ST.JOHN`S MEDICAL COLLEGE HOSPITAL

SARJAPURA ROAD, BANGALORE - 560034

Enquiry no: - 22065000 **Appointment no: - 22065003**

CASE SUMMARY & DISCHARGE RECORD

DEPARTMENT OF PAEDIATRICS

Ms. THANUSHREE V
7 Years / Female
NO 88, 5TH CROSS
SATHYANAGAR, M S POST
KARNATAKA - 560033

WARD/ROOM
PAEDIATRIC MEDICINE WARD A I Floor - B BLOCK / 1003-D

UHID
5217165

IP NR.
2501251791626

UNIT
PAED3

ENCOUNTER NO
902501258053

DATE OF ADMISSION
25 JAN 2025

DATE OF DISCHARGE
11 FEB 2025

CONSULTANTS : UNIT III : WED and SAT : Dr. Ranjini Srinivasan (Assoc.Prof) , Dr.Jainy N J (Asst.Prof) , Dr. Shilpa S C (Asst.Prof), Dr. Dhrithi (Asst.Prof) , Dr. Pankudi Priya (SR) , Dr. Goolla Akhila (SR) , Dr.Tanya Saxena (SR) :- OPD TEL : 080-22065034 , Paediatric Ward Tel: 080-22065973 / 74 .

FINAL DIAGNOSIS : COMPLICATED COMMUNITY ACQUIRED PNEUMONIA WITH MODERATE *PLEURAL EFFUSION*
SEVERE THINNESS

PRESENTING COMPLAINTS : Fever x 9 days
Cough x 7 days

HISTORY OF PRESENTING ILLNESS : Child was apparently well before 9 days when she developed fever high grade recurrent not associated with chills and rigors and decreased on taking anti pyretics, highest temperature recorded 103F
Cough for 7 days wet sounding and increased at night
History of night awakening and increased cough on lying down position

History of post tussive vomiting 1-2 episodes per day at night non bilious non projectile food particles present
History of deceresed oral intake and activity since 5 days
History of fever and cough in neighbouring houses with whom she plays with
No history of rashes
No history of loose stools or abdomen pain
No history of recent travel
No history of past nebulisation
Visited OPD on 21/01/2025 child was not better and treferred to SJMCH (reports weight loss of 2 kgs in last 2 weeks)

BIRTH HISTORY : DOB-9/7/2017
Term
Birth weight-2.15kg
No NICU admission

IMMUNISATION HISTORY : Last vaccine taken at 5 years of age

PAST HISTORY : No history of similar complaints
No history of previous admission

FAMILY HISTORY : No history of asthma Tb chronic cough or cardiovascular disease

DEVELOPMENT HISTORY : Normal developmental milestone

DIETITIC HISTORY : Eggs everyday, chicken once a week and eats fruits and vegetable

Expected
Observed

ANTHROPOMETRY :

Anthropometry	Observed	Expected	Interpretation
Weight (kg)	18kg	21kg	(10,25)
Height (cm)	125.2	123	(at 50th)
W/L or W/H			
BMI	11.5		<3

Overall interpretation- Severe thinness

GENERAL EXAMINATION : PR-130bpm
BP-110/70-mmHg
RR-48cpm
SpO2-96%RA
Temperature- 101F
No pallor icteruys cyanosis clubbing or edema
Bilateral submandibular post cervical lymph node +

SYSTEMIC EXAMINATION : Oral cavity- posterior pharyngeal wall congestion+
tonsils grade 1
Nasal cavity normal
No skin rashes
RS
INSPECTION- Chest wall appears normal

31/01/2025	A/G Ratio	0.81		**31/01/2025**	Bilirubin Total	0.28	mg/dL
31/01/2025	Bilirubin Direct	0.16	mg/dL	**31/01/2025**	Indirect Bilrubin	0.12	mg/dL
31/01/2025	Serum AST	21	U/L	**31/01/2025**	Serum ALT	24	U/L
31/01/2025	Serum ALP	142	U/L	**31/01/2025**	Serum GGT	42	U/L
31/01/2025	Serum Creatinine	0.41	mg/dL	**31/01/2025**	Human Immunodeficiency Virus (HIV) Test	Nonreactive	

RADIOLOGICAL INVESTIGATIONS : **CHEST SCAN (25/01/2025)**

Left sided mild pleural effusion noted (~30-40 cc). No septations noted within.

Right lung field and pleural space appear normal.

CHEST SCAN (28/01/2025)

Left side mild – moderate pleural effusion noted with ~ volume of 180-250cc.

No obvious septation or echoes noted within the pleural fluid .No significant pleural thickening noted .

Collapse consolidation of underlying lung parenchyma noted predominantly involving lowerlobe and lingular lobe.

Trace of pleural effusion noted at right CP angle with underlying subsegmental atelectasis .

No pericardial effusion

COURSE IN HOSPITAL: : 7 year 8 month old female was admitted with complaints of fever and cough for the past 9 days. On admission child had tachypnea, high grade fever maintaining saturation in room air. Systemic examination revealed reduced air entry in the left infra axillary and mammary areas. Initial blood investigations showed normal total counts with neutrophilic predominance with no anemia. Serum total protien was low. Urine routine was normal, urine albumin trace.
Chest xray showed left lower lobe consolidation with pleural effusion.
Chest USG confirmed the quantity to be ~30 to 40cc. Child was started on Oxygen via nasal prongs and Injectable antibiotics. The child was closely monitored and on day 2 of admission distress worsened, started on oxygen via face mask. Repeat xray showed increase in effusion, repeat USG chest revealing ~180 to 200cc of fluid, hence was shifted to the ITU.

In the ITU :

Pediatric surgery reviewed and ICD was placed on 24.01.2025. In view of persistant fever spikes Inj Vancomycin started along with Syp Azithromycin. Pleural fluid LDH was elevated total count normal with neutrophilic predominance. Light's criteria (2.4) was exudative type. Pleural fluid AFB and GeneXpert negative.
HIV was non reactive.
As the child's condition improved, was shifted to the ward. Oxygen was tapered and stopped.
In the ward :
In the ward, Drain output was monitored and child was started on chest physiotherapy. Gastric aspirate AFB and GeneXpert were negative. Child was continued on Inj Vancomycin and Ceftriaxone.
Dermatology reference taken in view of erythematous rash, opined that it is unlikely drug induced.
Chest physio was provided. As the drain output was < 10 ml for 3 days *paediatric surgery opinion was sought again and the ICD was removed.* The child received ceftriaxone for 14 days and Inj Vancomycin for 10 days and switched to high dose oral Amoxiclav to continue for 2 weeks.
Counselled regarding high protein diet and need to continue incentive spirometry.
Currently child is hemodynamically stable taking orally well with good urine output. Hence being discharged on th following advice.

CONSULTATIONS TAKEN: : DERMATOLOGY-
IMPRESSION-Maculopapular rash secondary to ?drug
?Lichen planus pigmentosus

ADVICE
To continue antibiotics at present- rash looks unlikely due to drug etiology. To wait and watch for further progression, to decide on stopping further antibiotics. To inform SOS if rash progresses
Tabd ALLEGRA 120mg 0-0-1/2

PEDIATRIC SURGERY
ADVICE
ICD insertion

ADVICE ON DISCHARGE : 1) TAB AMOXICLAV 625 MG
1---0----1 X 10 days
2) TAB PARACETAMOL 650MG
1/2 TAB IF FEVER MORE THAN 100F.
4)SYP ZINCOVIT 5ML---0---0 TO CONTINUE FOR 1 MONTH.
5)TAB CALCIUM 500 MG 1---0--0 TO CONTINUE FOR 1 MONTH.
6) VITAMIN D SATCHET 60,000 IU ONCE A WEEK FOR 4 WEEKS.

CONTINUE CHEST PHYSIO