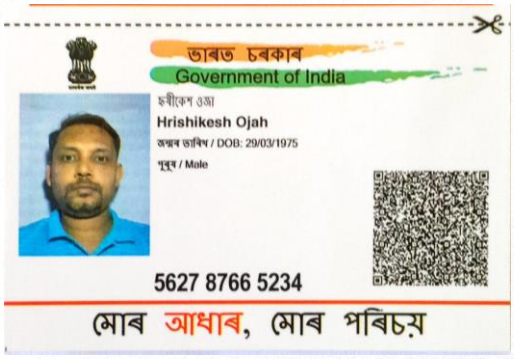
संस्था को चिकित्सक सहायता हेतु आवेदन पत्र

सेवा में,

संस्थापक
चाइल्ड सेवा ट्रस्ट
टी–53/4, सब्जी मंडी,
रेलवे कॉलोनी
नई दिल्ली 110007



विषय : संगठन के संस्थापक को चिकित्सक सहायता संबंधित अनुरोध पत्र।

महोदय जी,
"सविनय निवेदन यह है कि प्रार्थी हृषिकेश ओझा, असम (बरपीटा) का निवासी हूँ। मेरे बच्चे का नाम अंगराज ओझा जिसका आयु 8 वर्ष है। जिसका इलाज सर गंगा राम हास्पिटल में चल रहा है, मेरा बच्चा ल्यूकेमिया ब्लड कैंसर से पीड़ित है, बच्चे की चिकित्सक स्थिति संबंधित विवरण" बच्चों को लंबे समय से बुखार, बोन मैरो टेस्ट, किमो थेरेपी, ब्रेन मेरो इन्फेक्शन के बाद सर्जरी की शीघ्र आवश्यकता है।

हमारा परिवार बच्चे का इलाज करवाने हेतु आर्थिक रूप से सक्षम नहीं है एवं बच्चे की वर्तमान स्थिति के अनुसार बच्चे को सुचारू इलाज की शीघ्र आवश्यकता है।

प्रार्थी चाइल्ड सेवा ट्रस्ट से अनुरोध करता/ करती हूं कि आप मेरे बच्चे के इलाज में हमें आर्थिक सहायता प्रदान करें।

मैं अपनी सहमति से बच्चे के इलाज से संबंधित सभी चिकित्सक आलेख आपसे साझा कर रहा/रही हूं जिससे आपको मेरे बच्चे की वर्तमान चिकित्सक स्थिति से अवगत करवाया जा सके।

मैं और मेरा परिवार चाइल्ड सेवा ट्रस्ट एवं आप से जुड़े सभी दाताओं का दिल से आभारी रहेगा /रहूंगी।
धन्यवाद!

अभिभावक

हस्ताक्षर

अंगूठे का निशान

CHILD SEWA TRUST Reg. No. 48 NEW DELHI

संस्थापक
आपका अनुरोध चाइल्ड सेवा ट्रस्ट द्वारा स्वीकार्य है

यह प्रारूप परिवार की से शैक्षिक स्थिति एवं कोविड–19 को ध्यान में रखते हुए तैयार किया गया है, किसी प्रकार की त्रुटि के लिए संस्था क्षमा व्यापक है।

PAN No : AACTC8249B

CHILD SEWA TRUST

"YOU CAN RELY ON US"

REG. NO. 58
CHILD SEWA TRUST

Khasra No. 337-F, Gali No. 8 Ram Park Extn., Loni Dehat,
.P.-201102

Ref. No. 57

Dated 30-09-2023

चाइल्ड सेवा ट्रस्ट द्वारा आर्थिक चिकित्सक सहायता प्रदान करने पश्चात प्राप्त स्वीकृत सर्वनाम लेखन पत्र

चाइल्ड सेवा ट्रस्ट संस्था के माध्यम से आपके बच्चे अंगराज ओझा जिसकी 3 वर्ष है हर्षिकेश ओझा के निवेदन के आधार पर आपके बच्चे की चिकित्सक स्थिति एवं आपके द्वारा प्राप्त चिकित्सक साक्ष्यों के आधार पर बच्चे की वर्तमान चिकित्सक स्थिति एवं परिवार की आर्थिक स्थिति को देखते हुए संस्था चाइल्ड सेवा ट्रस्ट द्वारा आपके बच्चे के सुचारू इलाज के लिए आर्थिक सहायता प्रदान की जा रही है।

आशा करते है संस्था कि इस छोटी से पहल के द्वारा आपके बच्चे का इलाज सुव्यवस्थित ढंग से हो पाएगा

अतः संस्था अपने सभी दाताओं के सहयोग से सदैव आपको इसी प्रकार आर्थिक अनुदान सहायता प्रदान करती रहेगी एवं सदैव आपके साथ है

अभिभावक

हस्ताक्षर

अंगूठे का निशान

CHILD SEWA TRUST Regd. No. 58 NEW DELHI

संस्थापक
चाइल्ड सेवा ट्रस्ट

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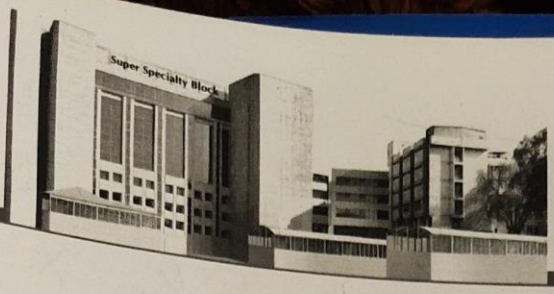
Website: www.childsewatrust.org

NABH
H-2008-0017
Since June 16, 2008



SGRH
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drswatipho@gmail.com

24 hrs Helpline Number

Angavaag.

25/9/23.

Plan.

Admit ↓ Paeds SP evening
- ↳ BMA, MRD
- CSF for malignant cells
- LP + IT MTX
- ↳ Mtx → @ 1600 mg total
- ↳ Send SGPT, creat
- ↳ Valgan – W/H x 3 days
- ↳ Omnacortil – Tapering
- ↳ Tab 6MP – ¼ once daily

PTO →

11.2 | 3090 | 3.1
1545.

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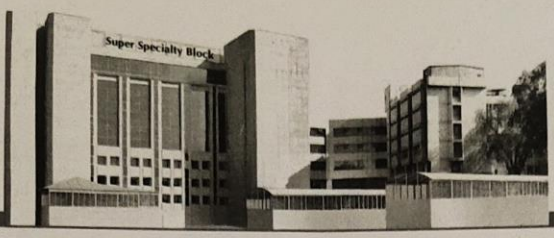

DISCHARGE SUMMARY
INSTITUTE OF CHILD HEALTH
DEPARTMENT OF PAEDIATRICS
SIR GANGA RAM HOSPITAL
PAEDIATRIC HEMATO-ONCOLOGY AND BMT UNIT (PHO)

NAME: Angaraag Ojah	**AGE: 3 years**	**SEX: MALE**
DOA: 11/08/23	**DOD: 18/09/23**	**MRD NO: 3205686**
Wt: 11.6 kg	**Ht: 93.5 cm**	**BSA: 0.54 m^2**

DIAGNOSIS:
Precursor B cell Acute Lymphoblastic Leukemia, CALLA Positive ,PGR
CSF Malignant cells- Negative, Molecular- Negative, NGS- Negative
Karyotyping- 45XY, del(1) (q32q44),dic(7;12)(p11.2;p11.2),add(12)(p12)[cp5]
Highest TLC- 29030 /cumm
TP1 MRD- <0.01%
Admitted on day + 15 post week 1 Consolidation
CMV Pneumonitis with ARDS with Secondary HLH due to CMV infection
PRES secondary to steroids.
Hypersenstivity to Inj Cefoperazone-Sulbactum
Started on Interim maintainence from 31/08/23
Discharged on day+4 post week 3 Consolidation
DISCHARGE ADVICE:

- **Syp Omnacortil Forte(15mg/5ml)2ml-0ml-2ml today**
  1ml-1ml-1ml (19/09-21/09)
  1ml-0ml-1ml (22/09-24/09)
  1ml-0ml-0ml (25/09-27/09) and stop
- Syp Septran (240mg/5 ml) 5ml - 0 – 5ml (Mon/ Wed/ Fri)
- Tab Lanzol Jr15mg once daily every morning to continue
- Tab 6MP **1/4th Tab once daily**
  (Avoid Milk and Milk products 1 hour before and after 6MP)
- Tab Valganciclovir(450mg) ½-0- ½ to continue till 23/09/23 , do not give dose Sunday onwards.
- Syp Levera(100mg/1ml)1.2ml twice daily to continue
- Midacip nasal spray (5mg/ml) 3 puffs SOS in case of abnormal body movements
- Muout Powder 1 scoop or Laxopeg ½ sachet twice daily for constipation
- Candid mouth paint 4 drops thrice a day to continue
- Listerine mouth wash thrice daily to continue
- Sitz bath twice daily
- Avoid raw fruits, salads.
- Plenty of oral fluids, No visitors, Strict hygiene
- To maintain genital hygiene and general hygenie
- Don't administer any vaccination to the child/ Avoid OPV to the family member

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- Follow up on 25/09/23 at 11 am in F55 for CBC/DLC or SOS and before if fever occurs

CASE SUMMARY

Angaraag, 2 years old male child, known case Pre B ALL now admitted on day + 15 post week 1 consolidation with complaints of fever. 2-3 spikes of fever were documented in a day. Maximum temperature spike recorded was 102°F. Fever was not associated with cough and cold, fast breathing, pain abdomen or any history suggestive of mucositis.

EXAMINATION:

On admission, febrile(temperature-102°F), HR-120/min, BP – 100/60 mm Hg, RR-22/min, pallor- absent, Lymph nodes- not palpable. Abdomen-Soft, Liver not palpable, Spleen – not palpable, CNS- Alert & Oriented, CVS-S1, S2 normal, Chest-B/L air entry equal.

HOSPITAL COURSE

Angaraag was admitted. CBC revealed Hb- 7.6 gm/dl, TLC- 250/cumm, Platelets-79000 /cumm, ANC- 90/cumm. After taking blood culture he was started on Inj Magnex as per the unit protocol. He received PRBC transfusion as per the requirement. IV antibiotics were continued and vitals were monitored closely.

Workup for Invasive fungal infection

In the background of severe neutropenia with persistent fever beyond 5 days he was worked up for IFI with HRCT chest which revealed evidence of linear atelectatic bands at places in both lungs, without any evidence of any obvious nodular or cavitating lesion on either side. No parenchymal consolidation was seen. He was subsequently started on Oral Voriconazole as prophylactic antifungal. In view of a suspicious LRTI a high index of suspicion for viral LRTI was kept and he was empirically started on on Oseltamivir .Blood culture was sterile. In view of persistent fever and cytopenias in the background of myelosupressive chemotherapy incipient infection by CMV was a differential and CMV PCR was sent **.Blood CMV PCR- 838080 IU/ml**. He was started on Inj Gancyclovir. .He was kept under close monitoring with regular blood counts.

Hyperinflammatory state/ Secondary HLH

On day 25 post week 1 consolidation ,he developed tachypnea, grunting and desaturations on room air. He was shifted to PICU. Serum ferritin was 80238ng/ml. Suspecting hyperinflammatory state he was started on pulse steroids with Inj Methyl prednisolone while carefully balancing Inj Gancyclovir for CMV reactivation. Respiratory swab was also positive for CMV with copy number 477360 IU/ml. Chest X-ray was done which showed b/l patchy consolidations .

PICU stay

He was shifted to PICU, antibiotics were upgraded to Inj Meropenem and Inj Targocid . Bedside USG revealed pleural effusion with hepatisation in bilateral lung(R> L) . In view of worsening vital paraemeters coupled with worsening oxygenation he was intubated and started and on IPPV with high ventilator requirements. USG guided drainage of pleural fluid was done and fluid was sent for cyto-chemical analysis. He was started on Inj Noradrenaline. On the following day he had sudden deterioration while in IPPV. USG and CXR revealed right sided pneumothorax which was drained using ICD. Over the next 48 hours there was marked improvement in clinical condition with cessation of ionotrope requirement and decrease in the ventilator requirements. He was subsequently extubated and weaned of to HHFNC which was followed by nasal canula. There was marked improvement in subsequent serum ferritin values which decreased to 1.6 lacs then 23000.Infectious disease (Dr Anivita) review was taken and advices followed . Pulse steroids was given for 5 days and then tapered and stopped. Pleural fluid reports were -

ADA- 64.96IU/L ,Albumin-2.13 gm/dl ,LDH-1455 U/L ,cell count-30cells(98% lymphocytes)

Hepatic Dysfunction(Mild)

There was increase in serum biliriubin and serum liver enzymes which was attributed to the sudden onset respiratory compromise and compromised haemodynamics. Prophylactic Voriconazole was withheld and subsequently reintroduced once there was documented improvement in LFT.

PRESS

Post extubation day +2 there was high blood pressure values which caused two episodes of tinci body posturing associated with tachycardia and desaturations. He was seen by paediatric neurology team and advice was followed. EEG was done and he was started on Inj Levetiracteam coupled with antihypetensives which was shifted to oral

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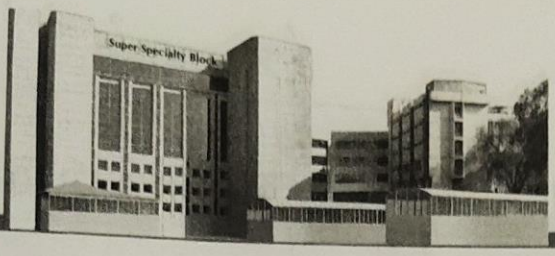

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drswatipho@gmail.com

24 hrs Helpline Number

Angaraag.

11/8/23.

B ALL / Week 3 consolidatn.

S/b Ds. Manas Kalra.

1. W/H cytarabine & 6MP
2. Febrile neutropenia counselled.
3. Septran, Candid (1)
4. Admit & Paeds SP.
   - PRBC Transfusn
   - Wait, if febrile. { Bld Cs. Magnex
   - Send urine R/E.

7.6 | 250 | 79K
90 | 40.

Ds Swati B

levera.Antihypertensives were eventually tapered off .He was shifted to ward after 9 days and continued on Valganciclovir and tapering doses of steroids .

Cefoperazone –Sulbactum Hypersenstivity

He developed fever spikes on tapering steroid and was restarted on Inj Magnex when he developed **hypersentivity to Magnex and it was stopped .** Inj Magnex was upgraded to Inj Meropenam .

Worsening CMV counts

He was kept on biweekly HLH markers and weekly CMV PCR monitoring , Voriconazole drug monitoring , on tapering doses of steroids he kept developing fever spikes with increase in ferritin to 64632ng/ml and it was decided to stop oral valganciclovir and give IV Ganciclovir and IVIG infusion was given .His fever spikes eventually stopped with fall in ferritin levels and CMV copies .He received total 28 days of IV Ganciclovir .

Interim Maintainence

In view of prolonged delay in chemotherapy he was started on **Interim Maintainence from 31/08/23** with Tab 6MP and weekly Tab methotrexate .Interim maintainence Week 2 and Week 3 lumbar punctures were done and it was planned to start High dose methotrexate from 25/09/23 after TP2 MRD evaluation and lumbar puncture .Investigations on discharge showed -CBC - Hb- 9.2 gm/dl, TLC- 4490/cumm, Platelets-1.16lac /cumm, ANC-3457/cumm , Ferritin-1131 ng/ml , CMV copies -153 IU/ml.

At present he is afebrile, with good oral intake, hemodynamically stable and is being discharged with advice to follow up on 25/09/23 with CBC/DLC in F55 OPD or SOS in Ward 9.

PROCEDURES: ICD insertion in PICU

REPORTS AWAITED: None

Dr Ayush/Dr Srijib
Dr Sani/Dr Saroj
Dr Ankita/ Dr Shivani
PHO Fellows

Dr. Swati Bhayana
Clinical Assistant

Dr. Anupam Sachdeva
Dr. Manas Kalra
Dr. Divij Sachdeva
Consultants

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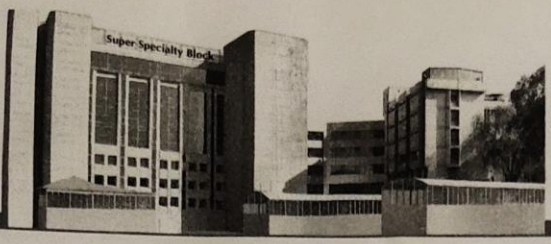

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24 hrs Helpline Number

28/7/23.

Week 1 Consolidation

Adv [s/b Dr. Manas Kalra].

1. Admit ↓ Paeds DC
   - Inj cyclo – 450 mg.
   - LP + ITMTX – 10 mg
   - Inj cytarabine ~~[illegible]~~ → 35 mg
   - Tab 6MP ½ tab.

10.8/4440/1.22
1687.

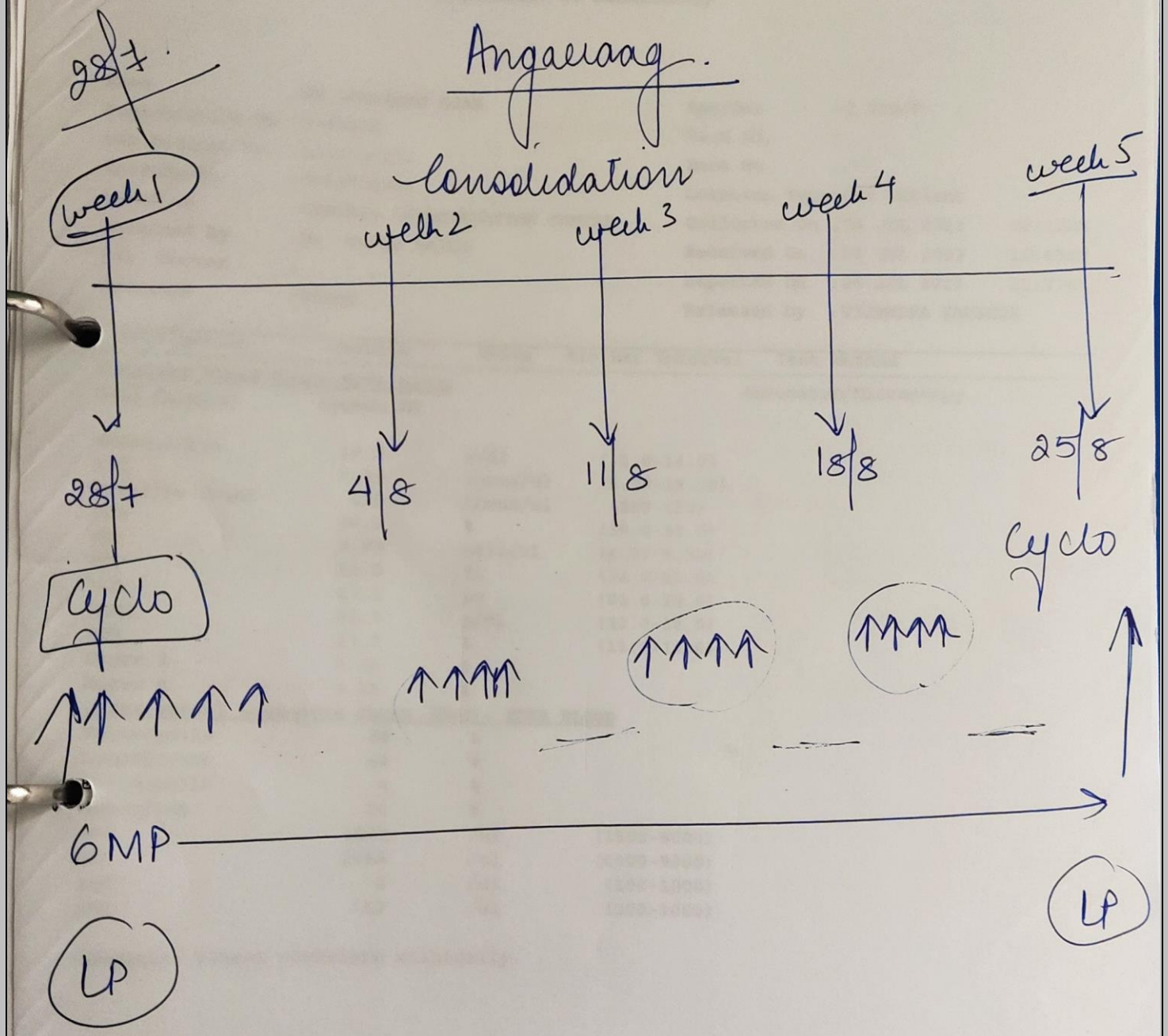
2. Sitz Bath
   Septran, Candid, Listerine

3. f/u after 1 week c CBC/DLC

Indent & cytarabine today.

Dr. Swati B


Super Specialty Block


28/7
Angaaaag.
week 1
Consolidation
week 2
week 3
week 4
week 5
28/7
4/8
11/8
18/8
25/8
Cyclo
Cyclo
6MP
LP
LP

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24 hrs Helpline Number

Angamag

04/8/23

Week 2 consolidation] MRD < 0.01%.

c/o Ds. Manas Kalra.

1. Inj cytarabine 35 mg IV OD on
   4/8, 5/8, 6/8, 7/8
   [Give premed < allegra 5 mL
   ondem DS 5 mL
   ondem MD 4mg

2. Tab 6MP (50 mg) ½ once daily

3. fu after 1 week c CBC/DLC

9.2/2560/1.36
2227

Dr Swati B.

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Anupraaj.

1. Syp. Alkind 2.5 ml OD.
   x 3 days
2. Syp. Crocin DS (240/5)
   2.5 ml SOS for
   fever