PEDIATRIC UNIT I DISCHARGE SUMMARY

NAME: Keshav	AGE: 9 ½ years	SEX: male	UHID No: 20130456387
DATE OF ADMISSION: 30/6/14	DATE OF DISCHARGE: 4/8/14	Bed: D5/2	
DIAGNOSIS: Post KTP with Asymptomatic transaminitis			
Consultants: Dr A Bagga, Dr P Hari, Dr A Sinha	RT No - 2144/14		

History: The child is a known case of CKD stage 5D on hemodialysis admitted for renal transplant.

Disease course : Disease onset in June 2008 at 3 years of age initial treated outside and diagnosed as FRNS(details and documents not known)and received steroid and endoxan(duration not known) and later on labeled as SRNS- late resistance in June 2011 and started on Cyclosporine A in Aug 2011. Renal biopsy done at that time was s/o FSGS with MGN. Child presented to AIIMS in Nov 2011 when Cys A was withheld but was restarted in Dec 2012. Child relapsed in May 2013 when Cys A was stopped and repeat biopsy was done which was s/o Non proliferative GN with chronicity of 30%. Child was later on lost to follow up. Child again presented in Feb 2014 with features of fluid overload and uremic encephalopathy when child was admitted and PD was done after which he was shifted to HD. Thereafter child was in maintenance hemodialysis.
Work up for transplant was started and donor was maternal grandmother. Both donor and recipient were appropriately investigated and child was adequately immunized.

On examination in ward: Child is afebrile, active, emaciated
Peripheries- warm, CFT< 3 sec; HR- 106/min, RR-24/m, SpO2 98% in RA, BP-132/98 mm Hg ,
Pallor+, no icterus, cyanosis, clubbing, dehydration ;
Chest: B/l AE +, no added sound
CVS: S1 S2 +, no murmur
P/A: soft, non tender, liver and spleen not palpable
CNS: no focal neurological deficit, CNS : alert and active, no CN or motor deficits, no meningeal sign
Anthropometry: Weight-21 Kg(3rd-15th centile), length: 118 cm(3-15th centile)

Hospital Course: Child was admitted for renal transplant. Prior Biopsies were discussed for native disease and confirmed to be FSGS considering renal biopsy and disease course.
Pre operative course: Child was given Inj Rituximab on 5/7/14 and 6 plasma exchanges were done from 8/7/14 to 16/7/14. Nutrition was built up by involving the dietician with addition of Nephro HP. Caregiver counseling and consent were taken. Second dose Rituximab were given just before transplant on 22/7/14. Induction immunosuppression comprising of IV Basiliximab and IV methylprednisolone and triple immunosuppression was given. Child underwent Live related renal transplant on 23/7/14 and was nursed in AB7/ KTP ward till 28/7/14. No intraoperative or post operative complications seen and drain was removed on post operative day 5. Child was shifted to D5 ward.

Post operative course: Hypertension was adequately controlled on drugs, fluid intake was optimized. Tac levels were consistently low so pangraf was increased from 5 mg/day to 7 mg/day; last Tac level was 6.9 (5/8/14). Child had derangement in liver enzymes which was thought to be transient and planned to follow. CMV and HCV PCR were sent. Child and bystanders were adequately counseled with regards to hygiene, adequate hydration and strict compliance with drugs and planned for discharge with close follow up.

INVESTIGATIONS

HEMOGRAM:

Date	Hb	TLC/ DLC	Plt
1/7/14	8.7	8300	150000
14/7/14	5.6	5400/N72L15	157000
17/7/14	9.7	9900	180000
24/7/14	10.3	11400	198000
2/8/14	11.2	12100/ N51L30	279000
6/8/14	11.5	9300/N48L52	228000

BIOCHEMISTRY

DATE	UREA/CR	Ca/ PO4	TP/ ALB	OT/PT	SAP	Na/K	Chol
1/7/14	72/4.2	9.1/4.1	7.6/4.3	23/23	740	132/4.5	
24/7/14	15/0.6	-	-	-	-	-	
27/4/14	13/0.6	-	-	-	-	-	
30/7/14	23/0.5	8.4/2.3	-	34/75	337	124/3.1	
1/8/14	26/0.5	8.3/3.1	5.9/4.1	68/222	405	137/3.7	
2/8/14	29/0.6	8.6/4.1	6.4/4.6	53/197	410	134/3.9	
4/8/14	24/0.4	8/4.2	5.8/4.3	79/273	399	140/4.3	233
6/8/14	29/0.5	9.2/4.0	6.2/4.6	98/-	496	138/4.3	270

Hb A1C – 5.1 g%

LLEC scan (28/7/14) - normal functioning transplant kidney with non obstructive clearance;

USG Doppler: normal

Tac level – 30/7/14 – 6.86

1/8/14 – 4.6 (increased by 1 mg/d)

5/8/14 -6.9 (increased by 1 mg/d)

CMV PCR (2.8.14): Awaited

Condition at discharge:

Child is afebrile, Active

Peripheries- warm, CFT< 3 sec; HR- 110/min, RR-28/m, SpO2 98% in RA, BP-116/84 mm Hg ,

No Pallor, no icterus, cyanosis, clubbing, edema, dehydration

Chest: B/l AE +, no added sound

CVS: S1 S2 +, no murmur

P/A: soft, non tender, liver, Spleen not palpable

CNS: no focal neurological deficit, no meningeal sign

Plan at discharge: DJ stent has been planned to be removed after 1 week.

To come to D5 ward at 8:00 a.m. for sampling on Friday (8/8/14)

Advice at discharge:

1. Tab Pangraf 3mg –4 mg BD (9 am- 9 pm)
2. Tab. MMF 500mg BD
3. Tab Wysolone 12.5 mg OD
4. Candid mouth paint LA BD
5. Tab. Labetalol 200mg BD
6. Tab. Minipress XL 5mg BD
7. Tab Amlodipine 5 mg BD

Follow up in Peds Unit 1 Renal Metabolic Clinic at Thursday 2 PM after 7 days.
To follow up in Surgery Unit IV OPD.

14 AUG 2014

Senior Resident
Dr.Priyanka/ Dr Swati

Junior Resident
Dr Vinay

All India Institute of Medical Sciences

Department of Surgical Disciplines

Surgery Unit IV

Prof.M.C.Misra,Dr.V.K.Bansal

Dr.L.R.Murmu,Dr.Subodh Kumar,Dr.Sushma

OPD: Every Thursday and 2nd/ 4th Saturday Time : 9 am to 12:30 pm

Discharge Summary

Name:	Keshav	**OPDNo:**	2013045638	**F/UClinic No:**	
Age:	9 **Yrs** **Sex:** Male	**CR No:**	489606	**DOO:**	23-7-2014
Address:	H. No 515 kiridi place dhobi ghat	**DOA:**	30-06-14	**DOD:**	06-08-14

Pre OP Diagnosis: CKD-V Kidney transplant recipient

PostOPDiagnosis: CKD 5(Nephrotic syndrome)

Operation: LRRT

Operative Details: Right external iliac vein and right external iliac artery skeletonised.
End to side anastomosis of the renal vein to the right external iliac vein (recipient) was done.
End to side anastomosis of renal artery with Rt common iliac artery
Immediate pinkish coloration of the donor kidney with turgidity and good pulsation in the renal artery and distended renal vein.
Clamp on - off time-25 min.On table Brisk urine output identified
Modified Lych - Gregoir extravesical ureteroneocystostomy done with PDS 5-0
DJ stent placed.Hemostasis achieved
18 Fr drain placed

HOPI: K/c/o kidney disease since 3 years of age
diagnosed as focal segmental glomerulosclerosis which was initially managed by steroids,cyclophosphamide and cyclosporine
later on started on maintainence haemodialysis since march 2014 and is on thrice weekly maintainence haemodialysis
haemodialysis access through right IJV,previously through left IJV and left femoral

Past History: no past history of type1 DM/HTN/renal stone/

Rx History: tab shelcal 500mg 1 tab tds
cap cabadex 1 cap OD
inj. EPO 4000 IU twice weekly
IV iron 45mg once/week
tab amlodipine 5mg BD
tab minipress 5mg BD
tab envas 5mg OD
tab labetalol 200mg TDS

Examination: Alert, active and afebrile
PR=106 , BP=132/98, RR=22/min
Pallor present
No icterus,cyanosis,clubbing,oedema
weight=21kg
height=118cm

Post Op Course: POD0:I/O:17500/15400ml .urea-45,creatinine-1.7 Drain-350ml serosanguinous,BP-162/108.
POD1: I/O:21900/20570ml, urea-34,creatinine-0.7, Drain-250ml.BP-168/100,
Tab amlodipin, labetalol and minipress started.
POD2: I/O:14000/15200, Drain-50ml,Wound healthy.
POD3: I/O:9600/9255.Drain-10ml.Wound healthy, catheter, CVP line and foleys removed
POD4: I/O:5800/6700,POD5: I/O:4900/4500,Drain-10(removed)
DTPA- Normal perfusion and non obstructive clearance. Tac level-7.4
POD6:I/O:4800/4550.Wound healthy
Patient was transferred to pediatric department for further management.
POD7: I/O:4890/4390.Patient had raised liver enzymes so CMV quantitative profile has been sent.
POD10:I/O:5300/6000. TAC level- 4.6
On POD13 patient asymptomatic ,BP and blood sugar within normal limits.
He is maintaining good intake and output and at the time of discharge his Sr Creatinine is 0.6.
Tac level is 5.9 and all cultures sterile.DJ stent insitu,to be removed after 1 week.

Date	Hb (gm%)	TLC (/cumm)	P	L	M	E	B	DLC (Secs)	ESR	PT (C/P) (/cumm)	Platelets
23-7-2014	10	4200								198000	
24-7-2014	11.6	15000								163000	
1-8-2014	11.5	13800								337000	
3-8-2014	11.2	11500								288000	
28-8-2014	11.4	12100								158000	

Date	RBS	FBS	PP	BUN	S Cr	Na	K	Ca	PO4	U A
23-7-2014				45	1.7	137	3.8			
24-7-2014				24	0.7	140	3.3			
28-7-2014				16	0.5	140	3.7			
1-8-2014				26	0.5	137	3.7			
3-8-2014				24	0.4	140	4.3			

Date	Bilirubin		Protein			OT	PT	ALP	Amy	Chol	TG
	T	D	I	T	A	G					
1-8-2014	0.5						5.9	4.1	68	222	404
3-8-2014	0.3			6.4	4.6	53	197	410			

Date	T3	T4	TSH	Others	
1-8-2014				TAC Level	4.6
5-8-2014				TAC Level	5.9

Imaging:

Date	Type	Body Part	No.	Report	Remarks
28-7-2014	DTPA scan			Normal study	

28-7-2014	Doppler Scan	Normal Study

Treatment on Discharge:

SNo	Type	Drug	Dose	Frequency	Duration	Remarks
1	Cap	Pangraf	3.5 mg	BD		
2	Tab	MMF	500 mg	BD		
3	Tab	Wysolone	12.5	BD		
4	Tab	Labetalol	200 mg	BD		
5	Tab	Minipress XL	5 mg	BD		
6	Tab	Amlodepine	5 mg	BD		
7	Tab	Pantocid	20 mg	OD		
8	Tab	Septran	480 mg	HS		

Advice:

SNo	Advice
1	Follow up in Surgery 4 F/U Transplant Clinic,Thursday 2 pm,Room No. 4, Vth Floor
2	Maintain input/output chart,urine output and sugar charting
3	In case of reduced urine output,fever,cough report to c7 ward immediately
4	Avoid renotoxic drugs and dehydration
5	In case of loose stools,haematuria report to c7 ward immediately
6	Drink 3-4 litres of water daily

In case of emergency,contact 9868397726 / 9868397712 / 9868397703

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Surgery Unit IV

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OPD: Every Thursday and 2nd/ 4th Saturday Time : 9 am to 12:30 pm

Discharge Summary

Name: keshav
Age: 10 **Yrs** **Sex:** Male
Address: H N -515, Kiribi place, dhobi Ghat, delhi

OPDNo: 20130456987 **F/UClinic No:** 0797-14
CR No: 505079 **DOO:** 27-8-2014
DOA: 27-08-14 **DOD:** 28-08-14

Pre OP Diagnosis: FUC of LRRT, DJ stent in situ
PostOPDiagnosis: FUC of LRRT, DJ stent in situ
Operation: DJ stent removal
Operative Details: DJ stent removal done under GA.
No immediate complication

HOPI: patient is a FUC of LRRT. Underwent LRRT on 23/7/2014.
presently planned for DJ stent removal

Past History: no past history of type1 DM/HTN/renal stone

Rx History:

Examination: Alert, active and afebrile
PR=106
BP=132/98
RR=22/min
Spo2-98%
no icterus,cyanosis,clubbing,oedema

Post Op Course: allowed orally and self voiding from POD-0. mild hematuria on first passage of urine post procedure. No hematuria thereafter. Discharged in stable condition on POD-1.

Investigations:

Date	Hb (gm%)	TLC (/cumm)	P	L	M	E	B	DLC (Secs)	ESR	PT (C/P) (/cumm)	Platelets
19-8-2014	12.2	7000								202000	

Date	RBS	FBS	PP	BUN	S Cr	Na	K	Ca	PO4	U A
22-8-2014				58	1.2	135	3.4	8.7		

Date	Bilirubin			Protein			OT	PT	ALP	Amy	Chol	TG
	T	D	I	T	A	G						
22-8-2014	0.5			6.7	4.8	1.9	24	28	663			

Treatment on Discharge:

SNo	Type	Drug	Dose	Frequency	Duration	Remarks
1	Tab	wysolone	10 mg	OD		
2	Tab	mycept	500 mg	BD		
3	Cap	pangraf	4mg	BD		
4	Tab	septran	1Tab	OD		
5	Tab	lobet	100 mg	2 tabs tds		
6	Tab	amlodipine	5mg	BD		
7	Tab	minipress	5mg	BD		

Advice:

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Admin
28-08-14