

STATE BUDGET HEALTH CARE INSTITUTION  
«SCIENTIFIC RESEARCH INSTITUTE – OCHAPOVSKY REGIONAL CLINICAL HOSPITAL  
№ 1»

OF MINISTRY OF HEALTH OF KRASNODAR KRAI

167 May 1 street, Krasnodar city, 350086, Russia

staffroom tel: (861) 252-73-38

**The Pulmonology department**

**DISCHARGE REPORT**

**FROM THE MEDICAL CARD OF THE INPATIENT № 31306**

**FULL NAME: \*\*\* DOB: 19.12.1961**

**Age (y. o.): 60**

Registration address: \*\*\*

Occupation:

Payment: OMS (Insurance Policy) series: number: \*\*\* Issued: LLC Rosgosstrakh Insurance Company – Medicine – Rosgosstrakh – Krasnodar – Medicine, Krasnodar city.

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The patient underwent medical treatment: in the pulmonology department from 18.04.2022 to 27.04.2022

**Clinical diagnosis:**

ICD-10 of primary disease: J84.9 Unspecified type of interstitial lung disease

**Primary disease:**

Idiopathic pulmonary fibrosis accompanied by «honeycomb lung» formation.

**Complications of primary disease:**

Type I (one) respiratory failure

**Associated diseases:**

Incompetence of cardia. Superficial gastritis.

Deforming osteoarthritis) of both pelvis joints – 1st-2nd degree pathology in the left side, 3rd degree pathology in the right side with aseptic necrosis of the femoral head of 3-4 degree. 3rd degree of impaired joint disfunction.

**Admission complaints:** labored breathing while minimal physical activity, self-care, intermittent severe cough with almost inseparable white viscous cough sputum weakness)

**Case history:**

Patient considers herself to be sick since 1994 after the childbirth, labored breathing, cough, the act of treatment at the «REGIONAL CLINICAL HOSPITAL № 2» with sarcoidosis diagnosed. Such symptoms as cough, labored breathing, debilitation and chilly sensations reappeared in 2012. Residential treatment, Alveolitis was diagnosed in Israel, 12 tablets per day with incremental dose decline, 2 tablets intake per day lasted until 01.2019. Pain in joints – arthrosis aseptic, necrosis of the femoral head, Prednisolone dose reduction to 1 tab per day, taking into account aseptic necrosis of the femoral head.

The patient was directed to consult a pulmonologist to the Center of Thoracic Surgery, Krasnodar city. The patient was on pulmonology department hospitalization in April, 2019. The act of undergoing a medical examination is fixed.

Hypersensitivity pneumonitis (HP) with further emergence into fibrosis was diagnosed. The beginning of Prednisolone dose decline taking into account aseptic necrosis of the femoral head.

The patient has been on consultation with pulmonologist for approximately 3 months on conditions of residential treatment, with regard to labored breathing Azathioprine therapy was started 150 mg twice a day.

27.04.2022

Chest CT displayed negative changes. The patient was directed to the Center of Thoracic Surgery, Krasnodar city. The patient was on pulmonology department hospitalization in February, 2020.

Idiopathic pulmonary fibrosis was diagnosed. Nintedanib therapy was started. In association with Vargatef patient complains of stomachache, liquid stool. The patient underwent dynamic treatment regime while hospitalization in November, 2020.

CT results are steady. Antifibrotic drugs therapy has been prolonged.

According to patient, labored breathing, general debilitation and cough exacerbated approximately 1 month ago.

The patient was directed to consult a pulmonologist to the Center of Thoracic Surgery, Krasnodar city. With regard to clinical negative changes the patient was admitted to pulmonology department for hospitalization.

The patient was on pulmonology department hospitalization from 23.06.2021 to 25.06.2021 – according to CT-scan results, breathing process was steady – in the form of drastically crude restructure of lung tissue accompanied by «honeycomb lung» formation, disruption of initial structure of lung tissue. Patient has acquired disease complications, respiratory failure. Idiopathic pulmonary fibrosis is in evidence. The disease presupposed consequences (prognosis) are extremely inconvenient, the disease itself has an inevitably progressive course. Work qualification is lost unconditionally. According to vitals, prolongation of antifibrotic drugs therapy is essential – Nintedanib. The patient was dismissed in satisfactory state with recommendation of dynamic hospitalization regime in 6 months repeatedly. The drugs intake has satisfactory consequences for the patient.

The patient was on pulmonology department hospitalization for conducting dynamic estimation patient's condition in association with Nintedanib intake in December, 2021 – the decision of proceeding on antifibrotic drugs therapy to the full extent was made.

After inpatient discharge the patient's state was satisfactory. The patient was following therapy prescriptions on regular basis until the end of February, at the end of February and in March the patient was taking Vargatef 1 tablet once a day. Since April, 2022, the dose has increased to 1 tablet twice a day.

Over the course of 2 months, the patient complains of incremental exacerbation of labored breathing and cough exacerbation. The patient was directed to consult a pulmonologist to the Center of Thoracic Surgery, Krasnodar city, examined and directed to pulmonology department for hospitalization for dynamic estimation in association with therapy.

Hospitalized to pulmonology department for dynamic estimation of the process.

**Patient's life history:** Smoking –denied

Occupational history – pharmacist

Tuberculosis, sexually transmitted diseases, HIV, hepatitis, peptic ulcer, cardiac accident, acute cerebrovascular accident and diabetes mellitus are denied.

Earlier diseases: Autoimmune thyroiditis Euthyrox 112 mg, hypertensive disease

(Amlodipinum 5 mg, Betaloc® ZOK 100 mg)– drugs were handed over due to Federal benefits

Surgical interventions: video-assisted thoracoscopy in the left side of the body, year 2013, hip replacement November 2019, Injuries: denied

Allergic anamnesis: drug allergy – INDAPAMIDE – SWELLING

No hereditary taint is revealed.

**Instrumental researches conducted:**

ELECTROCARDIOGRAM done on 18.04.2022

Heart rate: Sinus rhythm, cardiac rate 77 per min, QT378 ms.

Location of electrical axis of heart: is declined to the left.

Cardiac conduction disorder: leftanterior hemiblock.

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Signs of hypertrophy: Predominance of biopotentials of the left ventricular. Enhancement of left atrium.

**Changes:** amplitude decay of electrocardiographic waves R from V1-V6

Heart arrhythmia/diastolic: no heart defects were detected.

RESPIRATORY FUNCTION done on 18.04.2022

Severe disruptions of respiratory failure of restrictive type. Moderate disruptions of respiratory failure of obstructive type. Forced expiratory volume (FEV1) – 42% (0.98)

Forced vital volume (FVV) – 41% (1.14)

ECHOCARDIOGRAM PROTOCOL done on 19.04.2022

#### **AORTA**

Ascending aorta: not expanded 34 mm (N: reaches 38 mm)

Aorta: hardened, not expanded 33 mm (N: reaches 38 mm)

Fibrous ring of the aortic valve: calcium deposit

Aortic valve cusps: hardened, calcium deposit

Opening amplitude of the aortic valve: regular (N: reaches more than 17 mm)

There are single hyperechoic layering on the aortic walls.

#### **LEFT ATRIUM**

Left atrium: is not expanded 42 mm (N: reaches 38 mm) Four-chamber view shows: 42 X 57 mm (N: reaches 40 X 49 mm).

#### **LEFT VENTRICLE**

Cavity of the left ventricle: is not expanded; End-diastolic dimension: 48 mm (N: reaches 55 mm)

Ventricular septum: is thickened 11 mm (N: reaches 10 mm)

Posterior wall: reaches the upper normal level 10-11 mm (N: reaches 10 mm)

General contractility of the myocardium of the left ventricle: left ventricular ejection fraction is satisfactory: >55% (N: reaches more than 55 mm)

Regional contractility of the myocardium of the left ventricle: is not defected

#### **MITRAL VALVE**

Mitral annulus: calcium deposit

Mitral valve leaflets: hardened, calcium deposit

Antiphase: present

In systole: closed

Doppler sonography of mitral valve: +/++, mitral valve regurgitation followed by multiple organ failure

#### **RIGHT ATRIUM**

Right atrium: reaches the upper normal level. Four-chamber view shows: 39 X 51 mm (N: reaches 40 X 49 mm).

#### **RIGHT VENTRICLE**

Cavity of the right ventricle: slightly expanded 29-30 mm (N: reaches 28 mm)

#### **TRICUSPID VALVE**

Tricuspid valve leaflets: hardened

Doppler sonography of tricuspid valve: +

#### **PULMONARY ARTERY**

Pulmonary artery valve: signs of moderate hypertension

Systolic pressure: 38 mm Hg

#### **INFERIOR VENA CAVA**

Inferior vena cava: is not expanded

Inferior vena cava response: appropriate

Pericard: significant quantities of exudate are not located(visualized)

**CONCLUSION:**

Dilation of the left atrium (LA). The initial stage of development of hypertrophy of the left ventricular myocardium. Left ventricular diastolic function. Moderate pulmonary hypertension. Atherosclerosis of aorta. Pleural cavities ultrasound: exudate is not located (visualized).

ECHOCARDIOGRAM, ECG DYNAMIC MODEL, QT, HEART ARRHYTHMIA DIACRISIS  
done on 19.04.2022

Heart rate: Sinus rhythm, cardiac rate 72 per min, QT-386ms.

Location of electrical axis of heart: is declined to the left.

Cardiac conduction disorder: leftanterior hemiblock.

Changes: diffuse changes of the left ventricular myocardium.

**RESPIRATORY FUNCTION:** moderate decrement of respiratory failure of restrictive type.

CT PROTOCOL done on 19.04.2022

Study № 5547

Unenhanced images of chest from the lung apex level to phrenicocostal sinus level were received due to topogram images and axial sections in the CT series.

Lungs to their full extent. Lung airness is diffusely decreased caused by enhancement of spreading «Ground glass opacity» loci and the occurrence of new lung consolidation loci in subpleural portions. Prominence of perihilar markings areas of «honeycomb» type are preserved predominantly in subpleural portions.

Segment S9 of the right lung calcification reaches 4,5 mm – as earlier.

Bronchi are visualized as usual.

There are cylindrical bronchiectasis in the right lung segments S3, S10 and in the left lung segments S8, S9, S10 (as earlier).

Intrathoracic lymph nodes: tracheobronchial constitute 13 mm in the right side (earlier 12 mm), pretracheal constitute 12 mm as earlier.

No free liquid in posterior sinuses is revealed.

Cardiac orifice partially prolapses into the esophageal opening in the diaphragm.)

Bones structures are examined special windows. No osteolytic and osteoplastic foci were detected.

**Conclusion:** negative dynamics of ILD – CT scan showed UIP (Usual Interstitial Pneumonia).

Lymphadenopathy mediastinal – no changes.

Hiatal hernia (HH)

Ultrasound study done on 20.04.2022

Vital information for U/S results interpretation: Visualizations is perplexed –aerocoly+esophageal-gastric bleeding (EGB)+apparent decrement of tissues conductivity.

**Liver:** right lobe (RL) oblique vertical dimension (OVD) 145 mm. Left lobe (LL) 90\*62 mm.

Boundaries are plain, distinct. Echogenicity is increased. Structure is diffusely inhomogeneous.

Vascular pattern is poor. Intrahepatic bile ducts are not expanded. There are no focal masses on loci accessible for examination. Portal vein: 11 mm. Choledochousduct: 4 mm.

**Gall bladder:** of 72\*26 mm size with constrictions and angulations. Gallbladder wall is not thickened, 3 mm. Lumina is inhomogeneous – single units of particulate matter in gallbladder.

**Pancreas:** (fragmentarily visualized) of average size. The borders are plain and distinct. Echogenicity is increased. Structure is diffusely inhomogeneous. Wirsung canal is not visualized.

There are no focal masses (on loci) accessible for examination.

**Spleen:** of average size, usual shape. Borders are plain. Echogenicity is regular. Structure is homogeneous.

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**Kidneys:** right kidney: normal location, usual shape. Border is plain, distinct. Corticomedullary differentiation is maintained. Size: 111\*53 mm. Thickness index of parenchyma in mid-end – 19 mm. Echogenicity is increased. Structure is diffusely inhomogeneous. Central echo complex is of regular shape, normal area, increased echogenicity. Pelvicalyceal system and renal duct are not expanded. Ureteroliths with acoustic shadow of 6 mm in size in lower calyceal group.

Left kidney: usual location, regular form. Border is distinct, plain. Corticomedullary differentiation is maintained.

Size: 127\*55 mm. Thickness index of parenchyma in mid-end — 18 mm. Echogenicity is increased. Structure is diffusely inhomogeneous. Central echo complex is of increased echogenicity, fragmented. Pelvicalyceal system and renal duct are not expanded. Cystic lesions of 27 mm in size in the parenchyma. There are hyperechoic signals with weak acoustic shadow up to 5 mm in middle and lower calyceal groups. Paranephric fibre on both sides without any abnormalities.

**Abdominal cavity:** no free liquid in abdominal cavity is detected.

**Conclusion:** ultrasonic signs of diffuse changes in liver, pancreas, kidney parenchyma, bilateral nephrolithiasis and cystic lesions of the left kidney.

Thyroid Ultrasound study done on 22.04.2022

**Right lobe:**

a: 9 mm, b: 8 mm, c: 18 mm, **volume:** 0,6 cm<sup>3</sup>

**Left lobe:**

a: 7,5 mm, b: 5 mm, c: 23 mm, **volume:** 0,4 cm<sup>3</sup>

**Isthmus of thyroid:** 0,8 mm, **total volume:** 1,0 cm<sup>3</sup>

(N- ♂7,7-22,6 cm<sup>3</sup>, ♀4,5-19,3 cm<sup>3</sup>)

**Borders:** some of them are irregular. Thyroid is typically located.

**Displaceability:** normal

**Echogenicity:** moderate

**Echostructure:** diffusely inhomogeneous

**Vascularization:** during Color Doppler Imaging blood flow is poor – single loci

**Focal masses:** not visualized

**Regional lymph nodes:** cervical glands of 7\*3 mm on both sides, corticomedullary differentiation is maintained, supraclavicular lymph nodes are not located

**Conclusion:** ultrasonic signs of diffuse changes in reduced thyroid.

**Laboratory assessments conducted:**

The results of laboratory assessments done on 18.04.2022

**Coagulology:** prothrombin time 11.00 sec (9.40-12.50), INR 0.97 (0.80-1.14), aPTT 35.70 sec (24.00-38.00), aPTT-ratio 1.22 (0.82-1.81), Fibrinogen 4.97 g/l (1.74-4.04)

The results of laboratory assessments done on 18.04.2022

**Biochemistry of blood:** Glucose level – 4.70 mmol/L (3.50-6.38), Urea level – 3.30 mmol/L (2.50-8.30), Creatinine level – 50.60 umol/L (44.20-97.00); total Bilirubin level – 12.10 umol/L (3.40-20.50); total Protein level – 78.70 g/L (64.00-83.00); Aspartate transaminase level – 29.0 u/L (0.0-35.0); Alanine transaminase level – 47.0 u/L (5.0-55.0); C Reactive Protein level– 3.00 mg/L (<8.00)

The results of laboratory assessments done on 18.04.2022

**Clinical blood analysis:** leucocytes (WBC) 7.00 10E9/L (4.00 – 9.00); red blood cells (RBC) 4.72 10E12/L (3.80 – 5.30); hemoglobin (HGB) 146 g/L (117-160); hematocrits (HCT) 43.80% (34.00-46.00); mean corpuscular volume (MCV) 92.80 fL (80.00-100.00); average amount of hemoglobin per red blood cell (MCH) 333 g/L (322-358); platelets (PLT) 260 10E9/L (150-400); red cell distribution width, coefficient of variation (RDW-CV) 13.80% (11.50-14.50); mean platelet volume (MPV) 10.60 fL (7.40-10.40)

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--Differential leucocyte count--: Neutrophils (NE) 52.30% (47.00-72.00); Lymphocytes (LYMF) 38.30% (19.00-37.00); Monocytes (MON) 6.60% (3.00-11.00); Eosinophils (Eo) 2.10% (1.00-5.00); Basophils (Ba) 0.70% (0.00-1.00); Neutrophils (NE) abs 3.66 10E9/L (2.04-5.80); Lymphocytes (LYMF) abs 2.68 10E9/L (1.20-3.00); Monocytes (MON) abs 0.46 10E9/L (0.09-0.80); Eosinophils (Eo) abs 0.15 10E9/L (только я сейчас заметила, что букву l добавила, но маленькую, а надо было большую) (0.02-0.50); Basophils (Ba) abs 0.05 10E9/L (здесь тоже большая должна быть) (0.00-0.20)

--: Erythrocyte Sedimentation Rate (ESR), Panchenkov's method 27 mm/h (2-15)

The results of laboratory assessments done on 18.04.2022

**General clinical research:** microprecipitation test (-) negative (negative)

The results of laboratory assessments done on 19.04.2022

**Sputum analysis (physico-chemical properties):** mucoid, viscous sputum of light-yellow colour.

**Microscopic investigation:** huge quantities of squamous epithelium, columnar epithelium single; alveolar macrophages per high power field 0-2-3; leucocytes per high power field 10-12, isolated and unchanged red blood cells, modified red blood cells are not detected, Eosinophils in preparation were not detected; Curschmann's spirals, Charcot-Leyden crystals, Fibers and Phungi are not found.

The results of laboratory assessments done on 19.04.2022

**Microscopic investigation for tuberculosis:** investigation for acid-fast mycobacteria (1 glass) – negative; investigation for acid-fast mycobacteria (2 glass) – negative

The results of laboratory assessments done on 19.04.2022

**Clinical common urine analysis:** pale straw colour (transparent yellow, pale straw colour); Transparency is to the full extent (to the full extent); Relative density of urine 1.011 (1.010-1.020); PH 7.5 (5.0-7.0); Leucocytes negative (negative); Nitrites negative (negative); Protein negative (negative); Glucose negative (negative); Ketones negative (negative); Urobilinogen normal level (norma); Bilirubin negative (negative); Red blood cells negative (negative)

The results of laboratory assessments done on 19.04.2022

**Enzyme immunoassay, Regional Clinical Hospital:** HBsAG is not detected (not detected); Anti-HCV is not detected (not detected)

Bacteriologic examination done on 25.04.2022

Biomaterial <sup>1</sup>	mucous membrane of tongue
Diagnosis	
Date of admission to hospital	21.04.2022
Department	

№№	Isolated pathogens	Amount
[1]	Candida dubliniensis	

#### **Pharmaceutical treatment:**

Ringer's solution 500 ml, Omeprazol 20 mg twice a day, Oxygenotherapy

#### **Recommendations:**

1. Residential observation at General Practitioner.
2. Avoid freezing.
3. Seasonal flu vaccination on annual basis.
4. Antifibrotic drugs therapy, Nintedanib 150 mg 1 tablet twice a day long-term.

5. Consultation with pulmonologist over time in 6 months at the Center of Thoracic Surgery (residential referral, CT scans are necessary) with a follow-up hospitalization for conducting dynamic estimation of patient's condition.
6. Monitoring CBC, BAC, GBA, ECG, glucose profile under control accordingly with the residence.
7. Active breathing exercises applying breathing simulators (oPEEP – therapy Acapella, COACH-2).

**Temporary disability leave: absent**

PulmonologistI. V. Gorbatko <Signature.>

Head of departmentL. V. Shulzhenko <Signature.>

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