DEPARTMENT OF PEDIATRICS

UNIT I

DISCHARGE SUMMARY

Name: Keshav	Age: 11 yrs	Sex: Male	CR. No: H-670418-15	UHID: 20130456387
Date of Admission: 07.04.16		Date of Discharge: 13.04.16		Bed: D5/8
Diagnosis: Post Renal Transplant with FSGS reoccurrence (June 2014, Donor – Grandmother) with Acute gastroenteritis with Pancytopenia (? MMF induce? Vit B12 def.)				
Consultants: Dr. A Bagga, Dr. P Hari, Dr. A Sinha, Dr. R. Malik				

HISTORY: Renal transplant recipient, on regular follow-up now with
Fever – 3 days
Loose stools and vomiting- 3 days
Stools watery and intermittent, not A/W blood or mucus. Frequency of 5-6 times /day. Associated with vomiting 2-3 episodes. Fever was moderate-grade, 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 grandmother. H/o previous three admissions for loose stools and treated as acute gastroenteritis an received Nitazoxanide. Was on Immunosuppressant and Antihypertensives. For FSGS recurrence in transplanted kidney it was decided to undergo 12 sessions of PEX followed by administration of Rituximab(once TLC improved). 7 session of PEX were already completed.

ON EXAMINATION: Afebrile, HR 148/min; RR 24/ regular, BP 90/60 mmHg (RUL supine), CFT <3 sec; SpO2- 99% on room air, peripheries cool, decreased volume pulses, all peripheral pulses palpable, mild dehydration.
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: 22.5kg (<3rd centile), Height: 125 cm (<3rd centile)

HOSPITAL COURSE: Child was admitted i/v/o acute gastroenteritis. At the time of presentation the child had features of hypovolemic shock and so IVF bolus was given once after which tachycardia improved with normal BP and warm peripheries. Possibilities of infectious gastroenteritis vs MMF induced diarrhea were kept. IV antibiotics were started. Diarrhea subsided within 2days and is currently asymptomatic. It was decided to change MMF to MMF sodium in view of lesser side effects after the remaining tablets get finished. The investigations showed pancytopenia and was attributed to MMF. So MMF dose was reduced and now is given at minimal dose of 250 mg OD. In v/o possibility of Megaloblastic anemia S. Folate and S. Vit B12 levels were sent and Inj Vit b12 inj and oral Folate were given. and is planned to continue after discharge and administer Rituximab once Pancytopenia settles.

Hemogram:-

Date	Hb	TLC/ DLC	Platelets
07/04/2016	7.7	3400/-	1.25 L
09/04/2016	5.8	3400/N34 L53	99,000
11/04/2016	5.1	3100/N30 L57	97,000
13/04/16	9.6	6300/N42 L47	1.74 L

ALL INDIA INSTITUTE OF MEDICAL SCIENCES (A.I.I.M.S.)
24 x 7 CALL CENTER NO. 011-40401010

BIOCHEMISTRY

DATE	UREA/CR	Ca/ PO4	TP/ ALB	OT/PT	Na/K
07/04/2016	117/3.5	-	-	-	130/4.2
08/04/16	86/2.2	7.6/4.0	5.9/3.2	44/42	136/3.8
09/04/16	47/1.4	7.9/2.6	5.7/3.1	41/46	139/3.8
11/04/16	38/1.3	8.4/4.0	6.8/3.3	43/50	131/3.9
13/04/16	42/1.0	8.9/3.9	6.6/3.7	41/50	137/4.2

Up/Uc (8/4/16) – 0.64

S. Folate and S. Vit B12(13/4/16) -Awaited

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:

To come to D5 ward on Monday 18/04/16 for next PEX

1) T MMF 250 mg OD
2) T Pangraf 3 mg PO BD
3) T Shelcal 500 mg PO BD
4) T Folvite 5 mg PO OD
5) T Nodosis DS TDS
6) Syp Potklor 10 mL PO TDS
7) T Oflox 200 mg PO BD for 3 more days
8) Cap Cobadex Cap OD
9) T Autrin 1cap OD
10) T Wysolone 5 mg PO OD
11) Inj MgSO4 2 mL PO OD

18/4/16

PEX done BSA 0.9

• Inj Rituximab 500 mg. i/v in 250 ml NS over 5 hr vv slowly.

23/2/16

Senior Resident
Dr. Jitendra/Dr Priyanka

Junior Resident
Dr. Vaishakh

16/4/16

u/ce 41/1.0
Ca/P 9.1/4.2
OT/PT 110/95
SAP = 152

TLC = 6200
Hb = 8.3
PLT = 1,40,000

up/uc = 0.6.

neha.

Tac level on 9/4/16