HOLY FAMILY HOSPITAL
Okhla Road, New Delhi-110025
Phone : 011-35034000, 44020000
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CASE SUMMARY

CASE SUMMARY

NAME: BHAVYA SINDHWANI
IP NO: 2600[illegible]
MR NO: 3418[illegible]
DATE OF ADMISSION: 08/01/2026

Diagnosis- TBM WITH COMMUNICATING HYDROCEPHALUS WITH RAISED ICP

11 month old child born 1st in birth order from non-consangiuneous was well till around 23rd october 2025 then he developed fever which was low moderate grade associated with lethargy, mild cough, coryza. Child was shown to pediatrician, initially given symptomatic treatment but child improved by 15/12/2025. Child then again developed fever on 24/12/25, 6 hourly spikes not associated with any other symptoms. He was admitted in cloudnine hospital then admitted to HFH on 08/01/2026 with complaint of fever for 15 days. Child was managed with IV ceftriaxone, Oral Azithromycin and other supportive treatments. Child was throughly investigated. Inflammatory markers were normal. USG WA done reported normal. Xray chest done, reported normal.. ENT consult done, showed resolving ASOM. In view of persisting fever 2D echo done, reported normal. CT chest + abdomen reported normal. Skeletal survey done, reported normal. In view of (D5) High grade Fever spikes occurring every 4-6 hours, even after no focus of fever. Child is being referred to DR. SUJATA SAWHNEY (senior consultant in pediatric and Adolescent Rheumatology gangaram hospital).

Child was taken to Gangaram hostpital in 20/01/26 and was admitted for 5days in the duration of which Blood CS, pofile 2D echo was repeated, reported normal. Immunoglobin profile and mantoux reported neagtive. Bone marrow aspiration and biopsy was done, verbally told to be reactive. Gram stain was AFB -ve.

In suspicion of atypical kawasaki disease IVIG was started. As diagnosis was not clear and child was extremely irritable with continous fever, he was started on iv streoids. 24Hr after IVIG and after starting methylprednisolone, child became afebrile and was discharged on oral steroids.

Child presented to HFH again on 24/02/2026 with complaint of vomiting for 12hours and decreased apetite and fever. child was managed with IVF, iv Ceftriaxone and other supportive treatments. Blood culture was done, showed no growth. During the course of stay fever reduced in intensity and duration and the appetite improved and hence child was discharged.

However, child was readmitted to HFH hospital on with complaint of fever, vomiting and abnormal body movements (2 episode of GTCS each lasting 10-15 seconds) i/v/o which EEG was done reported normal. In suspicion of CNS vasculitis MRI brain with contrast was done, was suggestive of CNS tuberculosis with enhancing granulomatous lesions, basal exudates and moderately severely

Patient	: Master. BHAVYA SINDHWANI	Order Number	: 190633577
MR No.	: 2436744	Accepted Dt & Tm	: 26/03/2026 2:03
Age/Sex	: 1 Years 1 Months 3Days / Male	Approved Dt &	: 26/03/2026 5:47
Ref. Doctor	: Dr. DINESH RAJ	Bill No.	: 262090050
IP	: 26007272	Approved By	: Dr. RENEE G. KU
Ward/Bed	: IPCU / 304 / 007	Typist ID	: 8287

EMRI BRAIN

Clinical Information
H/o abnormal body movements.

Protocol
MR imaging of the brain was performed on a 1.5 Tesla scanner using standard protocol sequences T2, FLAIR, DWI/ADC and SWI, with sagittal and coronal reconstruction. This was followed by a co enhanced study.

Findings

Brain parenchyma
Normal grey white matter differentiation **with evidence of periventricular hypodensities and a conglomerate of avidly enhancement mildly thick-walled rim-enhancing lesion in the left periventricular region.**

Ventricular system and CSF spaces
Cortical sulci are partially effaced with preserved basal cisterns and evidence of enhancin basal exudates and exudative material along the floor of fourth ventricle extending into the spinal meninges.
The ventricular system is moderately dilated with compression of the left frontal horn. The no shift of midline.

Midline structures
The midline is centered with radiologically normal corpus callosum and pituitary gland.

Extra-axial spaces
Unremarkable with no evidence of extra-axial hemorrhage, mass or collection.

Vascular flow voids
Normal flow voids of major intracranial arteries

Sinuses and mastoid air cells
Paranasal sinuses and mastoid air cells are clear

Skull and orbits

paeds

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NEW DELHI-110025

ENT OF EMERGENCY MEDICINE
AL ASSESSMENT SHEET

MRNo/ENo	:2436744
Name	:Master.BHAVYA SINDHWANI
Relative Name	:S/O.VIPUL SINDHWANI
Age/Gender	:1 Y 28 D /Male
Mobile	:9654435073
Date & Time	:23/03/2026 08:17:34 pm

☐ Walking ☐ Wheelchair ☐ Stretcher — Allergy: nil

8.05 pm ट्रैफिक

Seen by Dr: [illegible]
Time: 8:15 PM

1 R, 2 Y, (3) G, 4 B

BP mmHg	Temp °C	Pain Score	Important
	38.1		

SpO2	RBS mg/dl	LMP
96% on room air / on O2 at L/min		—

Name & Sign of S/N- Rocci Soro — Time: 8:05pm — Type: ☐ MLC ☐ Non MLC — Wt - 8.2 kg

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Presenting Complaints:

Vomiting x one day
↳ food particles, nP, nB.

fever x today
loss of appetite.
Hard stool. h/o Constipation.
u/o = (+)

d with
ed
d
taneous Breathing

Examination:

CNS = Con.
CVS = S1S2 (+)
RS = B/L AE ⊕. clear
P/A = soft, NT, ND.

ular/Irregular
/ Central pulse - Vol -
or / Absent
Awake / Alert
to Verbal commands /
esponsive
V- M-
Lt-
k / Sluggish

Past History:

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[signature] → evaluation

Provisional Diagnosis:

mmy Extremities
Bleeding
f any)

ECG	VBG / ABG	CBC	MP (F&V)	KFT	LFT	S. Amylase	S. Li
Trop-I	Blood C/S	Dengue	PT/INR	S. Electrolytes	UPT	Urine R/M and C	
CXR	Pelvis - X-ray- AP	Abdominal X-ray E/S	USG	C- Spine - NCCT or X-ray AP / Lat	NCCT Head	Others	

tions
d:
ogy:

Admit in ward → Paed. ca

F-17B

HOLY FAMILY HOSPITAL, NEW DELHI-110025

OPERATION REPORT

P.D. NUMBER	SEX	AGE	I.P.D. NUMBER
ME	ROOM No.		ACCOMMODATION

MR NO / IP NO : 2436744 / 26007272 23/03/2026 08:29 PM
Name : Master. BHAVYA SINDHWANI
Relative Name : S/O.VIPUL SINDHWANI
Age / Sex : 1 Y 28 D /M Mobile: 9654435073
Bed No : 301 / 010 at 3WD - NSB Cash / Hospital
Admitting Dr. : Dr.DINESH RAJ
Co Consultant :

Date 30/03/26

sthesia GENERAL ANAESTHESIA

sthetist DR. MAMTA

Time Started 8.20 a.m. Ended 9.45 a.m.

geon DR. VIKRAM

Assistant —

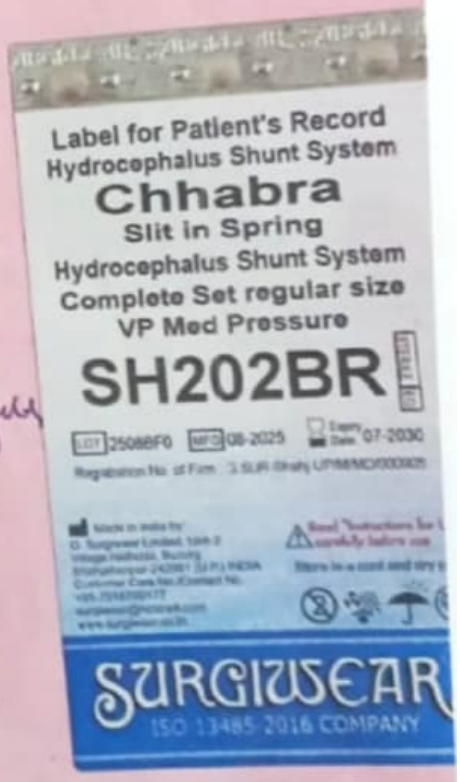
Operative Diagnosis Hydrocephalus

Sponge Count Correct. Whom SONIYA DONA TSUMAR

-Operative Diagnosis

ration (R) VP shunt with slit spring med. pressure

cription



SURGEON'S SIGNATURE
DR. VIKRAM

ent to Pathology Lab.

ness, shock and in rare cases death also and there may be reactions which are yet unknown to medical science

communicating hydrocephalus, I/V/O which child was started on ATT. Neurosurgery consultation was taken and Plan is to do CSF analysis to analyse csf proteins, if normal to plan for VP shunt.

Dr. Dinesh Raj
Senior Consultant Pediatrics
Holy Family Hospital, Okhla

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