**IQRA NATIONAL UNIVERSITY**

**DEPARTMENT OF ALLIED HEALTH SCIENCES**

**Final-Term Examination**

**DPT 8th semester**

**Course Title: Surgery II Instructor: Dr Sara Naeem**

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**Q1. Differentiate between communicating and non- communicating hydrocephalus. Give prognosis of hydrocephalus.**

**Ans Differences between communicating and non-communicating hydrocephalus:**

**Communicating hydrocephalus:**

, also known as nonconstructive **hydrocephalus**, is caused by impaired CSF reabsorption in the absence of any obstruction of CSF flow between the ventricles and subarachnoid space.

**Non communicating hydrocephalus:**

**No communicating hydrocephalus** occurs when CSF flow is obstructed within the ventricular system or in its outlets to the arachnoid space, resulting in impairment of the CSF from the ventricular to the subarachnoid space.

**Prognosis:**

The **prognosis** for **hydrocephalus** depends on the cause, the extent of symptoms and the timeliness of diagnosis and **treatment**. Some patients show a dramatic improvement with **treatment**, while others do not. In some instances of normal pressure **hydrocephalus**, dementia can be reversed by shunt placement.

**Q2. Identify population at risk of developing nephrolithiasis. Give surgical management of kidney stones.**

**Ans: Nephrolithiasis** (kidney stones): is a disease affecting the urinary tract. Kidney stones are small deposits that build up in the kidneys, made of calcium, phosphate and other components of foods. They are a common cause of blood in urine

**Risk population of nephrolithiasis:**

**Factors that increase risk of developing kidney stones include:**

* Family or personal history. ...
* Dehydration. ...
* Certain diets. ...
* Obesity. ...
* Digestive diseases and surgery.

**Signs and symptoms** of **kidney stones** can include

**Surgical management of kidney stone**

**Surgical approach :**

[urologist](https://www.niddk.nih.gov/Dictionary/U/urologist) can remove the kidney stone or break it into small pieces with the following treatments:

**Shock wave lithotripsy.** The doctor can use [shock wave lithotripsy](https://medlineplus.gov/ency/article/007113.htm) *NIH external link* to blast the kidney stone into small pieces. The smaller pieces of the kidney stone then pass through your urinary tract. A doctor can give you [anesthesia](https://medlineplus.gov/anesthesia.html) *NIH external link* during this outpatient procedure.

**Cystoscopy**

**ureteroscopy.**

 During [cystoscopy](https://www.niddk.nih.gov/health-information/diagnostic-tests/cystoscopy-ureteroscopy), the doctor uses a cystoscopy to look inside the urethra and bladder to find a stone in your urethra or bladder. During [ureteroscopy](https://www.niddk.nih.gov/health-information/diagnostic-tests/cystoscopy-ureteroscopy), the doctor uses a ureter scope, which is longer and thinner than a cystoscope, to see detailed images of the lining of the [ureters](https://www.niddk.nih.gov/Dictionary/U/ureters) and [kidneys](https://www.niddk.nih.gov/Dictionary/K/kidneys). The doctor inserts the cystoscope or ureteroscope through the [urethra](https://www.niddk.nih.gov/Dictionary/U/urethra) to see the rest of the urinary tract. Once the stone is found, the doctor can remove it or break it into smaller pieces. The doctor performs these procedures in the hospital with anesthesia. You can typically go home the same day.

**Percutaneous nephrolithotomy.** The doctor uses a thin viewing tool, called a nephroscope, to locate and remove the kidney stone. The doctor inserts the tool directly into your kidney through a small cut made in your back. For larger kidney stones, the doctor also may use a laser to break the kidney stones into smaller pieces. The doctor performs [percutaneous nephrolithotomy](https://medlineplus.gov/ency/article/007375.htm) *NIH external link* in a hospital with anesthesia. You may have to stay in the hospital for several days after the procedure

**Q3. Give lab and radiological investigations for intestinal obstruction. what can be possible surgical management of intestinal obstruction.**

**Ans: Lab investigation :**

Complete **blood** cell (CBC) count: The white **blood** cell (WBC) count may be elevated with a left shift in simple or strangulated **obstructions**; increased hematocrit is an indicator of volume state (ie, dehydration) Serum lactate levels: Increased levels are suggestive of dehydration or tissue under perfusion.

**Radiological investigation for intestinal obstruction.**

Plain **X-ray** in **intestinal obstruction**- Plain **X-ray** remains the primary step in evaluation of **bowel obstruction**.

**Radiographic finding report:**

The intussuscepted may form a large, convex, soft-tissue mass in the region of the ascending or transverse **colon**,.

**Surgical management**

All **obstructions** will be treated with IV fluids and electrolyte correction. Occasionally, a nasogastric tube is placed to remove fluid and gas backing up in the upper digestive tract. Medications are used to help with nausea and severe pain. A complete **obstruction** may require surgery or stenting.

**Surgery Approach:**

**surgery** for a **Bowel Obstruction**. There are several types of **surgical** procedures used to relieve a **bowel obstruction**, which is a partial or complete **blockage** of the intestines. A **bowel obstruction** can be treated with a **surgical** resection, stenting, colostomy, removal of adhesions, or revascularization.

**Q4**. **What are the clinical manifestations of subarachnoid hemorrhage. Explain GCS .**

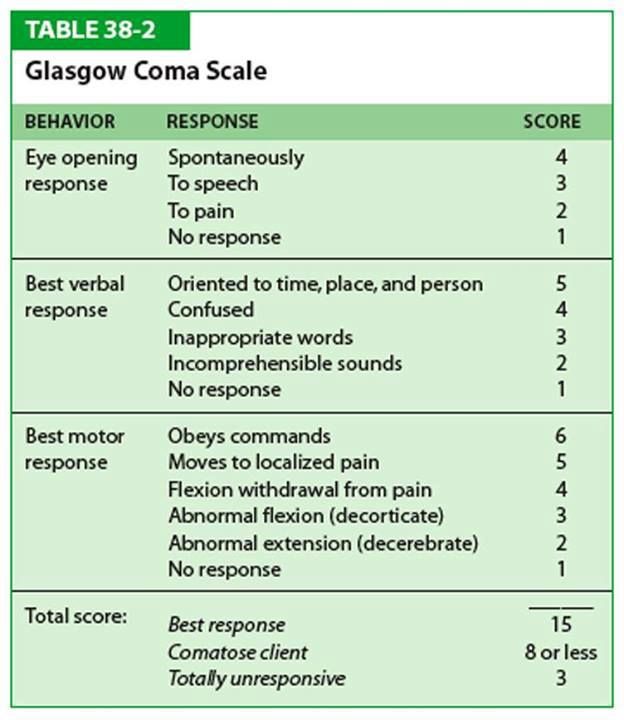
**Ans: clinical manifistication :**

The **headache** may be accompanied by nausea and/or vomiting from increased ICP and meningeal irritation. Symptoms of meningeal irritation, including nuchal rigidity and pain, back pain, and bilateral leg pain, occur in as many as 80% of patients with SAH but may take several hours to manifest.

**Gcs scale**

The **Glasgow coma scale** is used to assess patients in a coma. The initial **score** correlates with the severity of brain injury and prognosis. The **Glasgow Coma Scale** provides a **score** in the range 3-15; patients with **scores** of 3-8 are usually said to be in a coma

**Gcs score:**



**Q5. Enumerate vital clinical signs for confirmation of appendicitis. How can you manage a**

**patient with acute appendicitis.**

**Ans :Vital clinical sign of appendicitis**

**vital signs**: BP, 110/70;

* pulse, 106 and regular,
* Respiration 20; and temperature,
* 100° F (37.8° C).

Your physical assessment reveals diminished breath sounds bilaterally and significant tenderness of the right lower abdominal quadrant with rigidity and rebound tenderness.

**Manage****MENT**

* **IV FLUID**
* **ELECTROLYTE BALANCE**
* **PAIN KILLRER**
* **ULTRASOUND**
* **CT SCAN**
* **APPENDISECTOMY ARE RECOMMENDED IF THE SYMPTOMS ARE NOT REMOVED.**

**Thank you maam**