Ministry of Health
Emergency Medical Services ECHO
Case Presentation Form

Date: 22th April 2022

Presenter's name: Dr. Shanita Ankunda

Presenter's location: Nsambya Hospital

Patient Initials: NMM **D.O.A:** 31/12/2021 **D.O.A: 06/02/2021**

Age: 32 years

Sex: Female

Diagnosis:

30yrs old female with moderate head injury secondary to assault

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Presenting complaint
Convulsions x 4hrs

History of presenting complaint- Duration and Progress

- A 32year old P2+0, a referral from Hospital A, came on her 4th POD post EmC/S whose indication???
- Had had an EmC/S at 33WOA in a peripheral facility around the NSH, delivered an IUFD, had PPH and was referred to Rubaga for management of PPH
- While at Hospital A, an exploratory laparatomy was done-hematoma and 4L of blood drained and an abdominal drain left in situ
- Was transfused with 4 units of blood products(WB, FFPs, PRBCs). Noted progressive oliguria, rising RFTs and O_2 dependency and patient was referred our facility for hemodialysis.

Laboratory Investigations from the Referral Site

	27/12	29/12	30/12	31/12
WBC			**7.7**	
Neut			**6.06**	
Lymp			**1.22**	
Hb			**6**	
Cr	**2**		**5.5**	**6.4**
Urea	**52**		**74**	**113**
Na	**149**		**146**	**144**
K	**4.3**		**3.5**	**4.6**

On Examination

The patient was unwell, in respiratory distress, brought in on a mobile vent on CPAP mask, had an NGT that had drained 250ml of bilious content and a urethral catheter in situ that had drained 200ml of clear yellow urine over 3hrs

BP-130/70mmHg,PR-106bpm,SPO2-96% on CPAP

R/S: She had productive cough, bilateral rhonchi and fine basal crepitations bilaterally

P/A: Dressing was clean and dry, abdominal drain in situ that empty

Impression: P2+0 with-Pulmonary edema

-AKI

-Resolving DIC and PPH

Plan

1. Do urgent hemodialysis
2. Do post HD labs-Liver enzymes, LFTs, RFTs, Serum electrolytes and extended electrolytes, CBC, CRP, Blood grouping, HepBAg, HepC and HIV serology
3. O2 therapy at 6l/min by NRM
4. IV Ceftriaxone 2g od x 5/7
5. IV metronidazole 500mg 12hrly x 5/7
6. Fluid therapy (IV half-strength Darrows 500ml 12hrly i.e 1000ml/24hrs,IV Dextrose 25% 20ml 4hrly)
7. IV paracetamol 1g 8hrly
8. SC enoxaparin 40mg od x 3/7
9. IV omeprazole 40mg od x 3/7
10. IV hydrocortisone 100mg stat
11. Nebulise with Pulmicort(Budesonide) 0.5mg 12hrly x 2/7
12. Nebulise with combivent 0.5/2.5mg 3hrly x 3 doses then reassess
13. Assess NG feeds absorption accordingly
14. IV frusemide 20mg 4hrly x 4doses then reassess

	2nd DOA	3rd DOA	4th DOA	5th DOA	8th DOA	10th DOA
Concerns	Respiratory acidosis, Pulmonary edema, HIV-positive, sepsis, AKI		Anaemia, respiratory failure, fevers	Serum ToxoIgG &IgM-reactive, CRAG-neg	No growth on blood & aspirate culture, Urine; E.faecalis: ampicillin, vancomycin, linezolid & nitrofurantoin ,Uremic ,Metabolic acidosis	Anasaca, abdominal distension and bleeding from the incision site-DIC, hypoxemia
WBC	9.8		18.3		17.1	
Neu	2.87		17.1		17.5	
Hb	7.4		6.8		6.4	
PLT	174		263		533	
Cr	4.17		4.51		4.66	
Urea	94.3		122.3		159.7	
Urine output	450ml	500 ml	900ml	1700ml	1500ml	1800ml
Na/K/Cl	144/4.3		140/4.19		139/4.51	
Albumin	29					
CRP	30.86					

Plan	- Dialysis - Blood culture -CD4 count -191	- Urine and aspirate culture cotrimoxazole 960 mg od	HD, Meropenem, Blood transfusion	Septrin increased to 1920mg	HD Linezolid,fluconazole,NaHCO3	Tracheostomy, HD Relap scheduled

	12th DOA	13th DOA	15th DOA
Concerns		GCS-15/15,still on vent,High BPs,fever,mild dehydration	Afebrile-36.8 High BPs,SPO2-97% on T-piece at 2l
WBC	14.5	21.8	
Neu	14.3	14.63	
Hb	6.6	9.8	
PLT	786	725	
Cr	2.64	2.39	1.46
Urea	89.2	76.3	89.2
Urine output	1600ml	1500ml	3700ml
Na/K/Cl	146/3.88	151/4.06	

CRP			
Plan	**Relap was done, blood transfusion, antibiotics continued**	**Tepid sponging,amlodipine,moifloxacin,lasix**	**Discharged from dialysis and HD catheter removed Also d/c from ICU to HDU**

Follow-up on Ward

- While in HDU patient developed mild hypokalaemia of 3.13, Lasix was held, given IV ringers lactate 500ml 8hrly x 1/7
- Several episodes of exercabations of asthma that were managed with nebulization with salbutamol and budesonide(Pulmicort)
- Developed 2 episodes of GTC convulsions, no fever- Brain CT done was normal, controlled on phenytoin
- Patients urine output normal(100- 140ml/hr)
- Patient spent 3/52 on ward, improved on antibiotics and was d/c on the 37th DOA on antibiotics
- Patient was readmitted with retained necrotic tissue Pv,Pus d/c PV and fever,the necrotic tissue was expelled and patient discharged on oral antibiotics.

End