Afam Arni

DAT | CLINICAL HISTORY, EXAMINATIOI

21/5/92

PC Readmitted with pyrexia and irritability
Old notes not available.

HPC Off form past 12-24 hrs
pyrexic
irritable
vomited once
no diarrhoea.
no cough.

PMH well known to unit
hx of dilated ureters.
frequent UTIs

FHx nil of note

DH Fluconazole 50mg mane.
$NaHCO_3$ 7.5mg t.i.d
nitrofurantoin
no allergies known.

O/E irritable + off form
no meningism / neck stiffness
pyrexic
ears ✓✓ throat ✓

CVS HR 120 sr HS I+II no ⓜ.

RS chest clear

A/ Abdomen soft.
mildly distended no masses felt.
no organomegaly

054-057-128

AS - ROYAL

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS

Surg

1½ yr old boy well known to unit. admitted with H/o of pyrexia + being off form

Imp ? UTI

Mx FBP U+E ~~urine testing~~ Blood culture
change to oral cyproxin
urine → dipstick + OH
CXR + AXR.
encourage fluids

Na = 143
K = 3-4
urea = 14.5
TP = 78
creat = 30?

22/5/92 - Readmitted of pyrexia & feeling unwell
- Vomiting 2-3 times
- was irritable at admission, but is settled now.
- o/e. well hydrated
Clear chest abdo

I - awaiting culture of blood + urine
- on oral ciproxin

054-057-129

AS - ROYAL

23.5.92

Happy Temp settling
Tube fed

c Ciproxin 2/7
– check cultures
– Continue high fluid intake

22/5/92 1st urine 21/5/92 pseudomonas sensitive to ciprofloxacin.
2nd urine no growth

24/5/92. Still spiking temp
UTI ↑
GT and Ciprofloxacin.
Still has same drainage

25/5/92. Recurrent U.T.I despite prophylactic antibiotics Trimethoprim/Nitrofurantoin/Septrin
Has had many infections pseudomonas/staph./coliforms.
Renal USS does not appear worse. I think we need retrograde studies +/or urological opinion on whether drainage can be improved. Has stayed in pt Rx for 6/12 with only minor breaks. Need Mr Boston to see
HS

26/5. – afebrile
– GT and Ciprofloxacin.
– need to talk to Mr V. Boston

27/5/92 Apyrexic
Still refusing to feed properly – on NG feeds
awaiting surgical advice

054-057-130

DATE	CLINICAL HISTORY; EXAMINATION AND PROGRESS
28/5/92	- Surgeon to see him today & to check Ascr Retrograde Pyelogram
	- I/s on oral Ciflo
	- Urea & Electrolytes
28/5	Has discussed problem of recurrent U.T.I with Mr Brown – will review situation & consider possibility of surgery Explained to Ms Strain we must hear Mr Browns assessment to consider ~~surgery~~ further action HS
29/5.	Spoken To [redacted] – has Only option seems I/V [redacted] – no peripheral access. Perhaps we could get retrograde pyelogram and I/V at same time I will speak to Mr Brown again HS For Mag I/V line today ± cystoscopy + retrograde pyelogram. HS
29/5/92	Wt 10·7 Kgs.

DATE	SURGEON	ANAESTHETICS
29/5/92	McCallion Stewart Brown	McCarthy

Insertion Broviac line left common femoral vein – Xray shows tip of line in proximal SVC

Cystoscopy – (Mr Brown) (R) U.O. identified in midline at Report of intermittent bar

[redacted]

054-057-131

AS - ROYAL

DAT'	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	Ureteric catheters passed → Xray for retrograde.
	↓
	* catheter fell out. [signature]
30/5/92	temp ↓
	G7 I/V Ceftazidime
	Stop oral Ciproxin
	Start oral feeds.
	W R Dr M. Savage
31/5/92	Still spiking
	but well otherwise
	G7 Ceftazadime I/V
	Na 145 Hb 8.3
	* → K 3.0 PCV .25 [signature]
	Urea 11.4 WCC 9.9
	Pl 71.
1/6.	Anaemic. Urea steady. T° still sl ↑
	Needs creatinine Fe + ~~[illegible]~~ ferritin – Iron Studies
	Blood sugar. – glycosuria
	* Discuss repeat. Retrogrades + Surgery c̄ Mr Brown *
	Daily MSU. [signature]
2/7	Staph in urine – add furantoin
	If Mr Brown feels surgery no further help Mother requests Mr Barbers opinion Left DTPA ? obstruction. [signature]

AS - ROYAL

054-057-132

WNC

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
3/6	Still Pyrexial, chest in good form.
	GT MFT + I/V Antibiotics
	MC Bronchoscopy
	ABC
3.6.92	I cannot explain why he keeps getting infections. There is no evidence of abdominal malignancy. Function is too poor to give good images either with Gallium or Isotopes. The renal pelvis is too small to bother for descending pyelography. The only hope [redacted] This would probably require GA.
4.6.92	Temp touching still Well in bed Feeding OK Rx Fortum Nitrofurantoin Nil 1.6 Check MSU Biochem no

5/6/92 Weight 10.95

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
5.6.92	GA
	Urethral catheterisation and bladder filled to
	170mls. Grossly distended
	Ultrasound through bladder — fine and emptying
*	No evidence of urethral obstruction
	CSU → Lab
	[signature]
6/6/92	- mum wants to take adam home.
	- still having oc [redacted]
	- stopped I/V [redacted]
	- qT oral nitr [redacted]
	- Cuegas (Mr. Brown) → no evidence of obstruction.
	- last Hb = 9.1 gms.
	Arvind Saha
9/6/92	Ward rev
	Wt. = 10.94
	temp. = only once ↑ to 37.6°C.
	Good form otherwise. mum happy. not keen to stay
	day (7) of Nitrofurantoin —
	Central line ✓
	P - rev renal clinic 2/52
	- ↓ NFT x 4 days keep on prophylactic NFT later
	- U&E / FBP at renal clinic

054-057-134

AS - ROYAL

[signature]

DATE | CLINICAL HISTORY, EXAMINATION AND PROGRESS

23/6/92

DR. J.M. SAVAGE
NEPHROLOGY O.P.D.

WT. 11·8 Kgs
HT. 73·8 cms

URINE
SPEC TO LAB

- mild Pyrexia x 2 days
- Good form, No Vomiting/diarrhoea
- is on NFT at night.
- is Polyuric. passes 1·5 Litres/day

S/B Dr m Savage

BP ✓ clinically well

ENT - mild, inflammation of his throat

R
① MSSU - ✓ forward
② Sod. Fluconazole. [illegible]
③ If Pyrexia persist + if MSSU [illegible]
augmentin.
④ Rev 3/52 -

Ahmad Sah
- Reg

21/7/92

DR. J.M. SAVAGE
NEPHROLOGY O.P.D.

WT 12·78 Kgs Urine + Protein + Glucose
HT 75·6 cms Spec to Lab.

- good form, though mum says every other day he has a low grade Pyrexia - 38°C, responds to paracetamol/sponging
- no Diarrhoea or vomiting
- feeds well
- last Hb - 9.6 gms MCV - 85
Ferritin - (N)
BU = 13·9 S.creat. = 243

054-057-135

AS - ROYAL

DATE	CLINICAL HISTORY, EXAMINATIO

OE – MAD has delayed dentition.

P ① U+E / FBP
② MSSU
③ GT Prophylactic MFT / + NaHCO3
④ to stop oral Fe after 3-4 weeks
⑤ Rev 4/52

Alvind Sahni

25/8/92 **DR. J.M. SAVAGE**
NEPHROLOGY O.P.D. wt 12.48kg

[redacted]

* Wt static
* Keeping well. No problem with low grade pyrexia.
* No further problem with UTI.
* nocte dose Ab. Nitrofurantoin.
  NaBic 7.5 tid.

BP. 80/40.

FBP. SMAC . Vasce Dietetic.

4/52

13/10/92 **DR. J.M. SAVAGE** wt 11.4 Kgs urine + protein + glucose
NEPHROLOGY O.P.D. ht 77.4 cms. Spec to lab. ✓

14 mths. Attended ward on Friday – had +ve urine. Treated c Ciproxin – now much better
SMAC + in good form.
FBF Appetite poor so back on tube feeds. Drugs NaBic 7.5ml tds.
O/E BP – 80 systolic.
Wt 4. chest ✓ CVS

054–057–136

AS - ROYAL

DATE	CLINICAL HISTORY ...ATION AND PROGRESS
	Finish Ciprofloxin - back on Keflex (3 recent break-through infections on ~~keflex~~) Fluconazole)
	Mother to leave in specimen next Monday - clinic Tuesday pm
20/10/92	**DR. J.M. SAVAGE** **NEPHROLOGY O.P.D.** WT 11:22kg URINE Protein + HT 79.5 cms SPEC TO LAB. ✓ >50°C
	Age 14/12. dysplastic kidneys. obst° ureters. several reimplants. Now Y shaped anastomosis of ureters → bladder [redacted]
	GOR - fundoplication 16-92. Urea 21.3 ↑ 04.7 Sept) Hb 8.9 creat 363 ↑ (231 Sept).
	UTI 9/10/92 — Cephroxin. off back on Keflex ~~3/52~~ 5 days more
	Culture 14/10/92 — No growth yesterday → pseudomonas gram. Today BSU — 100 pus cells.
SMA Duocal NAT mineral supplement	NOT feeding at all — usually 900 - 1100 mls daily but needing all by tube now. Wt ↓ O/E Wt Ht >50° Fractious BP — impossible. T 37.2.
	D/W Dr Savage Admit. 054-057-137

AS - ROYAL

DATE	CLINICAL HISTORY, EXAMINATIO
	FBP U/E creatinine (Urgent) bld cultures. BD dnameip. IV CEFTAZIDIME. plot old growth parameter get USS Sept 92 repeated
20/10/92	
14:50.	Adam Strain Age: 14/12 Admitted via outpatients Department. PC: UTI → pseudomonas.
	HPC: · Not feeding well [redacted] vomiting twice Irritible, not himself. Vomiting → small amount after every feed. Not noticed to be projectile at anytime No diarrhoea No abdominal pain noted.
	PMHx: · Born at full term via C-section (baby too large → · Born with dysplastic kidneys. ~~Had~~ UTI Has had multiple UTI's → ureters obstructed o 22/11/91 → reimplantation of ureters. · Post op developed renal failure. · 28/11/91 → re-implantation again Postop → required CAPD. · Now has Y shaped anastamosis of ureters → bladder. · Had Severe gastro-oesophageal reflux → Fundoplication 16/3/92.
	Immunisations: All up to date.

AS - ROYAL

WMC

054-057-138

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS

Developmental milestones -

Talked at 1 yr. → now says many words
no sentences

Begining to try to walk now.

Systems Review:

Genitourinary: As per HP

Cardiorespiratory: No cough / wheeze.

Gastrointestinal: As per hx.

Neuromuscular: No fits / drowsiness
Not hyperactive
No concerns about vision / hearing / gait.

ENT & teeth: No ear discharge
No teeth eruption at the [redacted]

Medical Hx of family

No family history of renal problems.

Social history

Lives with mother & grandparents

Drug history

- Keflex
- NaHCO3 7.5 mls tds (8.4%)

Allergies

None known

Examination:

O/E: Nasogastric in situ.
Bright & alert.
Not tachypnoeic / tachycardia.
BP: Unrecordable
Temp: 37°C.

AS - ROYAL

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS

Genitourinary : Genitalia Normal.

Cardiovascular System : Pulse 120/min.

Apex beat normal position (5ICS(ML)

No thrills/parasternal heaves.

HS I & II heard No added sounds/murmurs

Respiratory System : No cyanosis.

RR : 25/min.

Trachea central.

Normal chest expansion.

Air entry good, regular breath sounds

No crepitations/wheeze heard.

Abdomen : Soft, non-tender

No organomegaly

No [redacted]

Bowel sounds heard -> normal.

CNS : Moving all 4 limbs

Uncooperative with the rest of examination.

Summary :

This is a 14/12 old boy, Adam Straw, who was admitted via OPD with a Pseudomonas UTI. He has been feeding v. poorly & vomiting. ~~He Otherwise abnormal~~ Nil to note on examination. Past history Hg for renal dysplasia (congenital), multiple UTI's, multiple reimplantation of ureter, now has a Y shaped anastamosis of ureters → bladder & ~~fb~~ a fundoplication for gastroesophageal reflux.

Diagnosis : UTI

Michelle Jong / 5th Med Stud.

054-057-140

AS - ROYAL

WNC

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
20.10.92	H + P as above admitted via OPD
	irritable
	1 admitted off food intake. Vomiting after feeds
	+ probable UTI vomiting after feeds
	↳ Pseudomonas
Na 133	BSU 100 pus cells
K 3.9	
Cl 26.2	Plan FBP
TP 66	U+E Creat
Creat 306	BC
	Ceftazidime continued
	IV fluids 300ml / over...
21/10/92	Better form today
	looks better hydrated
	Intake 1243 last pm. output ++ .
	O/E
	BP. 105/70
	Check urine sensitivity
	U+E
	urine - pseudomonal growth
	no sensitivities
	sensitive to Azlocillin
	★ CEFTAZIDIME — on 500mg bd IV
	Pipercillin
	Gentamicin
	Netilmicin + Cipro

054-057-141

AS - ROYAL

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
21/10/92	Venous abg: pH 7.35 Bicarb 20.1 #BE -4.3#
11.10.	pCO_2 35.7
	pO_2 30
	- a 7.5ml sodium bicarb TTD.
	U+E, creat, Ca^{2+}, alk phos, phosphate (Hodge (SHO)
22/10/92	On I/V Ca_2 3rd day
	I/V fluids O/N + N/G Fluids because still vomiting
	Vomiting is self induced to some extent
	Only takes Fluids NO solids
	* Ask psychologist re behaviour programme to stop self induced vomiting + [redacted]
	Psychologist referral made.
	Nat 130
	K+ 3.5
	urea 21.5
	TP 69.
	Ca^{++} 2.23.
	Creatinine 284.
23/10/92	. Repeat U+E + Creatinine
	. physio for developmental assessment
	. Xray femoral heads / wrists
	4 previous courses of aprokin
	. continue IV Ceftazidime 2gm 8/7
10/92.	M. Wolfenden Clinical Psychologist - Spoke with Ms Strain about Psychology becoming involved Will see again on ward on Monday p.m or send out an appt if pt has been discharged. M. Wolfenden.

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
24/10/92	Better
Na 137	1150 fluid + tube feed yesterday
K 3.2	DH IV ceftazidime.
U 15.0	NE Apyrexic
TP 60	BP 105/65.
Cr 262.	
	Cr. Mock
Hb 66*	Home for day tomorrow.
25/10/92.	Intake 1225 yesterday. ~~Apyrexic~~ BP ok. ~~x1~~ small vomit
	~~Do antibiotics~~
	~~Home for day~~
	temp.
26.10.92	SC. dy
	intake ↑ Improving.
	CT2 1/52
	Rpt MSU.
26.10.92	Denver developmental assessment (see front of chart).
	Adam sits well unsupported but makes no attempt to move out of this position. Unable to get from supine → sitting.
	He stands at a low couch for play but makes no attempt to 'cruise'. He is able to take some steps behind push along toy.
	Mum has been advised re exercises to improve mobility in sitting, encourage cruising, weight bearing through legs & arms in plane.
	Review apt in 4 wks

AS - ROYAL

Cathy Boyd
(Senior II Physio)

DATE	CLINICAL HISTORY, EXAMINATION AND PROG...
27/10/92.	~~Rx ceftazidime~~
	off ceftaz x 12 hrs
	Note Hb 6.6.
	Check U/E Creatinine
	Gp Xm — 15 ml/kg packed cells
	c̄ diuretic cover.
	Home am
	[signature] Reg.
28/10/92	Well.
	Had packed cells yesterday
	To leave venflon in ward tomorrow
	Home
	On keflex.
	R/V Tue 10th Nov Dr Savage Renal clinic
	[signature]
10/11/92	**DR. J.M. SAVAGE** Wt 11.3 Kgs. [illegible]
	NEPHROLOGY O.P.D. Ht 79.8 cms. Spec to lab
	urine - Protein +
	Glucose +
	keeping v. well.
	. on Tube feeds ≃ 1L (200mls orally only).
	. No further problem with UTI.
	. on keflex nocte. $NaHCO_3$. 7.5mls tid.
	last 2 samples of urine No growth
& Urine.	O/E v. well. Smiling
. SMAC + Bloodsugar.	Not dehydrated — (4.6/52)
- PBP	054-057-144

AS - ROYAL

WNC

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
24/11/92 am.	attended ward.
	* ↑ temperature * Irritable } sunday. * Cloudy urine. today
	Constipation 2/52.
	Read NMR version. last wednesday
	o/e, Not clinically dehydrated (AF slightly depressed) . looks well. Not cyanosed. . BP:- Temp:-
	on reflux. Lactulose. Smells bad.
	Check urine for bact. C&S. wt. 10.78kg.
	Wt ↓ Tube feed only Always takes 1L 1 day Psychologist Melanie working c refusal to eat
	Still itchs a lot
	Fundal Plication in March.
	Mum still worried same problem O.G.D.
	Urine Culture. showed. : Pseudomonas. ① Input- Urine. ② Ciproxin. 50mg bd 1/52. if urine still abnormal. ③ SMAC. +RSP. WB

DATE | CLINICAL HISTORY, EXAMINATION AND PROGRESS

O/E v. well afebrile. T 36.5 C°

4pm
• Repeated urine sample showed 40 pus cells
and + organism.
No ↑ of Temp. since am. Clinically
improving. Well not change antibiotic
till culture result tomorrow or if clinically deteriorating
to change to ciproxin (available at M.W).

M Banhl

430 Na 129 K. 3.1 urea. 20. ↑
Creatinine 385. T.protein ↑↑ Alb. 41.

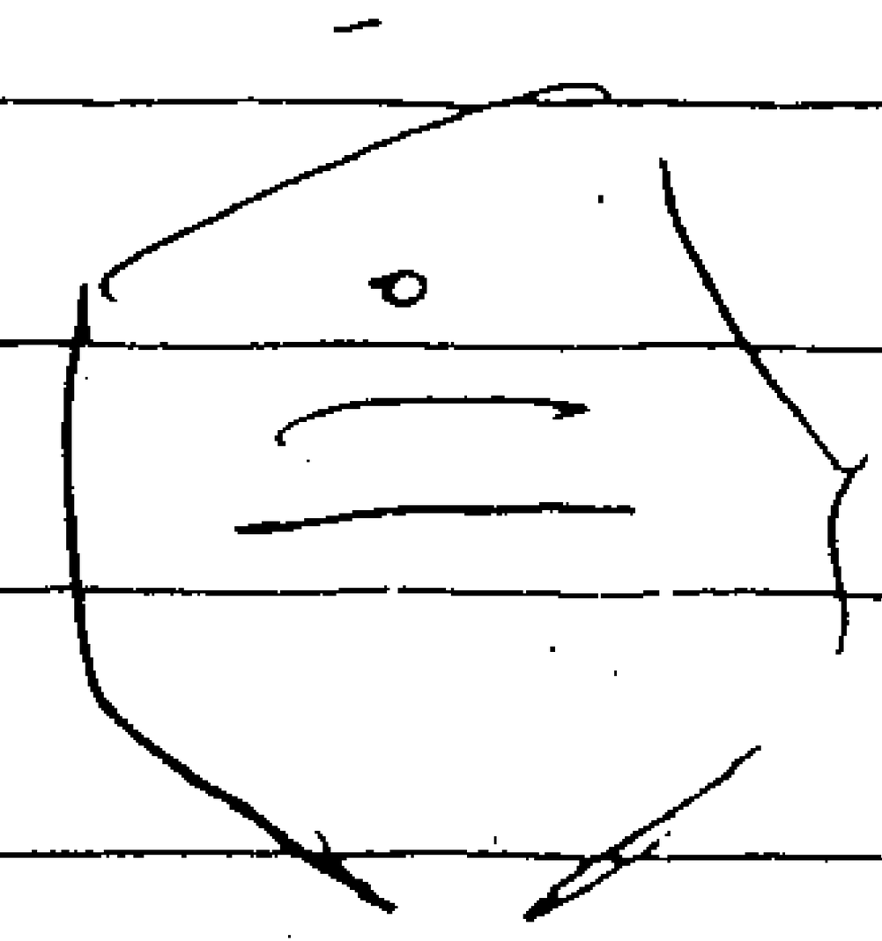
to call mum for admission. [illegible] fluids. [illegible]
IV Ceftazidime. 350 [illegible]

Admitted M Banhl
fluids erected
IV antibiotic.

looks well.
mum says has been losing weight over last
couple of weeks. Psychologist asked him to stop feeding
No vomiting
O/E Well looking
Not clin dehydrated

Chest :- Clear

Abd



AS - ROYAL

Plan IV fluid 2 [illegible]/hr + 1000 load

054-057-146

DATE	CLINICAL HISTORY, EXAM.....ION AND PROGRESS
27/11/92	15/12
	UTI — Pseudomonas (S) CIPZ
	UO pus cells 24/11
	UO pus cells 26/11/92
	On iv fluids + CIPZ
	Admitted on urea + 20 , Creat 363
	Repeat U+E. D/C iv fluids.
	cr Ceftazidime
	Urine from yesterday.
	Pseudomonas.
	Sens CA[redacted]
	∴ ct iv.
	Na 130 ; to have 5 mmol/kg/d
	K 2.5 in 500 ml N/S saline
	U 18.1 @ 20 ml/hr (start 17⁰⁰hr)
	TP 66 ~~if +~~
	Alb 38 Repeat K+ 23⁰⁰ hrs.
	Creat 359
28/11/92 9⁴⁵ am	. afebrile.
	. vomiting ++.
	. looks slightly dehydrated AF ↓ eye slightly sunken
	. RS ✓ CVS ✓ abd ✓ [redacted] CNS ✓.
	plan (1) continue with I.V. fluids if not tolerating orals ↑ I.V to 40 ml/hour. + oral as tolerated. (aiming for 1.5 L.) + KCl if needed. (10 mmol)
	(2) needs repeated U&E creatinine
	(3) Daily urine culture.

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	C/ Continue I.V Antibiotics.
	M. Bowmaker
29.11.92	UTI on CT2 4th day.
	1500mls → 830. voiding poor
	K low. now corrected.
	Check Culture results. ?? CT2 (S)
	LD.
30/11	Urea falling
	Took 1300mls mainly tubes
	Pseudomonas in urine
	[redacted]
	* Review X Rays. * *Review frequency of infection*
	Requested Cr EDTA clearance after 1/52 Rx.
	Arrange Care Discussion c Dr Sweeney / Mr Brown / Dr Sevage.
	HS
	Mr Brown. suggested Friday lunch time.
	CT2 6/7.
1.12.92	1200 ml intake
	OGD today Consent req'd.
1.12.92	Roberta Speech Therapy: contacted re Roberta Melanie ... contacted
	(SHO)
	Weight = 11.03 kgs.
	054-057-148

AS - ROYAL

DATE	CLINICAL HISTOF ... AND PROGRESS	Gallagher, Debra
1.12.92 ✓	Upper Endoscopy Ulceration of Lower oesophagus + fundus. Wrap 3/4 intact Histology: ~~[redacted]~~ antrum oesophagus. back	Gastric aspect. ulcer free.
	Impression Oesophageal ulceration despite fundoplication ? NG tube induced	
	Advise: Silastic ng tube Cisapride 0.2mg tds Ranitidine 3mg tds	
	Await histology	D Gallagher
2.12.92	No change c ≈ 1.2 - 1.5L intake anti secretory Rx Friday Review - Medicine	MR Brown Dr Swaney Remind Dr Savage please
2-12-92	spoken to Debbie about recent increase in vomiting + will await results of current investigations before restarting any programme for trying to decrease the vomiting [redacted]	
3/12/92 ✓	U+E, Ca albumin EDTA CTPR in progress Good night's sleep feeds - more regular, smaller volume tube feeds.	054-057-149 AS - ROYAL DKen

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	mum feels looks paller than usual
	to check urine — K+ 3.2 Na 138
	Blood U&E creatinine — U 12.1 creat 280
	FBP? Iron levels.
	on Keflex. — M. Bartlett
	Cisapride.
	NaHCO3.
	Ranitidine
19.12.92 2.30p.	Attended ward
	Mum concerned re puffiness & vomiting.
	woke this am side of face puffy
	vomited feed. o/e Apyrexial doesn't appear puffy.
	check U&E U 8.3
	K 3.3 Na 134 Cl 97 } improvement.
	Creat 269
	Await Direct.
	M Hamm
6/1/93	DR. J.M. SAVAGE
	NEPHROLOGY O.P.D. — wt 12.3 kgs
	Ht 81.5 cms
	On Ciproxin — pseudomonas — Urine +++ Glucose
	in MSU — cloudy — Skin to lab.
	+ [illegible] fun.
	Cont for 1/52
	Return to Keflex.
	054-057-150

AS - ROYAL

CH 36477 Vol 6 Page: ??

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
4/12/92	GFR 7.2 mls/min ~~[illegible]~~
	well.
	afebrile.
	Home today well review as planned before.
	M. Banh[illegible]
4/12/92	XRay + Case Discussion
	15 UTI's in the past year
	Most recently recurrent pseudomonas
	Review of ante pyelograms (Dr Thomas) suggest evidence of ~~[illegible]~~ drainage at V/U junctn to bladder is poor
	Surgical in view of infections
	? Reimplant
	? Ureterostomy
	Mother requests Mr Boston's opinion. [signature]
	Mr Brown suggests retrograde first.
15/12/92	DR. J.M. SAVAGE NEPHROLOGY O.P.D. — WT 11.6 Kgs Urine trace protein ++ glucose HT 80.1 cms. Spec to lab
	Keeping well
	Vomiting occasionally and only once daily
	Still [illegible] 1300 Daily
	No Spec [illegible]

AS - ROYAL

054-057-151