Urine R/E (29/9/15) – Protein – 1+, **RBCs** – 2-3/hpf, **WBCs** – 1-2 /hpf
Tacrolimus levels (15/9/15) – 9.5 ng/mL : **(29/9/15)** – 9.3 ng/mL
DSA (14/9/15)- Negative
CMV and BKV PCR(26/9/15) –Both Negative
Blood gas- (24/9/15)pH- 6.99 Hco3- 5.6
(25/9/15) pH- 7.2 Hco3- 11.2
(29/9/15) pH- 7.2 Hco3- 12.6

Treatment given: Inj Ceftriaxone, T Cellcept, T Wysolone, T Pangraf, Syp Potklor, T Nodosis

CONDITION AT DISCHARGE: Alert, afebrile and conscious
PR – 92/min, RR-20/min, and CFT < 3 Sec, BP- 100/68 mmHg
No pallor, No lymphadenopathy/No clubbing/Icterus/cyanosis
RS: B/L Air entry equal, No added sounds.
CVS: S1 S2 heard. No S3/murmurs
P/A: No organomegaly.
CNS - HMF-Normal, Tone - Equal in all 4 limbs, Power- 5/5 in all 4 limbs.

Plan at discharge: To repeat RFT & VBG after 2 days and decide further management

ADVICE AT DISCHARGE

1. Tab Nitazoxanide 200 mg BD for 1 more day . 9Am – 9pm
2. Tab Wysolone 10 mg PO OD for 3 days , then decrease to 7.5 mg OD for 3 days and then to 5 mg OD to continue 10Am
3. Tab Cellcept 250 mg PO BD 9-9
4. Tab Pangraf 3 mg PO BD – 9-9
5. Tab Shelcal 500 mg PO BD 6 – 6
6. T Nodosis 2 tabs TDS 8 – 3 – 10
7. Syp Potklor 5 ml TDS 8 – 3 – 10

Review after 2 days in D5 ward on Saturday at 9 am

JUNIOR RESIDENT

Dr. Vaishakh

SENIOR RESIDENT

Dr. Subhankar/Dr Kiran Kumar

ALL INDIA INSTITUTE OF MEDICAL SCIENCES

DEPARTMENT OF PEDIATRICS-UNIT I

NAME: Keshav	AGE: 11 YEARS	SEX: Male	BED.NO: D5/4
CR.NO:H-614009-15 UHID No: 20130456387	DATE OF ADMISSION: 24/09/2015	DATE OF DISCHARGE: 01/10/2015	
DIAGNOSIS: Post KTP patient with Acute gastroenteritis			
CONSULTANTS- Dr A Bagga, Dr. Pankaj Hari, Dr. Aditi Sinha			
Address: H No 515, Kiribi Place, Dhobi Ghat			

HISTORY AND EXAMINATION AT ADMISSION: 11 year old boy who underwent kidney transplantation in June 2014 now presented with Diarrhea for 2 days and Fast breathing – 1 day. Child was admitted in AIIMS from 12/9/15-21/9/15 following diarrhea with deranged RFT and was discharged following improvement. But after 2 days child again developed large volume loose stools. Associated with fast breathing . No history of fever/ cough/ decreased urine output/ edema.

Past History: Underwent renal transplantation (Right kidney) from AIIMS in June 2014 and grandmother was the donor. Pre operative diagnosis was FSGS and post transplantation period was uneventful.

O/E: Alert, afebrile and conscious, PR – 120/min, Regular and good volume, RR-40/min- acidotic breathing CFT < 3 Sec, BP- 110/64 mmHg

No pallor, No lymphadenopathy/No clubbing/Icterus/cyanosis and no feature of dehydration.

RS: B/L Air entry equal, No added sounds.

CVS: S1 S2 heard. No S3/murmurs

P/A: No organomegaly.

CNS - HMF-Normal, Tone - Equal in all 4 limbs, Power- 5/5 in all 4 limbs.

Anthropometry: Weight:-20 kg (<3rd centile); Height:- 124 cm(<3rd centile)

HOSPITAL COURSE:- Child presented with the above complaints and increased creatinine . Possibilities of infection, dehydration, rejection and CNI toxicity were kept. Child was started on IVF and antibiotics. Diarrhea subsided in 2 days but creatinine values were high and metabolic acidosis and hypokalemia persisted. Child required bicarbonate infusion for acidosis. Subsequently child was started on nodosis and potchlor. For ruling out graft infection CMV and BKV PCR were sent and were negative. Kidney bipopsy was planned but deferred as RFT were gradually improving. DSA sent during previous admission was negative. Since trough Tacrolimus level was high Tacrolimus doses reduced from 3.5mg-3mg to 3mg-3mg. Metabolic acidosis and RFT improved gradually. At the time of discharge child is accepting orally well and hemodynamically stable.

Investigations: HEMOGRAM:

DATE	HB	TLC	DLC	PLT
28/9/15	10.7	8000	N68 L24	1.87 L
29/9/15	10.3	6700	N42 L47	1.69 L

BIOCHEMISTRY

DATE	UREA/CR	Na/K	SGOT/PT	TSP/Alb	S.ALP	Ca/P
22/9/15	107/1.7	144/2.8	35/31	7.1/5.2	314	7.7/2.8
26/9/15	84/1.9	139/3	22/24	6.2/4	288	5.8/2.5
28/9/15	57/1.4	137/3.1	29/34	7/5	292	6.7/2.7
29/9/15	60/1.4	140/3.1	32/32	6.5/4.2	252	6.2/3.1