A CASE REPORT ON HYPERTENSION WITH CHRONIC ALCOHOLIC SEPSIS AND MULTIPLE ORGAN DYSFUNCTION SYNDROME

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Abstract:
Introduction: Chronic alcoholism causes a cardiac contractile dysfunction,may occur after 6 month to 1 yr of alcohol consumption. Sepsis, on a more acute basis, can also induce intrinsic cardiac dysfunction. chronic alcohol consumption caused no overt cardiac dysfunction by itself but did exacerbate the myocardial injury induced by sepsis.Cardiac dysfunction is common in patients with severe sepsis and septic shock. Alcohol is one of the world's most extensively used medications, and it creates problems in a variety of organs. However, there is little research on the consequences of persistent alcohol usage on acute lung injury and nonpulmonary organ failure. This research aimed to see how chronic alcohol misuse influenced the incidence and severity of septic shock patients' Multiple organ failure and acute respiratory distress syndrome in medical intensive care units. Current treatment for sepsis-induced cardiac dysfunction is based on appropriate treatment for the infectious focus (antibiotics and source control) and hemodynamic support (fluids, vasopressors, and inotropes).
Patient information: A patient is a 60year old male, having chief complaints right lower limb pain for one month which was associated with lower body part weakness which was sudden in onset, fever for 2days, altered sensorium since one day, seizures, breathlessness, abdominal pain etc. His weight is 65kg. He is admitted to the hospital on the date 02-02-2022.
Clinical findings: The patient appeared to be awake and oriented with individuals on general inspection. There are no high-risk variables. He was pale, anxious, and dysphonic throughout the examination. Patients with clinical symptoms that are very similar to those of our case have lately been described. **Medical management:**inj.meropenem IV 500 mg ,inj. levoflox IV 500 ,NJ.pan IV 40 mg,inj.emset IV 4mg this drug suppresses immunity system.
Nursing Management: Fluid replacement was administered (DNS and RL), maintained intake and the result charts and monitored all vital signs hourly.
Conclusion: Development of antibodies against Hypertension with chronic alcoholic sepsis with septic shock with multiple organ dysfunction syndromes after providing medication patient health was improved.

Keywords: Portal hypertension, Sequential organ, Acute, chronic, Predisposition insult.

Introduction:

The effects of chronic alcoholism on acute lung damage and pulmonary organ dysfunction remain largely unknown.[1]This research aimed to see how chronic alcohol misuse influenced the incidence and severity of septic shock patients' Multiple organ failure and acute respiratory distress syndrome.In medical intensive care units, [2] The term "sepsis" refers to a condition in which the body main the reason for death. Many organ dysfunction syndromes (MODS) are a condition in which multiple (MODS) are usually accompanied by symptoms of increased anaerobic metabolism despite supernormal oxygen supply in the body as a whole majority of fatal cases of sepsis. Tissue hypoxia has been thought to be for a long time the underlying the reason why mods, based on this clinical situation. Efforts to improve tissue oxygenation in patients with severe sepsis, on the other hand, have failed. Especially in postoperative patients, sepsis symptoms and indications can be modest and readily confused with symptoms of other

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conditions (e.g., dementia, primary cardiac failure, pulmonary embolism), Fever, tachycardia, diaphoresis, and tachypnea are common symptoms of sepsis, but blood pressure.[3]Other signs of the infection that caused the problem could be present. Confusion or decreased alertness may occur as if it were sepsis signs of progress or if a septic shock occurs, especially in the elderly or the very young.[4] The skin is paradoxically warm while the blood pressure drops. Later, the extremities turn. The skin is chilly and pale around the edges with cyanosis and mottling.
Additional organ-specific symptoms and indications questions are caused by organ dysfunction (e.g., oliguria, dyspnea). When a patient has been diagnosed with an infection and shows evidence of Inflammation across the body or within an organ malfunction, sepsis is suspected.[5] It's essential to keep track of the signs and symptoms of systemic Inflammation. Investigated for the purpose of infection using the patient's medical history, the physical examination, and the treatment plan testing, such as Urinalysis and urine culture (particularly in patients with indwelling catheters), blood cultures. Ultrasonography, CT, or MRI may be necessary for patients suspected of having a surgical or occult procedure source Sepsis is a type of sepsis that occurs when the body, depending on the suspected source.[6]Procalcitonin and C-reactive protein (CRP)levels in the blood are frequently increased in severe sepsis and can help diagnose the condition, but they are not specific.[7]

Patient information: This patientwas a 60year old male, having chief complaints right lower limb pain for one month which was associated with lower weakness which was sudden in onset, fever for 2days, altered sensorium since one day, seizures, breathlessness, abdominal pain etc. His weight is 65kg. He is admitted to the hospital on the date 02-02-2022.

Patient-specific information: The patient was admitted to hospital with the above chief complaints. All routine investigations are done.

Primary concerns and symptoms of the patient: A 60 yrs. old male was seen in the hospital's outpatient department with complaint of lower limb pain for one month which was associated with weakness, which was sudden in onset, fever since 2days, altered sensorium since one day, seizures, breathlessness, abdominal pain etc. Blood pressure 140/90 is mmHg, pulse rate is 96beats/minute, and respiration is 16breathe / minute.

Medical and family psychosocial history: No medical records were available in this case and surgical history, he is a nuclear family member. He was mentally sound and well-informed. He maintained intense contact with his family, doctors, nurses, and other patients.

Clinical findings: The patient had right lower limb pain for one month, which was associated with lower weakness which was sudden in onset, fever for 2days, altered sensorium since one day, seizures, breathlessness, abdominal pain etc. Blood pressure is a problem there.140/90 mm of Hg , pulse rate is 96beats/minutes and respiration is 16breathe / minutes. USG of pelvis done s/o hepatomegaly with altered echotexture with dilated veins of the liver. A blood investigation is done. CBC is also done, he is 9.5, MCHwas 28,mcv is 86.8,RBCs is 3.38,WBCs is 22700,platelet 0.27,HTC is 29.3calcium 7.7,45756cretine in body .KFT and LFT are also done.

Diagnostic Assessment:

Ultraviolet sonography: Hepatomegaly with dilated veins of the liver.
Gastroscopy: Gastroscopy of the patient is also done.
KFT : KFT is done , urea is 75,creatinine is 3.1,sodium is 129,potassium is 6.4
LFT: LFT is done , alkaline phosphate is 122,ALT(SGPT) is also 134,AST(SGOT) 274,total protein 8.2,albumine 3.1,total bilirubin 24.0, bilirubin coagulate 24.7,Globuline 5.6,bilirubin Uncoagulated2.2.

Prognosis: Blood investigation showed that the haemoglobin level was slightly low, and the WBC level was typical.

Therapeutic intervention:Present case took the medical managementwithinj. meropenem IV 500 mg ,inj.levoflox IV 500 ,inj.pan IV 40 mg ,inj. emste IV 4mg this drug suppress immunity system.

Nursing perspective: IV fluid was given to keep the fluid and electrolyte balance, monitored Patient condition.

Discussion:

Adult septic shock or severe sepsis patients were studied in a cohort formed in the past,Sepsis is fundamentally an inflammatory disease mediated by the activation of the innate immune system. Two key findings characterize the innate immune response in sepsis[8]. The first finding is that sepsis is generally initiated by simultaneous recognition of multiple infection-derived microbial products and endogenous. The presenting signs and symptoms of sepsis are variable and depend on the particular organ systems that are affected. Six types of organ dysfunction predominate in sepsis: neurological (altered mental status), pulmonary (with hypoxaemia), cardiovascular (shock), renal (oliguria and/or increased creatinine concentration), haematological (decreased platelet count) and hepatic (hyperbilirubinaemia). Multiple organ dysfunction syndromes may occur due to predisposition if several factors. One of the major risk factors includes pancreatitis and the incidence rate of severe acute pancreatitis induced multiorgan failure observed[9,10]. Among them, respiratory, renal failure and cardiac failure were most commonly absorbed but fails established a significant association between pancreatitis and organ failure. The most common

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cause of severe acute toxicity was alcohol consumption. Similarly, in our studies, we found the patient was associated with severe acute pancreatitis with highly elevated serum amylase and lipase level with a history of excessive alcohol consumptions. The chronic pattern of alcohol consumption ranging from 60 to 80 g of alcohol per day for 10-15 years may have a chance to develop clinically significant pancreatitis. But in our patients, pancreatitis was developed within 6 years of excessive alcohol consumptions. As excess alcohol consumption enhances inflammation, fibrosis and calcium deposition in the pancreas may also poor digestion, disrupt hormone production and regulation[11-13]. This may lead to weight loss, diabetes mellitus and steatorrhea. In this patient, we found patients with uncontrolled glucose levels and unexplained abdominal pain, which may be due to pancreatitis and alcohol consumptions. Similarly, in our case study, we found patients were associated with severe acute pancreatitis with a history of excess alcohol consumption[14-15]. Excess alcohol consumption also induced inflammation and cause damage at the cellular level. This leads to activation and deficit immune system along with a decline in lymphocytes.

Conclusion:

A patient is a 65year old male, having chief complete is A patient is a 60year old male, having chief complete is right lower limb pain since one month which was associated with lower weakness which was sudden in onset, fever since 2days, altered sensorium since one day, seizures, breathlessness, abdominal pain etc. His weight is 65kg. He is admitted in the hospital on the date 02-02-2022. The patient was admitted in the hospital with hiccups, giddiness, hematemesis Malena, yellow discoloration of the skin, fatigue, and weakness for form 2 weeks. USG of the patient is done. Gastroscopy of the patient is also done. A blood investigation is done. CBC is also done , he is 9.5,much is 28,mcv is 86.8,RBCs is 3.38,WBCs is 22700,platelet 0.27,HTC is 29.3 calcium 7.7,45756cretine in body .KFT and LFT are also done. medical management with drug-like inj meropenem IV 500 mg ,inj .levoflox IV 500 ,inj.pan IV 40 mg,inj. Emset IV 4mg this drug suppress immunity system. During the course, the in-hospital patient condition was improving. It was stable clinically and vitally, but the patient was advised to stay in the hospital for a few more days, but the patient was not willing. The patient was discharged on request.

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