**NOTE 9**

**PATIENT 1004**

**DATE: 6/7/22**

**Requesting Physician/Service**

NICU

**Reason for Consultation**

ASM management

**History of Present Illness**

Baby boy patient is a 3.5mo old infant, born extremely prematurely at 26 1/7 gestation ELBW 830 grams , now corrected with 42 week (cGA). Patient has a significant history for GBS meningitis/ventriculitis a ~ 2 weeks of life resulting in progressive, post hemorrhagic hydrocephalus that required neurosurgical intervention with subgaleal shunt placement on 4/4/22. and then transitioned to VPS on 5/27/22.  Additionally, Patient developed focal seizures upon the onset of his meningitis and was treated with phenobarbital and is currently on phenobarbital monotherapy. Neurology has been re-consulted in regards to anti-seizure medication management.  
  
**"Birth History/HOSP 2 NICU course:** Born to a 25 you G9P8 mother following a pregnancy complicated by PPROM with preterm labor. Maternal labs were B+/Ab/RI/HepB-/GC-. Mother was betamethasone complete. Did not receive antibiotics. Patient was delivered via c-section for concerning fetal tracings with variable and late decelerations. Infant was vigorous at delivery with spontaneous respiratory effort. Apgars were 4 & 7. He received CPAP, PPV, and intubation in the delivery room.  
  
Course at HOSP 1  
CV: Overall hemodynamically stable with history of hypotension during an episode of sepsis/NEC treated with Dopamine. History of PDA, s/p two courses of Tylenol. DOL 28 ECHO with no PDA, PFO vs ASD with left to right flow. Continues to have a murmur on exam. Planned for follow up ECHO 4/16.  
  
Resp: Intubated in delivery room with history of multiple modes of ventilation including HFJV. Received surfactant x 3 doses. History of multiple unplanned extubations which required reintubation. Successfully extubated to NIPPV on DOL 24. Transitioned to CPAP on DOL 33. He remains on CPAP 8 and 23-30% oxygen. On diuril since 3/24 for signs of pulmonary edema. Most recent CBG 7.46/63 with bicarb 44, base excess 17.  
FEN: Received PN while advancing enteral feeds which began on DOL 1. Reached full enteral feeds but made NPO on DOL 16 for NEC on KUB and abdominal US. Following 14 days of bowel rest and antibiotics, he was restarted on donor breast milk feeds and tolerated his advance. At time of transfer he is receiving 160 mL/kg/day breast milk 24 calorie (step 2 protein) with KVO fluid at 30 mL/kg/day. Electrolytes currently with hyponatremia and hypochloremia. Receiving NaCl and KCl supplements. Also noted to have direct hyperbilirubinemia, thought related to prolonged PN use. Are following serial bilirubin levels and GGT.

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Heme: Mom B+/Ab-, Baby A+/Ab-. History of phototherapy. Has required multiple PRBC transfusions. History of thrombocytopenia which resolved without transfusion. Most recent CBC on DOL 46 Hct 28.3 and Plt 343. Transfused with 15 mL/kg PRBC on 4/4 prior to OR.  
  
ID: Received 48 hours antibiotics for sepsis evaluation on admission. Blood culture remained negative. Found to be GBS colonized on surveillance swab. Sepsis work up on 3/3 for clinical decompensation; blood culture and tracheal aspirate positive for GBS and KUB with medical NEC. LP on 3/6 had limited sample, PCR was positive for GBS. Treated with 14 days ceftazidime and flagyl. Blood cultures on 3/5, 3/7, and 3/25 were negative. **Repeat CSF culture on 3/19 was negative. Continued on Ampicillin for GBS meningitis with ventriculitis for 6-8 weeks treatment.**  
  
Neuro: R GMH on initial HUS on DOL 1; stable on serial repeat imaging. Developed right focal seizures in setting of meningitis.  **Treated with phenobarbital with goal level in 20’s. Ventriculitis and ventriculomegaly noted on DOL 17. MR 3/30 with worsening enlargement of lateral, third, and fourth ventricle with mass effect on the cerebellum and brain stem. Serial HUS with worsening ventriculomegaly. Transferred from HOSP 1 for neurosurgical management of hydrocephalus with subgaleal shunt placed on 4/4/22. Requiring serial taps."**  
  
Since our last consult note, patient has overall been stable neurologically with no clear seizure activity

(last known seizure on 3/7). He recently had a PHB level on 6/5 on 15, and 6/7 on 16.5.

**Review of Systems**

**Assessment/Recommendations**

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Patient is a 111 day old-infant, born extremely preterm (26 1/7 week gestation) and ELBW (830 grams), now corrected to 42 weeks gestation with ongoing complications related to his prematurity and history of GBS meningitis which includes progressive, post hemorrhagic hydrocephalus s/ subgaleal shunt and now a VPS (placed 5/25) with most recent MRVC showing stable ventricle size. Neurology is consulted for phenobarb management in setting of seizure hx 2/2 GBS meningitis with last level on 6/7 16.5 (previously 20) with no recent clinical seizure activity with last known seizure (3/7/22). His GBS infection has been treated with prolonged course of ampicillin was 3/5-4/11/22 confirmed with repeat LP/CSF analysis. His exam today is overall reassuring with only mildly low tone, but otherwise moves all extremities well.  
  
Recommendations:  
- can wean PHB 1mg/kg/d every M/TR until off  
- Neurology will sign off at the current time based on the patient's neurologic stability, but please do not hesitate to reach out if further concerns arise.  
- please page if any activity concerning for seizures  
  
This note was generated using an automatic voice recognition software.  Please excuse any contextual errors.  
  
Arthur Perkins, MD  
Child Neurology, PGY-5  
  
Patient was seen, case discussed and plan formulated with Dr. Jackson, attending physician.  
  
   
**Attending Note:  Neurocritical Care Consult Service**  
   
I discussed the patient with the resident, examined the patient on June 7, reviewed relevant diagnostic studies, and edited the note above, which describes our combined assessment and plan.  We were asked to reevaluate this 3-1/2-month old boy with corrected postmenstrual age of 42 weeks as he was born extremely preterm at 26 weeks with birthweight of 830 g complicated by group B streptococcal meningitis and obstructive hydrocephalus requiring VP shunt who had acute seizures treated with phenobarbital, and the team was asking about phenobarbital management.  We reviewed his past history, the course of his seizures and previous EEGs that showed discontinuity and focal seizures at the time that he was acutely ill in March.  We recommended a gradual taper off the phenobarbital given that his acute seizures have resolved.  He remains at increased risk for developing epilepsy at an older age, and will need close neurologic follow-up after discharge, but we will take this opportunity to taper his phenobarbital however he remains in the NICU receiving NG feeds.  
   
Samantha Jackson, MDCM, FRCPC  
Attending Neurologist, Neurocritical Care Consult Service  
   
This note was dictated in part using voice recognition software. Please excuse any contextual errors or typos.

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**Problem List/Past Medical History**

Ongoing

ASD - Atrial septal defect

Baby premature 26-28 weeks

ELBW - Extremely low birth weight infant

Inguinal hernia

Post-hemorrhagic hydrocephalus

Historical

No qualifying data

**Procedure/Surgical History**

No Procedure History

**Allergies**

No Known Medication Allergies

**Medications**

Inpatient

acetaminophen, 40 mg = 1.25 mL, NG, Q6hr, PRN

ferrous sulfate, 38 mg = 0.86 mL, NG, Q12hr

glycerin (glycerin Supp Pediatric), 1 supp, PR, daily, PRN

glycerin (glycerin Supp Pediatric), 0.5 supp, PR, daily, PRN

hydroCHLOROthiazide, 8 mg = 0.8 mL, NG, Q12hr

multivitamin (Poly-Vi-Sol Drops), 1 mL, NG, daily

PHENobarbital, 7.5 mg = 1.88 mL, NG, Q12hr

simethicone, 20 mg = 0.3 mL, NG, QID, PRN

sucrose 24% oral solution, 0.4 mL, PO, Q2hr, PRN

Home

ampicillin, 115 mg, IV, Q6hr

caffeine (caffeine citrate 20 mg/mL intravenous solution), 10 mg/kg, IV, Q24hr

chlorothiazide (chlorothiazide 250 mg/5 mL oral suspension), 30.5 mg, PO, DailyMorning

cholecalciferol (cholecalciferol 10 mcg/mL (400 intl units/mL) oral liquid), 400 units, PO, daily

ferrous sulfate (ferrous sulfate 75 mg/mL (15 mg/mL elemental iron) oral liquid), 3 mg, PO, Q24hr

PHENobarbital, 4 mg, IV, daily

potassium CHLORIDE, 0.773 mEq, PO, daily

sodium chloride (sodium chloride 1 mEq/mL oral Liq (compound)), 1.52 mEq, PO, Q6hr

**Patient Language**

Preferred Language: English

Interpreter Needed (Patient): No

Interpreter Needed (Parent/Guardian): No

Vitals & Measurements

**T:**36.8  °C  (Axillary)  **T:**36.4  °C  (Temporal Artery)  **HR:**161 (Monitored)  **RR:**40  **BP:**78/37  **SpO2:**100%   
**WT:**3.855 kg  **WT:**3.8 kg  **Est. WT:**3.8