CLINICAL CASE PRESENTATION

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BJGMC PUNE

PATIENT PARTICULARS

- Name –ABC
- Age- 3yrs
- Sex – M
- Order- 2
- Marriage- Non- consanguineous
- Address- Hadapsar Pune
- Religion – Hindu
- Informant- Mother
- Date of admission-20th jan 2020

CHIEF COMPLAINTS

- Cough for 1 week
- Running nose for 1 week
- Fever for 5 days

HISTORY OF PRESENTING ILLNESS

- He was apparently alright 1 week back when he developed cough which was sudden in onset , non productive with no aggravating factors relieved on giving cough syrup with no diurnal variations.
- It was accompanied by nasal discharge which was sudden in onset and was watery in consistency.
- 5 days back the child also developed fever which was low grade continuous not associated with chills and rigors, no diurnal variation.

- No complaints of altered sensorium , abnormal body ache ,excessive sleepiness ,lethargy, headache , neck rigidity, vomiting
- No rashes ,difficulty in breathing, noisy breathing, sore throat, difficulty in swallowing, hoarseness of voice, ear ache or hearing difficulty
- No history of neck swelling
- No history of boils or abscess
- No history of injuries, bone pain , joint pain
- No history of impaired vision

PAST HISTORY

- At birth the baby was diagnosed as down syndrome with mongoloid facies and was screened accordingly.
- He is also known to have small ventricular septal defect and 6 months back he suffered from bacterial endocarditis for which he was admitted for about 6 weeks in a private hospital.
- He has suffered from recurrent respiratory tract infections about once in 2 months which were associated with fever and required hospital admissions

TREAMENT HISTORY

- For endocarditis he was treated with ampicillin and gentamycin i .v. for 6 weeks 6 months back.

Antenatal history

The child is of 2nd order born out of non consanguineous marriage with a gap of 2 yr between the first and the second child

1ST TRIMESTER

- No history of fever
- Dating scan was done
- Folic acid was taken
- No history of any other drug intake or radiation exposure
- No alcohol, tobacco or substance abuse

2 nd TRIMESTER

- Quickening was felt at 18 weeks
- 2 doses of tetanus toxoid taken 1month apart
- Iron folic acid and calcium taken
- Anomaly scan was done and no anomaly was noted
- No h/o of headache ,blurring of vision, pedal edema, documented hypertension
- No h/o of polyuria, polydipsia and OGTT was done and was normal

3 RD TRIMESTER

- Appreciated fetal movements well
- No h/o of maternal fever, diarrhea, UTI
- No bleeding per vaginum, foul smelling liquor

BIRTH HISTORY

- Normal vaginal full term delivery at 37 weeks
- Birth wt - 2kg
- Cried immediately after birth
- There was history of NICU admission due to poor feeding which was associated with hypoglycemia and seizures
- No history of prolonged jaundice
- Breast feeding was initiated after 2 days of admission
- No prelacteal feeds were given

DEVELOPMENTAL HISTORY

DOMAIN	MILESTONE	AGE OF ATTAINMENT	EXPECTED AGE	DQ
GROSS MOTOR	WALKS WITHOUT SUPPORT	3YR	15 MON	41.6%
FINE MOTOR	ABLE TO SCRIBBLE	3YR	15 MON	41.6%
SOCIAL	PLAYS SIMPLE BALL GAME	2YR	12MON	50%
LANGUAGE	JARGON SPEECH	3YR	15 MON	41.6%

IMMUNIZATION HISTORY

- Birth – BCG ,opv, hepb
- 6weeks- penta1, opv1 , fipv 1
- 10weeks- penta2 ,opv2, fipv2
- 14 weeks-penta3,opv3, fipv3
- 9mon- measeles, vit A
- 18 mon- MR, vit A , DPT booster

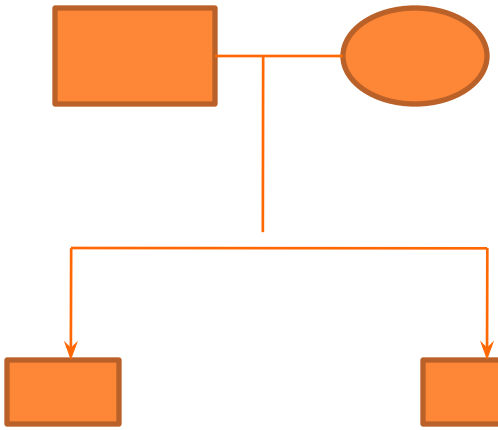
Dietary history

TIME	FOOD ITEMS	AMOUNT	CALORIE (KCAL)	PROTEINS(GM)
BREAKFAST	RICE DAL ROTI EGG	½ BOWL ½ BOWL ¼ 1	55 100 36 60	1 1-6 1 6
LUNCH	KHICHADI MILK SUGAR	½BOWL ½ CUP 1 TSP	75 36 20	1.5 1.6
EVENING	PARLE G	4	120	2
DINNER	ROTI DAL MILK	½ BOWL ½ BOWL 100 ML	75 100 36	2 2.5 1.6
TOTAL			707	20.8
EXPECTED			1050	20
DEFICIT			343	NO

Family history

- No history of down syndrome in other sibling or any other family member.
- No history of similar complains in any other family member
- No history of tuberculosis , asthma in any other family member

PEDIGREE CHART



40YR

35 YR

5 YR

3 YR

Socioeconomic history

Family is a nuclear family . There are 4 members in family. Father of child is head of family and belongs to class3 according to modified B.G. Prasad scale.

Lives in a pucca house

Source of water is tap water

No open defecation around house

PERSONAL HISTORY

- The child is friendly and loves music

SUMMARY

- 3 year old boy,2nd by order born out of non consanguineous marriage via full term normal vaginal delivery known case of down syndrome was brought to O.P.D. with history of cough and fever since 1 week most probably suffering upper respiratory tract infection most probably viral in origin .There is also a history of recurrent respiratory infection with small ventricular septal defect and global developmental delay.

GENERAL EXAMINATION

- The child was seated on mothers lap during examination.
- The child was smiling during the examination
- Vitals
- Temperature- 101.4 deg f(oral)
- Pulse rate-110beats/min regular in rhythm, normal character no radioradial and radiofemoral delay. Peripheral pulses are bilaterally and equally palpable
- Rr-40/min
- Cft-2sec
- Bp- 90/60mm of hg in right upper limb in supine position

HEAD TO TOE EXAMINATION

- Pallor- present
- Icterus- not present
- Cynosis- not present
- Clubbing- not present
- Lymphadenopathy- not present
- Edema- not present

- Head- brachycephaly , fontanales closed
- Hair- sparse
- Face-mongoloid facies(upward slant of eyes, epicanthic fold, protrubent tongue, hypertelorism, flattened nose bridge]
- Oral cavity-high arched palate .No cleft lip or cleft palate
- Teeth irregular placement of teeth
- Eyes- normal, no brushfield spots

- Ears- low set ears, antihelix is poorly formed
- Nose and nasal cavity-flat nasal bridge
- Neck- short neck
- Skin – no skin lesions
- Nails – no clubbing
- Hands- simian crease, brachydactyly
- Spine and back – normal
- Feet- sandal gap
- Genitals- normal

ANTHROPOMETRY

PARAMETER	OBSERVED	EXPECTED	INFERENCE
WEIGHT FOR AGE	11KG	15 KG	25 TH PERCENTILE
HEIGHT FOR AGE	86CM	95CM	50 TH CENTILE
WEIGHT FOR HEIGHT	0.12	0.15	50 TH CENTILE
MUAC	13.5 CM	13.5	NORMAL
HC	42 CM	49 CM	- 2 SD

Systemic examination

- Respiratory system examination
- Upper respiratory tract
- Nose- no flaring of nasal ala
- Nasal septum- no deviation
- Oropharynx - tonsils enlarged with no pus or memberane
- Posterior pharyngeal wall- posterior wall appears to be congested

LOWER RESPIRATORY TRACT

- Inspection
- Shape of chest- elliptical in shape
- Movement with respiration- equal on both the sides
- Trachea – central
- Both nipples are at same level
- Apex beat was seen
- No use of accessory muscles, no retractions.
- No scars , sinuses, dilated veins,

PALPATION

- All inspection findings were confirmed
- No tenderness
- No rise in local temperature
- Position of trachea –central
- Chest expansion equal on both the sides
- Vocal fremitus - could not be elicited
- Percussion- resonant notes on both the sides

AUSCULTATION

- Vesicular breath sounds were heard on both the sides
- No added adventitial sounds

CVS

- Inspection
- Shape of chest – normal
- Trachea –appears central
- Apex beat – seen in 5^{th} intercostal space in mid clavicular line
- Precordial movement seen at left parasternal border
- No scar or dilated veins present
- No epigastric pulsations
- Jvp- not elevated

- Palpation
- Apex beat felt at 5th intercostal space in midclavicular line which is poorly localized over 3 cm
- No parasternal heave
- Auscultation-
- S1 s2 heard
- Grade 3 pansystolic murmur heard loudest at lower left sternal edge

GASTROINTESTINAL SYSTEM

- Inspection
- Shape – normal
- Movement –all quadrants move equally with respiration
- Umbilicus- central inverted
- No skin scars
- Or incisions
- Superficial dilated veins not present
- No visible peristalsis
- No visible pulsations
- Genitals- normal

CNS

Cranial nerve	examination	Right	left
OPTIC	RECOGNIZES MOTHER PUPILLARY REFLEX	PRESENT	PRESENT
OCCULOMOTOR	ABLE TO FOLLOW OBJECTS IN ALL DIRECTIONS AND GAZE	PRESENT	PRESENT
TRIGEMINAL	CORNEAL REFLEX	PRESENT	PRESENT
FACIAL NERVE	EXAMINATION	NORMAL	NORMAL
VESTIBULOCOCHLEAR	RESPONDS TO SOUND	ABSENT	ABSENT

MOTOR SYSTEM	RUL	LUL	RLL	LLL
BULK	NORMAL	NORMAL	NORMAL	NORMAL
TONE	HYPOTONIA	HYPOTONIA	HYPOTONIA	HYPOTONIA
INSPECTION	NORMAL	NORMAL	NORMAL	NORMAL
PALPATION	NORMAL	NORMAL	NORMAL	NORMAL
RESISTANCE TO PASSIVE MOVEMENT	PRESENT	PRESENT	PRESENT	PRESENT
POWER	+3	+3	+3	+3

SUPERFICIAL REFLEX	
PLANTAR REFLEX	Normal
DEEP TENDON REFLEX	
BICEPS REFLEX	Hypoactive
SUPINATOR REFLEX	Hypoactive
TRICEPS REFLEX	Hypoactive
KNEE JERK REFLEX	Hypoactive
ANKLE JERK REFLEX	Hypoactive

DIAGNOSIS

- Known case of down syndrome with small ventricular septal defect associated with recurrent respiratory tract infections is suffering most probably from common cold and global developmental delay.