**Gul rukh**

**13372**

**Surgery paper**

**Semester 8**

**DPT**

**Dr.sara naeem**

**Question no .1**

 **Differentiate between communicating and non communicating hydrocephalus and their prognosis**

 **Hydrocephalus**

Condition in which there is an accumulating of cerebrospinal fluid with in the brain

  **Communicating**

 **When an accumulation**  is found outside the brain which usually present itself at birth or soon afterthat and this condition correct itself 18 months

  **Causes**

* Increased venous pressure
* Bacterial meningitis
* Post hemorrahge
* Malignant meningitis

 **Non communicating**

Occur when csf flow is obstructed with in the ventricular system or in its outlets to the arachnoid space resulting in impairment of the csf from the ventricular to the subarchnoid space

 It may happen to people at any age but most common aming the elderly

 May result from a subarachnoid hemorrhage ,head trauma ,infection ,tumour or complication of surgery

 **Prognosis of hydrocephalus**

Treat it accordingly may treat to long term neurological that require multidisciplinary medical teams to asist patient with development and lasting cognitive impairments

 Neurological damage that may have occurred prior to treatment is unfortunately irreversibale

***Surgical treatment***

***Shunt***

 *Surgical insertion of a drainage system called a shunt*

***Endoscopic third ventriculostomy***

 *In this your surgeon uses small video camera to have direct uses inside the brain your surgeon make ahole in the bottom of one of the ventricle or between ventricles to enable cerebrospinal fluid to flow out of the brain*

**Question no .2**

 **Population at risk of developing nephrolithiasis give surgical mangment of kidney stones**

 **Population at risk of nephrolithiasis**

Nephrolithiasis is a long term disease that develop over time and is usually found much later in patient life

While people of young ages are nit immune to or free from the development of kidney stones ranging from ages 18 to 95

 Commonly found in individuals 43 and older

 Stone development is more common in male than female

 Female ages 40 and older are now seeing a raise in stones development that incidence of men

 There has been a high amount of of nephrolithiasis incidence in younger women specifically calcium phosphate stones over the past years

 In obese people the rate of nephrolithiosis is higher

 People have hypertension diabetes and ckd 23 -27 can increase the risk of kidney stones

 **Surgical mangment of kidney stones**

Some procedure are

* Shock wave lithotripsy
* Ureteroscopy
* Precutaneous nephrolithotomy
* Open surgery

 ***Shock wave lithotripsy***

Commonly used process it is non invasive

 Patient lie on table take a medicine to limit pain or any discomfort doctor use x ray or ultrasound procedure to find stone then aims to high energy shock waves at your kidney from the outside then wave go through your skin and break the stone into small pieces

 Doctor use stent into your urethera this help the pieces of stone pass through

 The patient drink water to flush the stones pieces

 ***Ureteroscopy***

Treat stones in the kidney and ureters

 Uses a thin flexible scope to find snd remove stones no cut are made

 Your doctor will pass the scope through your bladder and ureter into your kidney she uses a small basket to remove stones it the stones are large the doctor will pass laser

 ***Precutaneous nephrolithtomy***

 ***I***f your stone is large and the above procedure fall to break the stone this will use

 Use small tube to reach the stone and break it up with high frequency sound waves

 ***Nephrolithotomy***

 *Remove the stone through tube*

 ***Nephrolithotripsy***

 *Use sound waves or laser to break up the stones and then vaccum up the stones pieces with suction machine*

 **Open surgery**

Ita rarely done for kidney stones if your stones is very large and not remove by laser o shock tjen it remove by an open surgery

 **Question no .3**

 **Give lab and radiological investigation obstruction what can be possible surgical mangment of intestinal obstruction**

 **Intestinal obstruction**

Any condition that interfer with normal propulsion and passage of intestinal contents

  **Lab investigation**

Lab test are needed including the following

*Serum chemistry*

Results are usually normal or mildly eleveted abnormal results early in the disease are generally due to vomoiting or dehydration

 *Blood urea nitrogen level*

May be increased due to decreased volume state

 *Cbc*

The WBC count may be elevated with a left shift in simple or strangulated increased hematocrit is an indicator of volume state

 *Serum lactate levels*

Increased levels are suggestive if dehydration or tissue underperfusion

 *Urinalysis*

Type and crossmatch as well as prothrombin time interbationl normalization ratio and partial thromboplastin time these are adjunctive laboratory test used in the evaluation of sbo

**Radiological investigation**

* Plain radiograph
* Through CT
* Air fluid level and masses shadow

**Surgical mangement of intestinal obstruction**

* Repair of hernia
* Removal of foreign bodies
* Resection colostomy
* Lysis of ofgending adhesions

 **Question no .4**

 **Clinical manisfestations of subarachonid hemorrhage explain GCS**

 **Subarachonid hemorrhage**

 Refers to bleeding with in the subarachnoid space which is the area between the brain and the tissues that cover the brain

**Clinical menfistations**

It has several symptoms but the main is sudden headache some people have poopong sensation in their head

 May also have

* Neck pain
* Numbness through out the body
* Shoulder pain
* Confusion
* Irritability
* Sensitivity to light
* Decreased vision
* Nausea
* Vomiting
* Rapid loss of alertness

**GCS for subarachnoid hemorraghe**

1. Glasgow coma scale 15 no motor deficit
2. GCS 13 to 14 motor deficit
3. GCS 13 to 14 with motor deficit
4. GCS 7 to 12 with or without motor deficit
5. GCS 3 to 6 with or without motor deficit

**Question no .5**

**Vital clinical sign for confirmation of appendicitis how can you manag a patient with acute appendicitis**

**Appendicitis**

 Inflammation of the appendix a finger pouch that projects from your colon on the lower right side of your abdomen

**Clinical sign**

* Abdominal pain
* Low fever
* Nausea
* Vomiting
* Loss of appetite
* Constipation
* Diarrhea
* Difficulty passing gas

Not all people will have the same symptoms but its crucial that you see a doctor as quickly as possible

 Appendix can repture as quickly as 48 to 72 hours after the onset of symptoms

**TO manage acute appendicitis**

**The** current definitive treatment for appendicitis is laparscopic appendicetomy

There is some debate surrounding the use of conservative antibiotic therapy in uncomplicated appendicitis a recent cochrane analysis found that appendicectomy should remain the standard treatment for acute appendicitis

 Primary antibiotic treatment for simple inflammed appendix can be successful but has a failure rate if 25 30 % at one year

**Surgical intervention**

Laparascopic appendectomy is good fir treating appendicitis due to a low morbidity from the procedure