PEDIATRICS COHORT,GRAND ROUND PRESENTATION ON 9TH NOVEMBER 2022 GROUP C / 3

BIO DATA

NAME:C.M

AGE:12MONTHS 2Days

GENDER: MALE

TRIBE: MERU

RELIGION: CHRISTIAN

RESIDENCE: NKUBU

NAME OF CHIEF: MOKINA

NEAREST PRIMARY SCHOOL: MIKUMBURI PRIMARY SCHOOL

BIRTH WEIGHT: 2.8KG

CURRENT BIRTH WEIGHT:10 KG

EXPECTED WEIGHT: 10KG

DATE OF ADMISSION:30/10/2022

DATE OF HISTORY TAKING:5/11/2022

DUARATION OF STAY: 6DAYS

WARD: ONE

CUBE: 5

INFORMANT;MOTHER

CHIEF COMPLAIN

1. Hotness of body 4/7
2 Cough 1/52

HISTORY OF PRESENTING ILLNESS

The mother reports that 1 week prior admission the patient presented with a cough that had reoccurred after she had sought medical treatment in the previous days. She further states that, cough had begun 2 months ago where she took the baby to a clinic and drugs unknown to her were issued. On administering the drugs for 5 days cough subsided but occurred again after 3 weeks. She took the patient to a different clinic where similar drugs to the ones issued in the first clinic were issued to the patient. On completion of the drugs cough subsided for some weeks. The patient was well for some time but 7 days prior admission the baby had again developed cough which was gradual on onset, that

occurred mostly at night , which was productive, creamlike in color, aggravated by feeding ,associated with drenching night sweats , relieved by drinking warm water.

Three days later after the onset of cough the patient developed hotness of the body which was low grade , gradual on onset , on and off in nature ,mostly occurred during the night ,associated with poor feeding and was relieved by paracetamol syrup .

The baby was later referred to MeTRH where blood samples were taken, sputum and chest x-ray was done.

There is history of production of musical sound, history of difficulty in breathing, history of fast breathing, history of poor weight gain, no history of blood in sputum, no history of running nose , no history of sneezing.

There is no known history of TB contact. There is no history of travel to malaria endemic area.

REVIEW OF SYSTEM

CARDIOVASCULAR SYSTEM

No history of easy fatiguability

No history of difficulty in breathing when lying flat

GASTROINTESTINAL SYSTEM

No history of passing loose stool

No history of blood in stool

No history of difficulty in swallowing

GENITOURINARY SYSTEM

No history of change in urine color

No history of change in urine frequency

No history of pain while urinating

EAR, NOSE AND THROAT

No history of discharge from ears and nose

No history of nose bleeding

No history of hearing loss

ENDOCRINE SYSTEM

No history of dry skin

No history of neck swelling

RESPIRATORY SYSTEM

History of cough

History of fast breathing

History of gasping for breath

PAST MEDICAL AND SURGICAL HITROY

This is an index admission

PRENATAL HISTORY

The pregnancy was planned and she had a positive attitude towards the pregnancy .There was no history of illness during pregnancy. She attended four ANC visits. Tetanus toxoid was given 2days 1month apart and ANC profile was done.

She is of blood group A+

VDRL-ve

HB 14g/dl

Nutritional status was good, she was given ferrous sulphate.

There was no vaginal bleeding.

No other drug was given.

NATAL HISTORY

Delivery was at term through spontaneous vaginal delivery. Delivery was at Kanyakine hospital. Labor was 7 hours.

Birthweight was 2800 grams.

The baby cried immediately after delivery and was breastfed within 30 minutes after delivery.

The baby was pink in color.

POST NATAL HISTORY

No complication after delivery.

FEEDING HISTORY/ NUTRITION HISTORY

The baby was on exclusive breastfeeding for 6 months

DIVISION OF VACCINE IMMUNIZATION [DVI]

BCG scar present.

All immunizations were given as per DVI schedule

DEVELOPMENTAL MILESTONE

Social smile at 2 months [Normal 2 months]

Neck support 3 months [N 3-4]

Sitting with support 6 months [N 6-8]

Standing with support 9 months[N 9-10]

Fine motor

Palmar grasp 4 months [N 4]

Pincer grasp 10 months [N10]

Speech

Coos 2 months

Laugh and squeal 5 months

Babble mama and baba 7 months

At 11 months could say 20 -30 words 50% which could be understood by a stranger .

Ambulation

Crawling 9 months

PERSONAL SOCIAL AND ECONOMIC HISTORY

The child lives with her mother and father. The mother is a fruit vendor and father a shoe shinner. They live in a semi-permanent house that is well ventilated with two windows and one doors. They use tap water for domestic use.

There is no history of drug abuse and alcohol abuse. The mother is a class 2 dropout and the father a class 4 school drop out.

FAMILIAL HISTORY

The patient is the only child in the family. There is no history of any chronic illness in the family e.g. TB, asthma, diabetes and hypertension

SUMMARY

This is the history of CM 1yr 2days old ,male on day 6 post admission at MTRH who presented with cough for 1 week and hotness of the body for 4 days .A chest Xray was done ,blood samples were taken and sputum was also taken for further investigations.

GENERAL EXAMINATION

The patient is in fair general condition on his mother's laps lying supine with even hair distribution on the scalp and in good nutrional status

No Lymphadenopathy

No jaundice.

No finger clubbing.

No cyanosis.

No edema.

No dehydration.

No pallor.

VITAL SIGHS

PARAMETERS	DATE OF HISTORY TAKING	NORMAL RANGES
PULSE RATE	90	80-130
RESPIRATORY RATE	30	25-35 b/min
TEMPERATUR	37.0	36.5-37.5
OXYGEN SATURATION	96	95-100

ARTHROPOMETRIC MEASUREMENTS

Weight 10kg

Head circumference 45cm

Height 75cm

MUAC 23cm

SYSTEMIC EXAMINATION

RESPIRATOY SYSTEM

INSPECTION

Both nipples present and no discharge.

No use of accessory muscles of respiration.

No cosmetic and therapeutic scars.

No flaring of alae.

PALPATION

Trachea is centrally placed.

Chest expansion symmetrical.

No areas of tenderness.

No palpable masses

AUSCALTATION

Wheeze present

Normal vesicular breath sounds heard.

No crepitation

CARDIOVASCULAR SYSTEM

INSPECTION

No hyperactivity of the precordium

No visible pulsation on the neck

No Osler's nodes on fingers

No splinter hemorrhage

No surgical scars

PAPLPATION

Apex beat on the 4^{TH} intercostal space mid clavicular line

No heaves

No thrills

No palpable masses

AUSCULTATION

S1 and S2 heard

No murmurs

PER ABDOMEN

INSPECTION

Symmetrical abdomen that moves with respiration

Umbilicus is inverted and centrally located

No distended abdomen

PALPATION

No superficial mass

No organomegaly

No increased local temperature

CENTRAL NERVOUS SYSTEM

INSPECTION

Neck is soft

AVPU-[A]-could follow objects rotate in his field of view bilateral pupil reaction to light

REFLEXES

Motor reflex present

Hand grasp

Sucking reflex

Planter reflex

Rooting reflex

IMPRESSION

Tuberculosis

MANAGEMENT

INVESTIGATIONS

Lab work

Full haemogram

Sputum for gene x-pert

Mantoux test

P24 test

imaging work

Chest x-ray

SUPPORTIVE MANAGEMENT

1. admit the child in paediatrics ward
2. Monitor the vitals

SPECIFIC MANANGEMENT

2months RHZE 4 months RH

1. Intensive phase:

Rifampicin 50mg

Isoniazid 50 mg

Ethambutol 100mg

Pyrazinamide ½ tablet

2. Continuation phase

Rifampicin ¾ tablet

Isoniazid 3/4 tablet

Ethambutol 75mg

Pyrazinamide ½ tablet