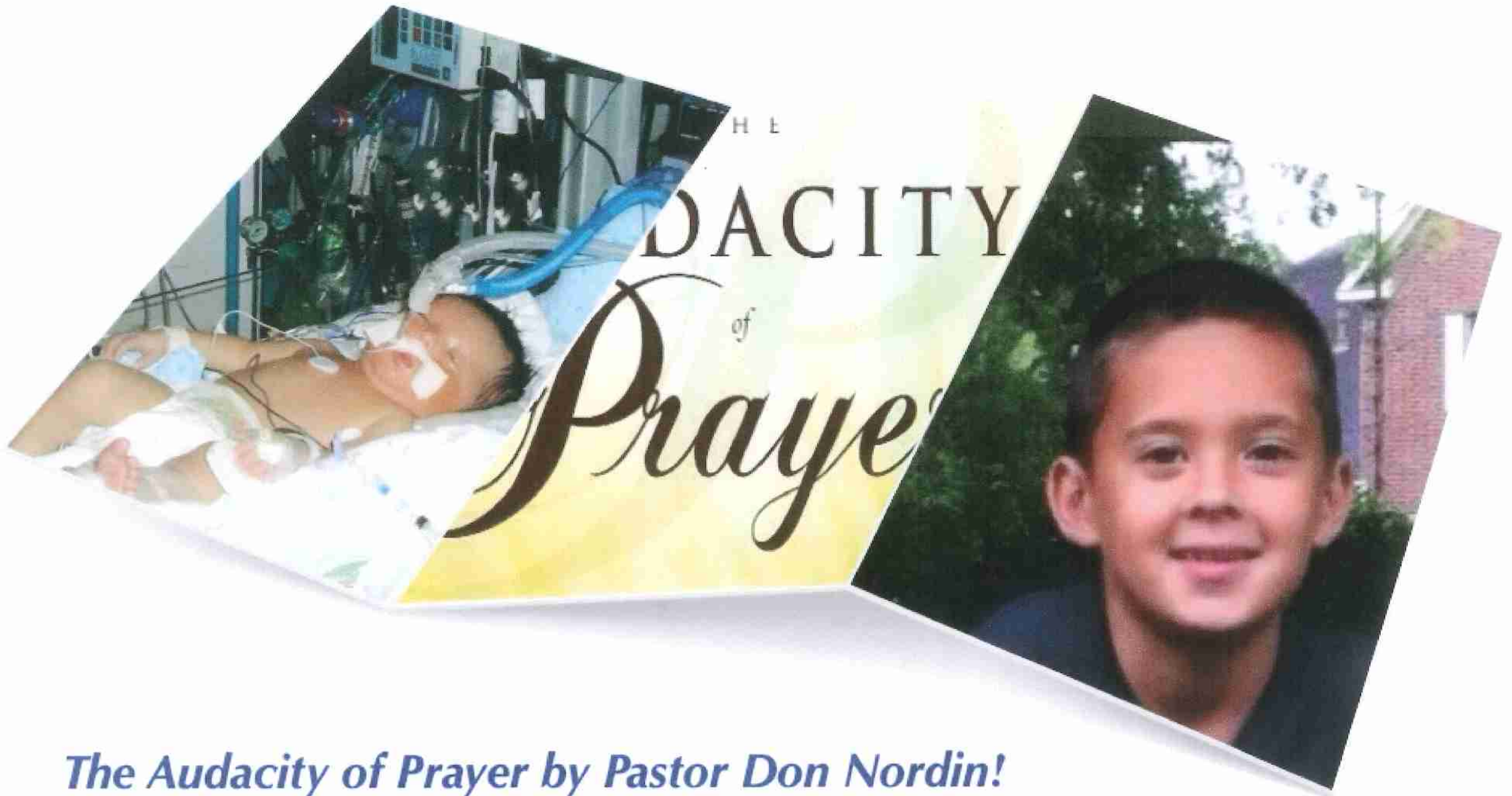
Lorri Roettgers

From: Turnbull [douglas.turnbull@sbcglobal.net]
Sent: Wednesday, October 29, 2014 4:35 PM
To: Lorri Roettgers
Subject: Re: pics



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DISCHARGE SUMMARY

PATIENT NAME: TURNBULL, BABYBOY
DATE OF BIRTH: 04/08/2005 Andrew
MEDICAL RECORD #: 8918446
DATE OF ADMISSION: 04/09/2005
DATE OF DISCHARGE: 05/21/2005
ATTENDING PHYSICIAN: DEBRA M. BOOTIN, M.D.

ADMITTING DIAGNOSES:
1. Thirty-four-week premi.
2. Respiratory distress.
3. Cardiac anomalies.
4. Hypocalcemia.
5. Hyperoxia.

DISCHARGE DIAGNOSES:
1. Scimitar Syndrome.
2. PAPVR.
3. GI cholestasis.

HISTORY OF PRESENT ILLNESS: This is a male born to a 25-year-old gravida 2, para 1 mom via repeat C-section. Birth weight was 3,237 grams at 37⁴/, WBD. Spontaneous rupture of membranes was four hours prior to delivery with clear fluid. Mom's labs were all negative. The patient was initially having some respiratory distress. Placed on an Oxyhood but persisted with increased work of breathing. Chest x-ray revealed dextrocardia. An ECHO was done at Womens which showed PAPVR, and ASD. The patient then was intubated for increased work of breathing and received bicarb secondary to acidosis. The patient then was transferred to TCH for further evaluation.

7.1 lbs
18.5

PHYSICAL EXAMINATION: Head circumference 35.5. Birth weight 3,237. Length 47 centimeters. Heart rate 150. Respirations 60. MAP 49/30. O2 saturation 100%. **HEENT:** AFOF. Eyes present bilaterally. Ears: Normal set. Palate intact. **CARDIOVASCULAR:** Heart sounds right side of chest. Soft 1-2/6 murmur. **PULMONARY:** Decreased breath sounds on the right. Clear on the left. Good chest excursion. **ABDOMEN:** No masses. The tip of the liver was palpable below the right costal margin. No splenomegaly. At that time, the VC and UAC in place. **EXTREMITIES:** Slightly mottled upper and lower extremities. Femoral pulses present bilateral. No joint swelling. **GU:** Tanner I male. Testes bilaterally descended. **NEUROLOGIC:** A paralyzed back. No dimples.

HOSPITAL COURSE BY SYSTEMS:
AB: The patient had initial respiratory distress. The patient

was transferred to TCH intubated on PIP and PEP 38/5. FIO2 at 1.0. Rate 60. TI of 0.2. ABG at OSH initially was 7.07/68/70/19/-11.3. The patient was started on INO on 04/10/2005. At that time, the patient's oxygenation and ventilation were poor and on 04/11/2005 required increased ventilatory support. The parents expressed a desire to not start Actol. PEP was subsequently increased. Albuterol was started. On 04/18/2005, INC was stopped. PS trial start on 04/23/2005. The patient was self extubated on 04/25/2005 and tolerated room air only for one hour. Therefore, had to be reintubated. Subsequently, the patient tolerated PS trails and on 05/04/2005 was extubated to room air. On 05/20/2005, was currently stable on room air.

CARDIOVASCULAR: An ECHO was performed and showed: 1. Dextrocardia. 2. Large PDA with bidirectional shunt. 3. PE PVR with anomalous PV to proximal IVC. 4. _ ASD. 5. Dilated coronary sinus with LSVC. 6. Moderate dilated hypertrophic RV. 7. Systemic suprasystemic RV pressures. The patient, then, was diagnosed with Scimitar Syndrome. The patient was initially on Dopamine which was weaned on 04/22/2005. Also, hydrocortisone was stopped on 04/24/2005. On 05/04/2005, Lasix was stopped. Cardiology was evaluating the patient for catheterization. On 05/18/2005, the patient had a catheterization and placement of two anomalous collateral vessels. The patient, afterwards, continued on heparin drip.

CNS: On 04/09/2005, NHUS was normal. The patient was initially started on fentanyl and Ativan. Fentanyl was stopped on 05/04/2005, and Ativan on 05/06/2005, without withdrawal syndrome. An MRI of the brain ruled out initial hypoxic damage. His scan was normal.

FENGI: The patient initially was n.p.o. with hypocalcemia. The patient received some calcium bolus and was then started on fluids. The patient had problems with persistent hypokalemia, hypocalcemia and acidosis and received multiple boluses of calcium, potassium, bicarb, for this reason. The patient had some hypoalbuminemia and received some albumin infusion on 04/12/2005. The patient was started on __ on 04/21/2005. Subsequently increased. On 05/05/2005, the patient was changed to feeding tube EBM/Similac 20. An abdomen ultrasound done on 05/06/2005 showed some calcification in the right upper quadrant. This was believed in the left liver and the left UVC and the left hepatic lobe. Initially, the baby had some poor feeding and was evaluated by OT. On 05/13/2005, the patient was taking good p.o. and was improving. The feeding pattern was sucking, swallowing, breathing pattern. The initial conjugated bilirubin was 3.3 on 04/28/2005, which was down on 05/11/2005 to 2.8, with increase to 5.4 on 05/19/2005.

GENETICS: The patient was evaluated. Scimitar Syndrome was

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diagnosed and the recommendation was given to recommend chest x-ray or ECHO for both parents, as there are some cases of dominant Scimitar Syndrome.
HEME: H&H was stable on transfer. The patient initially received some phototherapy which was discontinued on 04/15/2005. The patient was started on 05/02/2005 on iron 2 milligrams per kg.
ID: The patient initially was started on Naprosyn and gentamycin. The cultures were negative for 72 hours and was discontinued on 04/12/2005. The patient needs SVE prophylaxis.
RENAL: Renal ultrasound was normal on 04/09/2005. Initially, the patient had some decreased urine output on 04/11/2005 and a catheter was placed on 04/13/2005 for closer monitoring. On 04/13/2005, the patient's urine output stopped but improved after boluses and Lasix. Lasix was stopped on 05/05/2005. An abdominal ultrasound on 05/06/2005 showed some mild __ axis of the left kidney. A VCUG on 05/17/2005 was negative. It was planned to have circumcision prior to discharge.
SOCIAL: The patient, as mentioned earlier, had no desire to try Actol. The DNR was signed on 04/12/2005 without CPR and NO CODE, dose medication. The DNR order was taken off the chart on 04/18/2005 secondary to patient's improvement.

On 05/20/2005, the patient was doing well, had no further issues. Heparin drip post catheterization was stopped. Temperature was 99.6. Heart rate 110-150. Respirations 40/85. MAP was 50-55. O2 saturation was 91-100 percent on room air. Unconjugated bilirubin was 1.8/2.6. PT and INR were 13.3 and 1. PTT was 40.4. Nutrition wise, the patient was on EBM/Similac p.o. ad lib.

MEDICATIONS: Iron 6.4 milligrams p.o. daily, multivitamin ADC, and albuterol every six hours p.r.n..

On 05/20/2005, the patient was able to be discharged home.

FINAL DISCHARGE SUMMARY: Discharge patient home with parents.

DIAGNOSES:
1. Scimitar Syndrome.
2. PAPVR.
3. GI cholestasis.

CONDITION: Stable.

ALLERGIES: No known drug allergies.

ACTIVITY: Car seat, rear facing.

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DIET: BF/Similac p.o. ad lib.
MEDICATIONS: Ferrous sulfate 7.5 milligrams p.o. daily, multivitamin 0.5 milliliter p.o. daily.

FOLLOWUP: One month. Come back to EC or call PCP if patient has a fever of more than 100.1. Followup in one week with Dr. Bootin and follow in one month with Dr. Altmann in cardiology.

DEBRA M. BOOTIN, M.D. DATE

Dictated by: UNKNOWN LEE

DB:YOG/02193123/ss
D:06/06/2005
T:06/08/2005 08:20
JOB#:59065

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