



Name	Master CHUKKA SRIANSH	UHID	
Father/Guardian	Mr CHUKKA PRAJWAL	Age/Gender	5 Y 10 M 3 D/Male
Address	F T		
IP No	L	Admission Date	29-09-2026
Ref Doctor	DR K NARAHARI	Summary Date	07-09-2026

MEDICAL SUMMARY

Consultant : DR. SHAIKH FARHAN A RASHID MD, DNB(PED), Fellow Pediatric Critical Care, Head of Pediatric Intensive Care Unit, Consultant Pediatrician & Pediatric Intensivist Reg No. 66229	Co-Consultants : DR. KAPIL BHAGWATRAO SACHANE DNB, MRCPCH (UK) Fellowship in Neonatology (UK) Fellowship in PICU & CICU (UK) Fellowship Paediatric Critical Care Transport (London) Consultant Paediatric and Cardiac Intensivist Reg No: 2002/03/1356
---	--

FINAL DIAGNOSIS	ICD CODE
AUTOIMMUNE HEMOLYTIC ANEMIA	
SEPSIS/ THROMBOCYTOPENIA ASSOCIATED MULTIORGAN FAILURE (TMA-TTP Spectrum)	
ACUTE KIDNEY DISEASE ON CAPD	

Chief complaints & history of present illness: Master CHUKKA SRIANSH, 5 Y 10 M 3 D old boy with acute kidney disease on CAPD presented with history of back pain of severe intensity, pointing to lumbosacral vertebrae and multiple episodes of vomiting prior to admission. In view of persistence of symptoms, he was admitted at Rainbow Children's Hospital for further management.



MO	IP
Name	IP No

Name	Master CHUKKA SRIANSH	UHID	[REDACTED]
IP No	[REDACTED]	Admission Date	29-09-2026

Past History: Admitted on 08.09.2026 with Influenza A Illness/MODS/oliguria AKI/CAPD insertion on 15.09.2026. Child was discharged on CAPD, was doing well at home, urine output gradually improved.

Outside investigations:

Done on 27.09.2026: Hb - 9.7 gm%, WBC - 6400 cell/cmm, Platelets - 8.25 lakh/cmm. USG abdomen scan done on 28.09.2026 was suggestive of mild HSm, mild ascites present.

On admission clinical findings: He was febrile 102 F, SpO2 of 90 % at room air & hemodynamically stable. Heart rate was 112 /min, Blood Pressure - 107 /74 mmHg and Respiratory Rate - 22 /min. Peripheries were warm, pulses well felt. On auscultation of chest, air entry was bilaterally equal with occasional crepitation were present. Heart sounds were normal and there was no murmur. Abdomen was soft with no organomegaly. On neurological examination, child was drowsy. Pupils were bilaterally equal and reacting to light. There were no focal neurological deficits, no meningeal signs and no signs of raised intracranial pressure.

Weight on admission : 15.8 kgs.

History of allergy: Nil.

Prism III score :11
Admission sofa score :18
Worst sofa score :18
Day 1 PELOD :13
Worst PELOD :13

Investigations during hospital stay: Enclosed reports.

Course of Treatment during hospital stay: He was admitted in PICU and was started on IV fluids and IV antibiotics. ABG showed pH - 7.109 , pCO2-



Name	Master CHUKKA SRIANSH	UHID	
IP No		Admission Date	29-09-2026

29.1 mmhg, pO₂ - 118 mmhg, HCO₃ - 9.8 mmol/l, BE: -18.8 mmol/l suggestive of severe metabolic acidosis.

Mechanical Ventilation: In view of worsening of sensorium, child was intubated and put on mechanical ventilation on PRVC mode with settings of PEEP- 8, PIP- 22, Rate - 50/min & FiO₂ - 80%. ABG showed severe metabolic acidosis (pH - 6.89, pCO₂- 29mmhg, pO₂ - 345mmhg, HCO₃ - 6.2mmol/l, BE: -24mmol/l). In view of cool peripheries and hypotension child was started on inotropes (Adrenaline - 0.1mcg/kg/min and Nor- Adrenaline - 0.1mcg/kg/min).

Invasive hemodynamic monitoring was started. Serial ABG's and chest X-rays were done, accordingly ventilatory settings were optimized. Child's ventilator parameter was adjusted to maintain adequate oxygenation and ventilation.

Autoimmune hemolytic anemia:

On day 1 of admission, child was noticed to have Blood tinged PD output alongwith hematuria. CBP showed Hb 4.3g/dL with normal platelet count. Peripheral smear showed multiple spherocytes with agglutination suggestive of hemolysis. Autoimmune Hemolytic Anemia was suspected and DCT, ICT sent which were Positive. LDH is elevated. C3 and C4 levels were low. G6PD level was negative. ANA profile was negative. Post hemolytic episode child had Hypotension requiring Inotropic support. PRBC was transfused and child was started on IVIG, Methylprednisolone for hemolytic anemia.

In view of autoimmune hemolytic anemia child was seen by Dr.Sandhya and Dr. Sirisha Rani who advised to continue methylprednisolone and IVIg. Whole exome sequencing was sent, reports awaited. Bone marrow aspiration biopsy was done.

In view of gross hematuria, Dr. Harish(Pediatric surgeon)opinion taken advised for USG abdomen.

Ultrasound abdomen was done (29.09.2026) which suggestive of

Name	Master CHUKKA SRIANSH	UHID	()
IP No	()	Admission Date	29-09-2026

- 1) Normal sized liver with mild periportal edema & GB wall edema.
- 2) Bilateral grade I renal parenchymal disease.
- 3) Minimal ascites.
- 4) Minimal bilateral pleural effusion.

REFRACTORY METABOLIC ACIDOSIS/ SLED/PERITONEAL DIALYSIS: In view of Persistent Metabolic acidosis with acute kidney disease, Dr. Satya Prasad(Consultant Pediatric Nephrologist) opinion was taken for renal replacement therapy. 1st session of SLED was done on day 1 of admission. Child's metabolic acidosis settled after a session of SLED. Thereafter peritoneal dialysis sessions were continued and adjusted according to patient's volume status

THROMBOCYTOPENIA ASSOCIATED MULTIORGAN FAILURE (TAMOF):

Child had thrombocytopenia with shock/ Acute liver dysfunction/neurological dysfunction/coagulopathy with acute kidney injury. In view of thrombocytopenia with concurrent multiple organ dysfunction, a clinical diagnosis of Thrombocytopenia associated multiple organ failure (TAMOF) - TMA-TTP spectrum was kept and investigated in the same lines.

In view of suspected TMA -TTP spectrum with high ferritin and low platelet count, Therapeutic plasma exchange was planned. Child underwent 2 cycles of Plasmapheresis.

Encephalopathy: In view of encephalopathy with paroxysmal non-rhythmic involuntary movement, child was seen by Dr. Ramesh Konanki (Pediatric Neurologist) who advised MRI brain.

MRI brain was suggestive of multifocal punctate hemorrhagic foci involving the bilateral cerebral and inferior cerebellar cortical/subcortical regions with additional superficial convexity hemorrhagic changes suggestive of septic encephalopathy with features of raised ICP.

As the child's sensorium improved after 1st session of plasmapheresis, his ventilatory settings were weaned off and extubated to face mask on



06.10.2026.

5

Name	Master CHUKKA SRIANSH	UHID	E
IP No		Admission Date	29-09-2026

Dr. Dinesh Kumar Chirla
Director of Intensive Care Services

Dr. Kapil Bhagwatrao Sachane
Consultant Pediatric Intensivist

Dr. K. Venkat Sandeep Reddy
Consultant Pediatric Intensivist

Dr. Farhan Shaikh
Head of the Dept. of PICU

Dr. Anupama Yerra
Consultant Pediatric Intensivist

[Signature]
Registrar/Resident/C.M.O

Dr. SHAIKH FARHAN A RASHID

MD,DNB(PED), Fellow Pediatric Critical Care, Head of Pediatric Intensive Care Unit, Consultant Pediatric Intensivist & Pediatrician.
CONSULTANT PEDIATRICIAN & PEDIATRIC INTENSIVIST
66229