HOLY FAMILY HOSPITAL
Okhla Road, New Delhi-110025
Phone : 011-35034000, 44020000
Email : administration@hfhdelhi.org, Web : www.hfhdelhi.org

CASE SUMMARY

CASE SUMMARY

NAME: NAVYAM
2 YEARS 3 MONTHS MALE
IP NO 26011403

DIAGNOSIS :- CNS TUBERCULOSIS WITH NON- COMMUNICATING HYDROCEPHALUS – POST OP VP SHUNT

CHIEF COMPLAINTS & REASON FOR ADMISSION :-
C/O FEVER X 26 DAYS
C/O VOMITING X 2 DAYS
C/O DULLNESS X 2 DAYS
C/O ABNORMAL VACANT STARE X 1 DAY

CLINICAL HISTORY / PROCEDURE :-
Child was apparently well 26 days back when he developed high grade fever with 6 hourly spikes with a maximum recorded temperature of 102 F. Child was being treatment from outside hospitals on OPD basis- recieved Amoxyclav for 5 days and Cefixime for 7 days. However since 2 days the parents noticed deterioration in the condition of the child. He became dull and lethargic with reduced oral intake and 1-2 episodes of vomiting per day- NP, NB, NBS. On the day of admission the mother noticed intermittent vacant staring in child lasting for 5-10 seconds followed by drowsiness. Child was brought to HFH and admitted for further evaluation and management.

B/H: Term/ 38+3 weeks/ LSCS/ LONS + meningitis
F/H: H/O TB contact +

EXAMINATION AT ADMISSION :
GC -Fair, AF open flat
Temp – 39.5°C
RR - 34/min
HR - 144/min
SPO2 - 97% on Room Air
Euhydrated Peripheral pulses - Well palpable
P+/ I-/ Cy- / Cl - /L- /E
S/E :
CVS - S1S2+, no murmur
CNS- Conscious, irritable, no meningeal signs
Respi- B/L AE (+), clear
P/A - Soft, non tender, BS (+), no HSM

ent Name	: Master. NAVYAM	Bill No.	: 262134658
No / IP No	: 2464508 /26011403	Collected On	06/05/2026 9.57 PM
/Sex	: 2 Years 3 Months 1 Days / Male	Reported On	: 06/05/2026 10.53 PM
. Doctor	: Dr.VIBIN KUMAR VASUDEVAN	Approved On	: 07/05/2026 9.24 AM
rd Details	: IPCU / 304 / 001		

ept Dt	Sample No	Test Name	Result	Units	Bio.Ref.
05/2026	1454928	**KFT (KIDNEY FUNCTION TEST)**			
		SERUM UREA (UREASE(GLDH))	14	mg/dL	13 - 43
		SERUM CREATININE (MODIFIED JAFFE REACTION)	0.21 *	mg/dL	0.67 - 1.17
		SERUM URIC ACID (URICASE)	BELOW 1.5	mg/dL	3.5 - 7.2

erpretation : Clinical interpretation:
The analytes measured in the KFT panel are useful for screening and diagnosing impaired kidney function and for assessing the severity and monitoring the course and management of acute kidney injury (AKI) and chronic kidney disease (CKD).
These tests helps in differentiating prerenal disease (renal artery stenosis, renal vein thrombosis), true renal disease and post renal disease (obstructive uropathy, prostatic disease, urinary tract infection etc.).

7/05/2026	1455538	**ELECTROLYTES**			
		SODIUM , SERUM/PLASMA (ISE INDIRECT)	122 *	mEq/L	136 - 145
		POTASSIUM , SERUM (ISE INDIRECT)	2.96 *	mEq/L	3.5 - 5.1
		CHLORIDE, SERUM/PLASMA (ISE INDIRECT)	83.7 *	mEq/L	98 - 107
		BICARBONATE, SERUM/ PLASMA (ENZYMATIC, PEPC, MD)	24.2	mEq/L	23 - 29
08/05/2026	1456056	**ELECTROLYTES**			
		SODIUM , SERUM/PLASMA (ISE INDIRECT)	134 *	mEq/L	136 - 145
		POTASSIUM , SERUM (ISE INDIRECT)	3.79	mEq/L	3.5 - 5.1
		CHLORIDE, SERUM/PLASMA (ISE INDIRECT)	100.9	mEq/L	98 - 107
		BICARBONATE, SERUM/ PLASMA (ENZYMATIC, PEPC, MD)	24.2	mEq/L	23 - 29
		LAB-HEMATOLOGY			
06/05/2026	1454928	**CBC (COMPLETE BLOOD COUNT)**			
		HEMOGLOBIN (PHOTOMETRIC)	9.2 *	g/dl	10.2 - 13.7
		TOTAL LEUCOCYTE COUNT (ELECTRICAL IMPEDANCE)	13.2	10/µL	5.5 - 15.5
		NEUTROPHIL (VCS/MICROSCOPY)	80.7 *	%	23 - 45
		LYMPHOCYTES. (VCS/MICROSCOPY)	12.6 *	%	35 - 65

Patient Name	: Master. NAVYAM	Bill No.	: 262135350
UHID No / IP No	: 2464508 /26011403	Collected On	07/05/2026 1.46 PM
Age/Sex	: 2 Years 3 Months 2 Days / Male	Reported On	: 07/05/2026 3.21 PM
Ref. Doctor	: Dr.VIBIN KUMAR VASUDEVAN	Approved On	: 07/05/2026 3.23 PM
Ward Details	: IPCU / 304 / 001		

Accept Dt	Sample No	Test Name	Result	Units	Bio.Ref.
		Method : westergren			
		LAB-URINALYSIS			
07/05/2026	1455171	**URINE ROUTINE EXAMINATION**			
		COLOUR	PALE STRAW		
		APPEARANCE	CLOUDY		
		SPECIFIC GRAVITY (PKA CHANGE OF POLY ELECTROLYTES)	1.020		1.005 - 1.030
		PH (DOUBLE INDICATOR)	7.5		5.0 - 8.5
		PROTEIN (TETRABROMO PHENOL BLUE/ SSA)	TRACE		
		GLUCOSE (DOUBLE SEQUENTIAL ENZYME REACTION/ BENEDICTS)	POSITIVE (2+)		
		KETONE (NITROPRUSSIDE)	NEGATIVE		
		BILIRUBIN (DIAZOTIZED DICHLOROANILINE/ FOUCHET REAC.)	NEGATIVE		
		RBCS	NIL		0 -2
		PUS CELLS	OCCASIONAL	/Hpf	0-5
		EPITHELIAL CELLS	PRESENT		
		CAST	NIL		
		MUCUS	NIL		
		BACTERIA	PRESENT		
		CRYSTALS	NIL		
		PARASITE	NIL		
		Method : DIPSTIK			

SUDESH GOURAV
ATTENDING CONSULTANT

NAVNEETA MISHRA
CONSULTANT BIOCHEMIST

KIRTI PANWAR
CONSULTANT PATHOLOGIST

This is a computer generated report and validated electronically.

HOLY FAMILY HOSPITAL

Laboratory Services

Okhla Road, New Delhi-110025 Phone : 011-35034000, 44020000
Email : pathology@holyfamilyhospitaldelhi.org Web : www.hfhdelhi.org

Patient Name	: Master. NAVYAM	**Bill No.**	: 262134658
MR No / IP No	: 2464508 /26011403	**Collected On**	06/05/2026 9.57 PM
Age/Sex	: 2 Years 3 Months 1 Days / Male	**Reported On**	: 08/05/2026 9.13 AM
Ref. Doctor	: Dr.VIBIN KUMAR VASUDEVAN	**Approved On**	: 08/05/2026 9.16 AM
Ward Details	: IPCU / 304 / 001		

Accept Dt	Sample No	Test Name	Result	Units	Bio.Ref.
		LAB- SEROLOGY			
06/05/2026	1454928	**WIDAL**			
		S. TYPHI "O"	TITRE - LESS THAN 1:80		
		S. TYPHI "H"	TITRE - LESS THAN 1:80		
		S. PARATYPHI "AH"	TITRE - LESS THAN 1:80		
		S. PARATYPHI "BH"	TITRE - LESS THAN 1:80		
		SAMPLE TYPE	Serum		
		Method : Tube Agglutination			

nterpretation : /NOTE
1. Titres 1:80 and above of O antigen & 1:160 and above of H antigen are significant.
2. Rising titres are significant.
3. This test measures somatic O and flagellar H antibodies against Typhoid and Paratyphoid bacilli. The agglutinins usually appear at the end of the first week of infection and increase steadily till third/ fourth week after which the decline starts.
4. Positive widal test may occur because of typhoid vaccination or previous typhoid infection and in certain autoimmune diseases.
5. Non specific febrile disease may cause this titre to increase (anamnestic reaction)
6. The test may be falsely negative in cases of Enteric fever treated with antibiotics or in the early stages.
7. The recommended test, specially in the first week of infection, is Blood culture.

		LAB-CHEMISTRY1			
07/05/2026	1455538	**PROTHROMBIN TIME (PT)/INTERNATIONAL NORMALIZED RATIO(INR)**			
		MEAN NORMAL PROTHROMBIN TIME	11.7	SECONDS	
		PT VALUE, CITRATE PLASMA (TURBIDIMETRIC)	16.0 *	SECONDS	9.8 - 13.6
		I N R (CALCULATED)	1.37 *		0.84 - 1.16

nterpretation : PT assess coagulation factors in extrinsic pathway (F VII) and common pathway (F X, FV, prothrombin and fibrinogen).

INR is the parameter of choice in monitoring adequacy of oral anticoagulant therapy. Appropriate therapeutic range varies with the disease and treatment intensity.
For patient on oral anticoagulant therapy (INR 2.0 to 3.0).
Mechanical valve replacement (INR 2.5 to 3.5).

Causes of prolonged PT
1. Treatment with oral anticoagulants.
2. Liver disease.
3. Vitamin K deficiency.
4. Disseminated intravascular coagulation.
5. Inherited deficiency of factors in extrinsic and common pathway.

07/05/2026	1455538	**APTT**			
		CONTROL PLASMA	30.3	SECONDS	
		APTT, CITRATE PLASMA	30.0	SECONDS	24.7 - 35.9

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. Doctor	: Dr.VIBIN KUMAR VASUDEVAN	Approved On	: 07/05/2026 3.23 PM
rd Details	: IPCU / 304 / 001		

ept Dt	Sample No	Test Name	Result	Units	Bio.Ref.
		(TURBIDIMETRIC)			

rpretation : APTT is a measure of coagulation factor in intrinsic pathway (F XII, F XI, high molecular weight kininogen, prekallikrein, F IX and F VIII) and common pathway (F X, F V, prothrombin and fibrinogen).

Causes of prolonged APTT
1. Hemophilia A (F VIII) or Hemophilia B (F IX)
2. Deficiencies of coagulation factors in intrinsic and common pathway.
3. Presence of coagulation inhibitors
4. Heparin Therapy.
5. Disseminated intravascular coagulation.
6. Liver Disease.

LAB-CHEMISTRY2

/05/2026	1454928	**CRP**			
		C REACTIVE PROTEIN (CRP), SERUM (IMMUNOTURBIDIMETRIC)	4.53 *	mg/dL	0 - 0.5
/05/2026	1454928	**ELECTROLYTES**			
		SODIUM , SERUM/PLASMA (ISE INDIRECT)	124 *	mEq/L	136 - 145
		POTASSIUM , SERUM (ISE INDIRECT)	3.14 *	mEq/L	3.5 - 5.1
		CHLORIDE, SERUM/PLASMA (ISE INDIRECT)	88.3 *	mEq/L	98 - 107
		BICARBONATE, SERUM/ PLASMA (ENZYMATIC, PEPC, MD)	20.8 *	mEq/L	23 - 29
		REMARK	RESULT RECHCECKED		
6/05/2026	1454928	**LIVER FUNCTION TEST (LFT), SERUM**			
		BILIRUBIN TOTAL (DPD)	0.33	mg/dL	0.3 - 1.2
		BILIRUBIN DIRECT (DPD)	0.07	mg/dL	0 - 0.2
		BILIRUBIN INDIRECT (CALCULATED)	0.26	mg/dL	0.2 - 1.0
		TOTAL PROTEIN (BIURET)	7.2	g/dL	6.4 - 8.3
		ALBUMIN (BROMOCRESOL GREEN)	3.5	g/dL	3.5 - 5.2
		GLOBULIN (CALCULATED)	3.7 *	g/dL	1.5 - 3.0
		A/G RATIO (CALCULATED)	0.9 *		1.5 - 2.5
		SGPT (ALT) (UV-KINETIC, IFCC WITHOUT P5P)	22	IU/L	1 - 45
		SGOT (AST) (UV-KINETIC, IFCC WITHOUT P5P)	41 *	IU/L	1 - 35
		ALKALINE PHOSPHATASE (PNPP AMP IFCC)	138	IU/L	129 - 291

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Ref. Doctor	: Dr.VIBIN KUMAR VASUDEVAN	Approved On	: 07/05/2026 9.29 AM
Ward Details	: IPCU / 304 / 001		

Accept Dt	Sample No	Test Name	Result	Units	Bio.Ref.
		MONOCYTES (VCS/MICROSCOPY)	4.5	%	4 - 10
		EOSINOPHILS. (VCS/MICROSCOPY)	0.0	%	0 - 3
		BASOPHILS (VCS/MICROSCOPY)	0.2	%	0 - 1
		NEUTROPHIL-BAND (VCS/MICROSCOPY)	2.0	%	0 - 11
		OTHERS	NEUTROPHILS SHOWS MILD TOXIC GRANULATION	%	
		ABSOLUTE NEUTROPHIL COUNT	10.9 *	10/µL	1.5 - 8.5
		ABSOLUTE LYMPHOCYTE COUNT	1.7 *	10/µL	2 - 10
		ABSOLUTE MONOCYTE COUNT	0.6	10/µL	0.2 - 1.5
		ABSOLUTE EOSINOPHIL COUNT	0.0	10/µL	0 - 0.46
		ABSOLUTE BASOPHIL COUNT	0.0	10/µL	0 - 0.3
		ANISOCYTES	MILD		
		HYPOCHROMIA	MODERATE		
		MICROCYTES	MODERATE		
		POLYCHROMASIA	MILD		
		RBC COUNT (ELECTRICAL IMPEDANCE)	5.80 *	10^6/µL	3.34 - 5.41
		PCV / HCT (CALCULATED)	30.4	%	27.4 - 40.3
		MCV (DERIVED)	52.4 *	fl	68.1 - 87.8
		MCH (CALCULATED)	15.9 *	pg	20.3 - 29.8
		MCHC (CALCULATED)	30.3	g/dl	30.3 - 35.6
		RDW (DERIVED/CALCULATED)	20.9 *	%	11.6 - 14.0
		PLATELET COUNT (ELECTRICAL IMPEDANCE)	333	10/µL	200 - 490
		SAMPLE TYPE	EDTA, Whole Blood		
06/05/2026	1454928	**MALARIAL PARASITES (MP)**			
		MALARIAL PARASITES (MICROSCOPY)	NOT SEEN		
		SAMPLE TYPE	EDTA, Whole Blood		
07/05/2026	1455538	**ERYTHROCYTE SEDIMENTATION RATE(ESR)**			
		ESR, WHOLE BLOOD (MODIFIED WESTERGREN MANUAL METHOD)	32 *	mm/hr	0 - 10

HOSPITAL COURSE:

Child was admitted in ward with above mentioned complaints. All relevant investigations were done. Initial investigations showed HB 9.2 TLC 13.2K CRP 4/5, Na 124, K 3.1. Child was managed with IV fluids and IV ceftriaxone.

On DOH 1 the childs condition deteriorated he had one episode of seizure in ward characterized by vacant staring and loss of tone of all limbs lasting for < 1 min aborted with IV midazolam. On reassessment child was irritable with AF full with neck stiffness+.

Child was shifted to PICU where he had another episode of seizure. Raised ICP measures were taken with head end elevation, IV manitol, 3% saline infusion, pain and fever control. IV levetiracetam, IV vancomycin and IV dexamethasone were added to the treatment regimen. CECT head done showed non communicating hydrocephalus with basal exudates. Neurosurgery team was involved and CSF tapping was done- 12-15 cc of CSF tapped from Left ventricle . USG WA done showed free floating debri in UB, rest normal. Despite all measures the childs conditioned worsened and the child was intubated in view of worsening GCS and midazolam infusion was started. There was B/L papilledema on fundus examination. Paediatric neurology consult done, advised CSF diversion and ATT. CSF and GA Genexpert showed detection of MTB complex. CSF analysis s/o TBM. ATT was started. The child had multiple episodes of tonic posturing hence midazolam infusion was hiked and Lacosamide added. VP shunt was placed at the right side by Neurosurgery team.

The child is currently on MV PRVC mode FiO2 40%, TV 60, PEEP 5, RR 30.

Vitals: HR 136, BP 112/69, RR 28, SpO2 98

DR VIBIN KUMAR
SENIOR CONSULTANT
DEPARTMENT OF PEDIATRICS
HOLY FAMILY HOSPITAL

HOLY FAMILY HOSPITAL

OKHLA ROAD, NEW DELHI-110 025
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09.05.2026

To,

One Life Organisation
New Delhi

Sub: Request for help

Dear Sir,

This is to certify that Master Navyam 2 years and 3 months old male child came to Holy Family Hospital casualty on 06/05/2026 and admitted him due to fever since 26 days, vomiting, dullness, since 2 days, abnormal vacant stare since 1 day. Child is diagnosis with **CNS Tuberculosis with non – communicating hydrocephalus – post OP VP Shunt**. Parents are financially poor to afford his treatment, so financial aid is required.

It will be kind of you, if you can do some financial help to this child as his parents are not capable of paying so much.

Sr. Elsy Thomas
Department Incharge
Holy Family Hospital
New Delhi- 110025

PERSONAL DEVELOPMENT
HOLY FAMILY HOSPITAL
NEW DELHI - 110025