Dr. Ieetkar's
YASHONANDAN HOSPITAL & NICU
Kalyan (W). Maharashtra 421 301. Tel. : 0251-2212859

Dr. Anant Ieetkar
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MEDICAL SUMMARY
As on 4TH AUGUST 1 pm

Name: B/O RENUKA LAXMAN GHULE	UHID – I260724190000
Address :- BSUP, building no 2, room no 211, 2nd floor, near Muttha college, Umbarde, Kalyan west	Reg no :- 41/7/26
Date & time of birth : 23/7/2026 at 4:10 pm	
Date of admission :- 24/07/2026 at 08:30 pm	Birth weight :- 3.0 kg
Gestation:- Full term	Weight on admission:- 3.0 kg
Age of admission :- Day 2 of life	G6PD activity :- 18
Doctor Incharge- Dr Anant Ieetkar & associates	Gender : MALE

Diagnosis:-
A FULL TERM, DAY 2 MALE NEONATE
APPROPRIATE FOR GESTATIONAL AGE
BROUGHT IN RESPIRATORY ARREST
WITH MECONIUM ASPIRATION
WITH RESPIRATORY FAILURE
WITH EARLY ONSET SEPSIS
WITH ACUTE RENAL FAILURE (RECOVERED)
WITH SEIZURES
WITH PULMONARY HYPERTENSION

Medical History :-
A full term male neonate, AGA, delivered by emergency LSCS i/v/o meconium aspiration, precious pregnancy at Dr Prashant Jadhav's Anu nursing home Kalyan west was brought personally by Dr Prashant Jadhav in his car in emergency on day 2 of life with respiratory arrest ? cause for further neonatal management.

Maternal History :- Primigravida M/S- 8years LMP- 23/10/25 EDD- 30/7/26
h/o 7years primary infertility, conceived with ?IVF

Birth & Postnatal History:- Baby cried immediately after birth, h/o meconium stained liquor. Exact Apgar & other details at birth are not available. Baby was seen By Dr Shashank Sonekar (Paediatrician, Kalyan)at birth Baby was stable, so kept mother's bedside & was on oral feeds. After around 28 hours of life, during routine evening rounds, baby was found to have respiratory difficulty by Dr Jadhav. . Hence baby was immediately brought by Dr Jadhav to this NICU for further management.

On arrival here:-GC :- poor
Wt – 3.0 Kg
HR <100/min, peripheral pulses not felt
RR –no spontaneous respiration
Spo2 – not recordable due to poor perfusion
central cyanosis ++
Reticular pattern+
CRT >5 seconds **NIBP – not recordable**
CVS – S1S2 +
CNS – activity poor, baby limp **tone reduced**
Subtle seizures **P/A – Distension+**
Dx – 33mg/dl

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Clinical Course:-

Explained extreme seriousness to father & relatives. Baby shifted to NICU, airway cleared, baby intubated with no 3.5 ET and IPPR started. HR improved, baby shifted to SIMV ventilation – with PIP-16, PEEP- 6, Freq- 30, Fio2- 40%) to maintain target saturation upto 90%, baby required higher pressures and FiO2 to improve saturation. UVC inserted, necessary samples collected, baby received NS bolus @ 10 ml/kg over 20 min, and dextrose bolus, venous blood gases obtained as peripheral pulses not felt.
VBG suggestive of severe metabolic acidosis with severe hypoxia.(**Ph- 6.5, PCO2- 56, PO2- 41.8, HCO3- 5.2, BE- -30, Lactate- 16.9.** Normal saline bolus repeated, baby started on bicarb correction over next 6 hours. baseline antibiotic inj ceftriaxone empirically. Portable xray chest done on admission showed bilateral haziness with enlarged cardiac shadow. Cardiac POCUS done by Dr Pankaj Kasar (Cardiologist, Kalyan) s/o RA, RV dilated, severity of pulmonary hypertension could not be assessed due to poor RA, RV output. Baby was started on inotropic support inj. adrenalin drip 0.15mcg/kg/min) & inj noradrenaline drip (0.05 mcg/kg/min) for pulmonary vasodilatation.
Initial sepsis work up revealed TLC 19900, platelets 1.43 lacs, procalcitonin – 1.22 ng/ml. sr creatinine was 1.4 mg/dl at 24 hours of life. Baby had severe oliguria since admission (urine output<0.5 ml/kg/hour till next 48 hours).
Blood gases monitored at regular intervals, bicarbonate correction continued over next 24 hours. Baby ha fever spikes with mottled appearance and desaturation intermittently on day 2, fever managed with inj paracetamol, NS bolus repeated, and antibiotics empirically upgraded to inj Meropenem drip after sending repeat sepsis work up that revealed **procalcitonin – 42 ng**/ml, further drop in platelets.
Baby had intermittent seizures in form of tonic clonic movements, requiring loading dose of gardenal, later followed by levera.
Baby had severe oliguria, opinion taken from Dr Amol Madhavi, Pediatric Nephrologist, Mumbai.
IV fluids restricted, and baby started on furosemide drip @ 0.1 mg/kg/hr.
Serial POCUS showed persistent high pulmonary pressures, milrinone drip was started, noradrenaline drip discontinued.
Renal parameters closely monitored, urine output improved following Lasix drip, baby had generalised anasarca, Serum proteins checked, baby received inj Albumin 20% @ 1gm/kg slowly over 6 hours with mid transfusion Lasix.
Serial POCUS showed improving cardiac contractility.
Blood gases showed improved oxygenation and normal bicarbonate levels. Amplitude EEG monitoring continued in NICU, which revealed discontinuous pattern, with lower margin below 5 microvolt. Seizures were controlled on maintenance doses of gardenal and levera.
Blood culture sent on admission showed growth of gram negative bacilli, Pseudomonas aeruginosa sensitive to Inj Meropenem, which was continued.
On day 5, baby had an episode of ET bleed which was managed with suctioning and endotracheal adrenaline administration. Coagulation profile done showed INR 1.6.
Baby's CBC revealed severe thrombocytopenia, requiring one unit of platelet transfusion
Baby extubated to NIV (pressure controlled mode) with 25% FiO2 on day 6 of life. Later, de escalated to CPAP. FiO2 titrated gradually to 21%.
Lasix drip discontinued as urine output improved, renal function showed significant improvement.
RT feeds started and gradually increased as per tolerance. Serial POCUS showed reducing pulmonary pressures, TR jet today is 40mmHg, with mild dilatation of RA and RV. Milrinone drip discontinued.
Plan to do CSF once platelets improve,
Baby will need further continuation of treatment, but parents wish to take second opinion, so this summary has been issued.

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Investigations :-

Date	24/07	25/7/26	26/7/26	27/7/26	28/7/26	29/7/26	31/7/26
Hb	17.3	15.6		15.3		15	15.5
PCV	54	46.5		42.8		40.7	40.1
Tc	19900	15300		19200		7900	9600
N	56	63		88		65	64
L	37	25		8		25	30
PLT	1.43	97000		65000		32000	30000
CRP	0.6	2.90					
G6PD	18						
RBS	270		112	105			
procalcitonin	1.22	42.05		> 50.0			
BUN/creat	20/1.4	22.1/1.62	55.8/1.8	29/1.62	29/1.5		23.0/3.2/100
Na/k/cl	130/7/96	138/4/103	141/5.5/98	137/4.9/102	137/5/102		132/3.2/100
Ionised calcium	1.32			0.81	0.80		0.90
ABG – pH	6.57			7.39	7.39	7.66	
pCO2/pO2	56.9/41.8			22.7/110.2	35.2/79.6	21.1/140.0	
HCO3	5.2			14.0	21.8	18.9	
Urea							57

Date	2/8/26	4/8/26
Hb	16.9	15.9
PCV	45.4	43.4
Tc	7300	9800
N	58	59
L	36	35
PLT	34000	38000
CRP		
G6PD		
RBS		
BUN/creat	15/0.61	
Na/k/cl	135/5.7/100	
Ionised calcium	1.12	
ABG – pH		
pCO2/pO2		
HCO3		
Urea		
procalcitonin	14.40	0.75

28/7/26 Total Protine- 4.50, Albumin- 3.10, Globulin- 1.40, A/G Ratio- 2.21

PT – 22.0 PTT – 45.0 INR-1.64

X ray chest – bilateral severe haziness, with enlarged cardiac shadow

VBG on admission on FiO2 21%
pH = 6.5, PCO2- 56, PO2-41.8, HCO3-5.2
Portable Chest Xray done on admission showed left sided haziness, cardiomegaly
Blood culture (on 24/7/26) – growth of Pseudomonas aeruginosa, sensitivity report attached
(29/7/26) – ET culture – no growth
31/7/26 – urine examination – Ph – 6.0, protein – present, pus cells- 1-2 hpf, red blood cells – absent , crystals – absent,
Bacteria – absent
All original reports & xray handed over to relatives

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Treatment Given :

- NICU care, vitals monitoring.
- IV fluids as per requirement.
- IV NS boluses as per requirement @ 20 ml/kg
- SIMV ventilation (16/6/30/40% on day 1)
- NIV (16/6/20/25) – Shifted on 29/07/26 at 4 pm
- CPAP by nasal prongs with 30% FiO2 from 1/8/26 till date
- Inj Monocef (Ceftiaxone) on day 1
- Inj Noradrenaline drip @ 0.1 mcg/kg/min (24/7/26 to 26/7/26)
- Inj Adrenaline drip 0.15mcg/kg/min started from 24/7/26 to 31/7/26
- Inj Milrinone drip @ 0.5 mg/kg/min from 26/7/26 to 4/8/26
- Inj Meropenem drip @ 120 mg/kg/day from 24/7/26
- Inj Calcium gluconate 6 ml dil in 6 ml of 10% dextrose 8 hourly under heart rate monitoring
- Inj gardenal @ 20 mg/kg loading dose followed by 5 mg/kg/day in two divided doses from 26/7/26 to 4/8/26
- Inj Levera 20 mg/kg loading dose followed by 20 mg/kg/day in two divided doses from 26/7/26
- Inj Lasix drip @ 0.1 mg/kg/hour from 27/7/26 to 31/7/26
- Inj Human Albumin 20% @ 1 gm/kg over 6 hours with mid transfusion Lasix on 28/7/26
- Inj vit K 5 mg IV OD from 28/7/26 for 3 days
- Platelet transfusion on 29/7/26 with mid transfusion lasix
- Care of UVC.

Condition at present

- GC improving
- Activity poor
- Baby on CPAP with PEEP 6, FiO2 21% (since 1/8/26)
- HR 150/min, RR – 60/min, SpO2 – 95% on CPAP
- SCR + needs CPAP to maintain saturation
- On IV fluids as per requirement
- POCUS (4/8/26) – TR jet 40, TAPSE -1, improved cardiac contractility (milrinone drip discontinued today)
- RA & RV dilated
- Cranial POCUS (4/8/26)–nad
- Received platelet transfusion once
- **Urine output (4/8/26) @ 2 ml/kg/hour**
- **sr creatinine on 2/8/26 – 0.6 mg/dl**
- Blood culture sent on admission – growth of Pseudomonas aeruginosa sensitivity report attached
- Amplitude EEG (28/7/26)– discontinuous pattern, lower margin below 5 microvolts
- 4/8/26 – CBC – platelets – 38000, procalcitonin 0.75 ng/ml
- Plan to do CSF examination after platelets improve
- Explained poor prognosis to relatives.
- Explained need of prolong treatment
- Explained possibility of long-term morbidity
- Summary issued to get vacancy confirmation at convenient centre

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Prepared by	Checked by	Approved by
Dr. Chanda		Dr. Ieetkar

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डॉ. ईटकर यांचे

यशोनंदन हॉस्पिटल

रोशन पेट्रोल पंपासमोर, मुरबाड रोड, कल्याण (पश्चिम).
फोन : (०२५१) २२१२८५९, ९२२४५८१८६०

डॉ. अमोल ईटकर
M.B.B.S., D.O.R.L.
कान, नाक, घसा तज्ञ
Consultant E.N.T. Surgeon
वेळ : सकाळी ११ ते १
सायंकाळी ७ ते ९

डॉ. सौ. सुरेखा ईटकर
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सायंकाळी ७ ते ९

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बाल रोग तज्ञ
Consultant Paediatrician
वेळ : सकाळी ९ ते १२
(By Appointment)

डॉ. सौ. मंजुषा ईटकर
B.D.S.
दातांचे डॉक्टर
वेळ : सकाळी १० ते १ (By Appointment)

डॉ. सौ. चंदा अडवाणी
M.B.B.S., D.C.H.
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डॉ. सौ. लीना सुरंजे
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Fellowship In Neonatology

Date:- 4/8/2026

TO,
Bloom One Foundation
Mumbai.

Respected Sir/Madam
Greetings from Yashonandan Hospital

This is to state that **B/O Renuka Laxman Ghule** is admitted at Yashonandan Hospital on 24/7/2026, in NEONATAL INTENSIVE CARE UNIT in extremely critical condition.

Baby has **MECONIUM ASPIRATION WITH RESPIRATORY FAILURE WITH EARLY ONSET SEPSIS WITH ACUTE RENAL FAILURE (RECOVERED)WITH SEIZURES WITH PULMONARY HYPERTENSION BROUGHT IN RESPIRATORY ARREST**

baby is on ventilation since admission, (invasive ventilation till 29/7/26, at present on non invasive ventilation).

Baby will need intensive care for approximately 8-10 days more. .

Exact cost of treatment depends upon duration treatment which is difficult to predict

Approximate cost of this hospital treatment will Rs. 5 to 6 lakhs, Approximate NICU stay Considering 25 to 30 days.

Laboratory & Medicines expenses will be extra as per requirement.

Exact expenses depend upon duration of admitted days.

This letter has been issued on request of father for arranging finances.

Todays Total bill hospital :- 190700

Total paid till now 81140

Dr. Anant Ieetkar

YASHONANDAN HOSPITAL KALYAN

बालरोग चिकित्सा (Paediatric Medicine)
ओपीडीची वेळ : 9 Am. ते 9 Pm.
यशोनंदन हॉस्पिटलच्या 5 बालरोगतज्ञांच्या अथवा RMO डॉक्टरच्या टीमपैकी उपलब्ध डॉक्टर आपल्या बाळास तपासतील.
लसीकरण दररोज सर्व लसी उपलब्ध

प्रकृतीमध्ये सुधारणा नसल्यास फेरतपासणीसाठी यावे.

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