DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
3.9.91	**DR. J.M. SAVAGE**
	NEPHROLOGY O.P.D.

Wt 5.06 kgs.

Ht 59.3 cms

Urine Bag on.

Specimens to Lab. - 30 days old baby

- Dx'd as having B/L dysplastic kidneys at ulster hospital Sunderland

- BWt - 4940 gms
- Antenatally dx'd as having cysts ? Renal
- [redacted] kidneys c̄ large cysts

[redacted]

- IVP → No obstruction. minimal excretion
- DMSA - B/L abnormal shape kidneys ? dilated ureters
  - Considerably ↓ renal function in both sides
- S/E

Na - 137

K - 4.3

Bu - 7.1

Screat - 170 ugm

- baby is on SMA feeds (gold cap) takes about 29 oz / day. has been dx'd as having GE reflux on thickened feeds
- no haematuria / pyuria.
- at present has a URI

O/E. mild URI +

Gsn aba- | liver 2.0 cm soft

Chem | Could not feel any renal masses

AS - ROYAL

049-029-075

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	SB Dr M. Savage
	- Optimistic about long term ~~[illegible]~~.
	- Explained about the ~~[illegible]~~ nature of the kidney disorder and what could be done for him.
	- early am sample for urine osmolality - to be done at the Wessex hospital.
	- Rev 4/12
	A Sahu
15/10/91	DR.J.M. [redacted]
	NEPHROLOGY O.P.D. Ht 62.2 cms spec to lab
	A/N. Cystic Kidneys
	H.C. Normal
	IVP ~~[illegible]~~ Normal Plumbing Poor function
	DMSA. Cystic Equal function
	DTPA Scan.
	Has been on monotrim but 3 breakthrough infection 4 since. pyrexia. No septicaemia proven on culture.
	* Need Mag 3 Renogram Result.
	Admit Continue i/v Claforan
	Work out Renal + Urological situation
AS - ROYAL	Assess best prophylactic drug [signature]

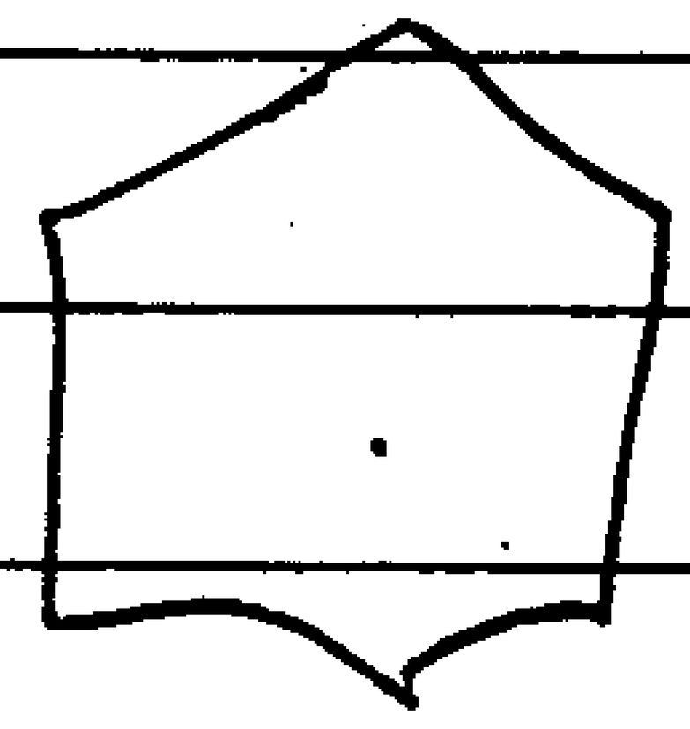
049 029 076

ADAM STRAIN

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
15/10/91 @ 5.30PM	ADMITTED FROM NEPHROLOGY CLINIC
	PC
	REFERRAL FROM UHD $\bar{c}$ UTI
	HPC
	10/52 OLD BOY $\underline{c}$ POLYCYSTIC KIDNEYS ANTENATALLY
	+ CONFIRMED BY USS FOLLOWING DELIVERY
	3 PREVIOUS ADM^{n} SINCE BIRTH $\bar{c}$ UTI
	ON THIS OCCASSION – IRRITABLE + OFF – FEEDS FOR 2/7
	AND HAD MILD PYREXIA.
	NO ↑ FREQ. OF MICT. / STRONG SMELLING URINE.
	VOMITED X 2 ON DAY BEFORE ADM^{n} – NONE SINCE.
	PMH
	BORN FT, C.S. FOR DELAYED 2nd STAGE.
	Birth. WT. 10lb 14oz
	PREVIOUS ADM^{n} AS ABOVE.
	DH
	TRIMETHOPRIM 50mg NOCTE.
	CEFURAN 200mg TID (STARTED IN UHD).
[redacted]	[redacted]
	O/E
	APYREXIAL
	LOOKS WELL
	NO A/C/J/NODES.

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS

Abd



SOFT
NON-TENDER
NO MASSES / ORGANOMEG.
BS ✓

CVS

P 120 REG
HS I + II + O

RS

GOOD A/E ALL AREAS
BS: VESIC [illegible]

CNS

BRIGHT + ALERT
PERLA
CN's I → XII INTACT
POWER }
TONE } NO NEURO. DEFICIT
REFLEXES } (R) = (L)

Summary

10/52 OLD BOY ē BILAT CYSTIC KIDNEYS ADM. ē
? UTI.

NIL OF NOTE ON EXAM^n.

U+E (TODAY) Na+ 128 Hb 12.9 (YESTERDAY).
K+ 3.6 WCC 16.8
Cl. 106 Plt. 357
CO_2^- 15
Ur. 9.2.

049-029-078

D. [signature]

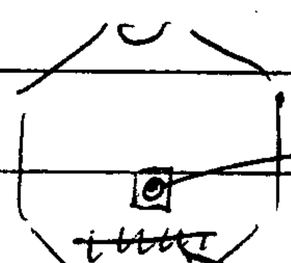
DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	Astrup needed ~~[illegible]~~ ? Acidotic
16/10	- baby of Cystic Kidneys - Any Deg.
	- 3rd episode UTI
	- is settling down at present
	- no real masses felt clinically
	- to discuss c̄ Dr Savage about further Renal urological workup
	- to collect Renogram Result
	- to collect Urine C/S result from Ulster hospital.
	A Saly
17·10·91	Poor feeding
	[redacted]
	Ceftazime 2/7.
	- Astrup + U+E
	- Get Renogram result from Nuc Med. (2/52 ago)
	- wie
	NS
	Mag 3 RENOGRAM RESULT (10/10/91)
	BOTH KIDNEYS SHOW POOR FUNCTION. THE RENOGRAM OF BOTH KIDNEYS SHOW PROLONGED 2nd PHASES WITH STEADILY INCREASING CURVES THROUGHOUT THE EXAMINATION. FORCED DIURESIS WAS NOT USED AS FALSE POSITIVE RESULTS MAY OCCUR AT THIS AGE GROUP WITH DYSPLASTIC KIDNEYS. THE APPEARANCES SUGGEST, BUT ARE NOT COMPLETELY DIAGNOSTIC OF BILATERAL OBSTRUCTION.
	BD.

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
17/10/91	Na^+ 135 pH 7·29
	K^+ 3·9 CO_2 29
	Ur. 11·0 O_2 121
	Prot. 71 Bx. Ex. −10·4
	Creat. 149 STD. BIC. 16·8.

049-029-080

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
26/11/91	Transfer of Adam Strain to Musgrave Ward from Unit. 0.
HPC	3½ month old ♂ infant born 4/8/91 by ECWSCS - Birth Wt 10lb 14oz - Was known to have congenital dysplastic kidneys - Has had 4 UTI's since birth. - Had ureteric reimplantation by Mr Brown. on 23/11/91. (i a supra pubic catheter inserted at the same time) but since then his urine output has ↓'d, becoming puffy Has gained wt 2 lb 2 oz over past 3 days BP + Vital obs have remained ~ normal.
Other Ix's.	Urea slowly ↑ing 10.5 24/11/91 to 17.3 26/11/91 Na^+ remaining low at 118 mmol. ABG - compensated met acidosis US. (R) kidney small & echo bright (L) " normal & " " No calyceal dilatation Aortic vein normal CXR Heart size - normal & no evidence of pulm oedema
	- Has been transferred for further mx of this post op renal failure.
	Maternal Obs Hx - No problems antenatally. A/N Scan → ? ovarian cyst in a girl!
	Drugs Has been on Claforan. (Septrin & Trimethoprim in the past).
	049-029-081
	Fam Hx - No Fam Hx of Renal Disease

AS - ROYAL

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
O/E	Obs Temp 36·8 c BP 95/55 RR 35 HR - 120.
Gen	Puffy Pale Alert - bright.
CVS.	HS I+II + No murmurs Fem Art ① ✓ ② ✓.
RS.	Bilat Scls - normal - nil added
Abdo	 Recent reimplant^{n} op^{n}. ? ② UOT. ① hydrocoele.
NS -	NAD.
Summary	3 ½ month ♂ infant with known congenital dysplastic kidneys, now 4/7 post ureteric implant^{1} & in oliguric renal failure.
	For mx of fluids & Tx as listed below by Dr Dalziell.

049-029-082

DATE | CLINICAL HISTORY, EXAMINATION AND PROGRESS

Adem Sivari

26.4.91

Today

Serum

pH 7.38 — Na 118 — Osmolality 267 — Hb 10.5

HCO_3 13.8 — K 4.6 — WC 9.2

pCO_2 ↓ — Cl 92 — pl. 259

CO_2 8

U 17.3. — wt 7.82 Kgs

Cr 598.

Renal failure Bilateral ureteric Implants

23-4-91

For

1. ½ N saline

(previous 4 hrs urine output + 4 mls / Hr) / 4 / Hr.

2. BP. × 4 / day
3. Daily weights
4. Daily U+E + Creatinine
5. DTPA Renogram c diuresis for tomorrow am.
6. Check BM.

Dalzell

26/4/91. D.T.P.A. Renogram in Radio-isotope 10^30 am tomorrow c cannula + "slightly drowsy".

Slraig
SHO.

AS - ROYAL

049-029-083

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
10Pm 26/11/91	- 3½ mo. baby
	- at present in A.R.F. - Latest { S.creat. 598; Bu 17.3; K 4.6; Na 118 }
	-
	S. osmolality 267
	- has had B/L ureteric implants on 23/11/91
	- has been passing ✓ small amount of blood stained urine post op
	- after shifting to [illegible] ward has passed about 12-15 mls blood stained urine
	- at present clinically he does not appear to be overloaded or hypertensive. Not acidotic.
	- for DTPA tomorrow
	- check U+E tonight
	- Keep a 6-7 mls/hour tonight as calculated.
*	< Medical causes ARF → ATN/ACN (cortical necrosis)
	Surgical causes ARF → obstructive uropathy → r/o [illegible] DTPA scan
	[illegible] Saha Reg
12 30 Am	BM- 1-2
	give 20% dextrose 6 ml
	give N/2 saline in 10%. dextrose
	Check Bm's 1-2h.
	[signature]

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
27/11/91	US scan + ~~[illegible]~~ DTPA scan today
	Wt loss ~~[illegible]~~ 200 gms since yesterday.
	US – (L) + (R) ureter dilated.
	free fluid in abdo.
	Need previous films to compare
	Renogram (Dr Laird)
	Appears roughly unchanged from last one
Na 130	wt 7.6 (↓200) Stacey
K 4.3	[redacted]
U 21.9 ↑	
Cr 720	
Bm 2.1	
	Plan (1) 15% dextrose / 0.45 NaCl } mix → 6 mls 1Hr
	(2) Repeat Biochemistry 20-00 hrs.
	(3) Recalculate fluid replacement as 4 hourly loss + 4 ml / HR.
	(4) Inform Dr Savage re Hypoglycaemia and ↓ urine output
	? P.D. Regd Dobrec
Na⁺ 131	
K⁺ 4.5	
Urea 22.1	
BS 3.9	HBurd (SHO)

AS - ROYAL

049-029

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
7AM.	Asked to see - Urine output
	low output since admission
	27/11 14mls from 8AM-6PM.
	overnight 2ml.
	d/w medical registrar regarding informing Dr Savage.
	- see (4) above. Unsure from this if Dr Savage was
	informed yesterday evening?
	Continue for now & inform day staff at 9am.
	urea yesterday evening - 22.1.
	morning - 21.9. Boyle (S.HO)
28.11.91	Anuric Alert.
	Hypoglycaemic
	Advice sought - check Biochemistry
	- 10% Dextrose
	- Watch BM Stix. (? Dextrose y hour)
	Needs - P.D. urgently
	[illegible]
	Mr Brian informed Catheter Req'd.
	by Dr Savage.
12 MD	BM 2-4 mmol
	Urine O/P 1ml in past 4hrs
	∴ input 4ml/hr.
	C/T Saline 0.45% + 20% Dextrose equal
	volume.
	S Craig SHO
	Recheck Bld Glc c̄ next BM stix.
	S Craig

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
28/11/91 4pm	- anuric
	- Na - 131
	K - 3.7
	BU = 23.5
	TP - 54
	SCreat = 821
	Ca = 2.00
	- would need P.D. cannula put in soon
	- ? would also need ureteric stents B/2
	- Dr. Savage informed.
	Reg
445	Bld sent for U+E,
	Xm 1 paedipaks
28/11/91	When returns from theatre
	100 ml cycles of (1.36% Dialysis fluid 140 Na^+)
	rapid cycles in + out with few minutes dwell time
	only until and blood staining cleared
	Add 500 U heparin to each 1L bag of dialysis fluid
28/11/91	for theatre and I.C.U. afterwards
	K^+ → treat as above. Spoke to nurse ...
5.11.91	Weight 7.54 Kgs

AS - ROYAL

049-029-089

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
8/11/[illegible] 815 pm	Theatre → ICU
	GA Dr Gallagher
	laparotomy performed
	Obvious dilatation of both ureters
	No significant pelvic or renal dilatation
	T tube drainage → both flanks
	PD cannula inserted
	Haemostasis, catgut, PDS, dexon.
	performed by Mr S Brown
8:30pm	Some urine draining from both nephrostomies
	Also leak around tubes - ? urine ? PD fluid
	? Are nephrostomy tubes extra peritoneal
	P.D. running satisfactorily
	100ml cycles 1.36% dextrose No1 Sol^n with 4 mmol KCl per Litre and 250 units of heparin per L
	Aim to achieve 200mls -ve balance O/N and replace fluid loss c N/S Saline in dextrose
	Check U+E Hb later. M [illegible]
	- Returned from theatre
1130Pm	- Passed total of 54 mls of urine (via B/L nephrostomies + catheter)
	- still leaking fluid via nephrostomy tubes + [illegible]
	- Hb - 7.1 gms. U&E - awaited
	- is on 7 mls/hour of fluids
	- P (1) withhold CAPD ∵ of leakage
	(2) Once the returns via PD cannula is clear to stop that.
	(3) withhold BT ∵ of risk of Pul. edema
	(4) fluids = $\left(\frac{\text{4 hours Output}}{4} + 4\right)$ mls/hour
	N/2 saline in 10% dextrose

AS - ROYAL

049-029-088

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	- Dr M. Savage informed
	- check U+E in Am
	Once leak stops to start on regular CAPD.
	Devi Saha
	Reg
29/11/91	Good urine output O/N
	1. 100mls packed cells
	2. TPN 500mls to be ordered.
	3. N/2 Saline c̄ 20m mol /500
	We will replace urine output /hr + 10mls/hr (insens)
	When urine + Bl U+E available adjust IV fl.
	Drugs 1. Ceftazidime I/V [redacted]
	No dialysis needed
	M Savage
29/11/91	As above.
	To have 100 mls Packed cells.
	U.O: 12 hrs = 407 mls.
	Investigations as above.
	Talk with bacteriologist re antibiotics
	Arrange TPN.
	YJ.
29/11/91	Central line leaking ∴ changed.
	attempted subclavian (L) side - failed
	LIJ inserted easily
	Need to be careful of developing pneumothorax.
	D/W Dr. Mahmud and Dr Rajan. YJ
	Cut back to U O + 50 mls hly [illegible]
	insensible loss YJ

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
17-30	Sr. Urine
	Na 146 (↑) Urea 47
	K 4·5 (↑) K 14
	Urea 14·4 (↓) Urea 45·
	Contacts Registrar. Asked to change ½ N-Saline to ¼ N-Saline and continue TDN as it is.
	Regim
30/11/91	Allow fluids = urine output to see if this ↓ polyuria Need to watch. Na Change to balance - just 2/3 fluids as TPN 1/3 as clear fluid N/S Saline then Dextrose clear fluid allowance [redacted]
30/4/91	As above. To try oral fluids today Renew notes 4, 2 results. TJ Gallagher.
1/2/91	NA^+ 145 @ 8 pm Morning Sat 52 K^+ 4·0 K^+ 11 Urea 12·6. Urea 50
	Yesterday had 745 ml 712 On feeds pre-illness: 3/4 SMA+ Duocal + Nutrigel. Loves his bottle: today gave more orally. Need to watch ooze around dressing may actually be leaking more urine this - 2 but only dressings change. Total: urine output (on 4 hrly basis) as yesterday Will monitor 4/2 carefully. Hallagher

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
1/12/91	Continue as yesterday but gradually ↑ oral feeds
	15mls of TPN/hr
	+ attempt 30 mls orally 2 hourly.
	M Savage
	530 pm. looks slightly dry.
	intake ≈ 290 output 248.
	Can have more fluids orally ≈ 45 ml / 2 hourly.
	Check U&E creatinine osmolality please
	MS
2/12/91	Improving renal function
	Sepsis - on Cefuroxime
	Stop morphine.
	Discharge MW
	Na 144
	K 4.2 Hb 9.8 gm
	Urea 15.8 WCC 9.3
	S. Cr. 169 plt 35
	Calcium 2.28
	Osm. 371 pH 7.27 Bicarb 14.5 BE 10.5
3.12.91.	Pyrexial since 2nd evening. Had 4 vomitings since yesterday.
	Fluids 1086 in - (including large vomits) - 654 out
	very unsettled / Restless last night. ; Abd: tense.
	This A.M.
	Active, Temp ↑. passing urine ;
	Abd. soft BS +.
	seen by Dr. Reid & Dr. Wilson → advised FBP / U/E ; Blood, urine culture.
	Mr Brown & Dr. Savage to be consulted.
	049-029-091
PERITONEAL FLUID	- Blood stained - Xanthochromic Leukocytes 710 Cytology - Mostly Polymorphs RBC 2100 Protein 2000 2.3gm Gm stain - NO

AS - ROYAL

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
3.12.91.	Summary: Adamstrain
	4 month old infant, c̄ Bilateral multicystic Kidneys
	was admitted in PICU on 28.11.91. He had ureteric
	reimplantation done on 23.11.91 c̄ supra pubic catheter insertion.
	But he was oliguric and developed Ac. Renal failure over
	next one week. U/S scan → Rt Kidney - smaller than left.
	Bilat hyper echogenicity. DMSA scan ~~re~~revealed Bilaterally abnormal
	Kidneys with abnormal shape as secondary compression of nephrons
	by cysts. He was put on Peritoneal Dialysis on 28th 11.91
	and also was operated on the same day. ~~and~~ At laparotomy
	there was obvious dilatation of ~~the~~ ureters c̄ no significant Pelvic or
	renal dilatation. T tube drainage was performed on both flank
	He has been passing good amount of urine and
	the fluids are calculated accordingly. The Sr. Creatinine, Urea
	levels ~~at~~ have come down to 169 & 15.8 respectively.
	Electrolytes are within normal limits; so also FBP.
	~~M~~etabolic acidosis has been noticed this morning on
	performing Arterial Blood gas monitoring. He is on
	oral feeds as well as TPN; He had fever & vomitings yesterday. Septic workup done and put on Antibiotics (Cefotaxime & flucloxacillin) one dose of gentamicin 20mg Vancomycin 250mg intra peritoneal given.
	The plan is to continue the fluids accordingly and
	transfer the child to Musgrave ward.
	Rajiv
	Plan Today — Pyrexial. On Cefuroxime.
	Culture Urine ✓ P.D fluid ✓
	Blood ✓ all excl.
[illegible]	Run in part of 250ml 1.36% CAPD bag Run
960mls	out + culture
~~[illegible]~~	Then put 20mg gentamicin + 250 mg Vancomycin ✓
240	
	Change a/biotics to Claforan + flucloxacillin. QDS
	Fluids - TPN ~~at~~ or N/5 Saline + KCl @ 30mls/hr.
	+ 4 or 5 bottles 30mls clear. or SMA
	Return to Musgrave Wd. MS

AS - ROYAL

049-029-092

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
4/12/91	- Wt. ↓ (7.02 Kg)
	- I/O = 1015 mls / 701 mls (R) 311 mls (L) 390 mls
	- afebrile
	- irritable + miserable
	- P - Check U+E ✓
	- run TPN at 30 mls/hour
Na 135	- cont antibiotics
K 3.7	- Check c Dr M. Savage about
Urea 10.9	antegrade Pyelograms Form sent ✓.
T prot 50	- Collect cultures
Cr t 196.	- G+ oral feeds as before
	Amirsalar
5.12.91	TPN 720 In wt ↑ 4 Kgs ?
	Fluids oral 330
	608. out
	Nephrostomy R 332 L 276 Antegrade Booked
Na 142	Sepsis Afebrile. Flucloxacillin Cefotaxime (3/7)
K 4.2	
Urea 12.6 ↑	Cultures -ve
Creat 132.	
	Reviewed by Mr Brown after antegrades
	Repeat Broviac + Cr + FBC tomorrow
	- Check cultures
	- Culture urine
	- Broviac urine. [signature]

049-029-093

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
·12 91	
Na 142	- Stop antibiotics IV — HG 10.5
K 4.0	- Start Trimethoprim po 25mg/day. — WCC 10.8
urea 11.7 ↓.	[signature] — PLT 563
prot 54	D/W Mr Brown - Surgery. — MCV 89
Ca 2.26	
	Antegrade pyelogram : 5.12.91
	"On (R) side the T tube was in renal pelvis
	Free leak of contrast from T tube into peritoneal cavity.
	On ? (L) side T tube in upper ureter. A little retrograde
	flow occurred into upper pole and antegrade flow
	into mid third of ureter. Free leak of contrast
	from tube into peritoneal cavity."
	Crossn
	Awaiting Mr Brown's opinion - thankyou.
7. 12 91	No new problems
	Main difficulty - keen to feed but vomits.
	O/E Chest ✓ CVS ✓
	AB - Normal bowel sounds. Abdomen soft.
	Suggest - start cisapride
	[signature]
145pm	(L) 'T' tube not draining,
	(R) 'T' tube has a leak around the exit site
	to inform surgeons about it.
	? may need repeat antegrade study
	to inform Mr Brown also.
	Alvind Sah Reg
7/12/91	U+E : Na^+ 142 Urea 12.6 (↑ 51.) Creatinine 118 (bs
	K^+ 4.6 Protein 55 Ca^{2+} 2.30 [signature]

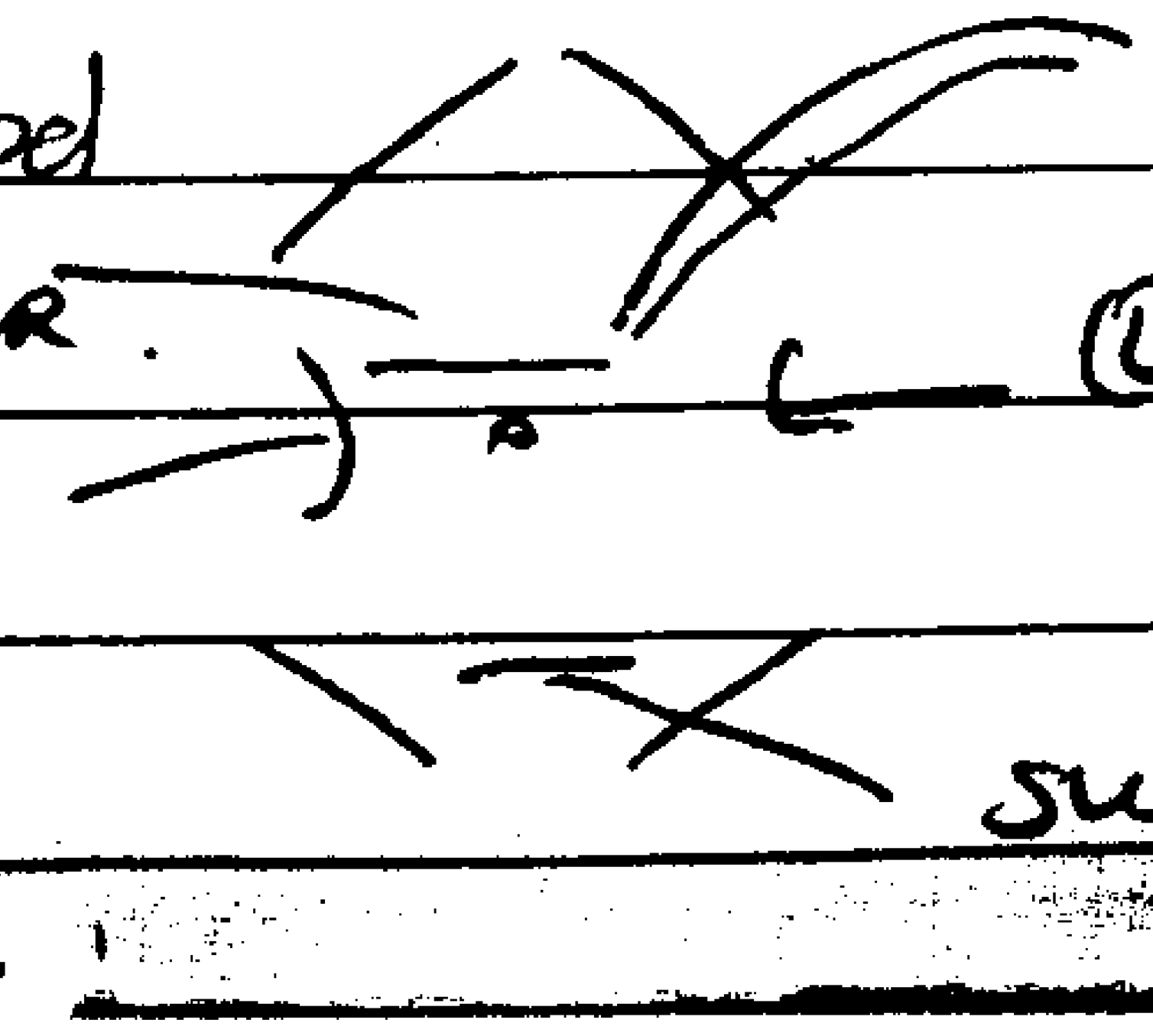
DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
7/12/91	Hb 10.1 PCV 0.32
	WCC 17.1 ↑ Plts 653,000.
	– FBP done as child pale, ?? septic
	WCC 17.1.
	(Lt) T-tube not draining
	Surgical reg. has come to see
	Hodge (SHO)
7.12.91	3.30pm.
	(L) T tube nephrostomy - minimal drainage via tube.
	Continues to leak via stoma.
	Slight leak from (R) stoma but [redacted]
	D/W Mr Bolton, agrees that [redacted]
	∴ (1) Antegrade
	Observe closely for possible recommencement of [illegible]
	Chen?
	(Locum Surgical Reg).
7.12.91 –	Injection of contrast via (L) T tube.
	The tip of the tube appears to be at the
	skin surface. The contrast did not enter the
	ureter, or even the abdominal cavity but
	extravasated onto skin surface and dressing.
	[signature]
5pm	– Note result of Antegrade Pyelogram.
	– Informed Dr M. Savage about this.
	–
	049-029-095
	[signature]

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
6.45PM 7/12/91	- Dr Savage / Mr Boston
	- baby would be going to theatre in AM (10.00) for double 'J' stent placement
	- PD cannula to be put onto free drainage
	- Child fasting.
	- Blood X matched.
	- fluids { TPM / N/5 saline
	Abdul Sal[illegible] Reg
7AM 8/12/91	- for Surg. at 10.00 AM
	- (R) T tube drainage = 385 ml. Intake = 745 ml
Na 136	(L) T tube out
K 5.8	
U 15.6	for double 'J' stent placement.
Ca 2.35	
Cr 152	
	[signature]

049-029-096

AS - ROYAL

DATE	CLINICAL HISTORY, EXAMINATION AND
8.12.91	Cystoscopy Laparotomy + (L) ureterostomy Central line
	Post op Antibiotics Oral fluids as tolerated.
8.12.91 1pm.	Transferred to ICU post op. 4/12 boy c̄ congenital dysplastic kidneys. Has had recurrent UTIs. Ureteric reimplantation [redacted]
pre op Na 136 K 5.8 U 15.6 Ca 2.35 Cl 152	28.11.91 – bilateral [redacted] inserted, urea ↓ ~~[illegible]~~ 10.9 on 4/12/91 5.12.91 – antegrade pyelogram → showed leak of fluid into peritoneal cavity from (L) nephrostomy. ∴ TODAY – theatre – (L) ureterostomy central line
	→ ICU post op.
	O/E. Pale. Perfusion fair Alert. T = 36.5 CVS p 140/min. BP 120/75 (cuff) ↓ 97/79. RS RR 44/min Broviac line (R) chest wall
	Soft Abd No BS. 049-029-097



AS - ROYAL

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	Plan
	① Measure + record output all drains
	② monitor P, BP. Temp
	③ FBP Hb ~~[illegible]~~ 10.5 PCV ~~[illegible]~~ 0.30 WCC ~~[illegible]~~ 28.6 Plat ~~[illegible]~~ 784 [illegible]
	U/E Na 136 K 5.0 U 15.4 Plat 144
	ABG pH 7.22 pCO2 25.6 Bic 10.7 BX -14.8
	→ given ½ correction ie 15 mmol Nabic.
	④ CXR to see central line position → SVC.
	⑤ Mr Boston suggests post op antibiotics → give
	cefuroxime IV.
	⑥ Regular BMs.
	⑦ Commence TPN. McCann
	Checked PBC.
9/12/91	Stable following [illegible] yesterday. TPN [illegible]
	Chest Clear. Drainage
	CVS 2HS 1/6 @ Apex.
	↑ Temp WBC 28 → 13 yesterday
	on Cefuroxime. No recent growth.
	? Gram -ve cover Stop Morphine.
	For M/W
	[signature]
9/12/91	For Urine cultures.
	[illegible]
9/12/91	S/B Dr [illegible] Savage.
	- flush PD cath. c̄ hep flush
	- Keep on a [illegible] bag
	- give ~ 1000 mls / day — TPN 28-30 mls/hr + oral fluids
	- U+E
	- GT [illegible] Rx.
	[signature]

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
10/12/91	- Wt. = 7.11 kg
	- afebrile
	- I/O = 1049/680 mls
	TPN = 669, Oral 380
	- (L) well, urostomy bag ✓. (R) well, urostomy draining fine.
	- active, demanding feeds. Central line ✓
	P - U&E today
	- try to ↓ TPN to 22-25 mls/hour
	- Cx leg as before
	- ✓ TPN sheet
	U&E → Na 143
	K 5. [redacted]
	Urea 14.8
10-12-91	R. ureter adequate in length but abnormal
	L. ureter the top has sloughed
	Will need ureteric-ureterostomy c̄ further reimplantation of (R) ureter
	Should be as planned provisionally next week
	(signature)
11/12/91	- In good form
	- afebrile
	I/O = 1025/378 → mainly via (R) side
	TPN 615, Oral 410
	- WCC 18.2
	- Urine - No growth from both nephrostomies
	- BU = 14.5 Creat. = 97 Na = 139 K = 4.4

049-029-099

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	P - U+E on 12/12/91
	- Try oral feeds
	→ for surgery next week
12/12/91	Still polyuric 850 yesterday
	Needs 1L+ fluid/day
Na 146	↑ TPN to 30mls/hr
K 5.1	+ ~~[illegible]~~ oral fluids at least 300mls thickened SMA
urea 15.1	Daily urine cultures needed.
tprot 59	Hb WCC ✓ U+E ✓ — checked 12/12/91
creat 105	urine [illegible]. YL Snaye
Hg 9.5	
WBC 13.1	
PLT 578.	
13/12/91	WR Dr M [illegible] I/O = ≃ 1000/450 mls
	- check urine cfs / fungus → urine: no significant growth.
	- U+E
	- C/T TPN (30 mls/hour)
	- rest as before
	[signature]
SHO	- temp. 38°C
	- not feeding well. Passed small amount of dirty urine per urethral catheter
	- WCC = 17.0 BU = 18.0 (↑) S creat. = 108
	- * fluid from PD cannula = Staphylococci coagulase
	(S) to Aminoglycosides / Chloro / Vanco / Emycin / NFT
	- Child has already had a full course of flucloxacillin, ~~Cef~~ cefotaxime + Cefuroxime
	049-029-100
	Start Netilmicin - loading dose 3mg/kg IV

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	✓ Check trough levels in Am
	✓ 840 Blood cultures
	✓ ↑ TPN 35 mls/hour = 840 mls/day
	Alvind Saha Reg
14/12/91	afebrile
	- looks better.
	- I/O = 840/803 mls. Still dyuric
	- Check trough levels of netilmicin go accordingly
	- U+E today
	[redacted]
	- aim at fluid 1-1.2L/day
	- Dr M. Savage
	- Continue netilmicin
	- also give vancomycin 250 mgs via CAPD cannula
	Alvind Saha Reg
14.12.91	Vancomycin 250 mgs given via CAPD cannula
2.00pm	1 hour later developed diffuse erythematous rash
	in axilla, groins and on back
	?Red man syndrome
	[signature]

049-029-101

AS - ROYAL

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS

14.12.91

2.10pm

Developed rigors
Started shaking
Temperature 37.9°C

Mum says he has done this on two previous occasions

- Rectal Paracetamol
- FBP (W.C.C)
- Bld cultures

Hb: 9.8
PCV .30
WCC 20.7 *
Plts 743

Bally

2.40

Trough netilin level 2.1

Commence Netilin 15mg BD
Check trough + peak level tomorrow morning

15.12.91 FBP ✓ U+E ✓ creat ✓ Net (T)(P) ✓

Trough ? 4.1 Peak 4.2 ✓ ok.

15/12. In view of rigor + erythematous rash following Vaucomycin just treat ℞ with i/v Netillin
Netillin trough + peak today

* WOULD DR CROSSIN OR DR GALLAGER PLEASE MAKE OUT A PURPLE RENAL FLOW CHART ON MONDAY *

* THE WARD CLERK (MARIE) NEEDS TO TIDY UP THE BIOCHEMISTRY FILING UNTO PROPER A MOUNT SHEET — not stuck on the back of a prvious card with sellotape!

Adam still vomiting. Talked c̄ mum A + P in wra advised
Creatinine static + effect of sepsis

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
16.12.91	Much improved generally — wt 7.2 Kg ↑ Temp settling
	- feeding Better 60 - 120 mls
	Small possetts
	Fluids TPN 30 mls 1 Hr — ≃ 1200 mls
	Oral
	Antibiotics - Netilmicin 80 — WC 20 x 10⁹/L
	- Ticarcillin
	Culture - wires ✓
	Plan - ↓ TPN 20 mls 1 Hr
	Free oral fluid
	- Check cultures
	Netilmicin level
	Bronchiolitis
	[signature]
	- Mr Brown will line up Surgery this next week
	(1) clamp (R) Nephrostomy + watch bladder drainage
	(2) for contrast study later. - Bootleet MD
Na 139 K 24.9 Cr 126	16.12.91 Netilmicin: T: 2.3
	P: 4.3 CC.

049-029-103

CLINICAL HISTORY, EXAMINATION AND PROGRESS

DATE	
17-12-91	T-tube in ureter (R) clamped 83mls of urine drained from suprapubic in 18hours Freed again for contrast study via T-tube (form sent ✓)
17/12/91	Urea ↑ 24 Creatinine 81 ↑ Need to evaluate Protein load in view of mainly TPN feeds Ask Janet to work this out + ensure he is on correct protein restriction Pyrexia settled ↓ Smiling + in good form but not feeding ↓ TPN rate by day + → hunger then compensate at night Need USS tests for comparison (urine flow per urethra) + dye down EF tract to evaluate Netillin levels not nephrotoxic HS

Calculated protein intake

	TPN(ml)	Prot	Oral(ml)	Prot	total kcal	total Prot	Urea
13/12	505	10.0	340	3.7	845	13.7	18.0
14/12	687	14	395	4.3	1082	18.3	20.9
15/12	709	14.6	460	5	1169	19.6	—
16/12	799	16.4	100	1.1	899	17.5	24.9

Average Protein Intake 17g
7.3kg → 2.3g P/kg.

Recommended min prot intake
1.8g P/kg.

J. Mercer
Dietitian.

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	Diagnosis : Ureter
17.12.91	Ultrasound No Hydronephrosis
	RT-tube ureterogram
	Dilated ureter - free flow to bladder
	Right ureteric distal ureter
	Catheter clamped (R) Nephrostomy
	~ Consider Suprapubic clamp + removal of
	neph./bladder drains
	Discuss Mr Savage NP
18/12/91	Checked U/E Creat ~
	FBC ~
	Stable
~	Not feeding Cisapride + Cyclizine 70 tds
~	TPN @ 150 mls Reduced Protein
	Urine flowing via Suprapubic catheter - clamp today.
~	Temp to a Netilmicin
~	Recultured urine, Blood.
	Consider removal Nephrostomy, Suprapubic Cath
	Discuss Mr Savage.
19.12.91	Weight ↓ 7 kgs
	Br 110/80 TPN
	Stable 605 — oral negligible
	output 534

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
19.12.94	
	Netilline 35
	24
	140
	700
	Cisapride 7(840
	Cimetidine 120.mg/day.
	* Hyper Natraemic
*	Nephrostomy unclamped last pm because
	Suprapubic drainage negligible
	Rx ① ultrasound to detect - ? dilated bladder or upper (R) tract
	as cause of ↓ suprapubic flow
Biochem ✓	② ↑ TPN 35 mls / Hr.
MSU ✓	
	[signature] 3=
	Hypernatraemic Need to ↓ [Na] in TPN.
	5% Dextrose 25 mls / Hr for 6 hrs
	Then recheck Biochem MD
4pm	→ Na 153 *
	K 3.8 ON Dr Savage PLAN →
	urea 20.0 1. ↓ TPN 25
	tprot 61 2. ↑ 5% dextrose 35.
	Ca 2.27
	creat 154 [signature]
	Dr Savage to r/v. CC.
	049-029-106

AS - ROYAL

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
30/12/91	WR Dr M. Savage.
	- Clinically well.
	- last Na = 152
	- Keep - 1/2 fluids as 5% dextrose
	+
	1/2 as TPN (with low Na)
	- Check U+E
	- Gt Nafcillin as before
	- 1
	[illegible signature]
3pm	- Spiking temp's
	- (R) side nephrostomy not draining
	- D/W Dr M. Savage
	① get 'T' tube Antegrade Pyelogram
	② Bloodcs. collect U+E results
	③ discuss with Dr M. Savage later c̄ results
	Ahmad Sat Reg.
30.12.91	bcultures✓ GpHold✓ CC.
4pm	Na 146
	K 4.1
	U 16.3
	Pro 60
	Ca 2.05
	Creat 173.

049-029-107

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
2?.12.95	Laparotomy
	Trans ureteric ureterostomy
	Both kidneys drained by silastic stents.
	Suprapubic in situ
	[signature]
	12 MN ICU
	transfer of Adam post op. after trans uretero-ureterostomy
	& stenting procedure.
	Plan I/V Morphine infusion.
	I/V 5% Dextrose at 10ml/hr + previous hourly
	urine output loss
	& checked FBC (note 80mls blood given in theatre)
	U&E
	Mum informed of procedure by Dr Dalzell. S Craig
	02.00
	Compensated Respiratory for Metabolic Acidosis
	pH 7.25 Na 141
	pCO_2 16.8 K 4.0 Ca 2.2.
	Bicarb 7.4 U 15.8
	XS −16.
	Well Perfused
	Give 50 mls PPF
	plus 20 mls 8.4% $NaHCO_3$ over 5 Hrs.
	* Check Astrup + Na after 2 Hrs
	[signature]
	If Na > 150 discuss with me
	If Na < 150 Continue $NaHCO_3$ infusion.

049-029-108

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
21.12.91.	• Seen by Dr. Savage, Mr. Brown & Dr. Wilson.
	• Had Trans Ureteric Ureterostomy.
	• Met. Acidosis last night needing correction c̄ Bicarb.
	• Passing urine well 188 over last 9 Hrs
	about 3 ml / kg / Hr. some leak around Ureterostomy tubes.
	• On Morphine infusion..
	• Bicarb infusion 20 ml 8.4 % $NaHCO_3$ over 4 Hrs.
	Na 142. mEq/L. at 7.00 AM checked again this morning.
	• Otherwise Stable,
	Ht S_1 S_2 no (m)
	lungs clear.
	Abd. BS — . Sp. Had one vomiting.
	• To Cont. $NaHCO_3$ infusion Check ABG / Na again later
	• Cont. A/B Cefuroxime & Netilin. – (levels? ~~outstanding~~)
	• Fluids Urine out-put + 10 ml / ~~Hr~~
	Na 141 mmol/L [signature]
	K 4.1
	Urea 17.7 ABG. 9.00 AM.
	Sr Cr. 213 pH 7.33
	Pr. 52 pCO_2 24
	Mag. 0.72 Bicarb 13
	Ca 1.96. BE -10.5
	pO_2 76..
	Transfer summary.
1.12.91.	Adam Strain 4½ mo old infant c̄ Bilat. Multicystic Kidney
	was admitted in CICU last night having undergone
	Laparotomy, Transureteric Ureterostomy. He had developed
	Met. Acidosis last night needing $NaHCO_3$ infusion c̄ an
	advice to keep a watch on Sr. Na levels. 049-029-109
	There is some leak from R. Bl. catheter. TPN & St. fluids
AS - ROYAL	~~The~~ plan is to continue the same A/B, fluids Urine out put and ½ : ½ ~~[illegible]~~ + 10 ml/hr