**NOTE 2**

**PATIENT 1002**

**DATE: 3/4/20**

**Patient Summary**

Patient, triplet A, is a 1+ week old 27 4/7 wks GA male infant with prenatal diagnosis of left CDH. RDS, currently on HFJV, NPO, vygon to suction. Planning CDH repair, tentatively 3/6.

**Events in Last 24 hours**  
- increased total fluids, morphine  
  
**Weight**  
Last weight: 830g (03/03/20)  
Weight change: +50g (03/03/20 to 03/03/20)  
Fluid Balance (3/3/2020 07:00 to 3/4/2020 06:59) In: 99 mL / Out: 59 mL / Balance: +39 mL

**Plan**  
CV:  Hemodynamically stable, although tachycardic. S/p 2 NS boluses during stabilization at HOSP. S/p stress-dose hydrocortisone q8 1 mg/kg x 24 hrs.  ECHO with likely transitional physiology across anatomic shunts (large PDA), +VSD, follow. Repeat echo 2/24 showed large PDA with bidirectional flow, PFO. Tylenol for PDA closure (2/24-2/25), PDA was closed on 2/27 echo after tylenol x 5 days, decision made to hold on further tylenol doses. Repeat echo pre-op 3/3 no PDA, good function.  
  
Access: UAC (2/17 - ) with tip central at T6. S/p low lying UVC (2/17-18).  PICC placed 2/18, tip at L1, central. Even though > 7d and increased risk CLABSI, will keep UAC per Surgery for ability to trend arterial O2 - will not come out until post op.  Given thrombocytopenia, US obtained 3/2 and showed multiple small non-occlusive clots around catheter. Monitor for now.   
  
Resp: RDS. HFJV, titrate to gas exchange. Failed trial of CMV 2/18, placed back on HFJV, 2 sigh breaths.**Increased sigh breaths to 4 on 3/4 given RUL collapse on CXR.**  Goal sats 90-95% (balancing premie O2 sat goals with PHTN goals). Follow blood gases, continue gentle ventilation with HFJV.  Continue caffeine. AM CXR and BID gases. Plan for CDH repair likely 3/6.  
  
FEN: TF 130 ml/kg/d of SMOF. Will remain NPO until post op, replogle to suction. At risk for insensible losses and premature kidney dysfunction but UOP appropriate, follow I/Os, lytes q24h. Optimizing nutrition.  Daily glycerin.  
  
GI/Bili: L sided CDH with liver up.  Neonatal jaundice, on and off phototherapy, rebound bili stable 3/2 of 5.9/0.9 (below LL 6.4), trend bili closely with repeat 3/4.  
  
Heme: Anemia of prematurity, recent crit (3/2) 30% s/p pRBC.  Also thrombocytopenia (plt 104K) stable, unclear etiology, no bleeding/oozing, will trend. Send urine CMV 3/2. Continue to trend CBC. **Pre-op labs 3/5.**  
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ID:  No current infection concerns. No risk factors for sepsis (delivered by C-section with intact membranes for twin reasons), so not started on antibiotics. Blood culture (2/18) no growth. Continue to monitor clinically for signs/symptoms of infection. **Pre-op COVID 3/5**. Urine CMV sent 3/2 with persistent thrombocytopenia, pending.  
  
Immuno: NBS initially with low TRECs, but highly likely to be secondary to prematurity and illness, correlates with the low lymphocyte count. plan to defer sending flow cytometry and just send another repeat NBS at 2 weeks.  If remains low consider sending flow post op CDH repair.  
  
Neuro: HUS 2/17 sluggish flow through anterior sagittal sinus, small L>R subdural fluid collections. HUS 2/20, 2/22, 3/2 without IVH. Plan for repeat HUS post-op and DOL 30.  
  
Sedation: S/p fentanyl drip, changed to morphine infusion 2/28, optimizing sedation while not removing respiratory drive completely. SBS goal 0 to -1 while intubated.  
  
Social:  Family from MA, with 6y, 4y, 1y and these triplets (2 other sibs at HOSP 1, on CPAP). Mom visits regularly, family meeting 3/3 with NICU. Continue to update and support.  
  
RHCM:  
- Newborn screening: Sent at 24 hours (2/19). Repeat DOL 13 on 3/2 (prior to RBC), pending.  
- Hepatitis B Vaccination: Deferred given < 2 kg, plan to give >2kg or 30 days.  
- Other Vaccinations: Will need.  
- CCHD: NA, had ECHO  
- Hearing screen: Prior to discharge  
- Car seat testing: Will require prior to discharge  
- Circumcision: Will inquire  
  
PCP: Will ask parents and update.  
  
**Decision-making and pre-operative planning for 3/6 CDH repair**: Multidisciplinary team huddle 3/3 to discuss this case and operative planning. The NICU attending physician (Dr. Cathy Cora) and the operating surgeon (Dr. Dora Beard) have carefully reviewed the patient's clinical trajectory and relevant medical record. Given the gestational age and need for HFJV in this extremely premature infant, it is our assessment that any attempt to move this patient, at this time, to the operating room for this planned surgical procedure is not in this patient's best interest as the risks of transfer to the patient greatly outweigh the benefit of having this planned procedure performed in the neonatal intensive care unit. We have explained our assessment of the risks and benefits of performing the planned procedure in the intensive care unit to the patient's parents as part of the informed consent for this procedure.  
  
Disposition: critically ill premature neonate with CDH, will require long term ICU care.