Mazumdar Shaw Medical Center
Unit of Narayana Health

DISCHARGE SUMMARY

Patient MRN	: 10020001277899	**Admission No**	: INP-1002-2105000196
Patient Name	: Mrs C Lakshmi	**Admission Date**	: 04/05/2021 04:02 PM
Gender/Age	: Female , 40 Years	**Discharge Date**	: 26/06/2021 01:08 PM
Patient Phone No	: 9443756089	**Discharge Reason**	: Normal Discharge
Referred By	: -		

Admitting Consultant: Dr. Nandish H K(MEDICAL GASTROENTEROLOGY), Dr. Jose Chacko / Dr. Hemant H R / Dr. Arjun Alva / Dr. Harish Mallapura Maheshwarappa / Dr. Vimal Bharadwaj / Dr. Chethan S / Dr. Jinay Gala(MICU)

FINAL DIAGNOSIS

ACUTE ON CHRONIC LIVER FAILURE

- **? DILI**
- **VIRAL HEPATITIS A**
- **LEPTOSPIROSIS**

CHILD - C MELD Na - 30

ASCITES - NO SBP

CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

Jaundice since 15 days
fever since 1 week
abdominal distension +
No pain abdomen/ altered sensorium/ GI bleed

PAST MEDICAL HISTORY

Similar complaints in Dec 2020. Improved with medications
Had jaundice in Feb 2021, took alternative medicine
H/O consuming alternative medicine since 10 years

VITALS

Pulse	:	78b/min
BP	:	120/90mmHg

Muzumdar Shaw Medical Center
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GENERAL EXAMINATION

Icterus +, Pallor +

SYSTEMIC EXAMINATION

Gastrointestinal System
P/A: Soft, non tender, BS +

Cardiovascular System
S1S2+, no murmur

Respiratory System
Bilateral air entry +

Central Nervous Systems
Conscious, oriented

COURSE IN HOSPITAL

Mrs C Lakshmi, 40 years old female presented with above mentioned complaints. On examination, she was conscious, oriented, and pallor/ icterus was present. Abdominal examination showed no organomegaly and presence of ascites. Lab investigations showed anemia, thrombocytopenia, altered LFT (BILIRUBIN TOTAL - 15.10 mg/dL ,CONJUGATED BILIRUBIN (DIRECT) - 6.41 mg/dL TOTAL PROTEIN - 5.9 gm/dL SERUM ALBUMIN - 2.4 gm/dL , SERUM GLOBULIN - 3.5 gm/dL, SGOT - 496 U/L SGPT- 317 U/L, ALP- 130 U/L, GGT-128 U/L) , INR -2.19 and normal RFT. Serology was negative for HBsAg, Anti HCV, and HIV. IgM Anti HAV and Leptospira IgM was positive. Igm Anti HEV was negative. Autoimmune hepatitis Panel showed positive for ANITI LKM1 antibodies. Serum ceruloplasmin was normal. ANA profile was negative. Normal immunoglobin levels. CECT Abdomen showed features of acute hepatitis and mild ascites. Asicitic fluid analysis was suggestive of high SAAG, low protein ascites with no SBP. Patient was managed initially in MICU with IV Antibiotics , Vit k, T. Udiliv, and other hepatoprotective medications. Initial blood culture and urine culture showed no growth. Later her blood investigations showed, high ferritin levels, high LDH and low fibrinogen levels. Hematologist opinion was taken in view of suspision of HLH and the advised for bone marrow study and to start on steroids. Bone marrow study showed no features of HLH. Serial monitoring of LFT and INR was done and no significant improvement was seen. Patient underwent liver biopsy on 12/05/21. Liver biopsy showed features of acute hepatitis with zone 3 bridging necrosis, canalicular cholestasis, mild fibrosis and minimal steatosis. Findings

COURSE IN HOSPITAL

were suggestive of acute viral hepatitis with possibility of drug induced liver injury. In view of persistent liver failure and coagulopathy, patient was planned for plasma exchange. She underwent a total of two sessions of plasma exchange. Simultaneously, Liver transplant team opinion was sought and patient family was counselled for the need of liver transplant. Patient family consented for the liver transplant and workup was started for the same. There was some improvement in bilirubin levels post plasma exchange. Prior to the 3rd session of plasma exchange, she developed fever, hypotension and hypoxia. Chest X ray showed B/L pleural effusion with consolidation. Antibiotics were escalated and patient was started on vasopressors. Blood culture showed growth of *Elizabethkingia meningoseptica* and patient was started of tigecycline and minocycline based on sensitivity report. Urine culture showed growth of candida species and was treated with antifugals. Patient condition improved with above treatment and shifted to ward. Repeat urine and blood cultures were negative. Presently patient is stable, discharged and referred to Liver transplant team for further management.

CONDITION AT THE TIME OF DISCHARGE

Discharge instructions about when and how to obtain urgent care:
In case of event pain abdomen, vomiting, jaundice please report to emergency care immediately.
Medications and Discharge Summary explained by: Dr. Nandish
Discharge summary issued to: _____
Review on date: _____ Time: _____

ADVICE AT DISCHARGE

Patient referred to Liver transplant team for further care.

MEDICATION AT DISCHARGE

Tab. Pantocid	40mg	1-0-0
Tab. Midodrine	2.5mg	1-1-1
Tab. Rifagut	400mg	1-1-1
Tab. Shelcal-M	1tab	1-0-1
Tab. Vlbact	1tab	1-1-1
		1-0-0

MEDICATION AT DISCHARGE

Tab. Aldactone	50mg	
Tab. Udiliv	300mg	1-0-1
Pentasure protein powder	2 scoops	1-1-1

CROSS CONSULTATION

- Dr.Manu P Thomas,LIVER TRANSPLANT on 15/06/2021
- Dr. Samarth R Shetty,CRANIO-MAXILLO FACIAL SURGERY on 11/06/2021
- Dr.Radhika Manohar,NEUROLOGY on 11/06/2021
- Dr. Rohit Raghunath Ranade,GYNAECOLOGY - ONCOLOGY on 11/06/2021
- Dr. Rohit Raghunath Ranade,GYNAECOLOGY - ONCOLOGY on 10/06/2021
- Dr. Bagirath Raghuraman,CARDIOLOGY - ADULT on 10/06/2021
- Dr. Basavaraj,INTERVENTIONAL RADIOLOGY on 07/06/2021

EMERGENCY MANAGEMENT

Contact Details: In case of any queries or emergencies please contact, Phone No:

CARE TEAM DETAILS

Dr. Nandish H K
Consultant
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Dr. Jose Chacko / Dr. Hemant H R / Dr. Arjun Alva / Dr. Harish Mallapura Maheshwarappa / Dr. Vimal Bharadwaj / Dr. Chethan S / Dr. Jinay Gala
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This summary and medication has been explained in the language I understand, and printed copy has been issued to me

Mrs C Lakshmi (10020001277899)

SIGNATURE R. Manish Kumar **DATE** 26/6/21
NAME
RELATION

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