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07/20/1992 12:00:00 AM
TRACHEAL STENOSIS SECONDARY TO MULTIPLE DIFFICULT
Unsigned
DIS
Report Status :
Unsigned
ADMISSION DATE :
07-20-92
DISCHARGE DATE :
07-25-92
REFERRING HOSPITAL :
Ca County Health Center of Hocall Plao
REFERRING MD :
Dr. Vernn Drepsloyd and Dr. Agold Jaquesube
PRINCIPAL DIAGNOSIS :
Tracheal stenosis secondary to multiple difficult intubations .
ASSOCIATED DIAGNOSIS :
Respiratory distress .
Developmental Delay .
Mental retardation .
history of crossed-eyes status post corrective surgery 3/31/88 .
Megacolon status post rectal surgery and biopsy ( positive ganglion cells ) 4/1/92 .
status post surgical disimpaction 6/19/92 .
Hernia repair and orchiopexy 07/30/88 .
Hypospadias repair 06/92 .
Hydronephrosis and ureteral blockage of the left ureter , status post repair 6/2/90 .
The patient is also status post pyeloplasty 10/12/91 .
Chronic otitis media status post PE tube placement times 7 .
Spinal agenesis .
Tethered cord with spinal cord tumor excision 1/31/91 .
Seizure disorder .
The patient is presently being weaned off Phenobarbital and advanced onto Tegretol .
MEDICATIONS :
Phenobarbital 30 mg b.i.d. , Tegretol 100 mg b.i.d. , Iron 50 mg q. day , multivitamin 1 p.o. q. day , Senekot 1 tablet b.i.d. , FiberCon 1 to 2 times a day .
Pavulon intravenous drip .
16 mg per kilo per hour and Morphine sulfate 3 mg per hour intravenous drip .
The patient 's weight is 15 kilos
ALLERGIES :
The patient has no history of allergies .
HISTORY OF PRESENT ILLNESS :
The patient is a 5 year old male with multiple anomalies transferred from Capa An- Medical Center of Ohio on 07/20 for management of airway obstruction secondary to tracheal stenosis / history of difficult intubations .
The patient has a history of multiple surgeries and intubations .
On 08/10/90 the patient had surgery to remove granulomas in the trachea after traumatic intubation for seizures .
The patient first presented with stridor and respiratory distress on 02/92 .
A bronchoscopy at that time showed a 50% tracheal stenosis .
Since then the patient has had intermittent episodes of stridor with agitation with upper respiratory tract infections .
On 07/19/92 the patient awoke with significant stridor , respiratory distress an

d the use of accessory muscles .
The patient was taken to the emergency room where he was taken to the operating room for bronchoscopy .
On 07/19/92 direct laryngoscopy showed an 80% tracheal stenosis beginning just b elow the sternal notch involving the proximal 50th percent of the trachea .
They were unable to get to the distal part of the trachea .
The patient was a difficult intubation and it was finally performed by a thoraci c surgeon using a 3.5 endotracheal tube .
The patient was then hospitalized in the Pediatric Intensive Care Unit at Asney Ewood Health Care in Losbroke Pringda Field Delp U and maintained with Pavulon a nd Morphine .
Dr. Fields was consulted and the patient was transferred by Ton Len N'ss Co mmunity Hospital to Ph University Of Medical Center Pediatric Intensive Care Uni t for evaluation and management by Dr. Fields on 07/20 in the p.m.
The patient was reportedly in his usual state of health immediately prior to thi s hospitalization with no history of upper respiratory tract infection symptoms , fever , cough , vomiting , diarrhea or decreased appetite .
HOSPITAL COURSE BY PROBLEM :
1. Respiratory :
The patient remained intubated and maintained on a Pavulon and Morphine drip thr ough until 7/21/92 .
The patient was brought to the Operating Room where bronchoscopy was done .
The patient was noted to have a stenosis of the proximal trachea approximately 3 cm long just below the vocal cords .
The patient was also noted to have mild right mainstem bronchus stenosis too .
Very mild .
The patient had a 3-0 Shiley trach placed approximately 1 cm below the vocal cor ds .
The trach extends approximately 1 cm below the area of stenosis .
Chest X-Rays shows clear lung fields bilaterally with the trach tube noted to be in good position .
I should also note that the patient has had multiple tracheal aspirates sent for culture and they have all been negative .
There is one Gram stain that showed some polys but otherwise they have been unre markable .
There is no clinical evidence of pneumonia that could have precipitated this eve nt and all X-Rays have been unremarkable .
The patient has a history of significant hyperinflation of the chest with an inc reased AP diameter which is mildly improved after the tracheostomy .
The patient received oxygen for approximately 24 hours after the tracheostomy an d is presently being maintained on room air with a humidified mask .
The patient generally breaths between 20 and 30 breaths per minute and is otherw ise stable .
Cardiac :
The patient is otherwise stable .
The patient had some evidence of doubled T waves on the day of arrival .
These T waves have since cleared and the patient is otherwise unremarkable .
Please note that the last arterial blood gases was Ph 7.40 , PCO2 of 41 , PO2 of 112 , bicarbonate of 25 .
Fluids and Nutrition :
The patient was initially NPO and then begun on Pediasure feeds the first two da ys of hospitalization .
The patient has presently been weaned over to his regular diet which is generall y some crackers , cereal and occasional bits of food .
The patient generally does not drink much fluid .
GI :
From a gastrointestinal point of view please note on _____ at 5 a.m. th e patient was noted to be aspirating bits of cereal and juices via his trach tub e .
This was felt to be mild aspiration .

The patient also had episodes of frequent coughing .
Clinical examination shows no decreased breath sounds .
The repeat X-Ray is generally clear and the patient is generally in no distress .
The patient was made NPO on 7/25 a.m. Dr. Fields 's team is coming to evaluate the patient .
Recommendations include probable evaluation for aspiration of upper airway contents and possible G tube placement in the future .
The patient has a history of longstanding constipation generally requires an enema every couple of days .
KUB on 7/23 showed hugely dilated loops of colon and small bowel which only briefly respond to an enema .
The patient last received enema on 7/24 in the p.m.
HEM :
The patient has generally been stable .
His initial hematocrit was 31% .
His hematocrit on transfer was 33% .
The platelet count was 351,000 .
The patient never received blood during the procedure .
The estimated blood loss was minimal .
Renal :
The patient has always had good urine output with normal BUN and creatinine .
Neurological :
The patient has a history of of seizure disorder .
He has been stable here .
He is presently being weaned off his Phenobarbital and advanced onto Tegretol by his Neurologist in Vanri , SC .
Levels on arrival showed a Phenobarbital level of 25 , Tegretrol level of 3.1 .
The patient has had problems taking p.o. Tegretol during this hospitalization and levels need to be checked in the near future .
Phenobarbital has been maintained by intravenous 30 mg b.i.d.
Infectious Disease :
The patient arrived receiving ceftriaxone for one day down in Mississippi .
The patient was switched over to Ancef to cover for Staph and usual flora for possible pneumonia .
The child only had a one time spike on pod 1 to 103 .
Three trach aspirates have all been unremarkable .
The blood cultures are unremarkable , sputum cultures are unremarkable , urinalysis was also negative .
The patient cannot be cathed as he has a recent hypospadias repair .
The patient is still being maintained on Ancef at the request of Dr. Fields 's team .
DOCTORS DISCHARGE ORDERS :
The patient will be transferred to Ral Medical Center in Saintarv on 7/25/92 by ambulance .
The patient has a 3-0 Shiley in place that is stitched to his neck and also has trach ties in places .
The trach appears to be quite stable and the patient is tolerating having his trach in quite nicely with a humidified mask .
The plans per ENT are that the patient 's trach will not be changed for at least one months time .
Dr. Fields will contact Dr. Roosekote as to probable plans .
It appears that Dr. Fields wants to re-evaluate the child in 4 to 6 weeks with another bronchoscopy and feels that possibly tracheal reconstruction may be possible at that time .
The parents are being transferred back to Newstonpend to learn trach care and to set up homecare .
If you have any questions please contact me .
Laymie Aslinke , M.D. , at Ph University Of Medical Center Pediatric Intensive Care Unit .

The number is 329-216-2977 .
There is always someone here .
LABORATORY DATA :
Additional laboratory data of note is a last white blood count on 7/24 was 9,000 with a differential of 70 polys , 25% lymphs , hemoglobin 10.1 , platelet count 351,000 .
Electrolytes were normal on 7/23/92 and the last gas was as stated above .
LAYMIE ASLINKE , M.D.
DICTATING FOR :
HIENSON FIELDS , M.D.
TR :
jfc / bmot
DD :
07-24-92
TD :
07/24/92
CC :
Pediatric Intensive Care Unit Dr. Sint Dr. Plinfluaitrive Dr. Fields
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