MRC= 55/17

ALL INDIA INSTITUTE OF MEDICAL SCICENCES, NEW DELHI-29
Division of Neonatology, Department of Pediatrics
Contact No C3 NICU: 9868397538

HIGH RISK DISCHARGE SUMMARY

Baby CR: 753023-16	Name of mother: B/O INDRESH	Mother's age : 32yr	MBG- O+ve
Mother CR: 752609	Name of father: Vishal	UHID - 102475764	NNPD: 16919
Address: TH 2/2 OM COMPOUND SEC-14 RAJ NAGAR GZB UP			
Telephone: 9650886618			

DOB :	TOB	Gestation:	Birth weight: 1109g	Sex	IU growth status:
28.12.16	6.05PM	29+6wk		Male	AFD

Resuscitation details:	Apgar : 1 min: 8	5 min: 9	Meconium stained liquor: No
Dexametasone was not covered. Received only 2 doses. Baby born cried immediately, early cord clamping done i/v/o APH & abruption placenta, received in cling wrap, initial steps done, HR more than 100, good respiratory efforts and SpO2 more than 90% → baby shifted to nicu A i/v/o very preterm and VLBW.			Cord pH: 7.36

Final diagnosis:

Single / Very Preterm / 29weeks / Male / 1109 g / AGA / VLBW / Emergency LSCS ivo severe pre-eclampsia with AEDF/ no GCA

Advice at Transfer:

1. Continue direct breast feeding followed by KS feeds 30 ml q 2hrly.
2. KMC atleast 8-10 hrs per day
3. Immunisation as per schedule
4. Vit D3 drops (400IU/ml) 1ml BD till 1 year of age
5. Tonoferon drops 3 drops BD
6. ROP follow up on ~~24/02/17~~ Thursday 2PM in NICU B at 2PM. 2/3/17 Thursday 2pm
7. Follow up in HRC clinic Wednesday 2PM after completion of ROP screening

Review in NHKC (NPW 1st floor) after 4 days .

Danger signs: Not feeding well, lethargy, fast or difficulty in breathing, fits, baby becomes blue;
In the presence of danger signs or in case of emergency, contact C3 NICU (9868397538)

Detailed Information: G3P1+0+1+1 with h/o birth asphyxia in previous baby.		Age	
Current pregnancy: G3	LMP:2.6:16	EDD:9.3.17	Mode of delivery: Em LSCS Indication : Abruption placenta

G1- 2004 year, spontaneous conception/ MTP abortion at 2 month POG ivo unwanted pregnancy
G2-2005 ,spontaneous conception/FTNVD/ did not cry immediately / Kept in NICU A for 10 days/ A&H.
G3 present pregnancy
-T1: Spontaneous conception/UPT done at home/ USG confirmed/Regular Folate intake.

T2/3: Quickening at 5 months POG/Regular Fe/Ca intake/received 2 doses of TT/ No foul smelling discharge/ no uterine tenderness/H/o spotting 2days before delivery → admitted with frank BPV. Level 2USG Scan -no GCA noted

Hospital course:

a) **Respiratory:** Baby was started on b CPAP ivo retractions and increased work of breathing. Baby has been stable and maintaining SpO2. But as baby developed one episode of apnea and recurrent desaturations on D2, weaning from CPAP was not tried. Septic screen done and it was negative. And ruled out all other secondary causes of apnea. Then started on Inj. Caffeine. Currently baby is on b CPAP 4/25%. Gradually baby was shifted to H3FNC mode of ventilation. H3FNC was removed on day 10 of life, however i/v/o desaturations baby was started on oxygen by open tube. Baby could be weaned off oxygen by day 24 of life and subsequently remained well in room air. Currently baby is under room air and is maintaining saturations well.

b) **Shock-** The baby remained hemodynamically stable throughout the hospital course.

c) **Sepsis:** No e/o sepsis. Septic screen was done once and negative. No antibiotics received.

d) **Jaundice:** Received phototherapy for 24 hours. Initiated at 20hrs of life and maximum value was 9.3. ABO incompatibility and other common hemolytic disorders were ruled out and jaundice was attributed to prematurity. There was no subsequent requirement of phototherapy.

e) **Nutrition:** Baby was kept NPO and started on IVF in view of respiratory distress for 18hrs. Then MEN was started. As baby tolerated well, gradually OG feeds were hiked. Baby had intolerance to HIJAM so feeds was increased to 220ml/kg without any fortification. However, i/v/o suspected evolving BPD feeds were reduced to 180ml/kg with added preterm formula. After weaning off the baby to room air feeds were again hiked to 200 ml/Kg to optimize weight gain. The baby developed osteopenia of prematurity for which preterm formula fortification was substituted by HIJAM which the baby tolerated well this time. Currently baby is on full feeds via KS (full EBM with HIJAM fortification) and breast feeding is being tried intermittently. Last week weight gain was 19 g/kg/d and plan is to continue DBF with KS feeds.

f) **Prematurity:** Ultrasound head done on 31/12/16 and 13/1/17: Normal; **ROP screen** on 02.02.17: B/l zone 3 immature, to review after 3 weeks.

Immunization given: BCG, OPV, Hep B on 2/2/17

Anthropometry:	**At birth**	**At discharge**
Weight	1109 gm	1790 gm
Length	40 cm	44 cm
Head circumference	26.5 cm	30.5 cm
Chest circumference		

Date of discharge: 04.02.2017 **JR (neonatology)**
Name: Dr. Mayank **Signature:** Mayank

Signature: Vijay **(SR Neonatology)**
Name: Dr. Surjeet

24/2/17 on DBF
wt - 2550 gm Wt. gain Adequate Plan
O/E Alert Active - T/c DBF
Vitals stable. - Tonoferon drops 5 drop PO/OD
Systemic - WNL - Vit D3 1ml PO/BD
- D/S explain.
2/3/17 - Review for ROP on 2/3/17 Vijay
wt - 2.750

MEDICAL RECORD

NOTE DATED: 02/04/2017 15:48 Progress Notes
LOCAL TITLE: OBSTETRICS DISCHARGE NOTE
STANDARD TITLE: OB GYN ATTENDING NOTE
ADMITTED: 02/03/2017 15:28 KMC
POSTNATAL DISCHARGE NOTE

DEPARTMENT OF OBSTETRICS
ALL INDIA INSTITUTE OF MEDICAL SCIENCES
NEW DELHI-110029

POSTNATAL DISCHARGE SUMMARY UNIT-I

UHID NO:102-47-2153 CR NO:752609
PATIENT NAME:INDRESH,INDRESH AGE:33 SEX:FEMALE
D.O.A.: 27/12/16 D.O.D.: 4/2/16
HUSBAND:VISHAL
ADDRESS: TH 2/2 OM COMPOUND SEC 14,RAJ NAGAR
PHONE NO:9650886618
LMP:2/6/16 EDD:9/3/16 POG AT ADMISSION:29+5 WEEKS

DIAGNOSIS: (unbooked)

G3P1+0+1+1 AT 29+5 WEEKS POG WITH ANTEPARTUM HEMORRHAGE
HOPP:

CONCEPTION: SPONTANEOUS CONCEPTION

1st TRIMESTER:

DIAGNOSED BY UPT 2 WEEKS AFTER MISSED PERIODS
CONFIRMED BY USG
H/O REGULAR INATKE OF FOIC ACID TAB+
NO H/O EXCESSIVE NAUSEA/VOMITING
NO H/O BLEEDING/SPOTTING PER VAGINUM
NO H/O FEVER/UTI
NO H/O TRAUMA
NO H/O TERATOGENIC DRUG INTAKE /RADIATION EXPOSURE
NTNB SCAN DONE-WNL
DUAL MARKER NOT DONE

2nd & 3rd TRIMESTER:

H/O REGULAR INTAKE OF IRON AND CALCIUM+
IMMINSED WITH 2 DOSES OF INJ TT
QUICKENING FELT AT ARD 5 MONTHS POG
NO H/O DERRANGED BLOOD SUAGR PROFILES/ELEVATED BP RECORDS
NO H/O FEVR/UTI
H/O SPOTTING PER VAGINUM TWO DAYS PRIOR TO ADMISSION.CONSULATED A PVT at 29+3 wks POG.
PRACTIONER.WAS ADVISED INJ PROLUTONBUT BLEEDING WAS NOT CONTROLLED.
NO H/O ABDOMINAL PAIN/DECREASED FETAL MOVEMENTS.WAS REFERRED BY HER PRACTITIONER
TO SOME HIGHER CENTRE DUE TO LACK OF NICU FACILITY.WAS THEN SELF REFERRED TO
AIIMS

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OBSTETRIC HISTORY :

I:2004/SPONT CONCEPTION/MTP DONE AT 2 MONTHS POG I/V/O UNWANTED PREGNANCY
II:2005/SPONT CONCEPTION/H/O REGULART ANC VISITS+/NO H/O ANC COMPLICATIONS/ETNVD AT A PVT HOSPITAL AT MUZZAFARPUR/BABY DID NOT CRY IMMEDIATELY AFTER BIRTH.B WT 3 KG/MALE/H/O DELAYED MILESTONES+
III:PP

PAST HISTORY:

NO H/O DM/HTN/TB/ASTHMA/EPILEPSY
NO H/O PREV SURGERIES

FAMILY HISTORY:

NS

EXAMINATION: (AT THE TIME OF ADMISSION)

GENERAL:

ORODENTAL HYGINE:F
BREAST :N
THYROID :N
CVS :S1S2
RS :B/L NVBS+
P/A :UTERUS TERM SIZE,RELAXED,NON TENDER/FETAL PARTS PALPABLE
VITALS
TEMP :AF PUL :88b/m
RES :16br/m BP :124/84mmhg

INVESTIGATIONS:

BLOOD GR:O POS
HB 12.2(30/12/16)
TLC 14500
PLT 1.5L
F.B.S 84
OTHERS:

HIV :NEG
VDRL :NR
TSH :3.24
URINE R :NAD
URINE CUL :STERILE
NTNP SCAN :(5/9/16)SL;IUF,13+2WEEKS,NT 1.6MMNB+
LEVEL II SCAN:SLIUF,NO GCA
USG(28/12/16)SLIUF,LIQUOR NIL,FALL OUT AREAS SEEN IN THE PLACENTA AND FEW AREAS OF PLACENTAL SEPARATION SEEN

HOSPITAL COURSE:

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PATIENT WAS ADMITTED.STARTED ON INJ DEXA.RECEIVED THREE DOSES OG INJ DEXA.USG DONE WAS S/O ANHYDRAMNIOS.DECISION FOR EM LSCS WAS TAKEN

DELIVERY DETAILS:

EM LSCS DONE AT 29+6 WEEKS POG
I/C:ABRUPTION WITH ANHYDRAMNIOS
DR VANDANA/DR MUKUL
DOB:28/1/2/16,TOB:6:05PM

MODE OF DELIVERY:

EM LSCS DONE AT 29+6 WEEKS POG
I/C:ABRUPTION WITH ANHYDRAMNIOS
DR VANDANA/DR MUKUL
DOB:28/1/2/16,TOB:6:05PM

INTRA-OPERATIVE:

RECTUS AND BLADDER HEALTHY.UTERUS ~30 WEEKS.LUS NOT WELL FORMED.SLIUF,CEPHALIC,50CC RETROPLACENTAL CLOT PRESENT.PLACENTA ANTR.B/L TUBES AND OVARIES HAELTHY.PLACENTA SEAPARTED AND CAME OUT WITH THE BABY.SKIN SUTURED WITH MONOCRYL SUTURES

POST PARTUM COURSE/COMPLICATIONS:

UNEVENTFUL.INJECTABLES DISCONTD ON POD 2.CATHETER DISCONTD ON POD 2.PASSED URINE AND STOOLS.ACCEPTING ORAL FEEDS WELL.HAD MINIMAL SEROUS DISCHARGE FROM WOUND SITE ON POD 4.WOUND C/S REPORT WAS STERILE.DAILY DRESSING DONE AND WOUND SUTURE LINE TURNED HEALTHY.DISCHARGED IN STABLE STATE WITH THE BABY ON POD 38

BABY DETAILS:

BABY WT/SEX:1109GMS/MALE A/S- 8/9
AFD/SFD/LFD: AFD DOB :28/12/16
TOB:6:05PM
PLACENTA AND MEMB COMPLETE

BABY COURSE:

ADMITTED IN NICU.MONITORED AND STARTED ON OG FEEDS F/B BRAEST FEED GRADUALLY.DISCHARGED IN STABLE STATE ON EXCLUSIVE BREAST FEEDING

ADVICE ON DISCHARGE:

ABSTINENCE X 6WKS,
T. FE X OD X 6 MONTHS,
T.CALCIUM X BD X 6 MONTHS,
EXCLUSIVE BREAST FEEDING X 6 MONTHS,
IMMUNISE BABY AS PER SHEDULE,
FOLLOW UP IN GOPD ROOM NO-18 REGARDING CONTRACEPTIVE DEVICE,

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02/04/2017 15:48 ** CONTINUED FROM PREVIOUS PAGE **

C3 SOS, CONTACT SR/JR-9868397313/16

Signed by: /es/ surabhi s
JR OBS&GYNAE
02/04/2017 16:45

Aiims Gynae ISR