A CHILD PRESENTING WITH FEVER

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Case Presentation

MA, a 4½ y/o female, referred from a peripheral facility with a 4 day history of fevers accompanied by vomiting, loss of appetite, associated with convulsions and eventual loss of consciousness.

These were preceded by dry cough for 1 day. At the time of admission, despite not being able to feed for 2 days, child had no feeding tube and urine clear much as tea colored urine had been reported earlier.

Emergency assessment and management

Airway and C-spine	Unable to support Neck No history of trauma	Lateral recumbent position
Breathing	Saturating 86% RA. Bilateral equal chest rise, reduced air entry in the right lung base with crackles in the right upper lobes.	Oxygen by nasal prongs flow 2L/min and SpO_2 improved to 97%
Circulation	Tachycardia at 134, full volume regular pulse, Capillary refill< 2 s, warm extremities BP not taken(No paed cuff) Moderate pallor	Blood grouping and cross-match IV maintenance fluids according to body weight.
Disability	GCS –E-2 V-2 M-4 Total 8/15 PEARL Reflexes-Normal	Lateral recumbent position
Exposure	No injuries to any part of the body	

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S	Signs and symptoms	**Fevers-Started as mild and intermittent then became severe and constant. Convulsions-Multiple episodes, GTC with frothing , stool and urine incontinence. Reduced level of consciousness Reduced urine Output- Tea colored(had cleared at the time of admission) , no facial puffiness Vomiting-1 episode, non-bilious, non-projectile. Reduced appetite Dry cough**
A	Allergies	No known food or drug allergies
M	Medications	Referring facility had given IV Artesunate , Ceftriaxone and Oral Carbamazepine ,Paracetamol
P	Past Medical History	Index admission for such symptoms
L	Last meal	2 days prior to admission(last normal meal), family members were giving fluid sips when unconscious.
E	Events	No traumatic events, no aura

Problem list

- Fever
- Convulsions
- Failure to feed
- Reduced urine output
- Aspiration pneumonia

Investigations

- RBS-10.4mmol/L
- mRDT-Positive, B/S Positive
- CBC-Hb-5.6g/L(9.5-14.1), Repeat Hb estimation was 7.6

  -Plt-82(150-450)

  -WBC within normal limits.
- Blood grouping-B^{+}

Treatment and follow up

Definitive management

- IV artesunate 33mg at 0,12 and 24 hours(two doses , stopped when B/S turned negative , then was started on Coartem 1 tablet b d for 3 days.

Supportive management

- Rectal paracetamol 125mg 8 hourly plus tepid sponging
- IV metronidazole 250 mg t.d.s plus IV gentamicin 55mg for aspiration pneumonia
- For the convulsions, 2 doses of diazepam were not responded to, thus IV phenobarbitone 165mg loading dose then maintained at 55mg till the seizures resolved.
- 1L of Ringers lactate every day every 24 hours till able to feed by mouth.
- IV D10 55mls prior to RBS measurement and later, NGT for feeding inserted
- Oxygen by nasal prongs flow 2L/min
- Catheter was to be inserted to monitor urine output, right size was not accessed

Follow up

- 25th-26th /08-Responding to only pain, Still febrile , feeding by NGT
- 27th –Responding to voice .
- 28th –Fever Subsided, B/S turned negative saturating at 97% off oxygen, weaned off oxygen, started on Haemofort syrup and folic acid
- 29th – Stable , afebrile , still moderately pale, GCS 15/15, able to feed, crackles were barely heard in the lungs , air entry had improved in the right lung bases
- 30th –Able to play normally , chest was clear
- 31st –Discharged home to finish coartem from home, and continued Folic acid and Haemofort, was stable, Afebrile,pulse-115, T-36.3, SpO_2 98% off oxygen.