Seed GLOBAL HEALTH

Project ECHO

ECHO SESSION CASE PRESENTATION

By Dr. Lawrence Ssegawa

Case Presentation

PC -Chest pain 2/7

Difficulty in breathing 1/7,

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HPC - K.T 16-year-old Female known Sickle Cell patient. She came in with 2days history of generalized body pain aching in nature with long bone pains, no joint swelling, Had chest pain piercing in nature radiating to the back associated with DIB with difficulty in breathing however no history of cough, also reported on and off fevers

Primary Survey (Emergency Assessment and Management)

A	Airway	Patent and well protected	
B	Breathing	In severe Respiratory Distress R/R of 36 cycles per min. Equal air entry Basal crepitations	O2 2L/m via N.P
C	Circulation	Tachycardia with Heart rate of 106beats per minute Normal Volume pulse, strong & regular. HS 1&2	I.V Fluids maintenance 200ml 8hrly

Primary Survey (Emergency Assessment and Management)

D	**Disability**	**AVPU = A** **RBS Not done**	
E	Exposure	Temperature 38oC Normal skin appearance	

Secondary Survey (Head-to-toe examination)

G/E - : she was in a pain, sick looking tachypnoic, small for age, febrile to touch T=38.0oc, Mod pallor, mod jaundice, no lymphadenopathy, not dehydrated, no digital clubbing, no edema. Tanner 1

Anthropometry: MUAC 13cm, HC 50cm, Ht. 110cm, 24kg BMI 19.8 (16.8 to 24.7)

CVS -: warm peripheries, Tachycardia PR 106bpm, normal HS I and II

R/S - In Respiratory distress, RR-36bpm, SPO2-85-88% on room air bilateral air entry, vesicular breaths, basal crepitation

Secondary Survey (Head-to-toe examination)

P/A - : Normal fullness, soft, non-tender, no appreciable organomegaly

ENT – Normal Findings

CNS - She was alert with a Glasgow -comma scale of 15/15, a soft neck, normal tone and reflexes. There were no focal neurological deficits.

MSK - Marked frontal and bi-parietal bossing, with long bone tenderness, No Joint swelling

SAMPLE History

S	Sign & Symptom	Generalized Body Pains 2/7 On & Off Fevers 2/7 Chest Pain 2/7 Difficulty in Breathing 1/	
A	Allergies	No Known Allergies	
M	Medication	Daily Hydroxyurea, Folic acid Monthly Fansidar	

SAMPLE History

P	**Past Medical History** **Past Surgical History** **FSH**	**Known Sickle Cell Disease patient. Has had multiple admissions especially before the initiation of Hydroxyurea** **Has had multiple blood transfusions** **1st Born of 5 siblings all other sibling screened and well**	
L	Last meal/LNMP	No Menercha yet	
E	Events	NO Events	

Problem List

Hypoxia

VOC

Acute Chest Syndrome

Investigations

B/S for Mps – No Malaria Parasites seen

CBC Hb 6.4, MCV 69.5, PLT 100, WBC 40.12, ANC 37.5, LYMP 7.03

Blood group O Rhesus D positive

Liver Function Test ::BILT 469, BILD 327, SGOT 51, GGT 31

Renal Function Test :Creatinine 46, Urea 3.8, K 3.20, Na 132

Chest X-ray- Showing Lungs Infiltrates

Post Transfusion CBC: Hb 8.6, PLT 234 , WBC 38.3,ANC 36.7 RBC 2.5, LYMP 7.03

Bed No.:

Mode: AL-WB-CD

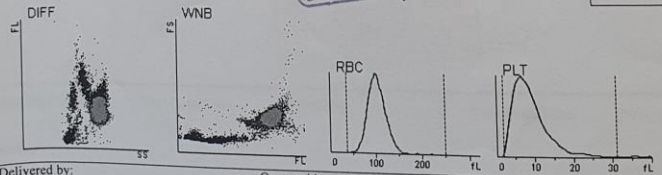
Date of Analysis:27/10/2024 11:00

Para.		Result	Unit	Ref. Ranges	Flag
1 WBC	H	38.35	10^9/L	4.00 - 10.00	Immature Gran?
2 Neu#	H	36.70	10^9/L	2.00 - 7.00	Lymphopenia
3 Lym#	L	0.58	10^9/L	0.80 - 4.00	Neutrophilia
4 Mon#		1.07	10^9/L	0.12 - 1.20	Leucocytosis
5 Eos#	L	0.00	10^9/L	0.02 - 0.50	Anisocytosis
6 Bas#		0.00	10^9/L	0.00 - 0.10	Anemia
7 IMG#		1.00	10^9/L	0.00 - 999.99	
8 Neu%	H	95.7	%	50.0 - 70.0	
9 Lym%	L	1.5	%	20.0 - 40.0	
1 Mon%	L	2.8	%	3.0 - 12.0	
1 Eos%	L	0.0	%	0.5 - 5.0	
1 Bas%		0.0	%	0.0 - 1.0	
1 IMG%		2.6	%	0.0 - 100.0	
1 RBC	L	2.70	10^12/L	3.50 - 5.00	
1 HGB	L	8.6	g/dL	11.0 - 15.0	
1 HCT	L	26.2	%	37.0 - 47.0	
1 MCV		96.9	fL	80.0 - 100.0	
1 MCH		32.0	pg	27.0 - 34.0	
1 MCHC		32.8	g/dL	32.0 - 36.0	
2 RDW-CV	H	19.1	%	11.0 - 16.0	
2 RDW-SD	H	69.2	fL	35.0 - 56.0	
2 PLT		234	10^9/L	100 - 300	
2 MPV		9.0	fL	6.5 - 12.0	
2 PDW		15.6		15.0 - 17.0	
2 PCT		0.209	%	0.108 - 0.282	
2 P-LCC		40	10^9/L	30 - 90	
2 P-LCR		17.3	%	11.0 - 45.0	
2 PLT-I		234	10^9/L	100 - 300	
2 NRBC#		0.019	10^9/L	0.000 - 9999.999	
3 NRBC%		0.05	/100WBC	0.00 - 9999.99	

BIS: No urgs Seen.

MRSI: Negative

RESULT REVIEWED
Sign:
Date: 27/10/2024



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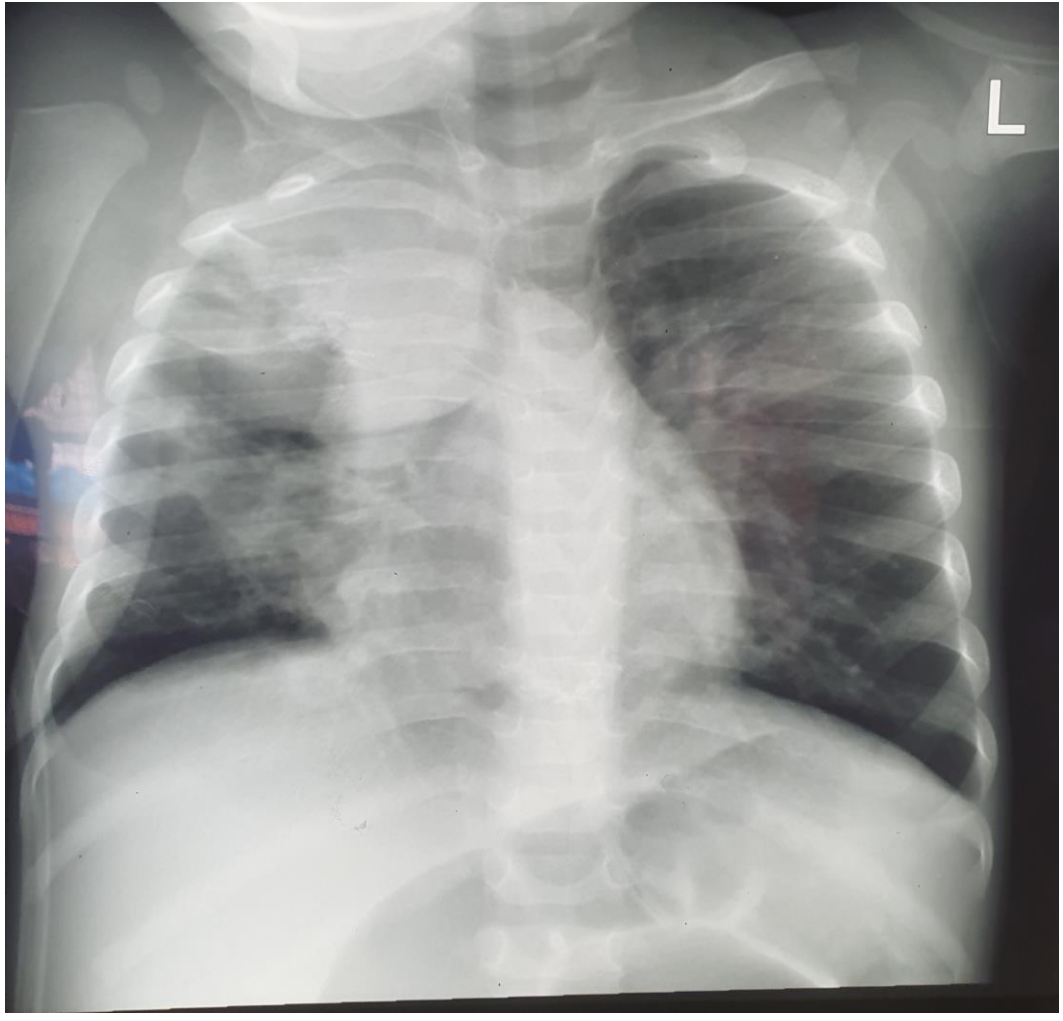
2C bed 8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Management

1. Admit
2. ABCD
3. Put on 2L oxygen Via progs
4. Transfusion Red Cell Concentrate 240ml

1. I.V Azithromycin 500mg O.D for 5days
2. I.V Ceftriaxone 2g o.d for 5days
3. I.V Paracetamol 1g 6hrly alternating with
4. Po Ibuprofen 400mg 6hrly
5. Po Morphine 10ml 4hrly

Follow-up

- Folic acid 5mg once a day for 2weeks
- Fansidar for malaria prevention monthly
- Hydroxyurea 500mg once daily for 2weeks
- To be reviewed after one week in the sickle cell clinic.

Disposition Plan

- Screen children for Asthma, COPD by Pulmonologist at Lung institute
- Do chest Physiotherapy by blowing ballons
- Counsel on adherence to medication
- Counsel about pubertal delays

Take Home

- Ensure adequate hydration (preferably PO)
- A non complicated painful crisis does not require a blood transfusion
- A painful crisis without fever does not require antibiotics.
- Treatment can be continued as an outpatient
- Adherence to routine medication is very key in management of sickle cell anemia

Thank you