40 year old male patient Mr Kanappan coming from Triplican who is a mechanic by occupation belongs to socio economic class middle lower came to the OPD with C/O WOUND in the Right foot for past 6 month

HISTORY OF PRESENTING ILLNESS

- The patient was apparently normal 6 month back after which he developed a wound during his work by a chisel
- Insidious in onset
- 6 month duration
- Progressive to attain the current size
- Assosiated with serous discharge
- No foul smelling
- Not assosiated with pain
- No h/o fever

- No h/o swelling
- No h/o loss of sensation
- No h/o restriction of movements
- No h/o loss of weight and apetite
- No h/o cough with expectoration
- No h/o evening raise of temperature
- No h/o urethral discharge or itching
- Ho h/o wound elswhere in the body

PAST HISTORY

- H/O DM for 10 years on regular treatment
- H/O HT for 2 year on regular treatment
- No h/o similar complaints in the past
- No h/o previous hospitalization or surgeries
- No h/o asthma ,epilepsy , jaundice, TB,STD

PERSONAL HISTORY

- Consumes mixed diet
- Normal bowel and bladder habit
- h/o alcohol intake for 20 years ,180 ml/day
- No h/o smoking
- No h/o bleeding dissorders
- No h/o blood transfusion

General examination

- Examination of patient after explaining procedure and getting consernt from the patient

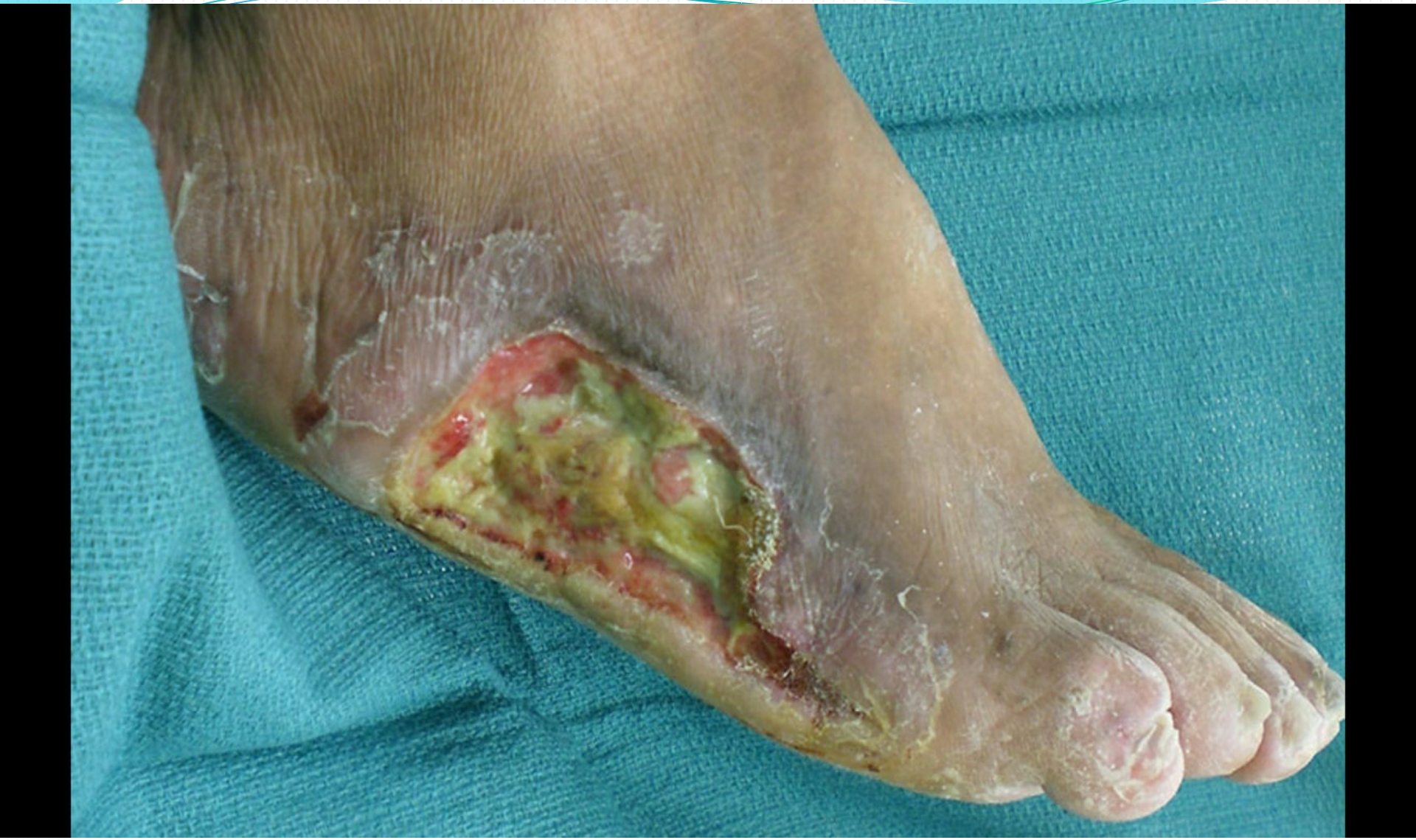
- PATIENT IS
- Conscious
- Oriented
- Moderately built and nourished
- No pallor /cynosis/icterus/clubbing/pedaledema
- No generalised lymphadenopathy

vitals

- PR 68/min regular in rhythm ,normal in volume and character
- All peripheral pulses felt
- RR 16/min abdomino thorasic
- BP 130/90 mmHg
- Temperature afebrile

LOCAL EXAMINATION

- EXAMINATION OF RIGHT FOOT
- INSPECTI ON
- single irregular ulcer of size 8*4cm on the lateral side of right foot
- Extend
- Anterior border 3 cm from little toe
- Posterior border 3 cm from latteral malleolus
- Inferior border along the lateral margin of sole
- Superior border 4cm from lateral margin of sole
- MARGINES well defined
- FLOOR slough and granulation tissue present
- EDGE sloping



- Serous discharge from ulcer
- Not blood stained or foul smelling
- Surrounding area hyperpigmented
- No pedal edema
- No loss of hair
- No dilated veins,scars or sinuses

- No fullness in inguinal region

PALPATION

- No warmth or tenderness
- All inspectory finding site,size, shape,floor confirmed by palpation
- No induration on edge and margin
- Base rest on bone
- immobile
- Depth 3cm

- Depth 3cm
- Not bleed no touch
- No restriction of ankle movement
- Surrrounding skin normal
- External genitaliya normal
- No palpable lymph node in inguinal region

NEUROVASCULAR EXAMINATION

- DPA and posterior tibial artery pulsation felt
- Femoral and popliteal pulsation felt equaly on both legs
- No sensory loss

Other system examination

- RS Normal vesicular breath sound heard ,no added sound
- CVS S1 S2 Heard ,no added sound or murmur
- CNS no focal neurological deficit
- ABDOMEN soft , non tender ,no organo megaly

DIAGNOSIS

- HEALING ULCER OF GRADE 2 ON RIGHT FOOT PROBABLY DUE TO DIABETES MELLITUS WITH OUT COMPLICATION

INVESTIGATION

- BASE LINE
- Blood sugar,urea,creatinine
- Urine sugar,albumin
- Complete blood count,DC,Hb%,platelet, ESR
- Chest x ray,ECG
- RFT

SPECIFIC

- Culture and sensitivity,AFB study,cytology
- Edge wedge biopsy
- Glycated hemoglobin
- Urine ketone bodies
- X ray foot
- Mantoux test
- Arterial dopler of lower limb
- VDRL

TREATMENT

- Control of Diabetes Mellitus by insulin
- Regular cleaning ,debridment of necrotic tissue and calus, dressing
- Antibiotic based on culture sensitivity
- Rest
- Elevation of limb
- Good nutriton
- Correct the deficiencies like anemia, protein and vitamin deficiency
- Once granulation tissues appear covered with skin graft
- Protective footware [microcellular rubber chappel]
- Patient education ,Prophylactic skin and nail care