Total urinary output over 12 Hrs. 286 + 41. = 327

+ Gastric Aspirate

DATE | CLINICAL HISTORY, EXAMINATION AND PROGRESS

- TPN @ 5% Dextrose ½ : ½
- NaHCO3 infusion to cont. Check ABG later
- Morphine 3.5 mg in 50 ml 5% Dextrose @ 1.5 ml/hr
- (ABG - fixed . on 3 occasions
  There was sample error.
  To repeat ABG later).
  in afternoon.

S/BA M. Savage

24/12/94

- has leakage around his Suprapubic cath + around B/L ureteric stents.
- afebrile, on multiple infusions
- later Urine - Na = 141
- later ABGl at 4pm pH = 7.33 H_{CO_3} = 16.0
- to give fluids total of 800-850 mls/24hrs

½ ½
Saline TPN

TPN

- has passed - 73mls via Suprapubic
  - 105mls via (L) nephr = 241mls
  - 63 mls via (R) nephr.

@ 5pm

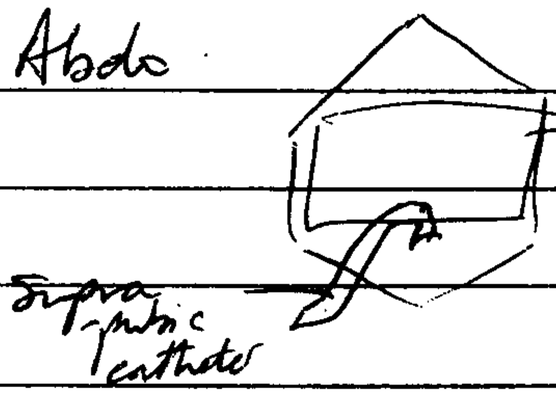
- G7 netrelin + Cefuroxime

Aamir Sahar
Reg

2-12-94

Cross this morning
Dressing from all three catheters.
Leave the dressings and I will change them on Tuesday

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
22/12	Wt ↑ post op partly plumbing but ? ↑ fluid Output good if difficult to assess ∵ accuracy ∵ of leak around supra pubic Drainage 1. Supra pubic 2 Nephrostomies 3 Leak Yesterday input/output seem balanced [Na] 140 Input TPN 18/hr 5% dextrose 17/hr Morphine 2/hr Today reduce to total 30mls/hr 15:15 TPN/dextrose Apyrexial On Cefuroxime / Netrillin Discontinue Netrillin today [redacted] to change [redacted] [redacted] supra pubic [redacted]
22/12/91	Results: Na+ 139 K+ 4.0 *Urea 15.3* *Creatinine 183* Ca2+ 2.03. [redacted]
22/12/91 20.55.	Phoned by nurse — Adam had an apnoeic episode - Apnoea alarm went off - Adam still not breathing when nurse went over to him - he was pale; required nurse to bang hard on cot side before resp = restarted - No cyanosis, pallor. RR not counted. O/E: Sl. Pale. Breathing spontaneously - RR 26/min - sl. indrawing + grunts; Resp = irregular - pauses then rapid breaths. N-G tube not draining much.

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
22/12/91	the Adam vomited +++ (not up N-G)
	+ continued retching despite N-G tube
	- ? N-G tube is not far enough in.
	Looks miserable in pain No cyanosis
	CVS: Pulse 160/m, regular
	R/S I+II+ nil. BP 93/72.
	Chest: AE good (Rt) = (Lt)
	BS vesicular, nil added
	Abdo  Sl. distended; Sl ft. Tympanitic U. for Bowel sounds
	Nerve: Looks miserable Awake.
	Moving all 4 limbs
	Fontanelle: normal
	PERLA.
	Δ Apnoeic episode
	? cause
	① - on morphine infusion 3.5 mg - 50 ml
	@ 2 ml/hr (≡ 140 mcg/hr
	- stopped when apnoea occurred = 20 mcg/kg/hr
	- max dose)
	?? apnoea due to this.
	② ? apnoea due to N-G tube being - oesophagus → retching + vagal stimul°
	③ ? apnoea due to pain.
	Plan: Monitor T, P, R, Urine
	? SaO_2 monitor
	? continue morphine infusion @ lower dose (1 ml/hr)
	(Dr Hodge 540)

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
23/12/91	Apyrexial No supra pubic leak or drain Flush supra-pubic 6 hourly. 10-20 mls. Dressing tomorrow Fluids 3.5mls/hr is 5% Dextrose 20. TPN Commence oral fluids Withdraw. HS
	Bld gases 23/12/91 PH 7.27 PCO_2 41.1 PO_2 39 BEb -6.8 SBC 18.7
	A Fally
23/11/91	Silastic tubes splinting meters found lying free in cot Ends entering abdominal wall free Small amt of urine leakage around ant. abdominal wall site Suprapubic catheter - flushed Phoned Dr. Savage Suggesting inserting 8F catheter
	Surgeons phoned - unable to contact Mr. Brown. Mr Stewart contacted - suggested observe to see if drains urine from suprapubic catheter L Fally

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
24.12.91	Ultrasound tests on
	no Drainage from suprapubic
	Ileus suggests some leakage into peritoneal
	cavity.
	Needs further surgery
	[signature]
24/12/91	Yesterday U+E best for many days
	Na K Urea acceptable
	137 3.7 12.8 Hb 12.3
	To have surgery today
	HS
24.12.91	GA Dr Taylor
Hb 12.4	Bladder opened. R. ureteric orifice cannulated
PCV .388	without difficulty. Good flow of urine from catheter
MCC 8.9	X-ray using Hypaque. Both ureters intact and draining
PLT 194	freely down to bladder distal R. ureter
Na 128	Ureteric orifice slit and incised open to improve
K 4.0	drainage
Urea 15.7	Catheter left in situ and brought out of bladder
Creat 227	Bladder closed catgut over suprapubic catheter
	Wound closed catgut and Dexon
	[signature]
4.30pm 24/12/91	- Shifted back to ward
	- Lower end of the "common ureter" seemed to be narrow and
	was reanastomosed. Stent put in the same segment of ureter.
	- Clear urine about 50 mls via the stent.
	- Suprapubic catheter - same as before not draining

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	- intra-op. film available of showing patent
	Ureteric-anastomosis in a "Y" shaped shape.
	- No leak seen from the anastomosis.
	- Child is stable, afebrile, on morphine infusion
	- P : - U&E.
	- fluids - would need at least 1000 ml/24 hours,
	or 100-200 mls above his urine output
	1/2 clear fluids + 1/2 TPN.
	- at morphine infusion, overnight
	- Urine U&E
	- [illegible]
26. 12-91.	Still looks miserable Drowsy but also dislikes being disturbed. Chest clear. AS Distended but soft. Occasional bowel sounds.
	Asim d Salu Reg
	ct iv fluids at present.
	Check U+E. ms
26/12/91	Na = 131 25/12/91 Na = 127
	K+ = 4.3 K = 4.0
	Cl = 107 Cl = 97
	Bu = 16.1 Bu = 16.5
	Screat = 194 Screat = 222
	24
27/12/91	Needs careful watch on [Na] ASalu
	TPN now 21 mmol Wt ↓↓
	T° normal
	Good urine output 500 mls yesterday 800 prev. day
	May be a little dry
	Needs ≥ 1000 mls/day
	TPN @ 40mls/hr + oral dioralyte. 10mls 2hrly.

AS - ROYAL   050-023-072

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	i.e. 960 mls TPN + 240 mls orally If does not tolerate oral ↑ T.P.N. to 85 mls/hr. MS
28.12.91	Surgical. Asked to see. Central line accidentally pulled out yesterday. Needs it for TPN Dr Savage would like another line inserted fasted overnight. For a line today. S Rejman
28.12.91	OPERATION NOTE Surgeon: Miss Rejman / JR McCausell LEFT anticubital fossa explored Vein cannulated Check CXR – satisfactory position Easily flushed. Closed c 4/0 PDS. tunnelled down forearm. S Rejman.
27/12/91	Urea 16.6 Na^+ 140 K^+ 4.5 Cl^- 113 Creatinine 180
28/12/91	Mum noticed him twitching ~ 7.30 pm 'Jittery' – started in his legs ispread to involve his arms – sleeping at the time O/E Alert RS ↓ ↓ to CVS Chest: Clear ~~Apyrexia~~ Moving all 4 limbs normally U/R Na^+ 135 m mols/l K^+ 3.5 m mols/l Cl^- 111 m mols/l Creatinine 158 m mols/l

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	Cat 2·31
	[signature]
29/12/91	Has been vomiting since anaesthetic +/- bile
	Apyrexial. Active. CNS ✓ – no twitches
	Abdo soft but few bowel sounds
U+E	BP ✓
creat	Hold off oral fluids
Ca^{2+}	Steel on IV. cefuroxime + oral nystatin
	M.D.S.
30/12.	Urea + creatinine satisfactory Hb 12.
	Fluid balance seems reasonable but a major problem with
U+E ✓	vomiting.
creat ✓	Recommence thickened milk feeds
Ca ✓	cisapride + cimetidine
	Mr Brown to arrange X Ray studies – dye up the nephrostomy
	stent + clamp to see if dye drains down around it to
	bladder.
	MB
31.12.91	Ur 7·35
	Still vomiting but taking better orally
	TPN 15 l/hr + background plus volulyte and water
	Wet nappy yesterday
	? Nephrostomy dye study today MB
1.1.91	
	DW Radiologists tomorrow
	Nephrogram Study MD

ATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
2. Jan 91	- afebrile
TPN ✓ ~~U+E~~ ✓	- good stoma. has diarrhoea 3-4/da, loose. mucus+
	- Wt. 2 7.2kg
	I/O = 1026 ← TPN = 726 Output = 463ml; Oral = 300
	- chest - clear
	- WS abd. v
	P - Check TPN regn, U&E
	- for nephrostomy study - to check if radiologists
	- check stools for Cl. difficile toxin / culture
	- aim at fluids about 1 Litre / day. Aleister Sal
21.92	Contrast shows leakage at PCN site. ∴ Continue on free drainage & observe & start for the moment. Another contrast X-ray in about a week.
1130 pm	~~Spiked temp again.~~
	Spiked temp again. message left by Dr Savage & Infam
	him if temp ↑.
	D/w Dr Savage to start on Augmentin.
3.1.92	↑ TEMP. - MB
	Note: leakage from anastomosis
	D/w Dr Savage / Dr Dalzell.
	→ D IV Cefuroxime ✓
	→ D peripheral cultures ✓
	→ D urine for yeasts (Mossy)
745pm	- Temp. 40°C.
	- abd - soft & present. BS+
	- ↓ bs behind fluids about 300 mls

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	I (1) add metronidazole 30 mg/kg/day
	(2) NPO
	(3) Check BS/ abd. girth 2-4h.
	(4) ↑ TPN 40 mls/h + start N/5 saline 10/h
	to give a total 500 mls overnight.
	(5) may need USS abd. to r/o collections
	(6) withhold antifungals for the time being
	(7) D/W Dr M. Savage in Am.
	Arvind Sah
9.30 Am - 4/1/92	S/he spiking temp.
-	abd. girth ↑ by 2.0 cms. BS(+)
	- D/W Dr M. Savage
	- may need abd. USS / opt. surgical opinion.
	- 4° FBP/ U&E.
	- 4° NPO
	Arvind Sah
	S/B Dr M. Savage
5/1/92.	Temp. settling.
	BS+ 420
	I - cont antibiotics
	- ↓ intake ≃ 750 ml/24h - TPN 30 mls/hour
6/1/92.	TPN today 35/hr — 840mls total
	Ba meal + follow thro' ✓ ASah
	Vomiting the big problem
	Ask Mr Brown for his opinion re management +
	aetiology of vomiting
	Check Astrup. MS
	pH 7.36 pCO_2 28.7 pO_2 100 HCO_3 16.5 BE -7.2

050-023-076

AS - ROYAL

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
7/1/92	Spiking T° again despite 3 days * Cefuroxime + Metronidazole. *
U+E✓	No growth on MSU Need blood culture result — no growth so far. USS to exclude pelvic abscess Need Mr Brown to see it ① ② Severe Reflux on Rx ? Fundal plication.
	U+E Satisfactory Hb 9.1 Continue I/v feeds. MSaurgr
7.1.92 2-30pm	USS → no pelvic abscess noted. Mr Brown has seen Adam. — does not want CROSSMO to consider fundal plication until urological problem resolved. MS ASTRUP 11-30pm (venous) pH 7.275 pCO2 29.2 pO2 56 HCO3 13.7 TCO2 14.6 BE -11.2.
	C+S ✓ CROSSMO
8/1/92	- Still Spiking temp. - pH = 7.27 HCO3 = 13.7 BE -11.2 - Mr. Brown wants a repeat USS of Kidneys - to D/W Dr M. Savage about Antibiotics + Sod. Bicarb Rx ↓ give 7.5 mls Soda bicarb x 1/24 bd ASaby
9/1	Still vomiting Commenced on Bi Carb T° ? settling Chest clear MSU result Scan result awaited. MS

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
9.1.92	Urine sent on 6.1.92 — YEASTS ++
	USS on 8.1.92 — P.
TPN screen sent.	"kidneys remain small no evidence of ascites Cross. localised fluid collection in the posteromedial aspect of (R) kidney - probably a dilated renal pelvis.
	Cross
	↓
	- Should have CT abd. to r/o abscess around (R) kidney.
	- w/d D/w Dr M. Savage in Am
	- fluconazole 6 mg/kg. (40 mg IV)
	-
	Allied Cat Reg
10/1/92	Try home for day hopermese T.P.N. line after IV drugs.
U+E	Stop Flagyl + Ceforoxime in a.m
cultured 11.1.92	Cont. Fluconazole
CC.	
11/1/92	WR Dr M. Savage
	- Still spiking temp. I/O : 1 Litres/ 8 counts
	- mild cough.
!	- CT I/V antibiotics over weekend
	- CT TPN ~ 1L/day
	- CT fluconazole
	- Check LFT's - monday
	Best

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
12.1.92	Returned after spending day at home Mum reported him to be in bad form all day
	O/E Pyrexia 37.8 Occasional cough HR 160 min RR 60 min
	HS I II +0
	Chest: Clear to auscultation
	Urine - ++ protein ++ blood
	FBP Direct urine Bld cultures UTE Venous astmp A Fullagar
	Hb 9.4 Urine direct 50 pus cells PCV .28 > 1,000 RBC WCC 5.9 Plts 215,00
	Na^+ 151 K^+ 4.6 Cl^- 126 Urea 10.9 Creatinine 120 Bld PH 7.27 PCO_2 39 Base Xs -7.7 Std Bicarb 18.8 PO_2 41
	Normal anion gap acidosis

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	Na^+ 151. this evening
	according to mum this is behind. fluids-intake as took nil
	at home. Na^+ result from Yesterday 151
	on $NaHCO_3$ 20 mmol/L daily iv.
	also getting Na with TPN.
	over night give ½ amount TPN.
	½ Dext 5%.
	Needs in am. use. Osmolality
	may need ↓Na in TPN as he
	is getting Naplex I.V. regularly.
	MB
13/1/92.	Still pyrexial (? settling)
	Check U+E for [Na]
	Stat dose Lasix 20mg oral as wt PP
	Dye to urinostomy
	Ask Dr Magill to ↓ Na in T.P.N.
	MS
16.1.92 2pm	Dye stain – no leakage
	Xrays seen by Mr Brown – will discuss case
	c Dr Savage.
	50 mls (N) saline injected into suprapubic –
	most leaked out of nephrostomy! sent for yeasts.
	Dr Magill putting low Na into TPN – would be
	able to put Nabic into TPN if Dr Savage agrees
	CROSS.

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	WR Dr M. Sandy
14/1/92	- Wt. = 7.7kg.
	- afebrile.
	- Cough ++
	- No leakage from ureteric anastomosis
	! (1) GT glucagon.
	✓(2) Physio.
	(3) Check TPN / LFT screen
	(4) to add 20 mmol of Na lactate to TPN bag ✓
	[signature]
15/1/92	- Wt. = 7.9kg.
	- afebrile.
	- good form
	- D/W Mr Brown → to remove stents on monday
	- Keep flushing suprapubic catheter
	- Check U+E / HCO3 today.
	- GT scan TPN
	- for TPN screen / LFT c 16/1/92
	- for DPT/OPV vaccine (DPT ↓ 0.5; OPV ↓ 3 drops)
	[signature]
	- TPN has added 20 mmol of Na lactate.
	- Not to give replacement
	[signature]
	AdamStrenn

050-023-081

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
16/1/92	Urea + Creatinine 9.8 and 87.
	Fluid balance fine
	900 mls in
	On Cenetderm ½.
	Apyrexial.
	* ↓ $NaHCO_3$ 20mmols ½ in TPN. *
	Vaccine today. MS
	On Monday to have start out.
17/1/92	WR Dr M. Savage
	- afebrile
	- good balance
	- No major change in overall Rx plan
	* Starts out on Monday *
	9/7 TPN
18.1.92	Home for day no ABah
19.1.92	doing well. afebrile
	Intake good
	Starts Out on 20/1/92 - inform Mr. Brown
	Chem U+E today
	Na - 138
	K - 3.5
	Cl = 114
	Bu = 9.4
	* BE - 8.2 — would need ↑ HCO_3/lactate to 30 mmol in feed TPN
	HCO_3 = 17.5 ABal

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
21-1-92	Ureteric stent removed
21/1/92	- Warn Catheter for ① Urine Output via Suprapubic - Catheter Drainage - to ↑ Na. lactate to 30 mmol/24h - TPN Bloods on Tuesday
	IVP - organised
22/1/92	Good drain drainage via supra-pubic Get IVP result. ? next step in plan ℂ Mr Brown MS.
23/1/92	IVP no contrast noble Output continues to be excellent Clamp supra pubic for 1 hour ×4 today 2 hours ×4 tomorrow Can go home for days as suits mum. ? Fundal Plication in 10 days if removal of supra pubic successful next week MS
23/1/92	Na^+ 143 K^+ 4.3 Urea 8.9 Creatinine 96
25.1.92	Leaking round S-pubic Nutrition all IV Have Inr spells MS

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
26.1.92	Happy Afebrile
	① Tolerate solids — not true MS TPN – 90%. ↓ Energy.
	② Still on Fluconazole IV. Yeasts on last one 23.1.92
	Rpt FBP SMAC MSU more.
	A. Review need for Fluconazole. B. ? nutrition review Dr Savage
27/1/92	Still major feeding problem
	Stop fluconazole
	urethral catheter need today — leaking around supra.pubic
	? needs repeat M.C. — ask Mr Brown before changing catheters.
	Discuss OGD c Dr Dalzell.
	GA Dr Anderson
28.1.92	Endoscopy
	Normal to D2
	Patulous lower oesophageal sphincter
	bx oesophagus duodenum NAD
	Suprapubic catheter removed
	urethra dilated
	16 Foley catheter passed

050-023-084

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
29/1/92	- WW. - Wt = 8.36 Kg - Suprapubic catheter - out ↓ UA is passing urine via urethral catheter. - Chem FBC / UEC.
	Urine cgs → Enterococcus (S) to Amplicillin I. Amplicillin orally - 125 mgs 6/24.
30/1/92	40mls x3 daily is max tolerated orally without vomiting Asch Try N/G tube feed O/N over W/C at 10mls/hr Kangaroo to see what happens.
	? Urinary catheter out Sunday P.M.
	Can go home by day after W/C- YLS
3/2/92	Sat night Naso / duodenal tube 10mls / hr tolerated Sun night 20mls/hr → vomited but tolerates 15mls / hr Had 1L intake TPN today 500mls oral feeds tube 180 mls } 700mls. PLAN TONIGHT 4/2. 20mls/hr NG O/N 240 mls TPN 20mls/hr ~~280~~ Soon 100

15
6×12
180

AS - ROYAL 050-023-085

Urine → coliforms (R) to all. yeasts ++

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
5/2/92	TPN – 591mls
	N/G – 240mls
	vomiting x4
	good [illegible]
	? [illegible] urine C/S and check for yeasts + (S) to Ciproxin
	? will need [illegible] [illegible] studies
	[signature]
5.2.92	results of MSSU
	3/2/92 → no growth no yeasts isolated.
	4/2/92 → no growth
	E. Clarke.
6.2.92	wt ↑ ≃ 10 kgs.
	[illegible] enteral feeds
	TPN 30 x 24
	7 150 /kg/day ← Enteral 20 x 15.
	Overnight ↓ TPN 20 mls / HR
	Enteral 20 / Hr overnight
	(1)
[illegible] [illegible] / [illegible]	
	NG feed 585 ml
	TPN 420 ml
	1005 ml 1005 kcal
	wt 8.74 kg 115 ml / Kg
	115 kcal / Kg
	J. Mercer
	(Dietitian)

AS - ROYAL 050-023-086

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
7/2/92	PROBLEMS ? facial oedema
	↑ mg creatinine
	episode of hypotension.
	fluid intake satis. Tolerated N/G tube better.
yesterday	MSU checked
Na 139 K 4.9	O&R.
Urea 9.2 Creat 185 ↑	USS Bladder + kidneys
TP 65 Ca 2.53	? any evidence of obstruction
	M Savage.
	+
	Yeasts + in vvie
	Dw dr Savage stating antifungal agent. MD
8/2/92	Pyrexial
	Irritable
	CXR ? some degree of fluid overload
	Wt ↓ because ↓ fluid intake
	Need to increase
	Recatheterise to accurately assess output : ? enlarged bladder USS
	Continue fluids as yesterday YHS
	Na- 152 *
	K- 5.0 Urine U/E = Na = 65 K = 20 Ref = Urea 276
	a = 116 Sucat = 1.4
	BU = 14.2
	P - repeat U/E
	- If Chem has ↑ Na⁺ to give some 5% dextrose as maintenance fluids
	- note the slight ↑ in BU -
	? would need IVP / DTPA to rule obstruction

Iv.n — Repeat U+E — Na [illegible] 157

- TPN has 58 mmol / bag which is v. high

- R Keep TPN at 20 mls/hour instead of 40/hour
+
Add N/5 Saline 4% dext 20 mls/hour

4T n/g feeds

4hr U+E in Am

get new TPN Solution

* adam is for DTPA diuresis renogram on Monday

Am - mum said adam had transient twitching of (L) eye. went Pale.
no tonic clonic movement of limbs.
Seen in casualty → observe
- whole of.

Arvind Sahu

7/2/92 - afebrile

- no further Problem.

- Check U+E today + adjust TPN / clear fluids accordingly

- DTPA - Monday

[signature]

9/2/92 Na 143
Pot 4.7
Cl 113
Urea 13.5

- continue present fluid regime

F. Casey

AS - ROYAL 050-023-088

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
10.2.92	
	DTPA Scan booking
TPN Review	CV 205
	Enteral 20
	TPN 30
	Need to get abs full enteral feeds NPO
11/2/92	- Was hypothermic yesterday 35.5°C
	- Is all right today
	- no fevers
	∴ DTPA → no obstructive
	but would want to see the actual curves
	- note ↑ BUN ↑ & creat - probably related to
	renal insufficiency
	- ? would Cr^51 EDTA to estimate GFR.
	- Chase (U) HCO_3.
	U&E ✓ Na = 140 K = 4.6 BU = 12.2 S.Creat = 211
	Dennis Sahi Reg
11/2/92	↓ protein content of feeds.
	5.4g / 480ml.
	1.1 kCal / ml.
	J. Mercer (Dietitian)

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
10.2.92	DTPA Scan Lodging
TPN Review	Cf 205
	Enteral 20
	TPN 30
	Need to get abs full enteral feeds NPO
11/2/92	- Went hypothermic yesterday 35.5°C
	- Is all right today
	- no fever
	∴ DTPA → no obstructi
	but would want to see the actual curves
	- note ↑ BUN ↑ & creat - probably relative to
	Renal insufficiency
	- ? would do EDTA to estimate GFR.
	- Chase (U) HCO_3.
	U&E ✓ Na = 140 K = 4.6 BU = 12.2 S.Creat = 211
	Dennis Sahi Reg
11/2/92	↓ protein content of feeds.
	5.4g / 480ml.
	1.1 kCal/ml.
	J. Mercer (Dietitian)

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
12.2	wt 98.8.
	Reach 900 mls Enteral
	Get off TPN by end of week
	Still vomiting - and of trial ++ Speech therapy
	Urine output ✓
	for Zinc level twice a week only @ present
	(anxiety level great - Number related)
Meds	
Cimetidine	
Cisapride	off fluconazole
Repeat urine Culture.	ND.
12/2.	On Continuous tube feeds 18 mls/hr
	Also on TPN 18 mls/hr
	Still vomiting
	? Time for a fundal plication. — urea normal 1/12
	Creatinine rising but DTPA no obstruction
	Why should renal function deteriorate
	1) ? infection — ? yeasts
	2) ? hypertension No
	3) ? obstruction No
	4) ? hypercalcaemia No
	Recommence Fluconazole
	* Get DPA result to look at. * M Savage
13/2	- good form
	- afebrile
	- is on 1/2 TPN + 1/2 n/g feeds
	- ! ① try to gradually ↑ n/g feeds
	② [illegible] ③ [illegible] TPN [illegible] [signature]

AS - ROYAL

050-023-091

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
14/2.	Allow Rene dressing the day Sat + Sun. Needs N 900mls/day Discontinue ½N + tube feeds while at home 10am – 8pm Then OTN
14 ·40 560	N/G @ 25mls/hr —— 350 TPN @ 40/hr —— 560mls } 900 If not tolerated could probably reduce to N 700mls/day
	PKenga
15.2.92	Well 20mls/Hr tolerated ng ≅ 400/day Press on ± A enteral volumes If unable to tolerate — t-plasty. - Check wt to year - Biochemistry Monday
17/2/92	- Wt = 8.76kg (↓) - mild low grade pyrexia - Otherwise in good form. - BP ✓ - Yesterday did not get TPN - is on ng feeds 24 mls/hour = 560 mls/day - ~~CF~~ Chest - clear Pallor + Cvs ✓ Mild Cough ① U+E ② Hb ③ ~~Cx~~ TPN at least 350 mls/day

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	- Would try to wean off TPN within 7-10 days
	- daily Urea - Yeasts + CFS
	Arvind Sah Reg
18/2/92	Renal function continues to deteriorate - rising creatinine
	DTPA result still not available in print
	Contact radio-isotopes again
	Re USS today ? any distention
	When we last both need to discuss situation c Mr Brown
	Feeding still a problem
	30mls/hr of N/G would enable withdrawal of TPN
	B.P. seems satis
	Low grade Pyrexia.
	Need to check recent Hb. in case dropped further.
	MB
18/2/92	FBP, Cote } checked