

# MULTIDRUG-RESISTANT *KLEBSIELLA* PNEUMONIA WITH COLISTIN-INDUCED ACUTE KIDNEY INJURY IN A PATIENT WITH EMPHYSEMA: A CASE REPORT OF A 70 YEARS OLD MALE WITH INTEGRATIVE YOGA PRANA VIDYA (YPV) HEALING SUPPORT

Leelavathi Nayak<sup>1</sup>, Venkata Satyanarayana Nanduri\*<sup>2</sup>

<sup>1</sup>Certified YPV healer and Trainer, Mangalore, Karnataka, India.

<sup>2</sup>Consultant, Research & Publications, YPV Ashram, Sri Ramana Trust, Thally-635118, Tamil Nadu.

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\*Corresponding Author: Venkata Satyanarayana Nanduri

Consultant, Research & Publications, YPV Ashram, Sri Ramana Trust, Thally-635118, Tamil Nadu.

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## ABSTRACT

**Background:** Multidrug-resistant (MDR) *Klebsiella pneumoniae* infections pose significant therapeutic challenges, particularly in patients with chronic lung disease. Colistin remains a last-resort antibiotic but is associated with nephrotoxicity. **Case Presentation:** A 70-year-old male with emphysema, diabetes, and hypertension presented on 28 December 2025 with breathlessness, cough, fever, and weakness. Initial management with Tazobactam, Clindamycin, and later Meropenem failed to improve symptoms. On 5 January 2026, he was admitted to Manipal Hospital, Bangalore, with severe hypoxia requiring HFNC oxygen. Bronchoscopy on 9 January revealed MDR *Klebsiella pneumoniae*, sensitive only to Colistin and Tigecycline. IV Colistin, Tigecycline, and steroids were initiated, leading to clinical improvement and discharge on 14 January. By 19 January, blood tests revealed acute kidney injury attributed to Colistin. Colistin was discontinued, and Tigecycline continued for 12 days. Renal function normalized by 23 February. Chest X-ray on 29 January showed ~60% resolution of pneumonia. Oral steroids and inhalers were prescribed. By February 2026, the patient remained stable with oxygen saturation of 90% without support, though mild cough and weakness persisted. Parallel Yoga Prana Vidya (YPV) healing sessions were administered throughout hospitalization and recovery, reported by family to aid faster recovery. **Conclusion:** This case highlights the importance of culture-directed therapy in MDR pneumonia, vigilance for antibiotic-induced nephrotoxicity, and the potential adjunctive role of integrative healing practices in recovery.

**KEYWORDS:** Multidrug-resistant pneumonia, *Klebsiella pneumoniae*, Colistin nephrotoxicity, Emphysema, Integrative healing, Yoga Prana Vidya System®, YPV®.

## INTRODUCTION

Multidrug-resistant (MDR) Gram-negative infections, particularly *Klebsiella pneumoniae*, are increasingly encountered in clinical practice. Patients with chronic lung disease such as emphysema are at heightened risk of severe pneumonia and poor outcomes. Colistin, often used as salvage therapy, carries a high risk of nephrotoxicity.<sup>[1-3]</sup> This case illustrates the clinical challenges of managing MDR pneumonia in a patient with emphysema, complicated by antibiotic-induced renal dysfunction, and explores the adjunctive role of Yoga Prana Vidya (YPV) healing.

Literature shows that YPV healing protocols have been successfully applied as complementary and alternative medicine, as an adjunct, in the treatment of many complicated medical cases including various types of malignancy and cancer.<sup>[4-12]</sup> As an integrated and holistic system YPV healing have been producing sustained results as evidenced in several studies.<sup>[13-15]</sup>

## CASE PRESENTATION

**Patient profile:** Male, 70 years, smoker (history of 40 years), comorbidities: emphysema, diabetes, hypertension, depression, prior stroke (recovered).

**YPV intervention** (Complementary healing Sessions):

Since 28 December 2025, the Certified Healer gave YPV healings for treating Emphysema COPD issue because he was a regular smoker for more than 40 years. From 28 December 2025 to 05 February 2026 Healing sessions were conducted twice daily in 20-minute sessions. Later on, the Healer reduced the sessions to once daily till 23 February 2026. Thereafter, at the request of his son, healings were continued till 05 March 2026 as maintenance healing, on alternate days as his symptoms (cough, shortened breath) reduced.

Then, it was decided to end the sessions as he was stable, practicing YPV Rhythmic yogic breathing on his own. Stated below are YPV protocols applied by the YPV Certified Healer as adjunct to Conventional medical treatment.

- YPV Psychotherapy to reduce stress
- Colour healing to clean, energise, and balance the Chakras
- Blood cleansing and strengthening techniques applied to lungs
- YPV Level 2 infection control
- Liver, spleen, and kidneys thoroughly cleansed.
- Healer Development Program Level 1 (HDP L1) protocol applied for kidneys.

**Timeline of clinical events:**

- **28 Dec 2025:** Admitted locally with pneumonia, hypoxia (O<sub>2</sub> sat 65–70%), hypotension. Treated with Tazobactam + Clindamycin, BiPAP oxygen.
- **30 Dec 2025:** Shifted to Eskey Hospital, Bangalore. Meropenem initiated, no improvement.
- **5 Jan 2026:** Admitted to Manipal Hospital ICU, HFNC oxygen support. (annexure 1).
- **9 Jan 2026:** Bronchoscopy → MDR *Klebsiella pneumoniae*, sensitive only to Colistin & Tigecycline. Started IV Colistin + Tigecycline + steroids.
- **14 Jan 2026:** Discharged, improved O<sub>2</sub> saturation (80–85% without support). Continued IV therapy at home.
- **19 Jan 2026:** Blood tests → acute kidney injury (↑ creatinine, ↑ urea). Colistin stopped, Tigecycline continued.
- **29 Jan 2026:** Chest X-ray showed ~60% improvement. Oral steroids and inhalers prescribed. Blood report dt 29-01-2026 shows acute kidney injury is at Annexure 2.
- **Feb 2026:** Stable, O<sub>2</sub> saturation 90% without support, mild cough and weakness persisted. Renal function and diabetes normalised (blood report is at Annexure 3).
- **March 2026:** A follow up of patient revealed that His doctor found his blood test and x-ray report showing normal, showing COPD with COP recovered. The Doctor was satisfied with the progress and advised to take one injection after one month and if necessary any time can use nebulizer

and inhaler if symptoms re-appear. It was observed that he was stable and stopped smoking completely.

**RESULTS: SUMMARY**

Renal function showed gradual improvement with supportive measures, though close follow-up was advised due to age-related vulnerability.

*YPV Healing as Supportive therapy:* Daily YPV healing sessions from 28 December 2025 for emphysema, continued during hospitalization and recovery. Patient's family reported faster recovery and stabilization, and their detailed feedback is at Annexure 4.

**DISCUSSION**

Infections by multidrug-resistant (MDR) bacteria have become a worldwide public health problem in recent years [16]. The causes of the development and spread of these bacteria are multifactorial, based on the indiscriminate use of antimicrobials for prolonged periods, as well as through contact with contaminated healthcare workers.<sup>[17]</sup>

**MDR \*Klebsiella pneumoniae\* in Clinical Practice**

MDR \*Klebsiella pneumoniae\* is recognized globally as a critical priority pathogen due to its resistance to multiple antibiotic classes. A recent review emphasized that therapeutic regimens often require \*\*double or triple drug combinations\*\*, yet outcomes remain limited, particularly in elderly or immunocompromised patients<sup>[16]</sup> In our case, culture-directed therapy with Colistin and Tigecycline was essential, echoing findings that empiric regimens are frequently ineffective against MDR strains.

**Case Comparisons from medical literature**

*Kidney transplant patient (Frontiers, 2025):* A case of MDR \*Klebsiella\* infection in a renal transplant recipient required aggressive therapy, but nephrotoxicity complicated management. This parallels our patient's "Colistin-induced acute kidney injury", underscoring the vulnerability of patients with comorbidities<sup>[17]</sup>

**Primary lung abscess (BMJ Case Reports, 2025)**

MDR \*Klebsiella\* caused necrotizing pneumonia with lung abscess formation, requiring prolonged therapy and careful monitoring. This highlights the potential for severe pulmonary complications beyond pneumonia, reinforcing the importance of early culture and sensitivity testing [BMJ Case].<sup>[18]</sup>

These cases demonstrate that MDR \*Klebsiella\* infections often demand prolonged, high-risk therapy, with nephrotoxicity and pulmonary complications being recurrent themes.

**Colistin Nephrotoxicity**

Colistin remains a last-line agent but is notorious for "dose-dependent nephrotoxicity". Literature reports nephrotoxicity rates ranging from 20–50%, often reversible upon discontinuation. In our patient, renal

function normalized after stopping Colistin, consistent with published outcomes. This case reinforces the need for close renal monitoring during therapy and consideration of alternative agents when feasible.

### Role of Adjunctive Therapies

While conventional literature focuses on pharmacological strategies, our case uniquely integrates Yoga Prana Vidya (YPV) healing as supportive therapy. Although evidence remains limited, integrative practices may contribute to improved patient resilience, symptom relief, and recovery. Documenting such adjunctive interventions adds value to case reports, especially in chronic disease contexts where holistic care is increasingly recognized.

### Findings learned from this case

- Culture-directed therapy is indispensable in MDR pneumonia.
- Colistin nephrotoxicity is common but reversible with timely discontinuation.
- Steroid-induced leucocytosis can confound infection monitoring.
- Integrative healing practices show promise to provide supportive benefits, and deserves further systematic study.

This case underscores several critical points:

1. Culture-directed therapy: Empirical antibiotics failed; bronchoscopy and culture were pivotal in identifying MDR *Klebsiella*.
2. Colistin nephrotoxicity: Despite clinical improvement, acute kidney injury developed within 5 days of therapy. Prompt discontinuation led to recovery.
3. Steroid-induced leucocytosis: Elevated WBC counts were noted, requiring careful interpretation.
4. Integrative healing: YPV healing was reported to aid recovery, suggesting potential adjunctive benefits in chronic lung disease and infection recovery.

The case highlights the delicate balance between effective antimicrobial therapy and drug toxicity, especially in elderly patients with comorbidities.

This case contributes to the growing body of evidence on MDR “*Klebsiella pneumoniae*” pneumonia, highlighting the balance between effective antimicrobial therapy and drug toxicity. Comparative cases confirm that nephrotoxicity is a frequent complication of Colistin therapy. Our report adds a novel dimension by documenting the supportive role of YPV healing, suggesting that integrative approaches may complement conventional management in complex infections.

### CONCLUSION

MDR *Klebsiella pneumoniae* pneumonia in emphysema patients requires culture-guided therapy and close monitoring for antibiotic toxicity. Colistin-induced nephrotoxicity can be reversible with timely

discontinuation. Integrative healing practices such as YPV may provide supportive benefits, warranting further study.

### ACKNOWLEDGMENTS

We are thankful to the patient and his family for sharing case details on assurance of anonymity. Our thanks are also to Sri Ramana Trust for permission to use their copyrighted terms Yoga Prana Vidya® and YPV®.

### Conflicts of interest

There are no conflicts of interest.

### Funding

There is no funding.


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**Annexure 1**

Discharge summary dated 14 -01- 2026 – pages 1 to 4




**LIFE'S ON**



**DEPARTMENT OF RESPIRATORY  
MEDICINE & PULMONOLOGY**

**DISCHARGE SUMMARY**



1 1 1 0 0 0 0 4 0 0 6 2 -

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<b>NAME</b> :	[REDACTED]	<b>HOSPITAL NO</b>	[REDACTED]
<b>Age/Sex</b> :	69 Yrs / Male	<b>IP NO</b>	[REDACTED]
<b>Admission Date</b> :	05/01/2026 11:39PM	<b>Medical Discharge Date</b> :	14/01/2026 12:50PM
<b>Admitted under</b> :	DR. VASUNETHRA KASARGOD	<b>Department</b>	RESPIRATORY & MEDICINE & PULMONOLOGY
<b>PayorName</b> :	ICICI LOMBARD GENERAL INSURANCE CO	<b>Ward/Bed</b>	MALE GENERAL WARD MHM/552

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**DIAGNOSIS**

HPE - organizing pneumonia.  
 COMMUNITY ACQUIRED PNEUMONIA - S/P BRONCHOSCOPY WITH CRYO BIOPSY SURGERY on 09/01/2026  
 TYPE I RESPIRATORY FAILURE

**CHIEF COMPLAINTS**

COMPLAINTS OF BREATHLESSNESS SINCE 25.12.2025 WORSENER SINCE 3.1.26

**HISTORY OF CURRENT ILLNESS**

HISTORY OF FEVER ON AND OFF ASSOCIATED WITH COUGH SINCE 25.12.2025

**PAST HISTORY**

-

**GENERAL PHYSICAL EXAMINATION**

Pallor : YES  
 Icterus : NO  
 Edema : NO  
 Clubbing : YES  
 Cyanosis : NO  
 Lymphadenopathy : NO

**PHYSICAL EXAMINATION**

BP:100/70 mmHg  
 Pulse:86/min  
 RR:20/min  
 Temp:97.1°F  
 SpO2:55% on room air  
 CVS: S1, S2+

Hospital Millers Road  
 Millers Road,  
 Anne's College,  
 Bangalore - 560 052.  
 P 7100 4500 / 80 6191 4686

Manipal Hospitals (Bengaluru) Private Limited  
 (Formerly Vikram Hospital (Bengaluru) Private Limited)  
 CIN: U85110KA2009PTC049257  
 Regd. Off. The Annexe, #98/2, Rustom Bagh, Off. HAL Airport Road, Bengaluru - 560 017  
 P +91 80 4936 0300 E info@manipalhospitals.com www.manipalhospitals.com

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<b>Age/Sex</b>	:	69 Yrs / Male	<b>IP NO</b>	:	[REDACTED]
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RS: Bilateral NVBS+  
PA: Soft. BS+  
CNS: Conscious, alert and oriented

**SURGICAL/THERAPEUTIC PROCEDURES**  
BRONCHOSCOPY WITH CRYO BIOPSY SURGERY done on 09/01/2026 by DR. VASUNETHRA KASARGOD

**COURSE OF TREATMENT IN HOSPITAL**

Mr. Panduranga .DT., aged 69 years, presented with above mentioned complaints. Now, admitted for further evaluation and management. On examination, he was -febrile , HR -86/min, BP 100/70mmHg, SpO2 -98% at RA. Chest had bilateral crepts, else systemic examination was insignificant. Relevant labs done showed Hb 8.2, TC 18180, Platelet count 230000, BUN 18.00, Sr. Creatinine 2.06, Sodium 134.0, Potassium 2.51, Sr. Bicarbonate 32.0, Sr. Vitamin B - 12 > 2000, Total Iron 21.0, Total Iron Binding capacity 187.9, Transferring saturation - 11.2, ferritin 222.10, HbAlc - 6.3, ABG showed pH 7.562, pO2 53.2, pCo2 38.0, ctHb 8.00, sO2 85.7, cLAC 1.1, cHCO3 34.60, TCO2 79.3, cBese (Ecf1) 11.00, ECHO:EF - 60 %, PASP - 19, NORMAL CHAMBER DIMENSIONS, GRADE 1 LV DIASTOLIC DYSFUNCTION, NORMAL LV & RV SYSTOLIC FUNCTION, NO RWMA, NO CLOTS/VEGETATIONS/PERICARDIAL EFFUSION /PAH.

Dr. Dheeraj Karanth .C (Consultant Gastroenterologist) opinion was sought in view of anaemia and advised for iron correction once infection settles and OGD and Colonoscopy on later days.

Outside CT chest suggestive moderate pleural effusion, mild pericardial effusion. Consolidation with reticulonodular opacities involving the posterior segments of both lower lobes and right upper lobe, dense consolidation in the right lower lobe, hence Planned for Bronchoscopy and Cryo-lung biopsy. After informed and written high risk consent bronchoscopy with fluoroscopy guided transbronchial cryo-lung biopsy + Bal done under GA on 9.1.2026, Bronchoscopy showed bilateral normal bronchial tree. Bal taken from bilateral bronchial tree, fluoroscopy guided transbronchial cryolung biopsy taken from right superior, middle, anterior, posterior lobes, hemostasis achieved. Patient tolerated procedure well, no complications, post procedure fluoroscopy showed no pneumothorax. Bal sent for- AFB smear, gram/KOH smear, gene Xpert-TB, TC/DC, aerobic and AFB culture, TBB- histopathology.

In view of low haemoglobin one pint of PRBC was transfused. Bal analysis showed TB - negative, WBC 250, neutrophil 80, lymphocyte 20 and cytology - negative. Upon stabilization, patient was shifted to ward with HFNC. Patient was continued on incentive spirometry and vitals were monitored regularly. If haemoglobin does not improve in 5 weeks to consider Pan GI endoscopy.

Bal culture showed Klebsiella pneumoniae - Pan resistant, Intermediate to Tigecycline and colistin, Histopathology showed organizing pneumonia.

Labs on discharge Total Count 10940, HB 9.2, Platelet 278000, Creatinine 1.25, sodium 134, potassium 3.70

Patient was treated with IV [Tigecycline, Colistin ], IV Methylpred, antacid, antipyretic, nebulization's, oxygen and other supportive medications. Patient is symptomatically

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LIFE'S ON



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better and patient is being discharged in stable condition with normal vitals and saturation of 95% on 1-2litre of oxygen .

**Condition At Discharge**

STABLE

**DISCHARGE ADVICE**

INJ TIGECYCLINE 100MG INTERVENOUS 1-0-1 X 5 DAYS IN 100ML NORMAL SALINE OVER 1 HOUR  
 INJ COLISTIN 4.5mIU INTERVENOUS 1-0-1 X 5 DAYS IN 100ML NORMAL SALINE OVER 1 HOUR

NEB LEVOLIN (0.63MG) 1(7AM)-1(11AM)-1(3PM)-1(7PM) X 1 WEEK AND SOS IN CASE OF SEVERE COUGH / BREATHLESSNESS  
 NEB FORAPRL (0.5) 1(8AM)-0- 1(8PM) X 10DAYS AND REVIEW (GARGLE MOUTH WITH WATER AFTER USE)  
 NEB GLYCOPRL 25MCG 1(9AM)-0-1(9PM) X 10DAYS AND REVIEW

TAB SOMPRAZ 40MG 1-0-0 X 10 DAYS (BEFORE FOOD)  
 TAB PREDMET 16MG 1-0-0 X 5 DAYS -- FOLLOWED BY 12MG 1-0-0 X 5 DAYS --- FOLLOWED BY 8MG 1-0-0 X 5 DAYS --- FOLLOWED BY 4MG 1-0-0 X 5 DAYS AND REVIEW

SYRUP POTKLOR 15ML 1-0-1 X 2 DAYS  
 TAB MUCINAC 600MG 1-1-1 X 5 DAYS (IN A GLASS OF WATER)  
 CANDID MOUTH PAINT 1-1-1-1 X 5 DAYS (BEFORE FOOD)  
 TAB DOLO 650MG SOS FOR FEVER / PAIN

TAB LASIX 40MG 1-0-0 X CONTINUE  
 TAB IVABRAD 5MG 1-0-0 X CONTINUE (IF HEART RATE >100)  
 TAB ESCITALOPRAM 10MG 0-0-1 X CONTINUE  
 TAB CLOPILET 75MG 0-1-0 X CONTINUE  
 TAB ATORVA 10MG 0-0-1 X CONTINUE  
 TAB TELMA 40MG 0-0-1 X CONTINUE (BP MORE THAN 140/90mmHG)  
 TAB TELMA-H 1-0-0 X CONTINUE (BP MORE THAN 140/90mmHG)  
 TAB JANUMET 50/500MG 1-0-0 X CONTINUE (BEFORE FOOD)  
 TAB DILZEM SR 90MG 1-0-0 X CONTINUE

**\*\*OTHER INSTRUCTIONS :**  
 HOME OXYGEN TO MAINTAIN SPO2 : 90 - 92% WITH 1-2LITRE/MIN 16 HOURS A DAY + OVERNIGHT  
 INCENTIVE SPIROMETRY  
 CBC, RP2 AFTER 2 DAYS AND SHARE ON WHTSAPP

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LIFE'S ON

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OGD AND COLONOSCOPY ON OPD BASIS  
MONITOR BLOOD SUGAR LEVELS AND FOLLOW UP WITH REGULAR DIABETOLOGIST

### FOLLOW UP ADVICE ON DISCHARGE

Review after 5 days with CXR - PA VIEW in Pulmonology OPD with Dr. Vasunethra Kasargod with prior appointment.

For Appointment, Please Call on 8884988383 (8:00 am-6:00pm)

For any kind of assistance, please call on 080-71004500/080-61914686 (24\*7)

Review after 10days with CBC in Gastroenterology OPD with Dr. Dheeraj Karanth C with prior appointment.

For Appointment, Please Call on 9900014825 (8:00 am-6:00pm)

For any kind of assistance, please call on 080-71004500/080-61914686 (24\*7)

### CONTACT IN EMERGENCY:

In case of emergency, please report to emergency immediately.

\*\*For Manipal Hospital, Millers Road ambulance services, please call 080-4500-4600\*\*

DISCHARGE SUMMARY EXPLAINED BY  
 \_\_\_\_\_ (Name / Signature)  
 DISCHARGE SUMMARY HAS BEEN EXPLAINED TO ME AND I HAVE UNDERSTOOD  
 \_\_\_\_\_ (Name / Signature)

We offer Homecare Services to provide care at your home.

For further details, please contact us on M: 8884445942.

**DR. VASUNETHRA KASARGOD**  
 MBBS, MD Pulmonary Medicine  
 Department of RESPIRATORY MEDICINE & PULMONOLOGY, Reg No:87920

Annexure 2  
Blood report 29 Jan 2026

Centre for High-tech Lab Services, Ultrasound Scan, Multislice CT Scan, 1.5T Digital MRI Scan, Digital X-RAY, ECHO, TMT & Endoscopy

vivekascans@gmail.com www.vivekascans.com

**VIVEKA SCANS & DIAGNOSTICS**  
No.1681, Next to Punjab National Bank, Vidya Nagar, Tumkur Road, T. Dasarahalli, Bangalore - 560057. Ph : 9108889990

ISO 9001:2015

REG/LAB NO. : 26012762 / 227468  
AGE/SEX : 70 Yrs / Male DATE OF COLLECTION : 19-01-2026 at 08:33 AM  
REFERRED BY : Dr. SHUBHA DATE OF REPORT : 19-01-2026 at 09:38 AM  
BILL NO. : 227549

TEST PARAMETER	RESULT	REFERENCE RANGE	SPECIMEN
<b>RENAL FUNCTION TEST (RFT)</b>			
BLOOD UREA METHOD: UREAISE - GLDH	128.1 mg/dL	13 - 40 mg/dL	SERUM
SERUM CREATININE METHOD: JAFFE'S	2.62 mg/dL	0.6 - 1.4 mg/dL	SERUM
Creatinine is a by product of muscle energy metabolism is produced at a constant rate according to the muscle mass of the individual. Creatinine is a fairly reliable indicator of kidney function. Creatinine levels should be correlated with clinical data and used in conjunction with other renal function tests for complete assessment.			
S.SODIUM	130.4 mmol/L	135 - 155 mmol/L	SERUM
Interpretation: • Low levels are noted in prolonged vomiting or diarrhea, diminished reabsorption in the kidney and excessive fluid retention. High levels are seen in case of excessive fluid loss, high salt intake and increased kidney reabsorption.			
S.POTASSIUM(K <sup>+</sup> )	3.38 mmol/L	3.5 - 5.5 mmol/L	SERUM
Interpretation: • Low levels are noted in reduced intake of dietary potassium or excessive loss of potassium from the body due to diarrhea, prolonged vomiting or increased renal excretion. High levels may be caused by dehydration or shock, severe burns, hemolysis, diabetic ketoacidosis, and retention of potassium by the kidney. False low or high values are found if the sample is not collected properly. Eg.Hemolysed samples, Anticoagulated samples.			
S. CHLORIDE	92.6 mmol/L	98 - 108 mmol/L	SERUM
Interpretation: • Low levels are noted in reduced dietary intake, prolonged vomiting and reduced renal reabsorption as well as some forms of acidosis and alkalosis. High levels are found in dehydration, kidney failure, some forms of acidosis, high dietary or parenteral chloride intake, and salicylate poisoning.			
RANDOM BLOOD SUGAR METHOD: GOD - PGD	116.1 mg/dl	70 - 140 mg/dl	SERUM

Dispatched by: DR.SHASHIKALA, M.D \*\*\*\*\* End of Report \*\*\*\*\* Printed by: THILAK KUMAR on 19-01-2026 at 10:39 AM

*Shubha*  
**Dr. Shashikala M.D**  
MBBS,MD  
Consultant Biochemist (KMC No: 90764)

Page 1 of 1

Centre for High-tech Lab Services, Ultrasound Scan, Multislice CT Scan, 1.5T Digital MRI Scan, Digital X-RAY, ECHO, TMT & Endoscopy

Annexure 3  
Blood report dt 23 Feb 2026

**CANARA DIAGNOSTIC CENTRE**  
Centre for HI-tech Diagnostic Services and Multi - Speciality Polyclinic  
# 14, S.M. ROAD, SHABARI NAGAR, (BEHIND RELIANCE FRESH) NEAR AYYAPPAN TEMPLE,  
JALAHALLI WEST, BANGALORE - 560 015. Ph. : 9900995369  
Dr. SUJATHA UDUPA. MBBS., MD. E-mail : sujathakudupa@rediffmail.com

Reg No : ██████████ Bill Date : 23-Feb-2026  
Name : ██████████ Age /Gender : 70Years / Male  
Referred By : DR.PRASHANTH B.V Rep Date : 23-Feb-2026 3:58 pm

Test Name	Result	Unit	Reference Range
<b>HAEMATOLOGY</b>			
COMPLETE BLOOD COUNT (Hematology Auto analyzer)		nmol/L	
Haemoglobin (Hb) (Automated)	10.4	gm/dl	MALE 14.0 - 17.0
RBC Count (Automated)	4.16	million/cmm	4.00 - 5.50
Packed Cell Volume (PCV) (Automated)	33.6	%	39.0 - 54.0
Platelet Count (Auto analyzer/verified in smear)	1.96	Lakhs/cmm	1.40 - 4.40
<small>Please repeat with another sample in case very low counts for reconfirmation</small>			
MCV	80.77	fl	76.0 - 96.0
MCH	25.00	pg	27.0 - 33.0
MCHC	30.95	gm/dl	30.0 - 36.0
WBC-Total Leukocyte Count (Automated)	15,100	Cells/cumm	4000-11000
<b>BIOCHEMISTRY</b>			
DIFFERENTIAL WBC COUNT (Automated/verified in smear)		%	
Neutrophils	75	%	40-75
Lymphocytes	21	%	20-45
Eosinophils	02	%	02 - 06
Monocytes	02	%	02 - 08
Basophils	00	%	00 - 01
Urea, Serum (Urease-GLDH, method)	34	mg/dl	20 - 43
Serum Creatinine (Jaffe's, Kinetic-method)	1.12	mg/dl	0.70 - 1.30
RANDOM BLOOD SUGAR	131	mg/dl	70 - 140

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End Of Report  
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T.G.  
LAB TECHNOLOGIST

For  
T.G. Gomati  
PATHOLOGIST

Annexure 4

**Detailed feedback from patient's son**

Atma Namaste, My father Mr.xxx aged 70 years from Tumkur, got admitted at nearby hospital on 28/12/2025 with history of Breathlessness, Cough, fever and Generalized weakness for 3 days. Then shifted to Bangalore Eskey Hospital on 30/12/2025 with history of Breathlessness, Cough, fever and Generalized weakness for 4 to 5 days. On examination, Blood test and Chest X-Ray, diagnosis of Right lung **lower lobe Pneumonia** was made, as WBC count was high and Oxygen saturation was 65 to 70, BP was less, so admitted in ICU, started with antibiotic injection.

Tazobactam and clindamycin, Paracetamol infusion, Bipap Oxygen support, nebulization, and even after 3 to 4 days no improvement in symptoms noted, hence changed antibiotic to injection. Meropenam, continued for 3 days, still getting fever, Oxygen saturation was dropping without support and infection was settling down, Hence planned for Bronchoscopy, at present hospital facilities were not present for Bronchoscopy, Hence referred to Manipal for further management. Known case of Diabetes, Hypertension on regular treatment and under control Depression and Lung emphysema since 1 year, all under control with alternate days YPV healings. Previously history of Stroke 3 years back completely recovered.

On 5/01/2026 got admitted at Manipal hospital, Millers road in ICU started with HFNC oxygen support with 10 to 15 L with nebulization, and continued same treatment for 3 to 4 days, On 9/1/2026 they did Bronchoscopy and sample sent to lab for culture and sensitivity test, malignancy test, Culture showed high bacterial growth of **Bacteria Klebsiella** and that to be **Multidrug resistant**, Only intermediary sensitivity to Colistin and Tegicycline, So there started IV injection. COLISTIN and Tegicycline and steroids was started after 2 days.

Noticed improvement in symptoms, No fever, no breathlessness and Oxygen saturation was 80 to 85 without support. So discharged on 14/01/2026. At home continued Oxygen support with 5L, Continued IV injection. COLISTIN and Tegicycline, after 5 days did Blood test S.Creatinine and blood urea, noticed antibiotic induced acute renal damage, Hence injection. COLISTIN WAS stopped and Tegicycline was continued for total 12 days and stopped, in between only one episode of fever came, no breathlessness, BP Blood sugar were stable, On follow up after 20 days, Chest X-Ray showed 60% improvement So Oral Steroids are advised to continue for 1 month and changed to Inhalers from nebulization, After 15 days Repeated Blood tests showed improvement in S.creatinine and b.urea (acute kidney damage is now normalized) but WBC count was more due to steroid induced, Now only Dry cough, Generalized weakness persists but no fever no breathlessness, Oxygen saturation without support maintaining at 90, From Day 1, 28/12/2025 parallel Yoga prana vidya Healings done by Leela madam by distant healing method, Thanks to Yoga prana vidya and Healings done by Leela madam helped for faster healing and early recovery.