Case presentation

Nephrotic syndrome

Presented by
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Core member white army

Demographic information

Name – ABC

Age -6 years

Sex – male

Address – hangal taluk (Haveri)

Religion-hindu

Informant-mother

Age-35 years

Literacy-4th standard

Date of admission-18/2/2020

- **CHIEF COMPLAINTS**

- Complaints of fever since 18 days
- Facial puffiness since 15 days
- Generalized swelling since 12 days

- **History of present illness**
- Patient was apparently alright 18 days back and then he had fever continuous type and not associated with chills and rigors no diurnal variation no agrevating factors relieved on medication

- Mother noticed swelling around the eyes and facial puffiness since 15 days, then it is gradually progressive to around abdomen and legs , swelling is more in the Morning and gradually decrease as day progresses No pain or redness over swelling

- History of decreased urine output since 10 days given by mother

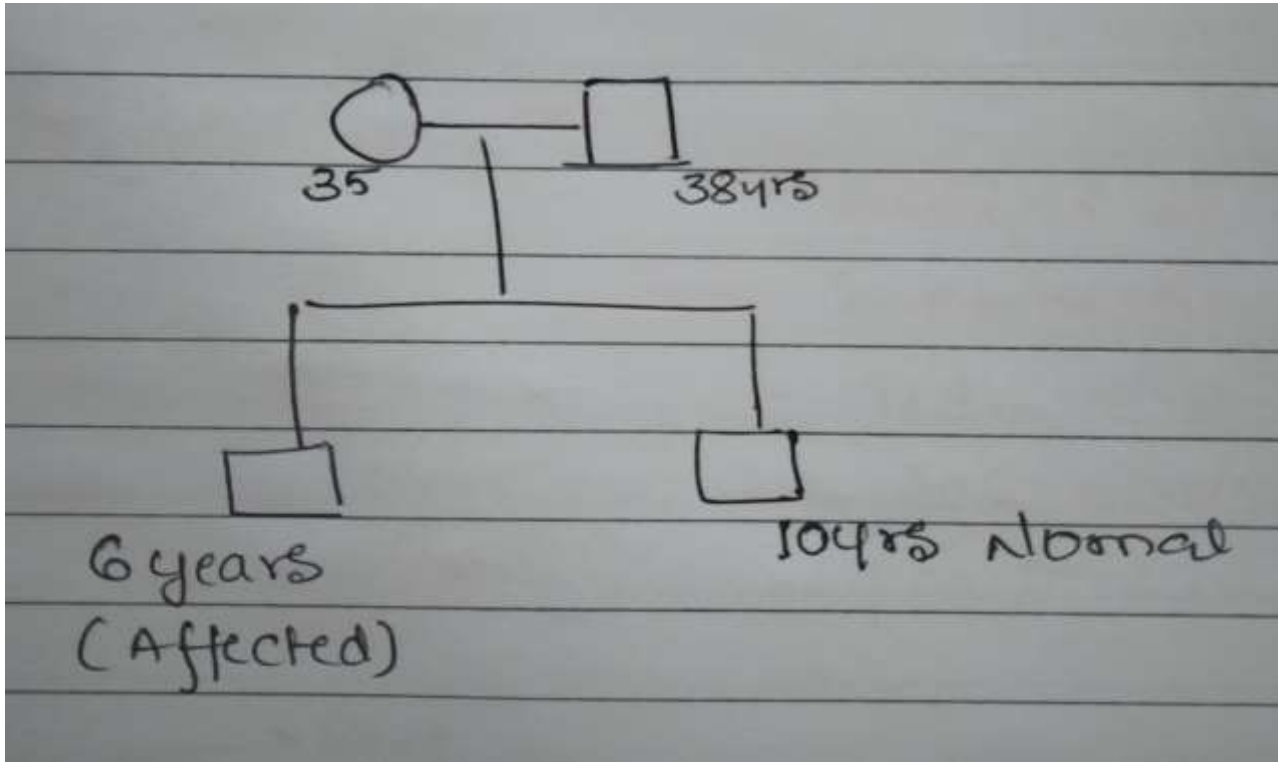
- No history of palpitations orthopnea dyspnea
- No history of prolonged intake of steroids
- No History of Loss of appetite loss of weight ,skin changes and irritability
- No history of yellowish discoloration or itching of skin
- No history of abdominal pain , vomiting, loss of appetite
- No history of insect bite or any allergic reaction
- No history Cola colored urine
- No history of blurring of vision , giddiness, headache,syncopal attack
- No history of sore throat and skin lesions

Past history

- History of similar complaint in past
- Admitted to KIMS at the age of 3years and was admitted for 20 days and symptoms reduced completely from medication

- No history of any blood transfusion
- No history of contact TB
- No history of hepatitis infection,UTI,infective endocarditis and malignancy
- No history of previous surgery

- **Family history**
- No similar complaints in family members



- **Birth history**

- **Antenatal history**
- Regular antenatal visits
- Iron Folic acid taken regularly
- No history of oligohydramnios
- Anomaly scan was done and it was normal

- **Natal history**
- Normal vaginal delivery with birth Wieght of 2.7kg baby cried immediately at birth
- No NICU admission and no complications

- **Post natal history**
- Exclusively breastfed for 6 month and breastfeeding continued till one year
- Suplimentary foods started from 6 month onwards

- **Developmental history**

- History of normal development

- Gross motor – Runs ,Walk upstairs and downstairs, can do skipping
- Fine motor – Can tie shoe lace and can draw triangle cross sign and gate
- Social milestone- Can follow 3 step command
- Language milestone- can remember names and Colors

- **Immunization history**
- Immunisedd upto date

- **Diet history**

Consumes diet of 1350 kcal and protein of 34 g per day

Required calories 1650 k cal and protein of 45 g per day

So deficient of 200 k cal and 11g of protein per day

- **Socioeconomic status**
- This child belongs to class 4 socioeconomic status according to modified BG Prasad classification
- Father occupation is farmer and studied till SSLC
- Lives in Kucha house but no overcrowding and good ventilation present

- **Summary**

Here is 6 year old male child belonging to class 4 socioeconomic status who consumes diet which is 200k cal and 11g protein deficient who is immunized till date with normal birth history and family history with significant past history of similar complaints came with chief complaint of fever since 18 days puffiness of face since 15 days and Generalized swelling for 12 days and history of decreased urine output

EXAMINATION

Here is a young male child conscious cooperative well oriented

Vital signs

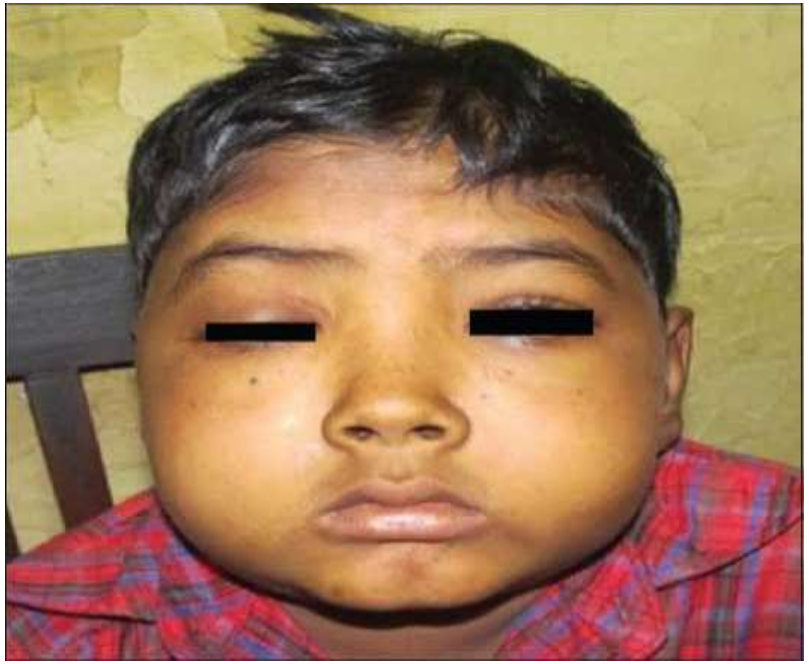
Pulse -92beats per minute

Respiratory rate – 27cycles per minute

Temperature -98 degree Fahrenheit

Blood pressure- 110/70 mm Hg

- Pallor –absent
- Icterus –absent
- Cyanosic- absent
- Clubbing- absent
- No lymphadenopathy



- Edema -
- Bilateral pitting type of edema on limbs
- Facial puffiness and abdominal edema is also seen
- Scrotal swelling seen

- **Anthropometry**
- Wieght- 25kg
- Hieght- 124cm
- BMI - 16.2 kg /mtr^2

Per abdomen examination

- Inspection – Abdomen distended umbilical central corresponding quadrant move equally with respiration,no scars or prominent viens

  hernial orifices are normal

- Palpation –
- No local rise of temperate and Tenderness No organomegaly appreciated
- On deep palpation liver ,spleen, kidney are non palpable

- Percussion
- Shifting dullness seen

- **Other systems**

- **RS –** Normal vesicular breath sounds heard Bilateral equal air entry no added sounds

- **CVS-** S1 S2 heard no murmur

- **CNS -** Higher mental function normal no sensory or motor deficit

DIAGNOSIS

- **Primary nephrotic syndrome with infrequent relapse and no impending complications**

THANK YOU