Progress Notes

Patient: Andrew, Nathan
DOB: 08/07/2006 **Age:** 1M **Sex:** Male
Phone: 661-309-1945
Address: 17914 Vista Ct, Canyon Country, CA-91387

Provider: Rochelle C. Feldman, MD
Date: 09/12/2006

Subjective:

CC:

1. 1 mos.

HPI:

Gastroenterology:

still not doing well with increased Zantac and now with more crying - ? increasing hydrocephalus.

Medical History: Exposed to adult w/ shingles on chest. - didn't hold him may have touched him but probably not, Holoprosencephaly - Dx'd in utero by Dr. Tabsch, looked at by Dr. Barrett at NBN - reportedly normal; chromosomes, He saw regional center, infant message therapist, child development therapist (Progressive steps), Family Focus therapist, Planning for physical therapist to come soon.

Family History:

Social History:

Medications: Zantac 15 mg/mL 3 ml BID

Allergies:

Objective:

Vitals: HC: 16, Ht: 22.5, Wt: 12.11, BMI: 16.82.

Examination:

General Examination:

General Appearance: NAD, well nourished and hydrated, crying but able to be comforted; fussy. HEENT: pharynx and tonsils normal, TM's normal, nose clear. Oral cavity: normal. Neck, Thyroid : supple. Heart: systolic ejection murmur, RSR, normal S1S2. Lungs: clear to auscultation. Abdomen: soft, NT/ND, BS present. Neurologic Exam: markedly extensor tone; 4+ head lag; mildly increased tone throughout. Skin: moist, warm. Extremities: normal ROM. Genitalia: no lesions.

Therapeutic Interventions:

Assessment:

Assessment:

1. Holoprosencephaly - 742.2 (Primary)
2. GERD [Gastroesophageal reflux disease] - 530.81
3. Hydrocephalus in newborn - 742.3
4. Hypertonic disorder NOS - 276.0

Addendum 9-19-06: PFO on echocardiogram.

Plan:

1. Holoprosencephaly Continue Zantac syrup, 15 mg/mL, orally, 180 ml, 3 ml, BID, 30 days, Refills 2 .

Immunizations:

Diagnostic Imaging: Echocardiogram, Ultrasound of Head, Barium Swallow

Preventive:

Follow Up: 4 Weeks, well check;

23845 McBean Parkway Valencia California 91355

Printed on: 09/27/2006 12:26:09

Name : ANDREW, NATHAN D
Pt# : 2890641 -O-DXO MR# : 528854
Age : 001M Sex: M Room#: OP#1-

Adm Dr: FELDMAN, ROCHELLE
Ord Dr: FELDMAN, ROCHELLE
Consit:

Procedure Location: ULTRASOUND
Date Procedure Completed: 09/19/2006

Req# : 6122611

*** Final Result ***

Seq #: 001 5876534-US Infant head

ULTRASOUND EXAMINATION OF THE BRAIN:

EXAMINATION DATE AND TIME: Sep 19 2006 10:13AM

COMPARISON: None.

REASON FOR STUDY: SEVERE IRRITABILITY, HOLOPROSENCEPHALY.

FINDINGS: There is no septum pellucidum and a monoventricle. No falx is identified and the interhemispheric fissure is incompletely formed. The corpus callosum is absent. There is partial separation of the thalami. The findings are consistent with patient's history of holoprosencephaly, likely semilobar form. There is a large cystic structure within the left posterior region which most likely represents a large left ventricular cyst. There is no definite parenchymal and are interventricular hemorrhage.

IMPRESSION:

Findings consistent with holoprosencephaly, semilobar form. Further evaluation can be made by MRI if clinically indicated.

Large left ventricular cyst.

TRAN, NHAN C M.D.

Documents for: DEVIVO, BABY BOY M

368-45-05 WW
DEVIVO, BABY B
Inpatient Consultation
PEDIATRICS/Genetics

Date of Service: Thursday, August 10, 2006
Referring Physician: Cynthia Barrett, MD

Date Of Birth: 8/7/06.

Chief Complaint: Holoprosencephaly.

History Of Present Illness: Baby boy Devivo was noted on prenatal ultrasound to have holoprosencephaly. The history is taken from the parents as well as review of the medical record.

He was born August 7, 2006 to a 26-year-old, G-1, P-1, Mom who had good prenatal care. Her prenatal labs were O positive, rubella immune, RPR nonreactive, and hep B surface antigen negative. Mom has a history of hypothyroidism, and was on Synthroid during the pregnancy. The pregnancy was uncomplicated until at 37 weeks estimated gestational age, the fundal height was not increasing and ultrasound revealed possible holoprosencephaly. Therefore, Ms. DeVivo was referred to Dr. Tabsh for further evaluation including amniocentesis. Amniocentesis showed normal karyotype 46-XY with FISH analysis showing no numerical aberrations of chromosomes XY 13, 18, or 21.

The baby was born by C-section with rupture of membranes 8/7/06 at 1932 and birth at 8/7/2006 at 1936. Apgars were 8 at one minute and 9 at five minutes. Birth weight was 3430 grams, length 48 cm, and head circumference 35.6 cm. The baby was 40 weeks gestational age and had mild hypotelorism.

A cranial ultrasound was done and showed a holoprosencephaly most likely semilobar.

Past Medical History: BIRTH HISTORY: Per HPI.

Illnesses: Holoprosencephaly.

Surgeries: None

Medications: None

Allergies: NKDA

Diet: Breast feed with formula supplementation.

Immunizations: None yet

Social History: Parents both at bedside.

Family History: Negative for holoprosencephaly spectrum including single central incisor. There is a maternal cousin with mental retardation due to perinatal asphixia. There is an uncle with history of SIDS.

Review Of Systems: Other than what is noted above, there were no issues in the following systems: constitutional, ears, nose, throat, eyes, heart, respiratory, gastrointestinal, genitourinary, musculoskeletal, skin, neurologic, psychiatric,

endocrine, blood, or allergy/immunology.

Physical Examination: Birth weight 3430 grams (75th percentile). Length 48 cm (25th -50th percentile). Head circumference 35.6 cm (90th percentile). In general, shows a well-developed, well nourished term male infant in no acute distress. Normal cephalic, atraumatic. The head shape is normal. The anterior and posterior fontanelles are open, soft and flat. There is very mild mild hypotelorism. The eyes are normal shape and size. Extraocular muscles are intact. Ears are normal shape and location. External auditory canals are patent. Nose is normal shape and location. Oropharynx is clear. Palate is intact to palpation. Neck is supple without lymphadenopathy. Cardiovascular: Regular rate and rhythm without murmurs, rubs or gallops. There is no palpable thrill. Lungs clear to auscultation bilaterally. Chest shape is normal. Abdomen soft, nontender, nondistended with no hepatosplenomegaly or masses. Normal male genitalia. Extremities warm and well perfused. Neurologically, he is alert and moves all extremities equally. No focal deficits are noted.

Studies Reviewed:
Cranial ultrasound 8/8/06 - abnormal configuration of the brain, with poor definition of the 2 hemispheres. In the frontal region, a partially developed interhemispheric is the fissure is noted superiorly. The thalami are fused. There is no visualization of the corpus callosum. The lateral ventricles are moderately dilated, and there is no separation between the lateral ventricles, which communicate with a large posterior fossa fluid collection. The cerebellum is visualized, compressed anteriorly. Conclusion: Findings are compatible with diagnosis of semi lobar holoprosencephaly. An MRI of the brain is suggested for further anatomic detail.

Prenatal Karyotype and FISH: Normal male karyotype (46, XY), with normal FISH for X, Y, 13,15, 21.

Assessment And Plan: This is a two day old male with holoprosencephaly with a negative family history and normal karyotype. Recommend electrolytes to assess pituitary function, Genetic testing for the single genes known to cause holoprosencephaly (to be sent to GeneDX), follow-up in Genetics clinic to discuss these results. If there is in any indication of pituitary dysfunctions, he will need an Endocrinology evaluation as an outpatient.

Genetics Clinic follow-up will be set up by my office and the parents were given the information as well as family support information.

Katrina Dipple, M.D. (P15561)
Electronically signed (8/11/2006 11:18:36)
MD5 checksum: 2965ec9dabda84183543fa83147bd0e6

cc:
CYNTHIA T. BARRETT(P03246)
UCLA Newborn Nursery

UCLA Genetics Clinic

Dictated: 8/10/2006 11:49
  By: Katrina Dipple, M.D. (P15561)
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Documents for: DEVIVO, BABY BOY M

368-45-05 WW
DEVIVO, BABY BOY MARCELA
Test Results
RADIOL
US HEAD NEONATAL PORT

Date of Procedure: Tuesday, August 8, 2006 15:43

US HEAD NEONATAL PORT

Neonatal head ultrasound done on August 8, 2006 at 15:43.

History: Newborn with large head, abnormal prenatal ultrasound.

Comparison: Not available.

Findings:

Sagittal and coronal scans of the brain were performed using a high resolution curved array transducer.

There is abnormal configuration of the brain, with poor definition of the 2 hemispheres. In the frontal region, a partially developed interhemispheric is the fissure is noted superiorly. The thalami are fused. There is no visualization of the corpus callosum. The lateral ventricles are moderately dilated, and there is no separation between the lateral ventricles, which communicate with a large posterior fossa fluid collection.

The cerebellum is visualized, compressed anteriorly

Conclusion: Findings are compatible with diagnosis of semi lobar holoprosencephaly. An MRI of the brain is suggested for further anatomic detail.

M Ines Boechat, M.D. (P08386)

Dictated: 08/08/2006 15:43
By: M Ines Boechat, M.D. (P008386)
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Document ID Number: 3482787

*** END OF DISPLAY #03482787 ***

Documents for: DEVIVO, BABY BOY M

2N 265F 368-45-05 WW
DEVIVO, BABY BOY M
Inpatient Note
PEDIATRICS/Neonatology
Consult

Date of Service: Wednesday, August 9, 2006

Date of Consult: 8/7/06

This consult was performed with Dr. Uday Devaskar, attending Neonatologist.

The NICU team was asked to speak the Mr. and Mrs. Devivo. The pt is a FT BB who was diagnosised prenatally with holoprosencephaly and anhydracephaly. The parents had specific questions regarding the patient's prognosis and what options were available to the family once the patient was delivered via scheduled c/s. It was explained that patients with this specific diagnosis patients generally do poorly secondary to decreased brain matter. However, patients have varying degrees of presentation at birth--some patients are vigorous and have adequate heart rates and ventialation. Some, on the other hand, may not have the ability to maintain an adequate heart rates, blood pressures, and oxygen levels. As a result, without medical intervention, such infants may die.

Once the patient was delivered, it was explained that the parents had the following options, parents can choose to: 1. provide comfort care (such as bulb suction of the nares and mouth, and warmth) 2. provide some manual stimulation (such as rubbing the back or flicking the heels) 3. provide blow by oxygen 4. provide bag mask ventialation 5. intubate the patient for maximal support.

After these options were explained, and the parents' questions were answered, it was stated that if the patient was to survive with or without medical intervention the parents would have the opportunity, should they choose, to have a head ultrasound performed. Also, if the patient was stable an MRI could be performed for better evaluate the brain.

It was also explained that should the patient survive, issues such as feedings would need to be addressed. It was stated that the mother could breastfeed or give formula if comfortable.

Lastly, if the patient does not require medical intervention and was medically stable, the parents were told the patient could be discharged home for furthur comfort care.

The parents' questions and concerns were addressed. Moreover, the mother expressed her desire to maintain contact with the NICU team at all times. She would like to be contacted for any interventions, or changes in status. Lastly, should the patient expire she stated that patient should be minimally handled, and not touched if necessary.

Total time of consult: 35 minutes.

Kara Calkins, M.D. (P24489)
Electronically signed (8/9/2006 14:15:34)
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