ST JOHN'S MEDICAL COLLEGE HOSPITAL

Sarjapur road, Bangalore 560034
<www.stjohns.in> Exchange no - 080 2206 5000/ Appointments no - 080 2206 5003

DISCHARGE SUMMARY

DEPARTMENT: PAEDIATRICS

NAME OF PATIENT:SHARON
OP/IP NUMBER: 4803401/1580839
AGE: 8Yrs/Female
DATE OF ADMISSION: 05/12/22
DATE OF DISCHARGE: 17/12/22

UNIT I Dr. Fulton D'Souza Head & Professor Dr. Maria Lewin (only on Monday)
Assoc. Prof
Dr. R N Poornima Asst Prof Dr. Saurav Jain Asst.Prof
Dr. Chaitra G SR Dr. Bindu . N SR Dr.Shilpa Dominic SR

OPD TEL # : 080-22065034 Paediatric Ward Tel #: 080-22065973 / 74

FINAL DIAGNOSIS
ACUTE ON CHRONIC LIVER DISEASE DECOMPENSATED
WILSONS DISEASE

Presenting complaint – Yellow discolouration of eye,abdominal distension,generalised tiredness,fast breathing x 3 weeks

HOPI- 8 yr old child had 1 episode of fever lasted for 2 days at 1st week of November,for which taken antibiotics and settled in 2 days.After that on November 16 child had yellowish discoloration of eyes and parents noticed having mild distension of abdomen,along with high colored urine.For yellowish discoloration,gone to clinician,was advised,but instead parent given ayurvedic treatment.No yellowish discolouration of skin,associated with easy fatiguability.Parents noticed child have abdominal distension,No h/o fever.USG on 05/12/22 showed gross ascites,B/L pleural effusion.h/o fever 1 week prior to jaundice.no h/o bleeding manifestations,abnormal movements.

Past history – loose stools for 1 week,at 1 year

Family history – No liver diseases in the family

Birth history -
Antenatal and intrapartum uneventfull
Normal Vaginal Delivery
Term Delivery
Birth weight-2.5
no h/o nicu admission

Immunization history - Child has been immunised according to the IAP Schedule.

Development history – Development milestone appropiate for age,studies in 2nd std

Dietary history – Mixed Diet

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General examination – BP- 107/71 mm of Hg
HEART RATE- 110 /min
RESPIRATORY RATE- 46 /min
SpO2-99% on RA
Icterus present,lemon yellow
B/L pitting edema
No Pallor/ /Cyanosis/Clubbing
No generalised lymphadenopathy

Systemic examination –
KF ring present.
No bitots spots/no skin discolouration
No petechiae,ecchymosis
No leukonychia,spider naevi,asterixis
CVS: Normal sinus rythm, S1S2+, no murmers.

RS:Chest wall normal, no asymmetry of chest, normal vesicular breath sounds heard bilaterally, no crepitations or wheeze.

P/A:
Grossly distended,mildly tense,umbilicus transversly stretched,flangs full,shifting dullness:present
Tenderness over abdomen in all quadrants.Bowel sounds sluggish
CNS:
Higher mental functions :Normal,gait:Normal,Speech:Normal
Cranial nerves:normal
Meningeal signs:Absent
Motor
Power: >3/5 on both upper and lower limbs bilaterally.
Tone:Normal in all joints
Reflexes:DTR 1+
B/L flexor plantars
Cerebellar signs :Absent
Sensory system normal

Anthropometry
Weight-23.5kg(50,75)
Height-120cm(25,50)
BMI-16.32(50,75)

Radiological investigation- Chest Xray done

CONSULTATIONS TAKEN:
Ophthalmology i/v/o Wilsons disease:Slit lamp for KF ring,Continue d pencillamine/diuretics,review
Gastroenterology i/v/o liver failure advised 24hr urine copper

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Course-in-the-hospital

child came with the complains of yellowish discoloration of eyes with abdominal distension generalised tiredness since 3 weeks associated with fast breathing since 3 days history of consanguinity-present.

On examination child vitally stable, sensorium noraml, icterus seen, bilateral pitting edema of legs, KF Rings + in eyes, per abdomen grossly distended abdomen, with dilated veins, everted umbilicus,flanks full and fluid thrill +, liver palpable 5 cm below the RCM. Blood investigation showed anemia with increased retic count, deranged PT INR and elevated Bilirubin , hypoalbuminea and increased ALT and GGT. Serum ceruloplasmin was less than 0.07, viral markers negative, coombs was negative.On evaluated and examination was diagnosed with Wilsons disease in acute liver cell failure,decompensated,hypoalbuminemia,with,complications

Was started on treatment with D pencillamine, cefotaxime, Lasilactone, vitamin A, D and E,NAC Infusion, lactulose . Child was regularly monitored for Abdominal girth and Respiratory distress in view of increased abdominal girth and respiratory distress, therapeutic ascitic tapping was done about 150ml was drained. Samples collected from ascitic fluid showed no bacterial growing and total counts normal. PT INR and LFT were monitored closely , no bleeding manifestation. 24 hour urine copper levels elevated. Gastroenterology reference was taken for the same and in view of NAC Infusion , along with that the need for liver transplant was explained. Advised to get other sibling for the screening. The child was monitored regularly .Currently the child is Hemodynamically stable and fit for discharge,

ADVISE ON DISCHARGE
D-PENCILLAMINE 250MG PO, 2 HRS BEFORE FOOD
1-0-1 X TO CONTINUE.
SYP LACTULOSE PO 0-15ML-15ML X TO CONTINUE
CAP. VITAMIN A 25000IU ONCE (TUESDAY /FRIDAYS) X TO CONTINUE
CAP. VITAMIN E 400IU PO 1-0-1X TO CONTINUE
T. VITAMIN K 10MG PO ONCE (TUESDAY/FRIDAY)
T. SHELCAL 500MG PO 1-0-0 X TO CONTINUE
T. LASILACTONE(20/50) PO 1.5 tab-0-0 X TO CONTINUE
CALCITRIOL SACHET 60K PO 1/3 SACHET ONCE A WEEK.
SYP. ZINCOVIT PO 0-5ML-0 X TO CONTINUE

TO REVIEW WITH GASTRO OPD ON 22/12/22 WITH DR. HARSHAD with LFT, PT, INR, SE.
TO REVIEW IN PAEDS OPD ON THURSDAY 22/12/2022 OR SOS.

In case of any emergency, please report 24/7 to our Emergency or to the nearest doctor or hospital in your vicinity

This is especially if you develop any of the following severe, persistent, new onset and unusual complaints listed below:

"Severe unbearable pains anywhere, bleeding anywhere, convulsions, unresponsiveness, loss of vision, inability to drink liquids, vomiting, diarrhea, breathlessness, palpitations, jaundice, absence of urine, fever, rash, joint swellings, behavioural changes including violence/self-harm/agitation, and weakness/fatigue"

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In addition, any of these listed specific complaints for your condition such as .....

Name of the patient

Name of the doctor Dr. Srikanth 112088
17/12/22