**NOTE 7**

**PATIENT 1005**

**DATE: 4/20/20**

**Reason for Consultation**

Cholestasis

**History of Present Illness**

Patient is a 2 month old former 24 weeker born in the setting of PPROM who has been admitted at the NICU. We are being consulted for cholestasis.  
  
Patient's NICU course has been complicated by respiratory failure, had failed extubation and is trailing course of steroids. He is s/p PDA ligation. He has had S aureus bacteremia, which may have been a contaminant, and neck mass that grew S aureus, s/p multiple course of antibiotics, now off antibiotics. He has been on PN for most of his life, but currently tolerating full enteral feeds.  He is having pigmented stools.  
  
From a liver perspective, he has had normal bilirubins in the past, first noted a direct bilirubin elevation to 1.2 on DOL 17, that then initially improved, and then as of late has been climbing. Most recent labs were on DOL 60 (4/19/22) with total bilirubin 5.2, direct bilirubin 4.2, AST 104, ALT 75, alkaline phosphatase 656, GGT 295, INR 1.1. Abdominal ultrasound was normal with visible CBD. Initial newborn screen had elevated methionine, subsequent newborn screens have been normal. No relevant family history per report.

**Assessment/Recommendations**

In summary, Patient is a 2 month old former 24 weeker born in the setting of PPROM, with sequelae of extreme prematurity including respiratory failure, mechanically ventilated, PDA s/p ligation, history of bacteremia and neck abscess s/p treatment, who has neonatal cholestatic hepatitis without liver dysfunction and normal ultrasound.  
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The differential diagnosis of neonatal cholestasis is quite extensive, including over 100 etiologies.  These range from intrahepatic to extrahepatic disorders, and from infectious to metabolic to structural and vascular diseases.  Generally the evaluation is guided by the pattern of laboratory studies and the physical examination, with the focus on identifying disorders that are treatable and etiologies that are common.  The level of the aminotransferases, the presence of an elevated or normal GGT, the age and onset, other associated findings, and the general well being of the infant will help to guide the evaluation.   
  
In Patient's case, this is likely multifactorial from critical illness, bacteremia, medication side effects, parenteral nutrition. We recommend continuing to trend the labs, obtaining some additional labs to evaluate for some causes of cholestasis.  
  
Recommendations:  
- Please trend liver panel with GGT weekly. Please also check thyroid studies, alpha-1-antitrypsin  level with Pi type, and urine CMV with next labs.  
- Start ursodiol 10mg/kg BID for cholestasis  
   
Thank you for involving us in the care of this patient.   
   
Patient seen and discussed with GI Attending, Dr. Avery.  
   
Christina Barnes, MD  
Clinical fellow, PGY-5  
Gastroenterology, Hepatology, & Nutrition  
  
Attending note:  Please see C. Barnes’s note for full details.  Patient was seen and examined.  History, physical, studies were reviewed at the time of the visit.  I agree with the assessment and plan as detailed above.  Plan was discussed with BI NICU  
   
William Avery, MD  
Attending in Gastroenterology/Hepatology