I. IDENTIFYING DATA

Patient: Christopher Guerrero

Attending Physician: Dr. Kokash

Source of Information: Mother

Medical Reason for Admission: "Fever x 2 days"

II. HISTORY

CC: Patient presented to the emergency room on 09/08/08 at 9:15 p.m. with a 2 day hx of fever.

History of Present Illness: 12 day old infant with a 2 day hx of fever, green nasal discharge & cough productive of yellow sputum & a 1 day hx of watery eyes & 1 x loose stool. Mom denies any vomiting & states that baby is eating, urinating & defecating well. Mom took baby to E.R. yesterday, 09/07/08, because baby felt hot. At the E.R. baby's temperature was 100.0 degrees Fahrenheit & both blood and urine samples were taken. Mom and baby were then sent home with a prescription for Tylenol which mom filled & has been giving to baby as directed. Today mom says that she received a phone call from the E.R. & was told that the baby needed to be admitted to the hospital because bacteria were found in the blood. Only sick contact has been mom who has had flu-like symptoms since early in her pregnancy.

Past Medical History: Patient was born at Thomasson at gestational age of 40 weeks, weighing 6 pounds 4 ounces. It was a normal vaginal delivery with spontaneous rupture of membranes. No complications during labor or pregnancy. Baby has not had any previous illnesses, surgeries or medication use, he does not have any known allergies, & the only medication he is on is Tylenol- which he is taking as needed for fever. Baby is up to date on all immunizations.

Review of Systems: Mother reports patient has no signs of oral mucousal irritation, or ear-pulling but did have "yellow eyes" for the first three days of life. ROS was negative for cardiac, pulmonary, or neurological symptoms (no heart palpitations, no dizziness, no syncope episodes, no shortness of breath, no difficulty breathing, no wheezing, no behavioral changes, no ataxia, and no changes in vision or hearing.) No known abdominal pain, no blood or mucous in the stool, and no blood in the diaper. No psychological changes noted by Mom. No bruising, bleeding, weakness, or other signs of hematological disorders.

Family History: Non-contributory- Mother and Father, along with the rest of the family, have no known medical history.

Social History: Patient is an only child and lives with mom, dad, grandma, three uncles and a cousin in a four bedroom, two bathroom apartment in El Paso, TX. Father is an 18 year old Hispanic and works in a restaurant as a cook. The Mother is now a stay-at-home mom and receives emotional and financial support from all family members living in the home.

Grandma does smoke tobacco outside the home but no one in the home drinks alcohol, or uses illegal drugs. There are no pets in the home. Mother receives WIC, Medicaid, and food stamps.

Diet: Patient's nutrition is regular for age- three to four ounces of Similac Advanced formula every four hours. Mom states that she only breast fed for 7 days- at which time baby stopped taking her breast.

Age Appropriate Development: Patient has normal development- age appropriate reflexes, tone, movement & reactions to various stimuli.

this is not development

III. PHYSICAL EXAMINATION

Vital Signs: (see attached growth chart)

Temperature 99.6 degrees Fahrenheit
Heart Rate 150 bpm
Respiratory Rate 40 breaths/min
Blood Pressure 71/46 mmHg
Weight (kg) 3.62 (>25th %ile)
Height (cm) 52.5 (50th %ile)
Head Circumference (cm) 38 (>75th %ile)

General: Patient is alert and oriented to his surroundings & he has a good pink color.

HEENT: Normocephalic, atraumatic, no hematoma. Pupils are equal, round and reactive to light. Tympanic membranes pearly gray with cone of light well seen. No evidence of jaundice. Oral mucousa dry, with no lesions. No lymphadenopathy. There are no ear anomalies and both are normally set. The nares are patent with an intact palate, with some dry mucous surrounding each nostril and upper lip.

Neck: The neck is supple, there are no masses. No lymphadenopathy.

Skin: Skin is supple w/ good color and capillary refill was <2-second. No rashes or bruises. No cyanosis or clubbing.

Cardiopulmonary: There are bilateral clear and equal breath sounds, a symmetric chest, and no evidence of respiratory distress. No rales or rhonchi, and no crackles auscultated. The heart sounds are of normal rate and rhythm, the pulses are equal in all four extremities, with no murmur auscultated.

Abdomen: The abdomen is soft and nontender, with no organomegaly or masses. The back and spine are straight, with no defects. There is no tenderness to palpation or distention. No scars or evidence of prior surgery or procedures.

Neuro

Extremities: There are no bony or joint abnormalities, and patient demonstrates good muscle tone and strength with symmetric movements. No cyanosis, lymphadenopathy, or edema and strong pedal & brachial pulses bilaterally.

Neurological: No neurological deficits. CNII-XII grossly intact. Patellar, ankle, brachial & radial reflexes 2+ bilaterally.

Genitalia: The external genitalia are normal. Testes descended bilaterally, no masses, no hernia, and penis without lesions.

IV. PROBLEM LIST

1) Subjective Fever (according to mom)
2) Green Nasal discharge
3) Cough productive of yellow sputum
4) Watery eyes
5) 1 x loose stool

V. ASSESSMENT

1) Possible Viral URI (Subjective Fever, cough productive of yellow sputum and green nasal discharge)
2) Gastroenteritis unlikely- No nausea, vomiting, diarrhea
3) Baby is still eating well, is well hydrated & stable
4) Bacteremia- Staph infection according to blood culture that showed gram (+) clusters
5) 12 day old baby– mom & baby seem to have familial support

VI. DIFFERENTIAL DIAGNOSIS

1) Meningitis
2) URI or other respiratory infection
3) UTI- we're awaiting U/A results
4) Pneumonia- but CXR ordered in E.R. came back normal
5) Gastroenteritis – but pt has no hx of vomiting and only had one loose stool just yesterday
6) Other, as yet unknown, infection

VII. PLAN

Diagnostic Plan:

1) Get a lumbar puncture to rule out meningitis
2) Monitor vital signs to assess temperature changes in response to infection, blood pressure changes in response to hemodynamic stability and pain, and respiratory rate to track any respiratory distress. We need to make sure baby does not develop sepsis.
4) F/U CBC to evaluate response to infection, hematologic stability
5) CRP to evaluate acute status of illness.
6) Urinary analysis and culture to rule out urinary tract infection and/or kidney infection– awaiting results but need to confirm that urine sample was obtained via catheterization
7) CXR to rule out pneumonia- E.R. already did this- report states that CXR was normal
8) Complete Metabolic Panel to monitor electrolyte status, kidney function, and hypo/hyperglycemia.

Therapeutic Plan:

1) Start baby on antibiotics:
a) Vancomycin 40 mg IV Q6
b) Ampicillin: 120mg IV Q8hr
c) Cefotaxime 180mg IV Q8hr

2) Monitor vital signs per protocol.
3) Tylenol for fever greater than 100.4 degrees Fahrenheit.
5) Discharge once he has completed his course of antibiotics- as long as patient's infection has resolved, he is stable, hydrated & afebrile

Patient/Parent Education: For mother & father- educate regarding developmental mile stones baby should reach by certain ages, about car seat use, nutrition regimen. She had no other questions, and was reminded to return to the E.R. if symptoms recur or worsen or call the pediatric hotline if she has any concerns or questions after discharge.