY	6/12	CF ⊕
EYEBROWS	Normal	Normal
EYELASHES	Normal	Normal
EYELID	Normal	Normal
EYEBALL- POSITION	Normal	Normal
SIZE		
MOVEMENT		
CONJUNCTIVA-BULBAR	Normal	Congestion encroachment towards cornea
PALPEBRAL		

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	RIGHT EYE	LEFT EYE
CORNEA	Transparent	Medial aspect - covered (Progressive
ANTERIOR CHAMBER	Normal	Normal
IRIS-	Normal	Normal
PUPIL	Round regular reactive	Eccentric position, dragged peripherally
LENS	Transparent	shimmering reflex +ve
LACRIMAL APPARATUS:	RT -ve	RT - ve

INVESTIGATIONS:
Probe test

PROVISIONAL DIAGNOSIS:
Pterygium

FINAL DIAGNOSIS:
Pterygium

TREATMENT:
Excision

(1)

CASE SHEET NUMBER: (5)

DATE: REG.NO.:

NAME : Pushpa Gupta

AGE: 45 yrs. SEX: M/F

ADDRESS: Kumharpara

OCCUPATION : Housewife RELIGION: Hindu

CHIEF COMPLAINTS:

Diminision of vision in right eye since 7 months.

HISTORY OF PRESENTING COMPLAIN:

There is gradual, painless, progressive loss of vision since 6 months
No lacrimation

PAST ILLNESS:

Not relevant

PERSONAL HISTORY:

Mixed diet
No addiction

FAMILY HISTORY:

No H/O addiction, diabetes, Hypertension, asthma

DRUG HISTORY:

No drug history

(2)

GENERAL EXAMINATION:

Patient is conscious & oriented with time, plau & person
No clubbing
No pallor
No cyanosis
No icterus
No lymphadenopathy

Vitals = Normal

SYSTEMIC EXAMINATION:

CVS
CNS
RS
ABDOMEN
} Normal

LOCAL EXAMINATION:

FACIAL SYMMETRY:
HEAD POSTURE:
FOREHEAD
} Normal

OCULAR EXAMINATION

	RIGHT EYE	LEFT EYE
VISUAL ACUITY	HM (+)	6/60
EYEBROWS	Normal	Normal
EYELASHES	Normal	Normal
EYELID	Normal	Normal
EYEBALL- POSITION	Normal	Normal
SIZE		
MOVEMENT		
CONJUNCTIVA-BULBAR	Normal	Normal
PALPEBRAL		

	RIGHT EYE	LEFT EYE
CORNEA	Transparent	Transparent
ANTERIOR CHAMBER	Normal	Normal
IRIS-	Normal in colour & pattern	Normal
PUPIL	RRR, Iris shadow +nt	RRR
LENS	Greyish. opacification	Normal transparency
LACRIMAL APPARATUS:	RT -ve	RT -ve

INVESTIGATIONS: Routine
Fundoscopy, Slit lamp, IOP, RT

PROVISIONAL DIAGNOSIS: Senile Immature cortical Cataract in right eye.

FINAL DIAGNOSIS: Senile Immature Cortical cataract in right eye.

TREATMENT:

SICS

Small Incision Cataract Surgery

CASE SHEET NUMBER: 6

DATE: REG.NO.:

NAME : Parvati

AGE: 28 yrs. SEX: M/F

ADDRESS: Bataguda

OCCUPATION : farmer RELIGION: Hindu

CHIEF COMPLAINTS:

1) Defective (Distorted) vision
2) Watering & discharge
3) Redness
4) Pain

HISTORY OF PRESENTING COMPLAIN:

Gradual, progressive, severe in nature.
Fever is not present.

PAST ILLNESS:

Not relevant

PERSONAL HISTORY:

No asthma
Mixed diet

FAMILY HISTORY:

Not relevant

DRUG HISTORY:

Not relevant

(2)

GENERAL EXAMINATION:

Patient is conscious, well - oriented.
No cyanosis No lymphadenopathy
No clubbing
No icterus

Vitals = Normal

SYSTEMIC EXAMINATION:

CVS, CNS, RS, ABDOMEN } Normal

LOCAL EXAMINATION:

FACIAL SYMMETRY:
HEAD POSTURE: } Normal
FOREHEAD

OCULAR EXAMINATION

	RIGHT EYE	LEFT EYE
VISUAL ACUITY	PL -ve	CF tnt 1 ft.
EYEBROWS	Normal	Normal
EYELASHES	Normal	Normal
EYELID	Ab Normal - Edematous hyperaemia	Normal
EYEBALL- POSITION	Proptosed	Normal
SIZE		
MOVEMENT	Abnormal	Normal
CONJUNCTIVA-BULBAR	Ciliary	
PALPEBRAL	Conjunctival Congestion	Normal

(3)

	RIGHT EYE	LEFT EYE
CORNEA	Cloudy edematous opacity	Normal
ANTERIOR CHAMBER	Shallow	Normal
IRIS-	Not visualised due to cloudy cornea	Normal
PUPIL		Normal
LENS	Normal	
LACRIMAL APPARATUS:	RT -ve	RT -ve

INVESTIGATIONS:

PROVISIONAL DIAGNOSIS: Corneal ulcer with panophthalmitis in right eye

FINAL DIAGNOSIS: Corneal ulcer with panophthalmitis in right eye

TREATMENT:

Evisceration
Broad spectrum antibiotics
Analgesics
Anti-inflammatory

CASE SHEET NUMBER: 7

DATE: REG.NO.:

NAME : Anita Deewan

AGE: 26 yrs SEX: M/F

ADDRESS: Nursing college, Jdp

OCCUPATION : Student RELIGION: Hindu

CHIEF COMPLAINTS:

Swelling in lid since 1 month in Right eye (upper eyelid)

HISTORY OF PRESENTING COMPLAIN:

Painless swelling
heaviness of lid
No disturbance in vision
No pain

PAST ILLNESS:

Not relevant

PERSONAL HISTORY:

No asthma
No BP
No diabetes,

FAMILY HISTORY:

Not relevant

DRUG HISTORY:

Not relevant

GENERAL EXAMINATION:

Patient is conscious, well oriented
No cyanosis No lymphadenopathy
No icterus No pallor
No clubbing
Vitals = Normal

SYSTEMIC EXAMINATION:

CVS	Normal
CNS	
RS	
ABDOMEN	

LOCAL EXAMINATION:

FACIAL SYMMETRY:	Normal
HEAD POSTURE:	
FOREHEAD	

OCULAR EXAMINATION

	RIGHT EYE	LEFT EYE
VISUAL ACUITY	6/6	6/6
EYEBROWS	Normal	Normal
EYELASHES	Normal	Normal
EYELID	Nodule away from lid margin	Normal
EYEBALL- POSITION	Normal	Normal
SIZE		
MOVEMENT		
CONJUNCTIVA-BULBAR	Normal	Normal
PALPEBRAL		

	RIGHT EYE	LEFT EYE
CORNEA	Transparent	Transparent
ANTERIOR CHAMBER	Normal	Normal
IRIS-	(N) in colour & pattern	(N) in colour & pattern
PUPIL	RRR	RRR
LENS	Transparent	Transparent
LACRIMAL APPARATUS:	RT -ve	RT - ve

INVESTIGATIONS:

PROVISIONAL DIAGNOSIS:

Chalazion
Stye

FINAL DIAGNOSIS:

Chalazion in Right eye

TREATMENT:

Incision & currettage

CASE SHEET NUMBER: (8)

DATE: REG.NO.:

NAME : Naresh Kumar

AGE: 10 yrs. SEX: M/F

ADDRESS: Metguda, Jdp

OCCUPATION : Student RELIGION: Hindu

CHIEF COMPLAINTS:

1) Swelling in right upper eyelid since 4 days
2) Pain

HISTORY OF PRESENTING COMPLAIN:

Swelling in upper lid since 4 days
Pain
Mild Lacrimation

PAST ILLNESS:

Not relevant

PERSONAL HISTORY:

Mixed diet
Not relevant

FAMILY HISTORY:

Not relevant

DRUG HISTORY:

Not relevant

GENERAL EXAMINATION:

Patient is conscious, well-oriented.
No cyanosis No icterus No pallor
No clubbing No lymphadenopathy

Vitals = Normal

SYSTEMIC EXAMINATION:

CVS, CNS, RS, ABDOMEN — Normal

LOCAL EXAMINATION:

FACIAL SYMMETRY, HEAD POSTURE, FOREHEAD — Normal

OCULAR EXAMINATION

	RIGHT EYE	LEFT EYE
VISUAL ACUITY	6/6	6/6
EYEBROWS	Normal	Normal
EYELASHES	Normal	Normal
EYELID	Swelling near the lid margin. Pus point seen	Normal
EYEBALL- POSITION	Normal	Normal
SIZE		
MOVEMENT		
CONJUNCTIVA-BULBAR	Normal	Normal
PALPEBRAL		

	RIGHT EYE	LEFT EYE
CORNEA	Transparent	Transparent
ANTERIOR CHAMBER	Normal	Normal
IRIS-	Pattern & colour Normal	- Normal
PUPIL	RRR	RRR
LENS	Transparent	Transparent
LACRIMAL APPARATUS:	RT - ve	RT - ve

INVESTIGATIONS:
Routine

PROVISIONAL DIAGNOSIS:
Stye
Chalazion

FINAL DIAGNOSIS:
Stye in right upper eyelid

TREATMENT:
A|B e/d with analgesic

CASE SHEET NUMBER: 9

DATE: REG.NO.:

NAME : Ramesh Gupta

AGE: 55 yrs. SEX: M/F

ADDRESS: Gangamunda

OCCUPATION : Carpenter RELIGION: Hindu

CHIEF COMPLAINTS:

Diminision of vision left eye since 6 months

HISTORY OF PRESENTING COMPLAIN:

Gradual, progressive, painless loss of vision
No lacrimation

PAST ILLNESS:

Not relevant

PERSONAL HISTORY:

No asthma
No BP
No DM

FAMILY HISTORY:

Not relevant

DRUG HISTORY:

Not relevant

GENERAL EXAMINATION:

Pt. conscious & well-oriented
No icterus No lymphadenopathy No cyanosis
No clubbing No Pallor

Vitals = Normal

SYSTEMIC EXAMINATION:

CVS, CNS, RS, ABDOMEN — Normal

LOCAL EXAMINATION:

FACIAL SYMMETRY: Normal
HEAD POSTURE: Normal
FOREHEAD: Normal

OCULAR EXAMINATION

	RIGHT EYE	LEFT EYE
VISUAL ACUITY	6/6	PL PR
EYEBROWS	Normal	Normal
EYELASHES	Normal	Normal
EYELID	Normal	Normal
EYEBALL- POSITION	Normal	Normal
SIZE		
MOVEMENT		
CONJUNCTIVA-BULBAR	Normal	Normal
PALPEBRAL		

(3)

	RIGHT EYE	LEFT EYE
CORNEA	Transparent	Transparent
ANTERIOR CHAMBER	(N) in depth	(N)
IRIS- Colour & Pattern	(N)	(N)
PUPIL	RRR	RRR
LENS	Transparent	Pearly white opacity
LACRIMAL APPARATUS:	RT -ve	RT -ve

INVESTIGATIONS:
Routine
~~fundoscopy~~, Keratometry, IOP, Slit lamp

PROVISIONAL DIAGNOSIS:

FINAL DIAGNOSIS:
Mature Senile Coritical Caterract in left eye

TREATMENT:
SICS

(1)

CASE SHEET NUMBER: (10)

DATE: REG.NO.:

NAME : Suresh Kumar

AGE: 60 yrs. SEX: M/F

ADDRESS: Kondagaon

OCCUPATION : Shopkeeper RELIGION: Hindu

CHIEF COMPLAINTS:
Diminision of vision in right eye - Since 8 months

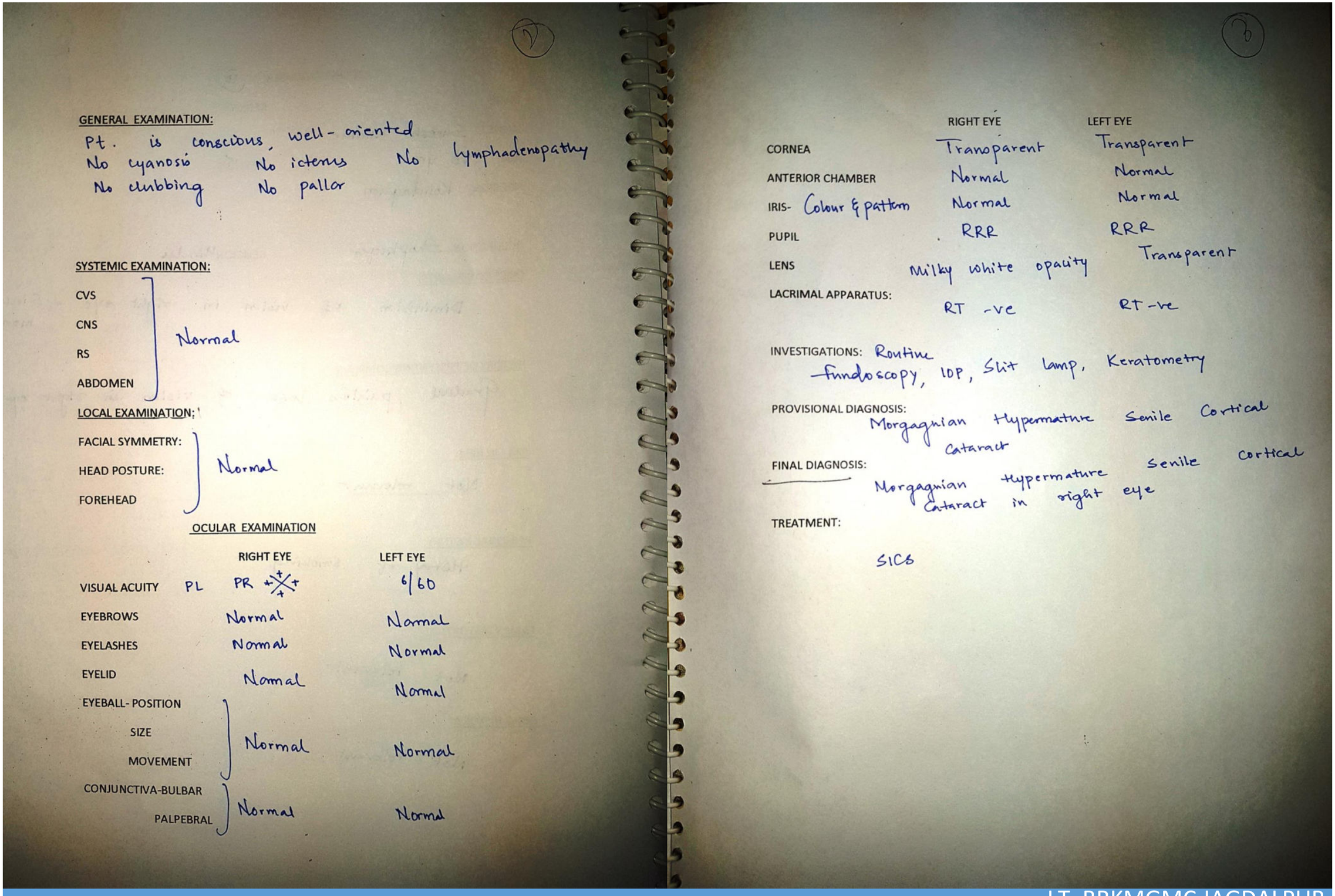
HISTORY OF PRESENTING COMPLAIN:
Gradual, painless loss of vision in right eye

PAST ILLNESS:
Not relevant

PERSONAL HISTORY:
History of Smoking

FAMILY HISTORY:
Not relevant

DRUG HISTORY:
Not relevant



GENERAL EXAMINATION:

Pt. is conscious, well-oriented
No cyanosis No icterus No lymphadenopathy
No clubbing No pallor

SYSTEMIC EXAMINATION:

CVS
CNS
RS
ABDOMEN
— Normal

LOCAL EXAMINATION:

FACIAL SYMMETRY:
HEAD POSTURE:
FOREHEAD
— Normal

OCULAR EXAMINATION

	RIGHT EYE	LEFT EYE
VISUAL ACUITY	PL PR +/+/+/+	6/60
EYEBROWS	Normal	Normal
EYELASHES	Normal	Normal
EYELID	Normal	Normal
EYEBALL- POSITION	Normal	Normal
SIZE		
MOVEMENT		
CONJUNCTIVA-BULBAR	Normal	Normal
PALPEBRAL		

	RIGHT EYE	LEFT EYE
CORNEA	Transparent	Transparent
ANTERIOR CHAMBER	Normal	Normal
IRIS- Colour & pattern	Normal	Normal
PUPIL	RRR	RRR
LENS	Milky white opacity	Transparent
LACRIMAL APPARATUS:	RT -ve	RT -ve

INVESTIGATIONS: Routine
fundoscopy, IOP, Slit lamp, Keratometry

PROVISIONAL DIAGNOSIS:
Morgagnian hypermature Senile Cortical Cataract

FINAL DIAGNOSIS:
Morgagnian hypermature Senile Cortical Cataract in right eye

TREATMENT:

SICS