CH.96AEC213536
CLAIRE
ROBERTS
DOB 10-JAN-87
DATE
TIME
AE DEPT: RBHSC

DATE | CLINICAL HISTORY, EXAMINATION AND PROGRESS

2/10/96. 8pm. 9 year old admitted via A+E

PC Vomiting at 3pm and every hour since
Slurred speech + Drowsy
Off form yesterday, Loose motion 3 days ago

HPC Severe learning difficulties
Seizures 6 mo - 1yr. - Controlled by Mc Valproate -
Age 4 - x1 seizure
Anticonvulsant gradually weaned until
Epilim stopped.

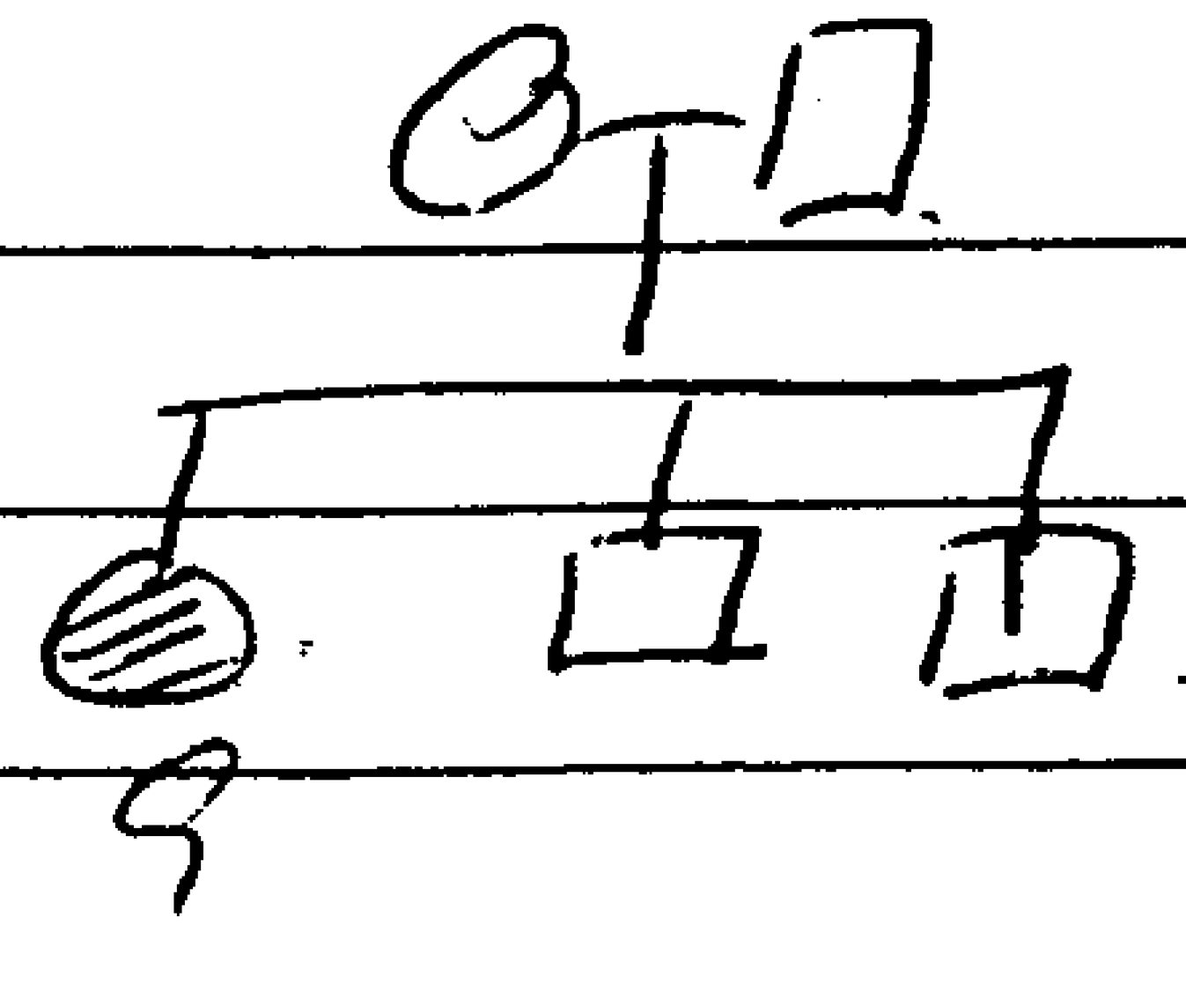
H+S Speech - ca speech in sentences, meaningful.
Hearing ⓝ
V. Vision ⓝ
FM scribbling - feed herself c̄ supervise.
Cannot dress herself
GrossM Walk, Run, UP + Down Stairs, favours left side & body
- Torbank Special school Dundonald

- Dr. Gaston UHD, previously Dr Moyo

Recently tried Ritalin - Dry mouth, Then became agitated, Dry mouth

DH nil

PH.



all nil

CR - RVH

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
8/c	37°
	CVS I + II 80/min.
	RS. clear
	Abd soft. Not tender No masses.
	CNS. Fundii normal, Discs Not blurred.
	PERLA
	~~[illegible]~~ VII ✓ IX ✓ X ✓
	PNS , Sit-up + stairs [illegible] ?Ataxic
	power not assessed
	R. L
	Tone. upper limb Cogwheel Rigidity ↑ tone
	lower limb ↑ tone ↑ tone
	R L
	Reflexes BJ ++ +
	TJ ++ +
	SJ ++ +
	KJ ++ ++
	AJ. + +
	P ↓ ↓
	clonus+ clonus+
	Sens - not responding to parent's voice / intermittently responding to deep pain responding

Maire Robert

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
Δ.	1. Viral illness
	2. ~~Encephalitis~~
Inv.	FBC –
	U+E –
	BCx –
	Viral titres ± LP – afebrile.
Mx.	IV fluids,
	iv diazepam if ? seizure. Activity.
	Re-assess after fluids. [signature]
12mw	Slightly more responsive – No meningism.
	Observe + reassess am. [signature]
	Na 132. ↓ Hb 10.4
	K+ 3.8. PCV .31
	U 4.5 WCC 16.5 ↑
	Gluc. 6.6. platel. 422.000
	Cr 36.
	Cl. 96.
	Nofeon (SHO)
22/10/96	W/R Dr Sands
	Admitted ? Viral illness.
	Usually very active +, has not spoken to parents as per norma
	Wretching. No vomiting.
	Vagueness/Vacant (apparent to parents)

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
	No seizure activity observed.
	Attended Dr Gaston (UHD)
	6mth hx seizures. and Rx for this - NAD.
	U+E - Na+ 132. FBC - Wcc ↑16.4. Gluc 6.6.
	CXR Apex c. On IV fluids.
	Pale colour. Little response compared to normal
	CNS Pupils sluggish to light. Cxs
	Difficult to see fundi Nose difficult to
	Bilat. long tract signs full exam
	Resp. Non fitting status. ~~/ encephalitis / encephalopathy~~
	Plan. Rectal DIAZEPAM
	Dr West
	DW Dr Gaston re PMHx
22-10-96	Neurology - Thank you
4pm	• 9yr old girl with known learning difficulties - Parents not available.
	Grandmothers Hx - vomiting + listless yesterday pm - followed by
	prolonged period of poor responsiveness
	On No AED.
	• Not appeared to improve following rectal diazepam 5mg at 12-30.pm
	O/E Afebrile., No meningism. Pale
	Rousable - Eye opening to voice, Non verbal., withdraws
	from painful stimuli. Reduced movements Rt Side?
	Hypertonicity all 4 limbs.
	Mildly increased tone both arms
	Reflexes symmetrically brisk -

CR - RVH

090-022-053

WNC 76:

CH 328770
MISS CLAIRE ROBERTS
[redacted]
10/01/87
Female
[redacted]
EHSSB
CONSULTANT

DATE | CLINICAL HISTORY, EX/ WD/OP

22.10.96 — Clonus - sustained both ankles
Toes ↑↑.
- Sits up - eyes open + looks vaccantly.
Not obeying commands.
- PERRL - 5mm
Optic discs pale. No papilloedema
Facial palatal + lingual movements appear (N).

Imp - I don't have a clear picture of prodrome + yesterdays episodes.
Her motor findings today are probably long standing but she needs to be checked with Notes. The picture is of acute encephalopathy most probably postictal in nature. I Note (N) biochemistry profile

Suggest i) starting iv phenytoin 18 mg/kg stat followed by 25 mg/kg 12 hrly. Will need levels 6 hrs after loading dose
ii) Hrly neurobs
iii) CT tomorrow if she doesn't wake up

D Hobbs

22/10/96
9.30 pm — 24 kg PHENYTOIN 18 mg/kg - loading dose = 18 × 24
= 632 mg

24 kg. PHENYTOIN 2.5 mg kg 12 hrly = 60 mg 12 hrly either IV or orally

Check levels at 9pm.

T Phelan

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
22/10/96	S/B. Dr Well
	Still in status
	1. MIDAZALAM 0.5 mg/kg STAT DOSE = 0.5 x 24
	= 12 mg IV Stat
	2. MIDAZALAM 2 mcg/kg/min = 2 x 24 mcg/min
	= 48 mcg/min
	= 48 x 60 mcg/HR
	= 2880 mcg/HR
	= 2.88 mg/HR. INFUSION
	= 69 mg/24 HRS.
22.10.96	
17.00	- Claire has had a loading dose of phenytoin + a bolus of midazolam. She continues to be largely unresponsive. She responds by flexing her (L) arm to deep supraorbital pain + does have facial grimace - but no localisation. She has intermittent mouthing + chewing movements.
	- Background from mum - contact with cousin on Sat who had a G.I.T upset. Claire had loose motions on Sunday + vomiting Monday. She had some focal szs on Monday c̄ Rt sided stiffening.
	- Plan. 1) Cover c̄ cefotaxime + acyclovir x 48 hrs - I don't think meningoencephalitis is likely
	2) Check viral cultures ? enterovirus - stool, urine blood + T/S
	3) Add IV sod. valproate 20mg/kg IV bolus followed by infusion of 10mg/kg IV over 12 hrs.

[signature]

090-022-055

CR – RVH

....57

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
22/10/%	Na 121.
23:30	K 3.3 Phosphate 23.4 mg/l (10-20)
	Urea 2.9
	Gluc 33.
	Hyponatraemic - ? Fluid overload & Low Na Fluids.
	? SIADH.
	Imp - ? Need for ↑ Na Content in Fluids
	- Olw Rg - ↓ Fluids to 2/3 of present value - 41mls/hr.
	- Send Urine for osmolality.
	Mid & Hunt
	(SHO).
~ 7AM	called to see
	had been stable when suddenly she
	had a respiratory arrest and developed fixed
	dilated pupils
	When I saw her she was Cheyne-Stoking
	and requiring O2 via face mask
	Saturation with bagging in high 90's
	Good volume pulse
	I attempted to intubate - not successful
	Anaesthetic colleague came and intubated
	her orally with 6.5 tube
	transferred to PICU.

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
4 am	9½ yr old girl c learning difficulties admitted 32 hours ago
	c ↓ level of consciousness.
	s/B Dr Webb. - acute encephalopathy ? aetiology.
	Covered c Acyclovir + cefotaxime.
	Loaded c phenytoin + valproate added in @ 1700 hrs.
	11pm - phenytoin level = 23.4 Na^+ 121 K^+ 3.3.
	Fluids restricted to 2/3rd maintanence.
	Obs otherwise stable.
@ 3am.	Reg asked to see because of resp difficulties.
	Cheyne - Stoke breathing
Hb = 10.2	- Intubated + transferred to ICU.
WCV = 0.29	At present intubated + ventilated
WCC = 9.4	has had some Midazolam but it is no longer running
Plat = 406,000	Pupils fixed + dilated
Serum Neutrophil = 14.2	Bilateral papill oedema L > R.
Na 121	No response to painful stimuli.
K^+ 3.7	BP - 90/65 HR = 100/min.
U = 3.6	Plan - Mannitol stat,
B ur = 43	- Dopamine infusion.
Creat = 45	- urgent CT scan. HSSch
Osmol = 249	
23.10.96	
4.40 AM	Neurology.
	• S.I.A.D.H - hyponatraemia, hypoosmolarity / cerebral oedema
	+ Convulsions prolonged epileptic seizures
	• Pupils fixed + dilated following normal diuresis
	• No eye movements.
	→ For CT Scan
	JWebb

Clarke Rhodes

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
23-10-96 0530	P. KENNEDY (RADIOLOGY REG CT BRAIN There is severe diffuse hemispheric swelling, with complete effacement of the basal cisterns. No focal abnormality is identified. [signature]
23.10.96 6Am	Brain Stem Death Criteria Evaluation ! • Aged 8-9 m unresponsive Doll's Eye Movements Corneals Absent — No Gag Response Iced Calories 40ml to both Ears — No Response • No Response (Motor or Autonomic) to deep supra orbital pain • Apnoea Test in progress CT. Cerebral Herniation Under No sedative / paralysis medication Clarke fulfils criteria for Brain stem dead Two examinations should be repeated 4 hrs - 6 hrs apart D Webb (Paed Neurologist)
23/10/96 07'10 McHAIGNE.	9 yr. old girl admitted to PICU from Allen Ward. suffered a respiratory arrest, was initially bagged and intubation performed by Dr Clarke (SpR Anaes) on the ward. At the time of intubation vomitus was noted in oropharynx - liquid material no solid material. Following intubation trachea was sucked out - and a small amount of watery

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DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS

material was aspirated.
oral ET tube then changed to nasal ET tube
in PICU.
Initially admitted to hospital with decreased
level of consciousness with the clinical picture
of acute encephalopathy. Status epilepticus
subsequently developed requiring phenytoin,
valproate and midazolam.
serum Na also noted to be low 121
presumably on basis of SIADH.

In PICU hypo ventilated and given mannitol
0.5 g/kg.
pupils fixed and dilated.
BP ~ 95 systolic. peripheral dopamine infusion
commenced.
arterial line (R) dorsalis pedis and
(R) ant. tib. right 5/8.
then transferred for CT scan
transfer uneventful.
CT scan shows severe cerebral oedema.
1 set of brain stem tests performed by
Dr Webb / Dr Stean. serum Na also checked
at same time. (133 — blood gas analyser PIC
no resp. effort with ABG's.
pH 7.13 pO_2 124.5 pCO_2 79.2

Plan: maintain circulatory support as Claire
is a potential organ donor.
- dopamine infusion to maintain SBP
~ 100 mmHg.
- close check on serum Na and serum
osmolality and urine output.

CR - RVH

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS

if serum Na >150 and osmolality >300 then commence desmopressin.
- will need conc. K infusion.
- maintainence fluids with Dextrose 4% / Saline 0.18%
- ventilate to pCO_2 35.
-

Dr Webb / Dr Stean have discussed Claire's clinical condition with her parents. They initially appear to be giving consent for organ donation but Dr Webb will speak again to both parents at ~ 10^{00}.

check CXR shows central line and ET tube in good position. There is some mottling of both hilar regions more so on the (R) side. There has been a deterioration in ABG's. pO_2 76 on FiO_2 0·6. I would be concerned that ~~Claire~~ this picture could be explained by pulmonary aspiration or early neurogenic pulmonary oedema. Any potential transplant centre should be alerted to possibility of pulmonary aspiration.

Lab. Sample at time of brain stem tests
: Na 129. K 3·6 Cl 94 urea 3·7.
glucose 7.2 osmolality 274.

09^{50}.
check 2 hrly U+E's.
change maintainence fluids to 0.9% saline

PMcHaigue

DATE	CLINICAL HISTORY, EXAMINATION AND PROGRESS
23/10/96	Hypotensive BP 70/s ? D.I. given HPF 500 ml Needs DDAVP to limit polyuria Appears B.S. Dead informally. But only 7 hrs post arrest. Na^+ 129 (from 121). Plan – Maintain BP >100 – DDAVP.
18.25.	- Diagnosis of Brain death protocol completed. No spontaneous resps - CO_2 7omm Hg. Discussed ? parents - agree that ventilation should be withdrawn Consent for limited p.m given. Hoskin.
23/10/95 18[45]. M/MAGNE.	ventilation discontinued at 1845.
	Death certificate issued - cerebral oedema 2° to status epilepticus.
24/10/95 12 PM	GP informed.
11.11.96 3.35 pm	- Spoke @ length with Mr + Mrs Roberts earlier today. They are naturally still trying to come to terms with what happened & Dec. I talked through the events before her death and also talked generally with them. They are naturally anxious to discuss the PM results with someone. I will pass this on to Dr. Keen ASAP.