Case Reports

October 2009

Rheumatoid Arthritis

Dr. Sahni's Homoeopathyclinic.com & Research Center Pvt. Ltd

Dr. Sahni B.S

Introduction

Rheumatoid arthritis (RA) is a chronic, systemic inflammatory disorder that may affect many tissues and organs, but principally attacks the joints producing an inflammatory synovitis that often progresses to destruction of the articular cartilage and ankylosis of the joints. Rheumatoid arthritis can also produce diffuse inflammation in the lungs, pericardium, pleura, and sclera, and also nodular lesions, most common in subcutaneous tissue under the skin. Although the cause of rheumatoid arthritis is unknown, autoimmunity plays a pivotal role in its chronicity and progression.

About 1% of the world's population is afflicted by rheumatoid arthritis, women three times more often than men. Onset is most frequent between the ages of 40 and 50, but people of any age can be affected. It can be passed down in families. It can be a disabling and painful condition, which can lead to substantial loss of functioning and mobility.

Changes in the Joints

Changes in the joints often, though not always, progress through three stages.

1. **Stage I.** The synovial membrane becomes inflamed and is, therefore, hyperaemic and infiltrated by inflammatory cells. The secreting cells become more active and the result is an oedematous membrane and effusion into the joint cavity. Inflammation tends to spread, to involve the peri-articular soft tissues, the capsule, ligaments, bursae, tendons and their sheaths. Clinical examination shows a tender swollen joint with movement probably limited by pain and muscle spasm. If the disease is arrested at this stage, the joint can return to normal though there is no certainty that the inflammation will not flare up again at a later date.

2. **Stage II.** If the disease progresses, granulation tissue is formed within the synovial membrane and peri-articular structures. It tends to spread from the membrane over the periphery of the articular cartilage. The cartilage, now covered by this tissue, gradually thins and disintegrates, leaving areas of bone covered only by granulation. Sometimes granulation tissue invades the bone ends from the remains of the perichondrium and from the tissue growing in over the cartilage. Much decalcification of bone occurs, probably due to the hyperaemic condition around the bone ends. With the destruction of articular cartilage and filling of the joint with granulation tissue, adhesions are formed between the synovial membrane and the thickened capsule and the tendons and their sheaths. Thus the joint movement is permanently impaired. Some cases never progress beyond the second stage and may retain a useful, though reduced, movement even in the face of active inflammation.

3. **Stage III.** The granulation tissue becomes organized into fibrous tissue and thus the soft tissues are matted together with adhesions forming between tendons and capsule and between the articular surfaces. Contractures develop and deformity and gross limitation of movement result. In such joints the articular surfaces may be partly covered with cartilage and partly with fibrous tissue, giving rise to much irregularity, or they may be completely joined by fibrous tissue or even by bone. Where such changes have occurred, little improvement in function can be expected.

Signs & Symptoms

Joints in which some or all of these changes have developed will show certain characteristic features. Pain and tenderness, swelling, limitation of movement, muscle atrophy and deformity are all to be expected, though they will occur in differing degrees according to the severity of the changes.

- *Pain* is present in all three stages. In the first stage it is often continuous, and since several joints may be affected, the patient's life may be a misery unless the pain is medically controlled. Movement increases the pain; hence the joints tend to be held rigid. In the second stage, pain is often less noticeable at rest but is more marked on movement or weight bearing, so that if the knees or ankles are involved, walking is a real difficulty. In the third stage, when inflammation has subsided and fibrous tissue has formed, there is usually no pain at rest but only on movement when the fibrous tissue is stretched and a pull is, therefore, exerted on sensitive tissues.

- *Tenderness* will always be present when there is any active inflammation in the joint. It can be elicited by gentle pressure of the joint and by palpation along the joint line. The degree of tenderness is a good indication of the activity of the arthritis. When the inflammation has subsided there may still be tenderness, but this is localized and not on pressure of the joint. It is felt over structures which are being persistently irritated by stretching, the result of abnormal posture. For example, at the knee there is often localized tenderness over the ligamentum patellae, the tibial attachment of the medial ligament, and the insertion of the hamstrings. In the latter case, the tenderness may be explained by the fact that the hamstrings are often contracted and then pull on the periosteum at their insertions.

- *Swelling* is usually present at all stages of the disease. In the stage of early inflammation, the swelling is soft, and often fluctuating owing to the presence of effusion. Sometimes there is edema not limited to the joint only; for example, the whole finger or fingers and hand may be puffy, while if the joints of the lower extremity are affected, there is often edema of the feet and legs. Later, as granulation tissue forms, the swelling feels firmer and spongier. It is often at this stage more noticeable owing to muscle atrophy proximal and distal to the joint giving rise to the spindle-shaped or fusiform swelling so often described in textbooks.

- *Muscle spasm* is a common feature. In the first stage the spasm is protective, its object being to prevent movement of a painful joint.

- *Muscle atrophy* is an outstanding feature and is largely the result of disuse. If movement causes pain then the patient moves the joint as little as possible. In some patients, atrophy exceeds that which could be explained by disuse alone. Atrophy is a serious feature because it means less protection of the already damaged joint and more likelihood of the development of fixed deformity.

- *Deformity* is one of the greatest dangers to fight against in rheumatoid arthritis. Each damaged joint has a characteristic deformity pattern. There is some position in which the capsule and ligaments are most relaxed and there is, therefore, most room for swelling with minimal pressure on nerve endings. In addition, at each joint, some muscle groups are more powerful than others. In many cases gravity has a powerful influence over the direction of the deformity. Thus we find a flexed knee, a dorsi-flexed everted ankle, clawed toes, adducted and medially rotated shoulder, flexed elbow, pronated forearm and flexed wrist. At the hand the deformity consists of ulnar deviation of the fingers, flexion of the metacarpophalangeal joints, hyperextension of the proximal interphalangeal joints and adduction of the thumb. At first the deformities are held by muscle spasm, but later they become more fixed due to contracture of the muscle framework, permanent shortening of the muscle fibers and shortening of the fascia and ligaments. Later destructive changes predominate with subluxation and dislocation sometimes proceeding to fibrous or bony ankylosis.

- *Limited movement* is another serious feature of the disease. In cases of gradual onset there is often a history of stiffness first thing in the morning, which wears off during the day, but recurs after exercise and at night. If an acute attack develops, the joint movement becomes grossly limited by spasm. Later, movement is restricted in all directions as a

Signs & Symptoms

result of muscle weakness and contractures, and, sometimes, because of gross destruction of the articular surfaces. Eventually, in some cases, movement is completely lost, due to fibrous or bony ankylosis.

It will be realized that no two cases are alike, and that each case varies from time to time. Thus there may be one joint at Stage I, another in Stage II, and several in the third stage, all at the same time. A joint in Stage III or Stage II may suddenly flare up and show all the features of acute inflammation. The disease is in fact unpredictable.

Diagnosis

Medical History

Taking a medical history is the first line to finding out if you have rheumatoid arthritis. Following is a list of questions your doctor might ask in a medical history:

- Do you have joint pain in many joints?
- Does the pain occur symmetrically – that is, do the same joints on both sides of your body hurt at the same time? Or is the pain one-sided?
- Do you have stiffness in the morning?
- When is the pain most severe?
- Do you have pain in your hands, wrists and/or feet?
- If you have pain in your hands, which joints hurt the most?
- Have you had periods of feeling weak and uncomfortable all over? Do you feel fatigued?

Physical Exam

- Joint swelling
- Joint tenderness
- Loss of motion in your joints
- Joint malalignment
- Signs of rheumatoid arthritis in other organs, including your skin, lungs and eyes.

Lab Tests

While there is no one test to confirm whether or not you have rheumatoid arthritis, doctor may use several different tests and imaging studies to help make a diagnosis. Most tests ordered to help with diagnosis will only have to be taken once. Tests designed to measure improvement or to check for drug side effects may need to be repeated regularly.

- Complete Blood Count

  People with rheumatoid arthritis often have a low red blood count, signally anemia, a common problem for people with RA. Anemia can contribute to feelings of fatigue. People with more aggressive disease tend to have more severe anemia.

Diagnosis

White blood cells may be high, signaling that infection is present in your body. A low white blood cell count could suggest Felty's syndrome, a complication of RA, or may be caused by some medications.

Your platelet count is elevated when you have inflammation present in the body. It can also be lowered by certain drugs.

- Erythrocyte Sedimentation Rate (ESR)

  The erythrocyte sedimentation rate (ESR) measures the speed at which red blood cells fall to the bottom of a test tube. The more rapidly your red blood cells drop, the more inflammation is present in the body. A high ESR indicates inflammation and the higher it is, the more severe the RA is. Your ESR will be checked frequently to see if treatment is working successfully.

  You should note that only about 60 percent people with RA have an elevated ESR. Because your treatment is based primarily on clinical symptoms, a normal ESR doesn't mean that you are cured and no longer need treatment for RA.

- C-Reactive Protein

  C-reactive protein (CRP) is found in the body and is elevated when inflammation is found in the body. The higher the level of CRP the more disease activity is involved. Although ESR and CRP reflect similar degrees of inflammation, sometimes one will be raised when the other isn't. This test may be repeated regularly to monitor your inflammation and your response to medication.

- Rheumatoid Factor

  Approximately 70 to 80 percent of people with rheumatoid factor (RF) also have rheumatoid arthritis. It is tested by measuring the amount of RF in your body. The higher the amount of RH present in the body, the more active and severe your disease is.

  Some people with RA do not have RF in their blood. They are called "seronegative." People with RF in there blood are called "seropositive."

- Radiographs (X-rays)

  Your doctor may take X-rays of your bones and joints upon diagnosis with RA to provide a valuable baseline for comparison with later X-rays. They show the swelling of the soft tissues and the loss of bone density around the joints – the result of your reduced activity and inflammation. As your disease progresses, your X-rays can show small holes or erosions near the ends of bone s and narrowing of the joint space due to loss of cartilage.

- Magnetic Resonance Imaging (MRI)

  A MRI can detect early inflammation before it is visible on an X-ray, and are particularly good at pinpointing synovitis (inflammation of the lining of the joint)

- Bone Densitometry (DEXA)

  Bone densitometry is an important imaging study for measuring bone density, used primarily to detect osteoporosis. Osteoporosis may be especially severe in people with RA due to joint immobilization, the inflammatory response itself and the use of certain therapies (such as glucocorticoids) that may hasten bone loss. Some doctors suggest that a bone density test should be part of the evaluation and monitoring of all people with RA, particularly for women after menopause.

Case Report

History

Mr.BS Kumar, on 28-01-2008 had injury in right knee while exercising (leg press) on Multi-gym at home. As a result of this, right knee swelled along with fluid deposit within a week.. Patent was treated at Lilavati Hospital, Mumbai and was successfully relived of the injury after 2 months.

Patient, again sprained his right ankle while taking bath in the month of July 2008, which was recorded in 29-09-2008 referral to rheumatologist by orthopedic. MRI was performed on 13-11-2008 which resulted in Edema around periarticular soft tissues with minimum fluid in the joints. However, during this treatment itself, patient's right knee started swelling again with fluid deposition.

Patient while still under treatment of rheumatologist, consulted Homoeopathy Clinic on 08-09-2008 for second opinion. While going through the medical history of the patient it was found that the C-Reactive Protein was 162.40 on 18-08-2008 along with other medical examinations like aspiration knee fluid for Tuberculosis, Malignancy, RA & ESR, including X-Ray & MRI all being negative. It was observed that no definite diagnosis was made by Rheumatologist during the course of treatment and apart from medication, patient was advised more bed rest.

Observation

- Patient walking with difficulty.
- Swelling of right knee.
- Knee was tender and hot.
- Knee pain better after continuous walk.
- Aggravation of pain by applying local heat.
- Family history of DM-II.

Homoeopathic Treatment

Based on the symptoms and C-Reactive Protein test results, patient was prescribed the following medicines with advise to discontinue the medication prescribed by rheumatologist.

1. Guaiacum Q: Immovable stiffness, local heat to the affected joint, joints swollen, painful, intolerance to pressure and aggravation from local heat
2. Jacranda 30: Pain in knee joint better by continuous motion, aggravation at the beginning of walking
3. Ruta G 1M: In view of the history of Injury caused by multi-gym. It acts on injured cartilages, tendons and formation of joints in joints Painful swelling and stiffness after sprains.
4. Ledum Pal 1M: Affects all aspects of Rheumatic Arthritis. The joints are painful swollen , hot aggravates by local heat.
5. Bacillinum 1M: Few doses ware given keeping in vie of constitution in the beginning of case.

Patient is now free of all complications and his C-Reactive protein result dated 31-07-2009 is NEGATIVE. Patient was advised for no further treatment and in general be careful while exercising at home.

Medical History & Reports

Attached are the scanned images of the patients medical reports and history along with the prescriptions during the course of the treatment.

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• Arogya Nidhi Hospital, Juhu. • Sujay Hospital, Juhu. • Gurunanak Hospital, Bandra (E). • Elite Polyclinic, Malad, (W).

MR. B. S. KUMAR M/ 28/1/08

C/O - Pain in (RT) knee. & swelling

O/E - Tend - ++
- EFFusion (+)
- R.O.M 10° to 120°
- Rest - (N).

Inv - Investigation

T- Arcoxia 90
1-0-1
T- Ranfera (150)
1-0-1
} x 5 days

Rabeprazole (L.A.)

- follow up on 28/1/08

28/1/08 Ct c the same.

T-ugesic (20mg) x 3 day's.

0—1—0

follow up after a week.

- Avoid - Crossleg seating/Clum bing

14/08

effision + (less)

Pain ↓↓

ROM 0-140

Adv - Physio

Rx Tab Zion (8 mg)

- 1 ——— 1

- Tab Mefkell forte

2 ——— 1

Pollong 10 days - Tab Ranxic 150

1 ——— 1.

10

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AND RESEARCH CENTR

Ref. Doc No. : OI/07/140616 Rpt Date/Time :28/01/2008 18:05
Ref. Accn No.: 82/0800343 Rcv Date/Time :28/01/2008 09:20

OP No. : OP/08/010791
Patient Name : Bharatbhusan S Kumar (Male / 40 y)
Ref. Doctor : Dr. JOSHI SHASHANK R

MRI OF RIGHT KNEE JOINT

Clinical History: History of injury. Pain in the right knee joint.

Protocol:
Multiplanar MRI of the right knee joint is performed using T1 & T2 weighted spin echo, turbo STIR & T2 weighted gradient echo sequences.

Observations:

The anterior & posterior cruciate ligaments are intact & appear normal. The medial & lateral collateral ligaments are normal.

The medial & lateral menisci are normal. There is no meniscal tear.

The bones show normal signals intensity. The articular cartilage is normal.

There is large joint effusion with fluid noted in the patello-femoral joint space and supra-patellar bursa.

Minimal fluid is noted in the deep infrapatellar bursa with subtle bright signals noted in the patellar tendon at the tibial attachment.

There is edema of soft tissue in the medial aspect of the knee.

There is edema of the popliteus muscle.

Conclusion:

MRI findings reveals :

Large joint effusion with edema of soft tissue on the medial aspect of the joint as well as popliteus muscle.

Degenerative changes in the patellar tendon with minimal fluid in deep infrapatellar bursa.

Dr. M. Deshmukh MD.,Fellow UCSF | Dr. M. Ruparel DNB.,DMRD | DR. M. Kulkarni MD. | Dr. H.V.Merchant DMRE,DMRD,DNB

Chkd by APARNAY
To : MRI Despatch

Radiologic & Imaging methods have limitations. Kindly consult your doctor who will correlate clinically and advise

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Mr Kumar. 21.2.8

effusion - Moderate

Pain - Nil

Fair Mobl

Rx

Tab Arcoxia 90 (200) — x (10)

x Tab Chymoral forte — x (7)

Tab Omez FF (20) — x (10)

Follow - 10 days

Aspirin - SOS

3/3/8

Opinion 4

Pull shoulder — Pain ↓

Tab Arcoxia 90 mg

Inj. Myoral (8 mg)

Tab Rabeg 60

Tab Pan 20

10

Physiotherapy - local application

following - 10 days

3/3/8

Cervical spine 2 days pain

Sudden onset

No radiation

Neck movements terribly painful

- Dr SM dg

Adv xr - cervical spine

LILAVATI HOSPITAL
AND RESEARCH CENTRE

Mr./Ms. Kumar Age Yrs. Date 3/3/8

℞

X-ray

cervical spine (AP
lat)

OPD Timings
Hospital OPD : 8 a.m. to 4 p.m.
Private OPD : 4 p.m. to 10 p.m.
Tel: 2642 1111, 2655 2222, 2645 5891 Extn.: 2052 / 54

Ref. Dr.

Reg. No.

For Gmd. Floor OPD Appointments Only : 2645 5947
For 2nd Floor Health Check - up Appointments Only : 26429911

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LILAVATI HOSPITA
AND RESEARCH CENT

Ref. Doc No. : OI/07/160762 Rpt Date/Time :10/03/2008 15:32
Ref. Accn No.: 71/0809279 Rcv Date/Time :10/03/2008 11:49

OP No. : OP/08/028682
Patient Name : Bharatbhusan S Kumar (Male / 40 y)
Ref. Doctor : Dr. Ongc

X-RAY CERVICAL SPINE AP / LATERAL **X-RAY NO : 7820**

X-ray cervical spine in the frontal and lateral projections reveal normally maintained curve.

Vertebral bodies, appendages and disc spaces are normal.

Spinal canal is normal in AP dimensions.

The prevertebral soft tissues are normal.

The craniovertebral junction is normal.

No bony cervical ribs are noted.

IMPRESSION :

Normal findings.

Dr. M. Deshmukh MD.,Fellow UCSF | Dr. M. Ruparel DNB.,DMRD | DR. M. Kulkarni MD. | Dr. H.V.Merchant DMRE,DMRD,DNB

Chkd by SHEETALV
To : Radiology & Imaging Despatch

Radiologic & Imaging methods have limitations. Kindly consult your doctor who will correlate clinically and advise

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B. S Kumar

17/3/10

Improving:
- Knee pain reduced
- Neck movement (N)

- Tab Lanol - BR
  1 — 0 — 1
- Tab Omez BR
  1 — 0 — 1

for pain.

- Contin exercises

(Dr. Vinod Agrawal)

LILAVATI HOSPITAL
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Mr./Ms. B S Kumar Age Yrs. Date 18/8/00

Rx

- Anti-CCP antibodies
- RA factor
- C-reactive protein

OPD Timings
Hospital OPD : 8 a.m. to 4 p.m.
Private OPD : 4 p.m. to 10 p.m.
Tel: 2642 1111, 2655 2222, 2645 5891 Extn.: 2052 / 54

Ref. Dr. 2211

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LILAVATI HOSPITAL
AND RESEARCH CENTRE

Date 18/8/18

Mr./Ms. Kumar BS Age Yrs.

Rx

T. Ace-Vah-P
1 — 0 — 1

T. Somprazi-40
1 — 0 — 1

x (10) days

Dr. ARCHIK

OPD Timings
Hospital OPD : 8 a.m. to 4 p.m.
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MICROBIOLOGY

Ref. Doc No. : OI/08/066764 Rpt Date/Time :19/08/2008 15:04
Ref. Accn No.: 40/0803249 Rcv Date/Time :18/08/2008 18:13

OP No. : OP/08/096592
Patient Name : Bharatbhusan S Kumar (Male / 40 y)
Ref. Doctor : Dr. Ongc

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Test	Result
RA (Rheumotoid Arthritis Factor)	
Specimen	Serum
Result	Negative.
Normal Range	0 - 8 IU/ml
Method	Latex Agglutination
Remark	The test was performed simultaneously with known negative and positive controls.
Note	Solitary pathology test have their limitations. The final diagnosis must be based in conjunction with clinical findings and/ or other investigation.

Dr. K. R. Dhunjibhoy
MD(Micro)

Dr. M. V. Doshi
MD(Bom),DNB(Path),MNAMS

Dr. N. M. Chavan
MD(Path)

Chkd by KALPANASIV
To : Pathology Despatch

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MICROBIOLOGY

Ref. Doc No. : OI/08/066764 Rpt Date/Time :19/08/2008 15:39
Ref. Accn No.: 40/0803249 Rcv Date/Time :18/08/2008 18:13

OP No. : OP/08/096592
Patient Name : Bharatbhusan S Kumar (Male / 40 y)
Ref. Doctor : Dr. Ongc

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Test	Result
Anti CCP (Cyclic Citrullinated Peptide)	
Result	Negative.
Value	1.90 RU/ml
Interpretation	Negative < 5 RU/ml Positive > 5 RU/ml
Method	Enzyme Immunoassay
Remark	The test was performed simultaneously with known negative and positive controls.
Note	Solitary pathology test have their limitations. The final diagnosis must be based in conjunction with clinical findings and/ or other investigation.

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MD (Micro)

Dr. M. V. Doshi
MD (Bom) ,DNB (Path) ,MNAMS

Dr. N. M. Chavan
MD (Path)

Chkd by KALPANASIV
To : Pathology Despatch

BIOCHEMISTRY

Ref. Doc No. : OI/08/066764 Rpt Date/Time :18/08/2008 18:38
Ref. Accn No.: 50/0856975 Rcv Date/Time :18/08/2008 17:46

OP No. : OP/08/096592
Patient Name : Bharatbhusan S Kumar (Male / 40 y)
Ref. Doctor : Dr. Ongc

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Test	Result	Unit	Reference Range
C-Reactive Protein (CRP)	162.40 H	mg/l	< 5.0

Note : Immunoturbidimetric assay.

H = High / L = Low

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Dr. N. M. Chavan
MD (Path)

Chkd by JIGNA
To : Pathology Despatch

Pathology tests have limitations. Kindly consult your doctor who will correlate clinically and advise

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HAEMATOLOGY

Ref. Doc No. : OI/08/106431 Rpt Date/Time :12/11/2008 15:21
Ref. Accn No.: 21/0859846 Rcv Date/Time :12/11/2008 13:20

OP No. : OP/08/131752
Patient Name : Bharatbhusan S Kumar (Male / 40 y)
Ref. Doctor : Dr. Ongc

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Test	Result	Unit	Reference Range
ERYTHROCYTE SEDIMENTATION RATE (ESR)	8	mm first hour	< 15

Dhanan

Dr. K. R. Dhunjibhoy
MD (Micro)

Dr. M. V. Doshi
MD (Bom), DNB (Path), MNAMS

Dr. N. M. Chavan
MD (Path)

Chkd by SHUBHANGI
To : Pathology Despatch

Pathology tests have limitations. Kindly consult your doctor who will correlate clinically and advise*

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Ref. Doc No. : OI/08/106521 Rpt Date/Time :13/11/2008 16:21
Ref. Accn No.: 82/0803814 Rcv Date/Time :13/11/2008 09:19

OP No. : OP/08/131836
Patient Name : B S Kumar (Male / 41 y)
Ref. Doctor : Dr. NANAVATI NIMISH J

MRI RIGHT ANKLE

Protocol:
MRI of the right ankle is performed using T1, T2 & STIR sequences in multiple planes.

Observations:

The alignment of the joint is normal.

The bones show normal signal intensity.

The ligaments around the joints appear normal.

The tendon around the joint is normal. Tendon achilles is normal.

Plantar fascia is normal.

There is edema of the periarticular soft tissue. Minimal fluid is noted in joint

Conclusion:
MRI findings reveal :

- **Edema around the periarticular soft tissues with minimal fluid in the joint.**
- **No other significant abnormality is seen.**

Dr. M. Deshmukh MD.,Fellow UCSF | Dr. M. Ruparel DNB.,DMRD | DR. M. Kulkarni MD. | Dr. H.V.Merchant DMRE,DMRD,DNB

Chkd by APARNAY
To : MRI Despatch

Radiologic & Imaging methods have limitations. Kindly consult your doctor who will correlate clinically and advise

Dr. ANANT JOSHI
M.S. Ortho. (Bombay), D.Ortho.,
Master of Sports Science (U.S.A.)

Savitri Sadan, 168-A,
Dr. Ambedkar Road,
Dadar, Mumbai - 400 014.
Phone : 2414 2929 / 2414 3240.
Fax : 022-2414 3699.
e-mail : asminst@yahoo.com
CONSULTATIONS :
Mon., Tue., Thurs. & Fri. : 3.30 to 6.30 p.m.

B.S. Kumar (41) 29.9.08.

(R) knee : ? minor twist during leg press in Jan '08

Had knee swelling - lasted for 2 months.

Was OK thereafter.

July 08 - twisting inj. (R) ankle.

this was foll. by knee swelling after 5-6 days.

Recently - more problems (R) ankle < to the knee.

OE : Hip rotations restricted (R) side

Knee almost full ROM.

Adv

- Physiotherapy

(R) ankle

Strengthing knee

(1) Xray pelvis c̄ both hips

AP view &

(2) Xray for sacro iliac jt.

To consult

Dr. Nimmish Nanavati

Rheumatologist

Telefax : 2745 9533

Dr. Sahni Bhupinder Singh

DHMS Hons., PGRT (Mumbai), F F Hom (Malaysia)

Registration No. 36955 (Maharashtra)

Clinic : B-1, 1st Floor, Building No. 7-B, Dwarkamai, Gurushranam, Vishrali Naka, Panvel - 410 206.

Authorised Medical Attendent, ONGC Ltd., CGEWCC

08.09.08

TUESDAY CLOSED

TIMING : 10.00 TO 1:00 AM 05.00 TO 8.00 PM

28/09/08

Telefax : 2745 9533

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12/10/2008

B S Kumar

C heater for ↑

30/10/08

① Rule 6 in - 2 for

② Lead Palin - 2 for

③ Secondary 3 for

④ Guaiacum Q - 1st

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B S Kumar 47 M 26/11/08

Rx

- Lactofal 17 - 2 tt

- Sucrande 30 - 2 tt

- Rubi 4/7 - 2 tt

26/11/08

06/12/08

Guaiacol 15 ml

6 hr

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BS Kumar 14/01/09

& Pk Ar Kuk

Cyclicum Q - 30 4

4 Workshops

- Lab Pulm
- Gerrandel
- Late Gin

14/1/9

TUESDAY CLOSED
TIMING : 10.00 TO 1.00 AM 05.00 TO 8.00 PM

17/1/09

30/01/09

P. D. HINDUJA NATIONAL HOSPITAL & MEDICAL RESEARCH CENTRE

(Established and managed by the National Health & Education Society)

VEER SAVARKAR MARG, MAHIM, MUMBAI - 400 016, INDIA
PHONE : 2445 1515, 2445 2222, 2444 9199 FAX : 2444 9151

DEPARTMENT OF LABORATORY MEDICINE
MICROBIOLOGY

ORDER NO. : 13095344 EX NO. : 1330292 ADM. NO. :

NAME : KUMAR B S AGE : 42 YEARS SEX : MALE

DATE : 31/07/2009 LOCATION : OPD REFERRED BY DR. : ONGC

Samp. Coll Dt : 31/07/2009 10:48:36AM WorkSht.DtTm: 31/07/2009 11:10:37AM

Test	Result	Units	Significant Titre
C.Reactive Protein			
Result	NEGATIVE		

Comments : Test technique : Latex agglutination
The CRP test is a acute phase reactive protein that is elevated in inflammatory processes.

* * End of Report * *

DR. CAMILLA RODRIGUES / DR. ANJALI SHETTY

MD MRCP,FRC Path

Consultant Microbiologist

Report Printed On : 31-Jul-2009 16:16