

Identifying Data

Full Name: OM

Address: Flushing, NY

Date of Birth: 10/15/2020

Date & Time: February 14th, 2022 @ 11:30am

Location: Pediatric ER Queens Hospital Center, NY

Source of Information: Father and medical resident

Reliability: Interpreter used

Mode of Transport: ambulatory

Chief complaint: "seizures x 12 hours"

HPI: 16 month old F preterm infant brought in by dad and medical resident from pediatric clinic for febrile seizures. Medical resident states that the father and pt arrived at pediatric clinic this morning for sick visit. Pt was previously in ER on 2/12/22 for a sick visit (cough) and told to return to PCP the following day for follow up. Pt was in pediatric clinic for follow-up when she had another seizure. Seizure was not witnessed by medical resident or any providers and abated without any intervention. Rectal temperature was 104F, acetaminophen suppository was given at the clinic (0930). Father states that pt developed cough and fever yesterday. She continues to drink normally with 6 urine diapers, no diarrhea, no emesis. Father states that patient had similar episodes of seizure activity last night of patient become limp, foaming at mouth and fingers becoming blue at 10pm and 11 pm last night and then 1am this morning. He states that each episode is self-limiting and lasts approximately 10 second. Pt is taken care of by babysitter, no known sick contacts. Pt was brought to ED yesterday, upper respiratory panel was negative; CXR showed increased bilateral perihilar markings; Azithromycin was prescribed and follow-up with PCP in 24 hours.

PMH:

Prenatal/perinatal: : Prenatal care with local MD, 32 weeks gestation, spent 3 weeks in NICU.remarkabe for bilateral resolving hemorrhage. G2P1011. No perinatal complications with pitocin-assisted delivery; birth wt: 7.8oz; APGAR = 8
Small for gestational age (10/20/20 – current)

Childhood immunizations up to date

Up to date.

Last vaccine: MMR, Varicella, Hep A dose 2 and Influenza Ilv4 given on 10/21/22

PSHx:

No known surgery

Medications: No daily medication

Allergies:

No other known food, environmental, or medication allergies

Family Hx:

Mother: "healthy" no PMHx; no hx of seizures

Father: Not in life however mother told him he had HTN

Social History:

16month old lives with mother and father, one other child in household older brother (25yo) in an apartment in queens.

Travel: has not been traveling

Pets: No animals

Smoking: No one smokes in the house

Sick contacts: no one is sick in the house

Alcohol: does not drink alcohol, even socially

Diet: infant is breastfed and bottle fed formula

Review of systems:

General: 16 month old appears fussy, uncomfortable, crying. Fever and diaphoresis present.

Denies fatigue, weakness, loss of appetite.

Skin, hair, nails: Pt father denies changes in texture of skin/hair, excessive dryness or sweating, discoloration, pigmentation, changes in moles, any rash.

Head: Pt father denies infant losing unconsciousness.

Eyes: negative for discharge or redness;

Ear: Pt father denies pt pulling at ear.

Nose: Nasal discharge and obstruction present.

Mouth/throat: Pt father denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, dentures. His last dental exam was last year; goes yearly.

Neck: no neck pain or stiffness

Breast: Pt denies any breast pain, lumps, nipple discharge

Pulmonary system: Positive for cough; Negative for wheezing, hemoptysis, and cyanosis

Cardiovascular system: negative for cyanosis

Gastrointestinal: No diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, blood in stool. No decrease in urine output or urine volume; no difficulty urinated

Genitourinary system: No discharge or trauma

Nervous: seizures present. Denies loss consciousness.

Musculoskeletal system: No Muscle/joint pain, deformity or swelling, redness noted

Physical

General: Active 13yo F; not in acute distress; well developed, normal weight; non-toxic appearing

Vital signs:

BP: 107/82 **HR:** 150 **Temp:** 102 F (2/14/22 @ 11:2) 98.1 (2/14/22 @ 1pm) **Wt:** 22lb

Skin: warm and dry texture, appropriate color for ethnicity, adequate skin turgor. No rashes, discoloration or lesions noted.

Hair: minimal dark hair with mostly bald areas; no masses, lesion, scars, contusions, discolorations

Nails: No abnormal coloring or markings; clubbing, capillary refill <2 seconds in upper and lower extremities

Head: normocephalic, atraumatic, non tender to palpation throughout head

Eyes: conjunctivae and sclera normal. No hemorrhage or discharge.. Normal pupils reactive; no nystagmus, swelling to eyelids.

Nose: Positive for congestion and rhinorrhea. The nasal septum is midline.

Ears: Symmetry/size, no lesions/masses / trauma on external ears. No tenderness to palpation of pinna or tragus, mastoid process. Visualization of tympanic membrane. No discharge

Sinuses – palpation/tenderness and percussion over bilateral frontal, ethmoid and maxillary sinuses.

Throat: Pink and moist oral mucosa, tongue symmetrical with normal movement. No exudates, erythema or swelling to pharynx. No masses, lesions or discolorations

Cardiovascular: Normal rate. No murmurs, gallops, rubs or abnormal sound auscultated. S1 and S2. No lifts, heaves, or thrills. Normal pulses radial and popliteal bilaterally.

Chest/Lungs: Clear to auscultation. No chest wall deformity or signs of trauma/tenderness noted. No signs of respiratory distress.

Abdominal: Soft to palpation, no tenderness throughout all quadrants. No scars, masses, lesions.

Genito Urinary/ rectal: No signs of trauma or discharge; no difficulty urinated or decreased urine output

Musculoskeletal: No neck pain or neck stiffness (negative meningeal signs); strength and ROM observed to be intact for age

Neurological: alert and oriented for age. GCS eye: 4; GCS verbal: 5; GCS motor: 6. Good muscle tone and bulk; sensation to light touch intact throughout.

Motor: No abnormal muscle tone or seizure activity noted

Differential diagnoses:

1. Complex febrile seizure
2. Infantile spasms
3. Benign generalized epilepsy
4. Benign neonatal sleep myoclonus
5. Psychogenic nonepileptic seizures
6. Syncope
7. Breath-holding spells
8. Dravet syndrome

Assessment/problem list

16 month old F with complex febrile seizures based on description by father and upper respiratory symptoms

1. Complex Seizures

- Patient needs baseline EEG and pediatric neurologist refer

2. Fever

- Checked again in acute care; 103; motrin administered
- Pt still drinking/eating normally

3. Upper respiratory Infection

- Negative respiratory panel
- CXR: increased bilateral perihilar marking; more indicative of viral etiology or atypical bacteria

4. Systemic infection

- Negative meningeal signs

Medications:

- Acetaminophen 160mg/5ml suspension take 3.1ml (100mg total) every 4 hours as needed for fever >100.4
- Azithromycin 100mg/5mg take 2.5ml (50mg total) orally x 4 days
- Ibuprofen 100mg/5ml take 5ml (100mg) every 8 hours for mild pain (1-3)

Plan**1. Complex Seizures**

- Call speak with Bellevue pediatric neurology for transfer of service

2. Fever

- Temperature check Q1 hours with acetaminophen PRN

3. Upper respiratory Infection

- Repeat respiratory panel
- Order CMP, CBC with manual diff, POC glucose, UA with reflex, Blood culture,

4. Systemic infection

- Negative meningeal signs