FIRST
CLASSIC

अ० भा० आ० सं० अस्पताल/A.I.I.M.S. HOSPITAL
बहिरंग रोगी विभाग /Out Patient Department

अस्पताल के अन्दर धूम्रपान मना है।/SMOKING IS PROHIBITED IN HOSPITAL PREMISES

OPR-6

एकक/Unit

विभाग/Dept.

ओ.पी.डी. पंजीकृत सं०/O.P.D. Regn. No.

नाम/Name	लिंग/पुत्र/पत्नी/पुत्री F/S	लिंग	आयु Age	पता/Address
Paediatric CL No 20180030001462 UHID 103473162 DEVESH S 4Y9M10D	Paediatric Queue No 51 Room 14 UHID 103473162 15-02-2020			

निदान/Diagnosis

दिनांक/Date	उपचार/Treatment
(2) 17.8 kg 106 cm	c/o T: NHL (IM) Doing well mild cough. No distress O/E - vitals stable chest - clear P/A - soft, non tender. Plan ① Tab Dexamethasone (4mg) 1 —— ⊕ 3 and ¾ 3/4 th ② Tab Lanzol Junior (15mg) 1 tab BBF

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CLEAN AND GREEN AIIMS / एम्स का यही संकल्प, स्वच्छता में बढ़ता कदम

अंगदान-जीवन का बहुमूल्य उपहार/ORGAN DONATION - A GIFT OF LIFE

O.R.B.O., AIIMS. 26588360, 26593444, www.orbo.org Helpline - 1060 (24 hrs service)

अ० भा० आ० सं० अस्पताल/A.I.I.M.S. HOSPITAL

बहिरंग रोगी विभाग /Out Patient Department

अस्पताल के अन्दर धूम्रपान मना है।/SMOKING IS PROHIBITED IN HOSPITAL PREMISES

OPR-6

एकक/Unit

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ओ.पी.डी. पंजीकृत सं०/O.P.D. Regn. No.

नाम/Name: Paediatric
CL No: 20180030001462
UHID: 103473162
DEVESH S 4Y9M10D

F/S/Paediatric
Queue No: F5
Room: 14
HID 103473162 18-01-2020

पता/Address

निदान/Diagnosis

दिनांक/Date	उपचार/Treatment
5	T-NHL
	- Interim maintenance
	- Had a minor fall 2/12 → ? cubitus # → slab x 2 weeks + oral calcium commenced.
	- Patient given therapeutic cranial RT 24 Gy / 12 # completed 1/1 } given therapeutic as he had received high dose retinyl pred before being diagnosed
Echo ↓ Normal	
	O/E. stable well Chest - ✓ P/A - soft
~~vit D levels~~ CBC - 9.0/1.8/147	Todays CBC awaited
	Rx - Continue 6MP / MTX / Septran - Gemcal to continue x 3 m
{ CBC vit D levels LFT RFT	CBC - 9.2/0.97/0.42 / 138 / stop 6MP/MTX. wed repeat CBC

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Paediatric
CL No: 20180030001462
UHID: 103473162
DEVESH S 4Y9M10D

Paediatric
Queue No: F3
Room: 14
UHID 103473162 22-01-2020

(3)

T-NHL / FN / Focus - ?

On Zosyn/Amika (from 20/1/2020)

Cough +
Fever ↓ing trend.
? Mucoid stools.

20/1/20

9 / 630 / N64. / 93000.
PCT → 0.10.
(Blood culture) awaited.

CXR - B/L ?? infl +.

Vit D → 22.7 (mild to mod. def.)

O/E:
P⊖/LN⊖.
RS - clear.
CVS - ⓝ.
P/A - soft.

W/H. CMP / Htn.

d/w. Dr Aditya

→ Continue ● I/V antibiotics
decide on duration
after collecting culture
& CBC.

SR Paeds.

PCT 0.10.
25/1/20 -
- Bld culture sterile

Vit D - 22.7.

PCT negative - 0.10
CXR - ✓
afebrile × 2d.
- Continue antibiotics till BC's report
If BC's negative can stop abx
start oral abx

1) Calcirol sachet 1 per wk × 8 wk.
2) To stop IV. Zosyn & IV Amika
3) Syp Augmentin - 228 mg / 5 ml - ? (350 ml)
7.5 ml BD. × 5d.

Cough & cold improved.

F/U on Saturday in Ped OPD

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Pat[illegible] 102473162

http://192.168.15.[illegible]

DEPARTMENT OF PEDIATRICS
DISCHARGE SUMMARY

PATIENT DEMOGRAPHY DETAILS :

Patient ID:	[illegible]	Name:	DEVESH MUKUL	Father's Name:	KK S Mukul
DOB:	01/16/2015	Sex:	MALE	Age:	4 Years, 1 Month, and 26 Days
Address:	706/21 PATAUDI CHOWK GGN, Haryana, INDIA			Mobile No:	931117404[illegible]
Status:	NOT SIGNED			Phone No:	

PATIENT SUMMARY DETAILS :

Date Of Admission:	FEB 06, 2019	Date Of Discharge:	MAR 11, 2019		
Speciality:	PEDIATRICS	Ward:	CS	Bed:	10
Dr. IPD:	PROF S.K KABRA	CR No:	H-012246-19	Prev. CR No:	

DIAGNOSIS :

Non Hodgkin Lymphoma/ Hemophagocytic Lymphohistiocytosis/ Tumor lysis syndrome (with AKI) (resolved)/ Neutropenic enterocolitis (resolved)/ Myocarditis- congestive cardiac failure (resolved)/ sepsis-LRTI (resolved)

HISTORY AND EXAMINATION:

PRESENTING COMPLAINTS:

Fever on and off for 1 year, high grade for 1 month

HISTORY:

4 year old child with a history of fever on and off for around a year, with no [illegible] where he was evaluated which revealed normal examination and routine [illegible] LFT, KFT [illegible] Widal [illegible] on multiple occasions. He also took some homeopathic medications from outside [illegible] fever became high grade in the last 1 month, associated with chills and [illegible] No h/o cough, [illegible] breathing, pain abdomen, loose stools, joint pain/swelling [illegible] In v/o prolonged fever without an apparent cause, he was admitted for diagnostic [illegible]

PAST HISTORY:

Not significant

TREATMENT HISTORY:

Multiple antibiotic courses, some homeopathic medications in the past year

FAMILY HISTORY:

H/O bone TB in mother during pregnancy, took ATT for 2.5 years

IMMUNIZATION HISTORY:

Immunised till 3 years of age
BCG scar +

BIRTH HISTORY:

Full term, no h/s/o adverse perinatal events

DEVELOPMENTAL HISTORY:

Normal for age

OTHER HISTORY:

EXAMINATION AT ADMISSION

Active, alert

VITALS: Temperature-102 F, HR: 124 /min, RR: 32 /min, CFT: 2 Sec, SpO2: 98 % room air

ANTHROPOMETRY: Weight: 12 kg, HC: cm, Length/Height: 103 cm

GENERAL PHYSICAL EXAMINATION : Left submandibular lymph node [illegible] cm,
No pallor, icterus, clubbing, cyanosis, edema

4990

3/1[illegible]/19, 1:45 PM

CHEST : B/L air sounds equal, normal vesicular breath sounds, no added sounds

CVS : Precordium normal, S1S2 normal, No S3, no murmur

P/A : Non distended
Soft, ward, non tender
Liver palpable 3 cm, firm
No e/o free fluid

CNS : HMF intact, no focal neurological deficits, power, tone normal, no meningeal signs

WARD COURSE:

The child was admitted for diagnostic work up for fever of unknown origin. His routine blood tests, serum chemistry, malaria work up, typhoid work up, scrub typhus, ANA, RF were all negative. He was started on iv Ceftriaxone. USG abdomen was normal. Chest X ray revealed some mediastinal widening. A CT chest was done which showed enlarged mediastinal lymph nodes (right paratracheal, subcarinal necrotic and left hilar nodes. Bronchoscopy and EBUS was done, which was inconclusive. BAL galactomannan came out to be positive. Mantoux test revealed a reading of 15 x 20 mm. On day 11 of admission, he was noted to have falling blood counts (Hb 8.3 g/dl, TLC 3700/cu mm, Plt 57000/cu mm). The child also developed tachypnea and required O2 support. I/v/o rapidly falling counts, and persistent fever, a possibility of HLH was kept and work up done. S Ferritin was found to be elevated (21060 ng/mL), and S. Fibrinogen low (85 mg/dL). His antibiotics were upgraded to Piperacillin-tazobactam and Vancomycin. Liposomal Amphotericin B was also added I/v/o positive BAL Galactomannan. A PET CT was done which revealed uptake in mediastinal and celiac nodes, liver, spleen and bone marrow. A bone marrow aspirate and biopsy was done for etiological work up. I/v/o rapidly falling counts and significant tachypnea and O2 requirement, the child was shifted to HDU on 18.2.19

HDU course

a. Diagnostic work up and Mgmt for HLH: methylprednisolone pulse dose (@ 30mg/kg/dose) and IVIG infusion started. He was further started on HLH protocol with Dexamethasone at 10 mg/m2/day. PET CT was discussed with nuclear medicine team and it was concluded that mediastinal lymph node and marrow uptake was suggestive of a malignancy (lymphoma). Initial BMA was inconclusive. A bone marrow aspiration and biopsy was repeated, and BMA and peripheral blood were sent for flowcytometry. An FNAC was done from sub-diaphragmatic lymph node, which [illegible] atypical mononuclear cells s/o NHL. BMA also revealed 25-30 % atypical cells, with 15-20 [illegible] cells [illegible] NHL with peripheral blood spill. He was started on cytoreductive chemotherapy [illegible] after 4 days, i/v/o worsening sepsis. Subsequently, he was started on [illegible] from 6.3.19, [illegible] was decided to administer BFM HR protocol for the child. Day 8 ITM [illegible] and inj DNR [illegible] were [illegible] on 8.3.19.

b. Respiratory: The child was put on HDFNC @ 6 L/min, i/v/o tachypnea [illegible] room air. A diagnosis of LRTI was kept. There was also b/l [illegible] HDU [illegible] worsening of respiratory distress, with increased B/L infiltrates [illegible] were upgraded and HFNC support increased to upto 8 l/min. His [illegible] the next [illegible] and he [illegible] room air by day 12 of HDU stay, maintaining [illegible] with [illegible]

c. Sepsis and gastrointestinal: [illegible] by day 2 of HDU stay [illegible] However, 2days was upgraded to Meropenem on [illegible] procalcitonin [illegible] tachypnea. His serum Galactomannan came out as positive [illegible] hypokalemia, it was changed to Voriconazole. The child developed [illegible] was changed to Teicoplanin. On day 5 of HDU stay, the child developed bloody loose stools. A [illegible] infectious/ neutropenic enterocolitis was kept and metronidazole added. The child was [illegible]. USG abdomen was done which revealed gross ascites, with normal bowel loops. The loose stools subsided [illegible] next 2 days. The child developed fever on day 7 of HDU stay. I/v/o worsening and profound neutropenia [illegible] along with markedly increased chest infiltrates on Chest X ray, ofloxacin and tigecycline were [illegible] added. The fever subsided with improvement in clinical status and falling procalcitonin (0.6 on day 8 of HDU [illegible]). Ofloxacin and Tigecycline were discontinued. Metronidazole was also stopped and Teicoplanin changed to Vancomycin. A repeat procalcitonin value came out as 6.2, and hence, iv antibiotics were continued. The antibiotics were stopped after ensuring a negative procal value (0.08 on 8.3.19) and afebrile period of 7 days. His repeat S. galactomannan (5.3.19) came out to be negative (0.17). Voriconazole was stopped after completing 14 days of treatment.

d. Cardiovascular: The child had tachycardia up to 150/min on admission to HDU. On day 7 of HDU stay, he was noted to have facial puffiness, and S3 gallop, with a positive fluid balance. A point of care Echo was done which suggested an EF of 45 %. Trop I came out as 18 [illegible]. A diagnosis of myocarditis (?septic, ?cyclophosphamide induced) was kept. He was started on inj Lasix (0.08 mcg/kg/min) and Milrinone (0.35 mcg/kg/min). The symptoms improved gradually and inj Lasix could be stopped by day 10 of HDU stay. Serial echo were done which showed improving cardiac function and Milrinone was stopped by day 12 of HDU stay after documenting an EF of 55-60 %. He was noted to have intermittent hypertensive records (steroid induced) and in consultation with peds cardio team, tab Envas was added. Tab Lasilactone was added to induce negative fluid balance and was stopped after 3 days. Pre-anthracycline echo showed normal ejection fraction.

e. Renal: Post methylpred pulse, the child was started on double hydration and allopurinol to prevent TLS. The child developed clinical TLS (Ca 4.6 mg/dL, Uric acid 9.2 mg/dL, Cr 0.8 mg/dl) on day 3 of HDU stay. He was continued on double hydration with strict urine output monitoring, and given a dose of Allopurinol. His renal and TLS parameters improved over the next 2 days, and normal maintenance fluid were allowed.

f. Neurological: the child developed an episode of seizure on day 6 of HDU stay. He was loaded with levetiracetam and started on levetiracetam @ 10 mg/kg/d, as well as iv calcium correction (i/v/o low calcium records) Work up revealed normal Na level, low Ca, fundus normal, NCCT and CECT head normal; Symptomatic hypocalcemic seizure. LP was withheld i/v/o hemodynamic and respiratory instability. An MRI was initially planned but later deferred in consultation with peds neurology team. An EEG was done which was provisionally normal. Formal EEG report is awaited.

g. Hematological: The child was pancytopenic on admission to HDU, with Hb as low as 7 g/dL, Platelet counts upto 14000/ cu mm, and required pRBC transfusion and multiple platelet transfusions including a SDP transfusion. His TLC and ANC dropped after starting cyclophosphamide (ANC upto 20/cu mm), and he was administered inj G CSF (3 doses) for the same. His CBC parameters improved by day 9 of HDU stay, and came to near normal range, with mild anemia persisting.

20.11.18 Thyroid function normal
7.2.19- malaria neg, scrub typhus neg, widal neg, RF neg, ANA neg, anti ds DNA neg
Urine calcium 9, urine creat 75

Date: FEB 12, 2019 Investigation Name:

BAL for genexpert not detected
BAL galactomannan 1.32 (positive)
13.2.19; S. Histoplasma Ab Neg
Mantoux 20 x 15 mm
LDH (15.2.19) 1125

Date: FEB 18, 2019 Investigation Name: HLH w/u

Triglycerides 167
Ferritin 21060
BMB s/o hemophagocytosis

Date: FEB 20, 2019 Investigation Name:

20.2.19: 13646
25.2.19: 1306
28.2.19: 1051
5.3.19: 644

Date: FEB 20, 2019 Investigation Name: S Galactomannan

20.2.19: 1.01 (+ve)
5.3.19: 0.17 (-ve)

Date: FEB 25, 2019 Investigation Name: [illegible]

18.2 (-ve)

OTHER INVESTIGATION

Date: FEB 20, 2019 Investigation Name: BAL, PS

BAL: infiltration by 25-30 % atypical lymphoid cells
PS: 19 % atypical lymphoid cells
Bone marrow NHL infiltration

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TREATMENT GIVEN:

Methylprednisolone (@30 mg/kg) 1 dose on 18.2.19
Ceftriaxone 6.2.19 - 14.2.19
Piperacillin tazobactam 18.2.19 - 20.2.19
Vancomycin 24.2.19 - 8.3.19
Liposomal Amphotericin B 18.2.19 - 24.2.19
Teicoplanin 19.2.19 - 24.2.19
Meropenem 20.2.19 - 8.3.19
Metronidazole 23.2.19 - 5.3.19
Voriconazole 24.2.19 - 9.3.19
Ofloxacin 25.2.19 - 28.3.19
Tigecycline 25.2.19 - 28.2.19

Inj Daunorubicin 17 mg, inj VCR 0.8 mg on 8.3.19
ITax 12 mg on 9.3.19

CONDITION AT DISCHARGE

Active, alert

VITALS: Temperature- 98 F, HR: 102 /min, RR: 26 /min, CFT: 2 Sec, SpO2: 99 % room air

ANTHROPOMETRY: Weight: 11.6 kg, HC: cm, Length/Height: 103 cm

GENERAL PHYSICAL EXAMINATION : no pallor, icterus, clubbing, cyanosis, edema, lymphadenopathy

CHEST : B/L air sounds equal, normal vesicular breath sounds, no added sounds

CVS : Precordium normal, s1s2 normal, no S3, no murmur

P/A :

https://missionhopp.org/

INVESTIGATIONS

< HEMOGRAM >

Date	Hb	TLC	DLC	PLT	ESR	PS	PCT
FEB 07, 2019	10.6	7880	N52L38M7	2.31 L			0.2
FEB 17, 2019	8.5	3710		57000			
FEB 19, 2019	7.3	1760	N55L35M8	14000	28		
FEB 20, 2019	8.8	11260		59000			51
FEB 21, 2019	8.0	11290	N4L86M11	35000		ANC 451	
FEB 22, 2019	7.0	4280		20000			19
FEB 23, 2019	7.1	3790	N1.8L85M13	15000		ANC 50	
FEB 24, 2019	9.6	1460		24000			
FEB 25, 2019	9.6	620	N10L42M48	55000		ANC 62	0.6
FEB 26, 2019	8.5	1390		69000		ANC 590	
FEB 28, 2019	9.6	1240		89000		ANC 3600	6.5
MAR 02, 2019	10.3	4190		1.2 L			
MAR 05, 2019	9.7	5620	N43L28M28	1.71 L		ANC 4647	0.06
MAR 09, 2019	9.8	5840	N79L9M10	1.85 L			

< BLOOD BIOCHEMISTRY >

Date	Ur/Cr	Na/K	TSB	OT/PT/ALP	TP/Alb	Ca/PO4	Blood Sugar
FEB 07, 2019	20/0.2	141/4.4		92/[illegible]	[illegible]	8.5/3.9	
FEB 16, 2019	26/0.3	141/3.36					
FEB 18, 2019	60/0.4	129/4.1		[illegible]	[illegible]	5.4/4.1	UA 8.0
FEB 19, 2019	79/0.4	131/[illegible]	[illegible]	[illegible]/2379	5.6/2.3	[illegible]	UA 7.3
FEB 20, 2019	82/0.6	[illegible]	[illegible]	200/[illegible]	5.6/2.8	4.7/2.4	UA 7.9
FEB 21, 2019	[illegible]	140/[illegible]	0.4	121/32/1336	5.6/3.0	4.6/4.0	UA 9.2
FEB 22, 2019	70/0.6	136/4.6	0.4	101/40/1422	5.5/3	4.6/3.6	UA 5.2
FEB 23, 2019	89/0.5	138/3.4	0.5	30/[illegible]/1034	5.5/2.0	/2.6	UA 0.1
FEB 25, 2019	31/0.3	141/4	0.5	31/22/837	6.2/3.7	6.2/4.0	UA 0.5
FEB 28, 2019	23/0.3	134/4.3	0.5	16/8/709	6.8/3.6	6.2/3.3	
MAR 02, 2019	15/0.2	131/4	0.5	16/7/770	7.2/4.1	7.8/3.5	
MAR 07, 2019	17/0.2	138/4.7	0.3	21/14/101	6.8/4.0	8.8/2.1	UA 1.8
MAR 09, 2019	20/0.4	133/5.1	0.4	16/20/328	6.9/4.0	6.8/4.0	UA 2.1

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< RADIOLOGY INVESTIGATION >

Date: FEB 26, 2019 Investigation Name: Echo Investigation No.:

26.2.19- bedside echo: decreased LV function, EF 40-45 %, minimal pericardial effusion (2-3 mm)
1.3.19- bedside echo: EF 60 %, mild pericardial effusion (5-6 mm), mild MR, mild TR
6.2.19- routine echo: normal study (EF 60 %), no effusion

Date: MAR 06, 2019 Investigation Name: USG abdomen Investigation No.:

8.2.19: Normal study
25.2.19: ascites, bowel loops normal
6.3.19: Hepatomegaly with heterogenous echotexture (lymphoma infiltration) mild perihepatic and subhepatic free fluid

< OTHER INVESTIGATION >

Date: FEB 20, 2019 Investigation Name: FNAC subdiaphragmatic lymph node

Diluted with blood, one of the smear shows blood clot with entrapped atypical mononuclear cells; s/o Non Hodgkin lymphoma

Date: FEB 11, 2019 Investigation Name: Previous investigations

https://missionhopp.org/

http://192.168.15.194/ewd/gv/ipdTuLXSPedV.ewd?ewd_toke

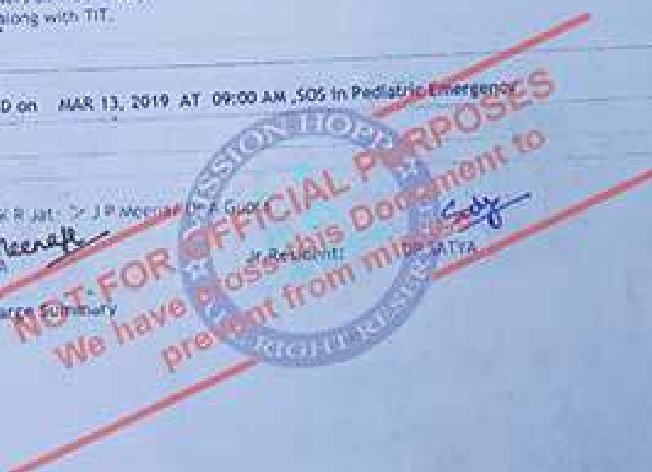
CNS : HMF intact, no focal neurological deficits, power, tone normal, no meningeal signs

P/a: Non distended
Soft, ward, non tender
Liver palpable 4 cm, firm
No e/o free fluid

ADVICE AT DISCHARGE :

Syp Omnacortil forte (15 mg/5 ml) 3.7 ml tds 0 — 0 — 0
Tab Lanzol JR 15 mg OD empty stomach 0
Syp Levetiracetam (100 mg/ml) 1.5 ml BD (@25 mg/kg/day) 0 — 0
Tab Isoniazid 300 mg ½ tab OD 0
Tab Enalapril 2.5 mg ½ tab OD 0
Syp Septran (40 mg/5ml) 6 ml OD alternate day
Betadiene mouth gargle / Sitz bath (1085)
To collect formal HPE report from pathology department
~~[illegible]~~
To do CBC, TLS monitoring parameters on Wednesday
Next IV chemo due on 15th March along with TIT.

Review in Pediatrics Unit 3 OPD on MAR 13, 2019 AT 09:00 AM ,SOS in Pediatric Emergency



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CONSULTANT:
Prof S K Kabra / Prof R Seth / Dr K R Jat / Dr J P Meena / Dr A Gupta

Sr.Resident: DR MEENA Meena
Jr.Resident: DR SATYA

Note: Please Laminate the Discharge Summary

अ० भा० आ० सं० अस्पताल/A.I.I.M.S. HOSPITAL
बहिरंग रोगी विभाग /Out Patient Department

SMOKING IS PROHIBITED IN HOSPITAL PREMISES

OPR-6

Unit

Dept

O.P.D. Regn. No.

Name	F/S/W/D of	Sex	Age	Address
Paediatric CL No: 20180030001482 UHID: 103473162 DEVESH S 4Y9M10D		Paediatric Queue No: F7 Room: 14 UHID 103473162 25-01-2020		

Diagnosis

Date: 5/

Treatment

T-NIL. FN. Focus [I/V antibiotics 4 days]

On Augmentin x 3 days

O/E: P⊕ LN⊖ RS-clear CVS-N P/A-soft

8.7 / 10300 (93000) (190) ↓ing trend

Continue syp Augmentin

Repeat CBC. Review on Wednesday 29/1/2020

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CLEAN AND GREEN AIIMS

ORGAN DONATION - A GIFT OF LIFE

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Paediatric
CL No: 20180030001462
UHID: 103473162
DEVESH S 4Y9M10D

Paediatric
Queue No: F3
Room: 14
UHID 103473162 01-02-2020

cough
runny nose } x 3 days

O/E
GC fair
P/A soft
No HSM.

CBC
↓
9.5 / 1.45 / 188
0.63

- Syp Maxtra @ 3.5ml PO TDS x 3 day.
- Rev c̄ report.

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Devesh A+
4y/M
103473162
wt - 11.4 kg
ht - 98 cm
BSA - 0.56 m²

I-M High risk protocol

Prephase

7 days of prephase steroid therapy (at increasing doses up to 60 mg/m2) together with one dose of IT-MTX

Protocol I

Protocol Ib

Consolidation (3 blocks)

Reinduction (protocol II)

Interim maintenance (with CRT)

Second protocol II (without ITM)

Maintenance

DOB - 9.10.14

POC No.

Name Devesh Ht. 98 cm wt 11.4 kg BSA 0.56 m² Date

Initial TLC Morphology Lymphoma Cytochemistry Lineage T-NHL

Cytogenetics

Day 8 P/S Day 15 P/S

LDH 1126 ECHO (1) EF 45% (26.2.19) (2) EF ≈ 60% (01.3.19) (3) Normal study 06.02.17

CNS disease

MT HBS Ag Neg HIV Neg

Prednisone response

BM after first induction

CxR SMS TLS

post Ia PET-CT → s/o good partial response
(FDY M/20565/14)
(15/4/17)

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अखिल भारतीय आयुर्विज्ञान संस्थान

नाम: Devesh | उम्र/लिंग: 5 10y/M | दिनांक: 27/8/20
वजन/लंबाई: 23.7 kg / 109 cm | रोग: T-ALL | UHID: 103473162

1600 kcal high calorie diet plan.
high protein – for gain in ht & wt.

आहार योजना

1. दूध — 800 ml
   (बिना पानी मिलाये)
   चावल / चिड़वा / दलिया / भुनीसूजी / सवई / साबूदाना (खीर)] 200 ml
   दही / रायता / लस्सी
   पनीर (तलकर या भूजी)] 200 ml
   आइसक्रीम / कस्टर्ड / फ्रूटशेक
   400 ml + Ess HP powder (2 scoop)

2. दाल (1)
   (1) कटोरी (½ चम्मच घी / तेल / मक्खन डालकर)
   (2m) दाल / बेसन चीला / पकौड़ा / वड़ा / हलवा
   या
   (1) अण्डा (उबला / भुर्जी / आमलेट) या चिकन / मटन / मछली
   या
   (1) 30 ग्राम भुना चना / मूंगफली

3. पराठा / रोटी — (5) (हरी पत्तेदार सब्जियां भरकर जैसे मेथी / पालक / बथुआ)

4. चावल — (1) कटोरी (बिरयानी / पुलाव / फ्राई)

5. सब्जी (2) कटोरी
   (½) कटोरी हरी पत्तेदार सब्जी (साग या पराठे में भरकर)
   (½) कटोरी मौसम की सब्जी (सब्जी या पुलाव में डालकर)
   (1) कटोरी आलू (टिक्की / चिप्स / पकौड़ा / हलवा)

6. फल (2)
   (1) केला / चीकू / आम ✓
   (1) सेब / संतरा / नाशपाती / मौसम्बी / अनार / अमरूद (100 ग्राम)
   पपीता / खरबूजा / तरबूज (300–400 ग्राम)

7. घी / तेल / मक्खन — (5) – घी + मखाना / बादाम – 5-8 ↓ 1 कटोरी
8. मीठा / चीनी — (3)-(4)
   } कोई परहेज नहीं

9. 2 liter तक साफ पानी है [उबाल कर ठंडा करके]

[signature] 27/8/20

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एक दिन की आहार तालिका

नाश्ता 8:00 Am

स्कूल-लंच 11:00 Am — 200ml ट्रेस + 1 चम्मच Essential+P

दोपहर का खाना 2:00 pm

शाम की नाश्ता 5:00 pm

रात का खाना 8:00 pm

सोते वक्त 10:00 pm — 200ml ट्रेस + 1 चम्मच essential+P

अनाज ऐक्सचेंज सूची	दाल ऐक्सचेंज सूची	दूध ऐक्सचेंज सूची
1 रोटी (25 ग्राम गेहूं का आटा)	1 कटोरी दाल (25 ग्राम कच्ची दाल)	1 गिलास दूध (200 मि.ली)
=1 कटोरी चावल/दलिया/सेंवई/सूजी	=25 ग्राम मूंगफली	=2 कटोरी दही
=1 मध्यम आकार प्लेन डोसा	=25–30 ग्राम भुना चना	=35 ग्राम पनीर
=2 इडली	=50 ग्राम अंकुरित दालें	
=125 ग्राम आलू	=1 अण्डा	
	=70 ग्राम चिकन/मीट/मछली	

↳ घर का बना साफ खाना ही दें।

↳ पनीर / दही / अंडा घर पर ही बनाएं।

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अखिल भारतीय आयुर्विज्ञान संस्थान, नई दिल्ली-110029 (REVISIT)

एम.आर.-9
M.R.-9

अखिल भारतीय आयुर्विज्ञान संस्थान, नई दिल्ली-११००२९
All India Institute of Medical Sciences, New Delhi-110029
परामर्श अभिलेख / CONSULTATION RECORD

नाम Name DEVESH | आयु Age 4 | लिंग Sex M | वैवाहिक स्थिति Marital Status | यू.एच.आई.डी. सं. UHID No. 103457362
सेवा Service Ped Oncology | वार्ड Ward CS-DC | बिस्तर Bed | व्यवसाय Occupation | धर्म Religion | स्थिति Status

Referred by Dr. SR – Ped Oncology to Dr. SR – Ophthalmology
Requesting Doctor — Consultant & Specially

Findings : Date :

Dear colleague,

Kindly evaluate the child a c/o B-ALL/HR/ maintenance – with intermittent redness of eye / itching & periorbital puffiness and advise for further management.

Thanking you

Diagnosis or Impression :

Yours truly,

Dr. Prasanth S
SR

Recommendations:

Consultant's Signature

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20/8/20

G1/B CMO RPC

Thank you for referral

Vn RE) attent 6/60 Pt not using follow-ups ...

Hx acfo redness in ... off, c itching

GOP RE) ...

O/E Pt not cooperative for ... exam

Dilate RE c ...

Adv.

B/E
- E/D ... BD
- cold compress B.D
- E/D Refresh tears QID
- Avoid rubbing of eyes
- Refraction ... in OPD.

ALL INDIA INSTITUTE OF MEDICAL SCIENCES, NEW DELHI
DEPARTMENT OF PEDIATRICS

...RGE SUMMARY

NAME: Devesh Deshmukh	**AGE:** 8 years	**SEX:** Male	**UHID No:** 103473162
DATE OF ADMISSION: 17/03/2020	**DATEOFDISCHARGE:** 25/3/20		**Bed:** D5/15
DIAGNOSIS: T NHL/ BFM reinduction/ Febrile neutropenia			
Consultants Incharge: Prof S K Kabra, Prof R Seth, Dr J P Meena,DrKanaramlat, Dr Aditya Gupta			
Address: Pataudi Chawk, New Delhi		**Phone:** 8287527879	

Chief Complaint: K/C/O T NHL/On BFM protocol Reinduction

- C/O Fever x 6 days

HOPI- Child is a k/c/o T NHL and was on BFM protocol/Reinduction. He received last chemptherapy on 8/3/20 (VCR and Doxorubicin)following which he developed he developed fever- high grade(104-105 F), continuous with chills and rigors. Along with it for initial 2 days he had cough and mild coryza- dry cough, not associated with respiratory distress. It was associated with sore throat. Cough and coryza subsided in 2 days but fever persisted (101 F)despite receiving medication .
No h/o headache/rashes/bodyache
No h/o noisy breathing/breathlessness
No h/o bleeding manifestations
No h/o pain abdomen/vomiting/loose stools
No h/o burning micturition
Treatment history: For these complaints he was initially started on oral Augmentin and later upgraded to IV Zosyn and Amikacin i/v/o neutropenia. As fever continued to persist after 48 hrs antibiotics were again upgraded to IV Zosyn and IV Teicoplanin.
Family History child of non consanguineously married couple .No h/o similar complaints in family
Birth History: Born at full term by NVD ,with no adverse perinatal events
Immunization History: complete as per NIS
Developmental history: appropriate for age

Examination at admission:
HR- 133/min, all peripheral pulses palpable, good volume
RR- 32/min
SpO 2 – 97% on RA
CFT- 2 sec
Peripheries Warm
Anthropometry
Wt:21 Kg

General examination:
No Pallor /icterus/ cyanosis/ edema or lymphadenopathy.

https://missionhopp.org/

No ulcer in oral cavity

Systemic examination:

Respiratory system:Trachea central, Symmetric chest expansion,B/L equal air entry, B/L bronchovesicular breath sounds

P/A: All quadrants moving equally with respiration.

Liver palpable 1cm below RCM ,Spleennot plapable, No free fluid, bowel sound +

Cardiovascular system: S1 S2 normal, no murmur

CNS : HMF normal, no CN palsies, tone normal in all 4 limbs,no meningeal signs

HOSPITAL COURSE:

Child who a k/c/o T NHL, on BFM protocol/Reinduction presented with the above complaints. He was neutropenic at presentation and was receiving IV antibiotics which were upgraded to IV Meropenem and Teicoplanin. IV Voriconazole was added in view of persistence of fever and neutropenia. Child was evaluated for focus of infection. Initial PCT was positive (0.35) and blood culture was sterile(13/3/20). CXR was normal. Repeat PCT and fungal work up all came normal. There were few episodes of vomiting on D2 of admission but without pain abdomen or loose stools. Fever spikes came down but continued to persist for which CECT PNS and Chest was done. CECT PNS was normal, however chest CT showed normal lung parenchyma with multiple parahilar, paratracheal lymph nodes which were calcified most likely secondary to primary disease process with no e/o fungal pneumonia. Hence Voriconazole was stopped after 7 days. USG abdomen is normal. Child became afebrile after day 2 of admission, however, blood Culture sent on 17/3/20 grew Acinetobacter baumenii sensitive to Amikacin and Colistin. It was discussed with our microbiology colleagues and it was told to be pathogenic but in vivo sensitivity could not be commented upon. As child was immunosuppressed child was started on Amikacin and Meropenem. Antibiotics were continued for 7 days IV but as child was essentially asymptomatic his IV antibiotics were made oral on day 9 of hospital stay. Child remained afebrile throughout, with normal oral acceptance and has no c/o cough, coryza, loose stool or pain abdomen and hence being discharged.

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Investigations :

Hemogram

Date	Hb	TLC	DLC	ANC	Platelet
18/3/20	9.8	1130	N31.9/L46/M 23	350	145000
19/3/10	9.6	1260	N25/ L52/M 20	315	152000
21/3/20	11	1850	23/55/20	320	200000
23/3/20	11.7	1890	21/51/25	396	250000

Biochemistry:

Date	Urea/creat	Na/K	Ca/Po4	OT/PT/ALP	Uric acid	TP/Alb
18/3/20	14/0.1	142/3.7		36/48/310	3.1	5.6/4.4
21/3/20	18/0.5	141/4.5	9.5/4.8	35/32/336	3.3	6.6/4.5
23/3/20	24/0.3	159/3	9.6/4.8	44/42/381	2.4	6.4/4.6

Investigations:

Date	Investigation	Report
13/3/20	Blood C/S	sterile
13/3/20 17/3/20	PCT	0.35 ng/ml 0.04 ng/ml

13/3/20 17/3/20	Galactomannan	0.31 ng/ml 0.16 ng /ml
17/3/20	Blood C/S	Acinetobacterbraumanii S- Amikacin, Collistin R- Ceftazidime, Piptaz,Imipenem, Meropenem, Magnex
17/3/20	Urine R/M	normal
17/3/20	Urine C/S	sterile
21/3/20	CECT Chest	Normal lung parenchyma,multiple parahilar,paratracheal lymph nodes which are calcified
21/3/19	Ferritin	565.02 ng/mL
21/3/20	Vit B12	30.5 pmol/L
21/3/20	Folate	16.0 ng/mL

Treatment given:

1.Meropenem for 8 days
2.Teichoplanin for 6 days
3.Oral Voriconazole for 8 days

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Condition at discharge:

HR- 133/min, all peripheral pulses palpable, good volume
RR- 28/min
BP:95/68mmHg
SpO 2 – 97% on RA
CFT- 2 sec
Peripheries Warm

General examination:

No Pallor /icterus/ cyanosis/ edema or lymphadenopathy.
No ulcer in oral cavity

Systemic examination:

Respiratory system:Trachea central, Symmetric chest expansion,B/L equal air entry, B/L bronchovesicular breath sounds
P/A: All quadrants moving equally with respiration,
Liver palpable 1cm below RCM ,Spleennot plapable, No free fluid, bowel sound +
Cardiovascular system: S1 S2 normal, no murmur
CNS : HMF normal, no CN palsies, tone normal in all 4 limbs,no meningeal signs

Plan:

1. To continue oral antibiotics x 7 days
2. To continue chemo from daycare in 3 days

Advice at discharge:

1. Syp Ofloxacin(100/5) 7.5ml BD 1—1 x 7
2. Syp Levera (100/1) 1.5ml BD 1—1
3. Syp Calcimax (250/5) 5ml BD 1—1
4. Syp Septran(40/200) 5ml BD on alternate days
5. To review with CBC,LFT,RFT after 3 days and decide regarding starting chemo

Dr Gargi Das
Senior Resident

Dr Sharan
Junior Resident

22/2/2.

11.2 $\xrightarrow{25Po}$ Plt → 3.4 lakh
ANC → 753.
Ur → 17 / Cr - 0.1, Ca/P/ALP → 9.2 / 4.7 / 203.
Na/K → 140/4.2 ; T.B/D.B → [illegible] ; AST/ALT → 164/87.
T.P → 5.9 ; Albu - 4.5.

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DELTA Pg No.
Date / /

R/S: BAE (+)
NVBS (+)
no added sounds

Other system: NAD

- Enrolled in Dr. Prasanth's thesis
- Randomized to Intervention arm.
(to stop antibiotics)

- Adv.
- To stop IV Antibiotics
- To withhold GMP/MTX till ANC > 1000
- To continue Septran
Levera
Charcoal
- Betadine gargle
Sitz Bath
- Danger signs explained
- Review SOS
- To do CBC on friday

Dr. Prasanth's
SR

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DELTA Pg No
Date

8/7/22 T. 6MP (50mg) in 5ml NS 3.8ml PO OD

T. MTX (15 mg) weekly x 2 wks.

T. prednisolone (10 mg) 1-1-1
T. Lanzol Junior (15 mg) 1 tab OD } 5 days

(Dr. Ushan. N)

20/07

CBC Hb: 9.4
Plt: 154 x 10³
TLC: 2600 ANC 1200

TB/DB: 0.1 (?)
AST/ALT: 23/19
ALP: 429

U/C: 24/0.3
PCT: 0.02
Bld C/S: Sterile

Afebrile x 3 days
No other complaints

Vitals PR: 98/m
RR: 24/min
Temp: warm
CP/PP: ++/++
CRT: 2-3 sec
SpO2:
BP - 113/61

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Sign

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DELTA Pg No.
Date / /

Demon

30/01/20.

40 T. NHL. (Lon- ureno 24/11)
Received Radiotherapy 1 wk back

40 Acue :: Fam, Temp, 1020F
cough x one morning
cough

Pain abdomen } "
Breathless

O/E Alert active — CBL - 9 / 630/400 / 43,000
RR - 90/m
HR - 140/m
Afebrile — PCT, Blood c/s } sent

CNS - B/L VBS @ clear — Started on Inj 20kg / Amikacin
16Kg — ROV & DDS. — Ferrous fesso
— CXR today
To cont for Gardner M/L

Imp: FN (Imp fever)

Inj 20kg 1.6g IV tds
Inj Amikacin

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DELTA Pg No
Date

23/10/20 Remdesivir

Rx

- Inj VCR 1.0 mg iv stat pm
- Inj Doxorubicin 21 mg/100 ml NS iv over 1 hr

24/10/20

C/O: CT-NHL

- C/o diffuse body pain - B/L UL & LL
- no fever
- no other complaints.
- C/o cough - ↓ed.

Vitals

PR - 96/m
RR - 24/m
Temp - Afeb
CR/PP - ++/H
CRT - 2-3 sec

GPE: pallor (+)
no oral ulcer
C/E: no swelling
tenderness

Systemic: WNL

Previously - Vit D/Ca - ↓ed on
Vit D/Ca supplementation × 1 mon.

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My NoteBook
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