DEPARTMENT OF PEDIATRICS
UNIT I
DISCHARGE SUMMARY

Name: Keshav	**Age: 11 yrs**	**Sex:** Male	**CR. No:** H-625584-15	**UHID:** 20130456387
Date of Admission: 03.11.15		**Date of Discharge: 07.11.15**		**Bed: D5/7**
Diagnosis: Post Renal Transplant (June 2014, Donor – Grand mother) with Acute gastroenteritis with hypocalcemia, hypokalemia, and hypomagnesimia				
Consultants: Dr. A Bagga, Dr. P Hari, Dr. A Sinha, Dr. R. Mallik				

HISTORY: Renal transplant recipient, on regular follow-up, admitted with c/o fever and loose stools for 3 days. Stools watery and intermittent, not a/w blood or mucus. Moderate-grade fever for the past 3 day, intermittent, not a/w chills or rigors, rash or bleed. No h/o pyuria/ hematuria/ oliguria/ bleeding from any site/ swelling anywhere over the body/ chest pain/ nasal discharge/ rash.

PAST HISTORY: Case of FSGS progressed to CKD. Kidney transplantation done in June 2014, kidney donated by maternal grand mother. H/o previous two admissions for loose stools and fever in past 2 months, treated as acute gastroenteritis an received Nitazoxanide.

ON EXAMINATION: Afebrile, HR 110/min; RR 24/ regular, BP 100/70 mmHg (RUL supine), CFT <3 sec; SpO2 99% on room air, peripheries cool, decreased volume pulses, all peripheral pulses palpable, mild dehydration.
Mild pallor/no cyanosis/ icterus/ clubbing/ lymphadenopathy/ edema. Chest: B/L AEE, NVBS, And CVS: S1 S2 +, No S3, No murmurs. P/A: Soft, non-distended, non-tender, BS+. CNS: Active, alert, no focal neurologic signs, no meningeal signs.
Anthropometry: Weight: 19.3 kg (<3rd centile), Height: 125 cm (<3rd centile), BMI:15.1 kg/m2

HOSPITAL COURSE: Child was admitted i/v/o acute gastroeneteritis. Child was started on IV fluids and hydration was maintained. Possibility of infectious diarrhea was considered and irritable bowel syndrome was less likely. Child was given IV Ceftriaxone for 4 days . Though child became afebrile from next day and loose stools also subsided. He was found to have metabolic acidos, with hypokalemia, hypocalcemia and hypomagnesiua. He was started on Potassium, Inj MgSO4 and calcium gluconate along with Oral calcium. Possibilities of post transplant tubular disorder was kept and planned for work up after improvement of present condition. He was continued on triplpe immunosuppressive drugs. Stool for atypical organism was negative. At the time of discharge, he had potassium of 2.5. Child is being discharge on oral potklor and planned to repeat K+ from d5 ward.

Date	Hb	TLC/ DLC	Platelets
3/11/15	13.0	9000/-	211000
4/09/15	10.3	4900/-	182000
5/09/15	10.5	5300/-	184000

BIOCHEMISTRY

DATE	UREA/CR	Ca/ PO4	TP/ ALB	OT/PT	Na/K
3/11/15	142/2.6	-	-	-	142/1.7
4/11/15	78/1.3	8.4/1.5	6.0/3.8	27/23	138/2.2
5/11/15	55/1.1	7.6/2.8	5.8/3.7	35/31	139/2.5
6/11/15	41/1.1	7.7/2.8	5.8/3.7	34/31	139/3.0
7/11/15	-	-	-	–	138/2.5

ECG: Inverted T waves, QTc- 0.42
Stool for atypical organisms (4/11/15): Negative.
Stool c/s (06/11/2015) Commensal flora grown on culture
Blood c/s (4/11/15): sterile

Condition at discharge:
Afebrile, HR 90/min; RR 24/min regular, BP 113/70 mmHg (RUL supine), CFT <3 sec; SpO2- 99% on room air, peripheries warm, normal volume pulses, all peripheral pulses well-palpable. Mild pallor/no cyanosis/ icterus/ clubbing/ lymphadenopathy/ edema. Chest: B/L AEE, NVBS, CVS: S1 S2 +, No S3, No murmurs. P/A: Soft, non-distended, non-tender, BS+. CNS: Active, alert, no focal neurologic signs, no meningeal signs.

ADVICE AT DISCHARGE:

1. **Tab cefixime 100 mg PO BD for 3 days** 0 0
2. **Tab TACROLIMUS 3mg – 3mg PO BD** 0 0
3. **Tab MMF 250 mg BD** 0 0
4. **Tab Wysolone 7.5 mg OD for 3 days then tab Wysolone 5 mg OD**
5. **Tab Shelcal 500 mg TDS** 0 0 0
6. **Sachet Adphos 500 mg 1 sachet PO BD** 0 0
7. **Tab Nodosis DS 1 tab PO TDS** 0 0 0
8. **Tab Septran (40 mg TMP) 2 tab -1 tab PO BD**
9. **Syp Potklor 15 ml QID** 0 0 0 0
10. **Inj. Magnesium sulphate 2 ml PO BD** 0 0

To come for VBG tomorrow to D5 ward. → K+ on 8/11/15 – 3.9
Review in OPD on Monday/Thursday at 9 am after 2 weeks.

Senior Resident
Dr. Subhankar/Dr. Kiran Kumar

Junior Resident
Dr. Vivek