

DISCHARGE SUMMARY

UHID : 142503124 Name : Baby KASHVIKA Age/Gender : 4 Yrs 11 Mths 11 Days/Female DOA : 12/07/2026 06:16 PM Discharge Status : Discharge on Request	IP NO : KH26/1610 Doctor : Dr. Huma Shaik Weight : 10.480 kg DOD : 08/08/2026
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DIAGNOSIS:

K/C/O CHRONIC GRANULOMATOUS DISEASE WITH SEVERE PNEUMONIA WITH SEVERE ARDS WITH ANEMIA.

Chief complaints:

Complaints of cough & Increased work of breathing since 1 day.

H/O PRESENT ILLNESS:

A 4 years old Female child k/c/o chronic granulomatous disease, presented with the history of cough & increased work of breathing since 1 day, for the above complaints child was brought to here for further management.

PAST HISTORY:

Child was on iv and oral medications in view of invasive aspergillus pneumonia for the past 3 weeks.

ON EXAMINATION

TEMP: 99.1F
 HR: 180/min
 RR: 52/min
 Spo2: 92% @RA, 100% @ 02
 BP: 97/63(69) mm Hg

General examination:

CERVICAL LYMPHADENOPATHY +, DULL LOOKING +, Oral Erythematous rash +.

Systemic examination:

CVS: S1S2+, FLOW MURMUR +, TACHYCARDIA +
 R.S: BAE +, MILD ICR +, TACHYPNEA +, BILATERAL CREPTS +, BILATERAL CONDUCTED SOUNDS
 P/A: SOFT, HEPATOSPLENOMEGALY +
 CNS: IRRITABLE CRY +

COURSE IN HOSPITAL -

RESPIRATORY SYSTEM:

Child presented with above complaints and was admitted in Pediatric Ward. Child initially had fever spikes, symptomatic treatment was given. Child was started on oxygen with nasal prongs @ 2 lit/min, IV fluids, IV antibiotics, IV Antifungals, antacids and other symptomatic treatment.

Initial chest x-ray done and showed bilateral patchy consolidations, USC CHEST showed pneumonitis changes with multiple patchy

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areas of consolidations seen involving bilateral lung parenchyma, bilateral mild pleural effusions.

After 24 hours of admission in view of increase in RD and fio2 requirements child was shifted to PICU and started on HFNC support with fio2-50%, flow-17litres/min and continued on same treatment

In view of increasing respiratory distress with increasing Fio2 requirements, on HFNC. ABG done s/o worsening (p/f ratio - On day 5 of admission sent gastric aspirate for CB-NAAT showed negative & sputum sent for fungal growth showed negative.

Serial monitoring of Blood gas, chest x ray done, which showed improvement. With spontaneous efforts child was extubated to HFNC on day 7 of admission. With clinical improvement & decrease in rd HFNC weaned off to nasal prongs on day 16 of admission.

After shifting to ward (shifted on 28/07/2026)- child was kept on O2 and continued same treatment, later Oxygen has been gradually decreased from 2 lit/min to 1 lit/min.

in between O2 free trials was done but in view of child having persistent tachypnea with desaturations, oxygen was restarted and continued.

HEMATOLOGY :

At admission , Investigations done and showed CBP-Hb-8.40%, PCV-22.6, WBC-18,000, PLC-1,87,000, CRP-383.4 mg/l.

Repeat septic work up done s/o decreasing CRP levels to 158.3, LFT showed mild transaminitis, RFT, serum electrolytes are within normal range. Serial monitoring of CBP, CRP done.

In view of anemia given 2 PRBC transfusions. Repeat CBP, CRP done s/o HB 10.6 & decreasing CRP to 28.7 on day 8 of admission.

Final blood culture showed no growth.

On 01/08/2026 investigations were done showed -Hb was 11.8 g/dl, WBC was 10700 cell/cumm, platelet count was 423000 lakh/mm. CRP was 12.5 mg/L. Serum electrolytes showed Sodium 137 mmol/L, Potassium 3.8 mmol/L, Chloride 103 mmol/L. LFT & RFT was normal.

On 06/08/2026 , repeat CBP showed Hb was 14.0 g/dl, WBC was 16400 cell/cumm, platelet count was 228000 lakh/mm. CRP was 25.5 mg/L. Complete urine examination showed normal. chest xray done.

CARDIOVASCULAR SYSTEM:

On day 9 of admission in view of high bp recordings started on oral clonidine. Serial BP monitoring was done showed improvement in BP readings gradually clonidine was stopped. 2DECHO done showed normal. Central venous access was secured on 17-07-26 and later removed on 5-08-26 , during the course central venous access hygiene was maintained.

GASTROINTESTINAL SYSTEM:

Initially child was kept on NBM , later started on tube feeds gradually upgrade to liquid diet followed by soft diet which is well tolerated by child orally. Protein rich diet was advised. During the course child had loose stools, symptomatic treatment added.

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CENTRAL NERVOUS SYSTEM:

No abnormality detected .

Child was regularly monitored by vitals , urine output and daily weight monitoring. And after full course of iv antibiotics , started on oral antibiotic and antifungal prophylaxis. Child was taking orally well and saturations maintaining with O2 - 1lit/min. Child needs oxygen support, and further monitoring, which was explained to patient attenders. In view of financial constraints child is being discharged at request with home oxygen support. Warning signs explained to attenders in their own language before discharge.

TREATMENT GIVEN:

1. HFNC SUPPORT
- 2.IV FLUIDS
3. IV CEFTAZIDIME - AVIBACTAM
4. IV AZTERONEM
- 5.IV VORICONAZOLE
6. IV VANCOMYCIN
7. IV PANTOPRAZOLE
8. IV METHYLPREDNISOLONE
9. TAB AKURIT
10. TAB CLONIDINE.
- 11.NEBULIZATION

CONDITION AT THE TIME OF DISCHARGE :Child is hemodynamically stable.

VITALS AT DISCHARGE:

HR: 126
 SPO2: 100 % with O2. 1lit/min
 RR: 38/min
 BP: 96/58 (67)
 TEMP: 98.2 F

DISCHARGE MEDICATIONS :

1. OXYGEN WITH NASAL PRONGS - 1LIT/MIN.
2. SYP FAROPENEM (200MG/5ML)- 7.5ML/PO/TWICE A DAY X 4 DAYS

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3. SYP ITRACONAZOLE (1ML/10MG)- 5.2ML/PO/ONCE DAILY /ON BEDTIME X TILL FURTHER ORDERS
4. SYP SEPTRAN (5ML/40MG)- 6.5ML/PO/ONCE DAILY X TILL FURTHER ORDERS
5. SYP PREDNISOLONE (5ML/5MG) -2.5ML/PO/ONCE DAILY FOR 3 DAYS (from 4/8/26 to 10/8/26)
FOLLOWED BY 1.2ML/PO/ONCE DAILY FOR 1 WEEK (from 11/8/26 to 17/8/26)
THEN - STOP
- 6.SYP KIDCARE PLUS 5ML/PO/TWICE DAILY FOR 1 WEEK
7. TAB AKURIT -4 - 1TAB/PO/ONCE A DAY (STARTED ON 16/7/2026 CONTINUE TILL 13/09/2026) AND TO FOLLOWUP FOR FURTHER TREATMENT CHANGES.
8. TAB JR LANZOLE 15MG-1TAB/PO/ONCE DAILY FOR 10 DAYS
9. NEBULIZATION -3%NS + LEVOLIN-8TH HOURLY X 3DAYS
10. CHEST PHYSIOTHERAPY & SPIROMETRY
- 11.ALLOW ORALLY (THREPTIN BISCUITS-2/ DAILY WITH MILK)
- 12.PROTEIN RICH DIET
13. PULSE OXIMETER MONITORING FOR - HEART RATE & SATURATIONS (SPO2).

FOLLOWUP ADVICE :

1. TO DO CRP AFTER 2 DAYS.
2. Review after 2 days with consultant pediatrician at Ankura Hospital in OPD services.

WHEN TO OBTAIN URGENT CARE :

- *Poor feeding
- *Decreased urine output
- *Persistent cry
- *Blue discoloration of lips or fingers or toes
- *Persistent vomiting and loose stools
- *Abnormal body movements or seizures
- *Dullness or decreased activity
- *Any other worrying symptoms

In case of emergency contact: 9154940209

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Summary was explained to us by: *Pravali*

Signature of clinical assistant: *Pravali*

Signature of parent: *K. Srujana. mother..*

[Signature]
Dr. Lakshman Deepa Shabasu (GENERAL
PEDIATRICS)

— Ankura Medical & Research Centre Pvt Ltd —

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