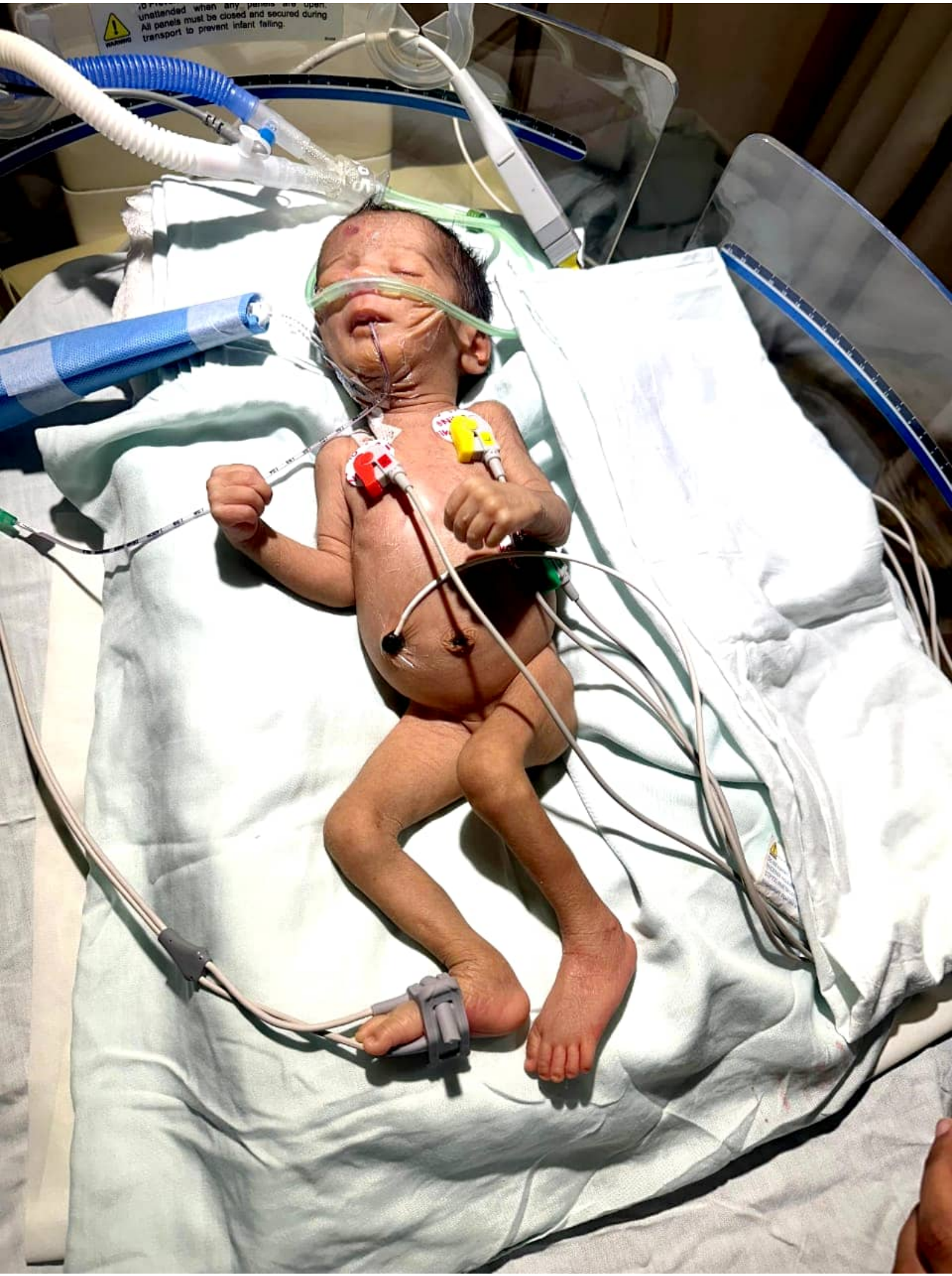

HOLY FAMILY HOSPITAL
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CASE SUMMARY

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LONS WITH PNEUMONIA WITH MENINGITIS WITH RESPIRATORY FAILURE- CSF AND BLOOD CULTURE PROVEN *Elizabethkingia meningoseptica*
CONJUGATED HYPERBILIRUBINEMIA
COAGULOPATHY
SEVERE THROMBOCYTOPENIA
OUTBORN/ TERM/ 37+3 WEEKS/ SGA/ TTNB

CLINICAL HISTORY:
Baby was discharged from Safdarjung hospital one day prior. At home the parents noticed the child to have sudden onset dullness and lethargy with reduced feeding. Child also developed difficulty in breathing in the form of fast breathing and retractions. Child was brought to HFH and admitted for further evaluation and management.

BIRTH HISTORY:
Term/ 37+3 weeks/ IUGR/ SGA/ CIAB/ LBW BW 1.58 kg/ Safdarjung hospital
Born to a 29 year old, G3P2L2 mother with severe preeclampsia with PROM with Severe oligohydramnios
Immunization Apt date according to NIS.

PHYSICAL EXAMINATION

GC -Sick
Sclerema+
Temp - 36.3°C
RR - 90/min
HR - 192/min
SPO2 - 82% on Room Air
Euhydrated
Peripheral pulses - Well palpable

P-/ I+++/ Cy- / Cl - /L- /E-

S/E :
CVS - S1S2+, no murmur
CNS- tone normal, reflexes reduced, poor suck, shrill cry, irritable, AF full
Respi- B/L AE (+), tachypnea + SCR+ ICR+
P/A - Soft, non tender, BS (+), no HSM

HOSPITAL COURSE
Child was admitted with above mentioned complaints. All relevant investigations were done.

Child was managed with IVF, IV meropenem, IV Amikacin, IV fluconazole, Vitamin K and other supportive treatments. NG tube was inserted and child was kept NPO.
Child was put on MV SIMV mode FiO2 21%, PEEP 6, RR 45

Meningitis:

LP done, CSF s/o bacterial meningitis. CSF culture showed growth of ***Elizabethkingia meningoseptica.***

Blood culture: ***Elizabethkingia meningoseptica.*** Antibiotics were changed to **IV Vancomycin and IV Ciprofloxacin.**

Child had abnormal posture in the form of increased tone and flexion of upper limbs. Loading with phenobarbitone was done. Paediatric neurology consult done, advised to continue antibiotics and phenobarbitone in maintenance dose and plan for neuroimaging (CECT/ CEMRI). Neuroimaging deferred until child stabilizes.

USG cranium done showed Presence of ventricular strands - may suggest ventriculitis with Indistinct grey-white matter differentiation- may be suggestive of normal vault or may suggest diffuse cerebral edema.

Abdominal distention:

On DOH 3 the child developed abdominal distention. X ray abdomen done showed Multiple mildly prominent gas filled bowel loops noted throughout abdomen. On clinical improvement in abdominal distention and sepsis, NG feeds were started (2 ml 2nd hourly) on DOH 6.

B/L Pneumonia:

CXR done showed Patchy reticulonodular opacities in bilateral lung fields (R>L)

Conjugated hyperbilirubinemia:

LFT showed T bil/ D bil - 21.2/13.6. USG WA done showed Distended with echogenic sludge and mucosal wall edema. Phototherapy was given. Serial monitoring showed SBR 24---21.4---20.7 mg/dl. Phototherapy was discontinued. Serial monitoring showed improving trend. Currently T bil 11.15, D bil 5.92.

Coagulopathy/ Thrombocytopenia:

Child had thrombocytopenia (Plt 11K), INR 1.9, PT 23, APTT 49. Child had one episode of ET bleed during intubation. IV vitamin K was given. Child received 3 FFP and 3 RDP transfusions. No further bleeding episodes. Serial monitoring of coagulation profile showed improvement.

Child is currently on NIV support FiO2 21% PEEP 6 RR 35

Hemodynamically stable.

On IVF, Aminoven, NG feeds 20 ml 2nd hourly, IV Vancomycin, IV Ciprofloxacin, IV phenobarbitone , IV Meropenem.

Dr Yogesh Parashar

Senior Consultant Pediatrics

Holy Family Hospital.

Patient Name	: B/O. KUMARI PINKI	**Sample No.**	: 1497032
MR No / IP No	: 2474364 26015110	**Collected On**	: 30/06/2026 12.19 AM
Age/Sex	: 21 Days / Female	**Reported On**	: 30/06/2026 1.25 AM
Ref. Doctor	: Dr.YOGESH PARASHAR	**Approved On**	30/06/2026 9.57 AM
Patient Type	: IP	**Bill No**	: 262189522
Bed No	: IPCU / 304 / 007	**Specimen**	: URINE

Test Name	Result	Units	Bio.Ref.Interval
URINE ROUTINE EXAMINATION			
PHYSICAL EXAMINATION			
COLOUR	PALE STRAW		
APPEARANCE	CLEAR		
SPECIFIC GRAVITY(PKa change of poly electrolytes)	1.025		1.005 - 1.030
pH(Double indicator)	7.5		5.0 - 8.5
CHEMICAL EXAMINATION			
PROTEIN(Tetrabromo phenol blue/ SSA)	TRACE		
GLUCOSE(Double Sequential enzyme reaction/ Benedicts)	NEGATIVE		
KETONE(Nitroprusside)	NEGATIVE		
BILIRUBIN(Diazotized dichloroaniline/ Fouchet Reac.)	POSITIVE		
MICROSCOPIC EXAMINATION			
RBCs	NIL	/Hpf	0 -2
PUS CELLS	OCCASIONAL	/Hpf	0-5
EPITHELIAL CELLS	PRESENT		
CAST	GRANULAR CAST (OCCASIONAL)		
MUCUS	PRESENT		
BACTERIA	PRESENT		
CRYSTALS	NIL		
PARASITE	NIL		

***** END OF THE REPORT *****

Dr. KIRTI PANWAR
MD, PATHOLOGY
CONSULTANT PATHOLOGIST

This is a computer generated report and validated electronically.

Patient Name	: B/O. KUMARI PINKI		**Sample No.**	: 1493782	
MR No / IP No	: 2474364	26015110	**Collected On**	: 25/06/2026	11.21 AM
Age/Sex	: 17 Days / Female		**Reported On**	: 25/06/2026	12.45 PM
Ref. Doctor	: Dr.YOGESH PARASHAR		**Approved On**	25/06/2026	1.37 PM
Patient Type	: IP		**Bill No**	: 262185162	
Bed No	: IPCU / 304 / 007		**Specimen**	: BLOOD	

Test Name	Result	Units	Bio.Ref.Interval
ELECTROLYTES			
ELECTROLYTES_SERUM			
SODIUM , Serum/Plasma(ISE INDIRECT)	141	mEq/L	136 - 145
POTASSIUM , Serum(ISE INDIRECT)	4.96	mEq/L	3.5 - 5.1
CHLORIDE, Serum/Plasma(ISE INDIRECT)	108.5 *	mEq/L	98 - 107
BICARBONATE, Serum/ Plasma(ENZYMATIC, PEPC, MD)	25.6	mEq/L	23 - 29

******* END OF THE REPORT *******

Dr. NAVNEETA MISHRA

MD, BIOCHEMISTRY

CONSULTANT BIOCHEMIST

This is a computer generated report and validated electronically.

Provisional Report

Patient Name	: B/O. KUMARI PINKI		**Sample No.**	: 1497018	
MR No / IP No	: 2474364	26015110	**Collected On**	: 30/06/2026	12.06 AM
Age/Sex	: 21 Days / Female		**Reported On**	: 30/06/2026	1.23 AM
Ref. Doctor	: Dr.YOGESH PARASHAR		**Approved On**	:	
Patient Type	: IP		**Bill No**	: 262189534	
Bed No	: IPCU / 304 / 007		**Specimen**	: BLOOD	

Test Name	Result	Units	Bio.Ref.Interval
CRP			
C Reactive Protein (CRP), Serum(IMMUNOTURBIDIMETRIC)	8.13 *	mg/dL	0 - 0.5

***** END OF THE REPORT *****

This is a computer generated report and validated electronically.

Provisional Report

Provisional Report

HOLY FAMILY HOSPITAL
OKHLA ROAD, NEW DELHI-110 025
Phone : 011-44020000, 011-35034000
E-mail : administration@hfhdelhi.org
website : www.hfhdelhi.org

To,

04.07.2026

EK KADAM NGO

Subject: - Request for Financial assistance.

This is to certify that B/O of Kumari Pinki(26015110) is admitted under Dr. Yogesh Parashar. Baby is born term/37+3 weeks/IUGR/SGA/CIAB LBW BW 1.58kg/ Safdarjung hospital. Born to a 29 year old, G3P2L2 mother with severe preeclampsia with PROM with Severe oligohydramnios. Child is currently on NIV support FiO2 21o/o PEEP 6 RR 35. On IVF, Aminoven, NG feeds 20 mi 2nd hourly, IV Vancomycin, IV Ciprofloxacin, IV phenobarbitone, IV Meropenem.

The child's family have financial crisis due to which they cannot afford the cost of the treatment. The condition of the child needs continues medical support at present. Therefore it would be kind of you, if you can help this child in these stressful times.

Thanking you

Yours sincerely

PERSONAL DEVELOPMENT
HOLY FAMILY HOSPITAL
NEW DELHI - 110025

Sr.Elsy Thomas
Personal Development Department
Holy Family Hospital,
New Delhi - 110025