Department of Pediatrics

PEDIATRICS UNIT I DISCHARGE SUMMARY

NAME: Keshav	AGE: 11 years	SEX: Male	Bed No : D5/4
CR.NO: H-649227-16 UHID – 20130456387	Date Of Admission: 27/01/2016	Date of discharge: 01/02/2016	
DIAGNOSIS: Post KTP- Recurrence of FSGS with severe ambulatory hypertension			
Consultants In charge: Dr. Arvind Bagga, Dr. Pankaj Hari, Dr. A. Sinha			
Address: H No 515 Kiribi Place, Dhobi Ghat, Delhi			

HISTORY AT ADMISSION: Post KTP patient , transplant done in June 2014, currently on triple immunosuppression in form of Tacrolimus, MMF and Prednisolone presenting with rising creatinine and high BP records. There is no h/o decreased urine output/dysuria/headache/seizures/altered sensorium/fever/cough/dyspnoea/respiratory distress /loose stools. A diagnosis of graft stenosis was considered on OPD basis and USG Doppler was done where RAS was ruled out however increased cortical echogenicity with poorly maintained CMD was reported and the child was admitted for renal biopsy.

PAST HISTORY: The child is symptomatic from 3 years of age and is a k/c/o FSGS which progressed to CKD and he underwent Renal Transplant in AIIMS in June 2014. The donor was maternal grandmother and the post op course was uneventful. There has been three admissions since then with acute gastroenteritis and also hypokalemia, hypomagesemia and hypocalcemia and the child is still continuing on supplements.

O/E: Afebrile, HR- 102/min, RR-24/min, SpO2-99 % under RA, CFT-2 sec, NIBP-130/92 mmHg (RUL), warm peripheries. Pallor+ (mild), No Icterus/significant LAP/Cyanosis .No rash.

CNS-conscious, oriented to time, place and person, pupils bilaterally NSNR, no e/o cranial nerve palsy, fundus: no papilledema, sensory examination unremarkable, tone and power normal, DTR elicitable, plantars flexor, no meningeal or cerebellar signs. **Chest**- bilateral symmetrical, air entry equal NVBS, no added sounds. **CVS**-precordium normal, S1 S2 normal, No S3/murmur .**P/A**-soft and nontender on palpation, non distended, no organomegaly, no free fluid clinically, BS+, scar present.

Weight: 22.6 kg (<3rd centile), length- 121 cm (<3rd centile)

COURSE IN WARD: The child was admitted with rising creatinine (last value of 1.6) and high BP records. Possibilities kept were ?rejection ?recurrence of the primary disease ?transplant glomerulopathy. Urine examination revealed 2+ proteinuria and spot Up/Uc was 1.6. The child was started on Amlodipine 2.5 mg BD i/v/o high BP records. ABPM revealed severe ambulatory hypertension and Envas was also added following which BP recordings were normal. There was no evidence of end organ damage due to

hypertension. Renal biopsy was done on 29/01/16 and the child was stable throughout the procedure with no complications. Biopsy provisionally revealed ?recurrence of primary disease. Plan is to discuss biopsy report and plan for further management on OPD basis and continue triple immunosuppression and BP monitoring on 2 antihypertensives. The child was hemodynamically stable at the time of discharge.

TREATMENT RECEIVED: T. pangraf, T. Wysolone, T. MMF, T. Shelcal, Inj MgSO$, T. Amlodipine, T. Envas, T. Nodosis, Syp Potklor

INVESTIGATIONS: Hemogram:

Date	Hb	TLC	DLC	Plt
28/01/16	9.0	7300	N61L27	18600
30/01/16	8.2	4400	-	20200

Biochemistry:

Date	U/Cr	Ca/PO4	TSB/Conj	OT/PT/ALP	TP/Alb	Na/K
28/01/16	54/1.4	8.3/3.7	0.4	36/34/5492	7.7/4.1	138/3.0
30/01/16	44/1.3	7.6/3.4	0.4	36/33/4565	7.1/3.8	135/3.5

Urine R/E (28/01): RBCs 5-10, WBCs nil, Prot 2+
Up/Uc (28/01): 1.6 ,24h Up/Uc (31/01/16):
Vit D (22/12): 14.12 ng/mL PTH (22/12): 313.6 S. Mg: 1.30 (1.7- 2.1)
Lipid profile: Tc 106, LDL 41, HDL 36, Tg 143
Eye exam: normal Echocardiography: normal
Renal biopsy (29/01/16): final report awaited

CONDITION AT DISCHARGE:
Conscious and alert
Afebrile. PR: 98/min, RR: 22/min, SpO2: 98% in room air, BP: 118/68 mmHg, peripheries warm, All peripheral pulse well palpable.
Pallor (+), no icterus, cyanosis, clubbing, lymphadenopathy
Chest: B/L AE present and equal. NVBS heard. No crepts/ wheeze.
CVS: S1 S2 heard, no murmur, no S3, S4
P/A: Non distended, soft non tender. Liver and spleen not palpable. Shifting dullness absent, BS+
CNS: Child is conscious, No motor deficit, no signs of meningeal irritation/ neck rigidity
Wt at discharge : 21.6 kg
Advise at discharge:

1. Tab Amlodipine 5 mg BD 00-00
2. Tab Envas 2.5 mg BD ~~0-0-0~~ 0-0
3. Tab Pangraf 3mg BD 0-0
4. Tab Wysolone 5 mg OD -0-
5. Tab MMF 250 mg BD 0-0
6. Inj MgSO4 2 mL BD 0-0
7. T. Shelcal 500 mg BD 0-0
8. Syp Potklor 10 mL TDS 0-0-0 9. Tab. Nodosis 1 tab TDS

To review in Unit 1 OPD on Mon/Thu at 9 am after 1 week.

Junior resident
Dr Deepika

Senior resident
Dr Jitendra