MEDICAL CHRONOLOGY - INSTRUCTIONS TO FOLLOW

General Instructions:

Brief Summary/Flow of Events:
In the beginning of the chronology, a Brief Summary/Flow of Events outlining the significant medical events is provided which will give a general picture of the focus points in the case.

Patient History:
Details related to the patient's past history (medical, surgical, social, and family history) present in the medical records.

Detailed Medical Chronology:
Information captured "as it is" in the medical records without alteration of the meaning. Type of information capture (all details/zoom-out model and relevant details/zoom-in model) is as per the demands of the case which will be elaborated under the 'Specific Instructions.

Reviewer's Comments:
*Comments on contradicting information and misinterpretations in the medical records, illegible handwritten notes, missing records, clarifications needed etc. are given in italics and red font color and will appear as * Reviewer's Comment*

Illegible Dates: *Illegible and missing dates are presented as "00/00/0000" (mm/dd/yyyy format)*

Illegible Notes: *Illegible handwritten notes are left as a blank space "_____" with a note as "Illegible Notes" in the heading of the particular consultation/report, areas which we have interpreted but are doubtful are presented in red italics.*

Specific Instructions:

- *The chronology focuses on clinical condition pertaining to Hirschsprung's disease and the surgical management as given below:*
  - *XX/XX/2016- XX/XX/2016: These hospitalization records summarized in detail from the initial presentation, diagnosis of Hirschsprung's disease, surgical management of transanal pull through on XX/XX/2016 and postoperative complication rectovaginal fistula along with its management till discharge on XX/XX/2016.*
  - *XX/XX/2016- XX/XX/2016: These records status post the surgical management of rectovaginal fistula, the outpatient visits and hospitalization for colostomy reversal are summarized briefly to assess the extent of the postoperative complications and the subsequent procedures performed.*
- *The PDF page numbers are given in brown color font when given within the occurrence column for ease of reference.*
- *Case significant details are highlighted in yellow for ease of reference.*
- *Repetitive details have been avoided in the chronology, wherever applicable.*

Brief Summary/Flow of Events

XXXXX Health Center:

***XX/XX/2016*:** 39-day-old female, born at 37 weeks via cesarean section for oligohydramnios, presented to ER for complaints of constipation and vomiting x 3 days – No bowel movement despite Glycerin suppository – Transferred to XXXX Hospital for surgery evaluation.

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XXXXX Health Center: (XX/XX/2016- XX/XX/2016)

XX/XX/2016: X-ray abdomen revealed diffuse gaseous distention of colon – Admitted for lower abdominal pain and distended abdomen with Abdominal Girth (AG) of 40 cm – Barium enema revealed focal area of narrowing at the upper rectum/sigmoid colon junction consistent with a transition zone – Findings suspicious for Hirschsprung disease – Placed Nasogastric Tube (NGT)

XX/XX/2016: Underwent full thickness rectal biopsy to rule out Hirschsprung's disease – Abdomen less distended and AG varied between 38-40 cm - Started on Total Parenteral Nutrition (TPN)

XX/XX/2016: Pathology report of rectal biopsy revealed no mature ganglion cells and findings suggestive of Hirschsprung's disease – Mother consented for surgical management after discussion regarding the risks and benefits - Underwent transanal pull through performed by XXXX, M.D. and XXXXX, M.D. – Operative findings revealed narrowed rectum and dilated hypertrophic colon proximally.

***XX/XX/2016*:** Post-operatively, patient had low grade fever and managed with antibiotics - Remained stable with less distended abdomen – Diagnosed with malnutrition related to acute illness – Tolerated per oral clears and passed stools –Discharged home in stable condition.

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XXXXX Health Center:

***XX/XX/2016*:** Presented with complaint of pain and straining with bowel movements – Patient found to have discomfort with tight anal sphincter – Dr. XXXX performed digital dilatation and taught mother how to perform digital rectal dilatation.

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XXXXX Health Center: (XX/XX/2016- XX/XX/2016)

XX/XX/2016: Presented with complaints of stool coming out of vagina – Admitted for possible ano-vaginal fistula – Barium enema revealed abnormal communication between the distal rectum/anus and the vagina/uterus – Recommended surgical exploration and revision of anastomosis.

XX/XX/2016: Underwent examination under anesthesia, including urethral catheterization, vaginoscopy, anoscopy and proctoscopy – Operative findings revealed no evidence of rectovaginal fistula – Diagnosed with severe malnutrition and under-weight per growth curve – Found stool still coming out from vagina – Planned revision surgery.

XX/XX/2016- XX/XX/2016: Taken to OR for rectovaginal fistula – Operative findings revealed rectovaginal fistula approximately 1.5 cm proximal to the site of the coloanal anastomosis – Underwent diverting loop colostomy – Post-operative course complicated by Urinary Tract Infection (UTI) and bronchiolitis - Condition improved with antibiotics and ostomy care – Stabilized and discharged with colostomy and Bactrim prophylaxis.

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XXXXX Health Center: (12/02/2016-02/03/2017)

Remained stable with functioning colostomy and tolerated diet – Planned colostomy reversal.

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XXXXX Health Center: (XX/XX/2017- XX/XX/2017)

XX/XX/2017- XX/XX/2017: Admitted for reversal of colostomy with coloanal anastomosis – Underwent closure of colostomy – NG tube placed.

XX/XX/2017- XX/XX/2017: Patient developed pneumoperitoneum – Operative findings revealed leak at the anterolateral aspect of the colocolonic anastomotic site - Underwent exploratory laparotomy, T-tube placement, closure of anastomotic leak on 02/12/2017 – Underwent construction of end colostomy on 02/16/2017 – Stabilized and discharged home.

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XXXXX Health Center: (XX/XX/2017- XX/XX/2017)

Condition improved and patient gaining weight with non-distended abdomen – Patient developing well with weight at 70th percentile.

**Reviewer's Comment: Further records are not available for review.*

Patient History

Past Medical History: Lower abdominal pain. Infant born to HIV positive mother.

Surgical History: No significant surgical history

Family History: Maternal HIV, diabetes

Social History: Lives with parents

Allergy: No known drug allergy

Detailed Chronology

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
	XXXX XXXX	**Reviewer's Comment: The available prior records from 09/08/2016 to 09/27/2016 were reviewed and there were no significant details related to Hirschsprung disease. Hence the medical conditions from these records are summarized in the patient history section alone.*	
XX/XX/2016	XXXX XXXX	**ER visit for constipation:** **Chief complaint:** No bowel movement x 3 days, crying a lot. **History of present illness:** 39-day-old female, born at 37 weeks at Bellevue via cesarean section for oligohydramnios with history of constipation since birth - moved bowels daily or every other day. Now presents with constipation for 3 days, vomiting for 3 days, projectile, non-bloody, non-bilious. Well-appearing female infant. No Acute Distress (NAD).	5347-5355, 5335-5340, 5358-5359

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Physical exam: **Vitals**: Temperature 99.2, pulse 149, Respiratory Rate (RR) 44, oxygen saturation 99%. **General:** Normal Consolability. **Abdomen:** Tender, distended. **Genitalia:** Normal female external genitalia without lesions or discharge. *Otherwise, unremarkable*. **X-ray abdomen**: *(XXXX XXXX, M.D.) (Ref 5358-5359)* **Clinical indication**: Abdominal distention. **Findings:** Upright and supine views of the abdomen demonstrate distended loops of bowel with multiple air fluid levels. These may represent bowel obstruction. Follow-up is advised. If indicated CT scan with contrast is recommended. **Impression:** Distended loops of bowel with multiple air fluid levels may represent bowel obstruction. Follow-up is advised. **ER notes**: *(Ref 5348-5349)* **Primary diagnosis**: Vomiting, unspecified. **Assessment and plan**: Abdomen with positive diffusely tender, distended. Abdominal X-ray consistent with small bowel obstruction. Will administer IV bolus normal saline. Will obtain Complete Blood Count (CBC), chemistry 7, urinalysis, urine culture. HIV screening – High risk none. HIV status self-reported negative and declines testing. **Labs**: *(Ref 5335-5340)* **Normal**: White Blood Cell (WBC) (9.4), hemoglobin (13.5), hematocrit (41), neutrophil % (43.1), neutrophil count (4) **Low**: Blood Urea Nitrogen (BUN) (5), creatinine (0.204), eosinophil % (0.4), total protein (3.8), albumin (3.4) **High**: Basophil % (1.4) **Urine analysis**: Abnormal – bilirubin (small 1+), ketones (5-trace) **Disposition**: *(Ref 5352)* **Disposition:** Transferred to another hospital **Transfer reason:** Services not available. **Primary diagnosis**: Other constipation **Discharge summary**: Transfer to XXXX Hospital for surgery evaluation. Attempted Glycerin suppository x2 – no bowel movement.	
XX/XX/2016	XXXX XXXX	**Other related records:** Consent *(Ref 5320-5322)* ER nursing notes *(Ref 5342-5346, 5364-5371)* Flow Sheet *(Ref 5334, 5357)* Medication Sheets *(Ref 5341, 5374-5375)* Nursing Notes/Records *(Ref 5356, 5372-5373)* Orders *(Ref 5324-5327)* Triage Record *(Ref 5360-5363)*	

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		**Reviewer's Comment: There are no significant details related to the case focus in these records hence not summarized; can be elaborated if required.*	
		XXXXX Hospital Center (XX/XX/2016 – XX/XX/2016)	
XX/XX/2016	XXXX XXXX	**@ 2334 hours ER visit for abdominal pain:** This XX-day-old baby was transferred from YYYY hospital with a history of constipation and abdominal distension. The baby was fully breast-fed and tended to have a bowel movement once daily. The baby now has not had a bowel movement over 3 days now. The X-rays and labs were done and that showed fluid levels and the child was transferred to XXXX Hospital. The surgeon has requested X-ray of the abdomen in the prone position. **Physical exam**: **Abdomen** is tense and distended. No organomegaly seen. **Genitalia**: Normal female external genitalia without lesions or discharge. *Otherwise, unremarkable*. **Working diagnosis**: Lower abdominal pain, unspecified. **Plan**: X-ray requested.	768-769
XX/XX/2016	XXXX XXXX	**X-ray abdomen:** **History**: Abdominal distention **Findings**: There is gaseous distention of the stomach and gaseous distention of the colon and rectum. The sigmoid colon is especially prominent measuring approximately 4.7 cm in transverse diameter. No obvious dilatation of small bowel loops. There is no discernible pneumatosis, pneumoperitoneum, or portal venous air. There is haziness of the partially imaged bilateral lung bases which may be secondary to atelectasis, prominent reticular markings, or consolidation. The partially visualized bones are unremarkable. **Impression**: 1. Diffuse gaseous distention of the colon extending to the level of the rectum. 2. Apparent hazy opacities at the partially imaged lung bases. Dedicated chest radiograph recommended for further assessment.	755-756
XX/XX/2016	XXXX XXXX	**@ 2354 hours Pediatric Surgery consultation for lower abdominal pain:** 39-day-old baby was transferred from YYYYY hospital with a history of constipation and abdominal distension. As per the patient's mother the baby was born at 37 weeks via c-section due to oligohydramnios. The baby moved her bowels on 1st day of birth. Patient has history of constipation and has 1 Bowel Movement (BM) per day. The baby was fully breast-fed. The baby now has not had a bowel movement over 3 days now. The X-rays was done at YYYYY hospital which showed dilated loops of small bowel consistent with small bowel obstruction. Patient has also been vomiting and spitting up her milk. Patient's mother reports subjective fever. Patient's mother denies any other complaints.	1086-1088

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Examination: **Vitals**: Heart Rate (HR) 141, RR 46, temperature 98.8. **Abdomen:** Tender to palpation, moderately distended, hypoactive bowel sounds. **Rectal:** No stool visualized. *Otherwise, unremarkable*. *Labs & X-ray reviewed.* **Assessment:** 39-day-old female with distended abdomen possible Hirschsprung's disease. **Plan**: Normal Saline (NS) bolus 70 cc. Nil Per Oral (NPO). Maintenance Intravenous Fluid (MIVF) (Dextrose 5% 1/3 NS at 17 cc/hour). Nasogastric (NG) tube. General Pediatric consult. **Attending notes:** *(XXXX XXXX, M.D.)* Transferred from YYYYY Hospital (LH). Has abdominal distension. X-ray from LH not consistent with small bowel obstruction. Prone film appears to be more like Hirschsprung's. Plan admit and work-up.	
XX/XX/2016	XXXX XXXX	**Admission for abdominal pain:** *History reviewed.* **Examination**: **Abdomen:** Tender to palpation, moderately distended, hypoactive bowel sounds. **Rectal:** No stool visualized. *Otherwise, unremarkable*. **Assessment:** 39-day-old female with distended abdomen possible Hirschsprung's disease. **Plan**: NS bolus 70 cc. NPO. MIVF (Dextrose 5% 1/3 NS at 17 cc/hour). NG tube. General Pediatric consult. **Attending notes:** *(XXXX XXXX, M.D.)* Transferred from LH. Has abdominal distension. X-ray from LH not consistent with small bowel obstruction. Prone film appears to be more like Hirschsprung's. Plan admit and work-up.	770-774
XX/XX/2016	XXXX XXXX	**@ 0600 hours Pediatric consultation for abdominal pain and vomiting:** 40-days-old female with history of constipation and perinatal exposure to HIV admitted for management of intestinal obstruction. Patient with history of constipation and perinatal exposure to HIV presenting with 3 days of absence of stool and gas, associated with decreased Per Oral (PO) intake, Non-Bloody Non-Bilious (NBNB), vomiting with every feed and 2 days of abdominal distention. The mother also refers tactile fever the night prior to presentation. Given that the baby persisted with vomiting and increased abdominal distention, she decided to take her to the ED at YYYYY Hospital. **Review of Systems (ROS)**: The baby passed meconium on the second day of life. According to the mother, since birth she only has	1089-1094

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		had one hard stool daily, so she has been giving 30-50 cc of apple juice diluted in water daily. The baby is feeding 50-75 cc of Similac every 2-3 hours. The mother dilutes 1 scoop in 75 cc of water (over-diluted). 5-7 wet diapers daily, but yesterday had less (is not sure how many). **Examination**: **Vitals**: Blood Pressure (BP) 108/64, HR 133, RR 42, temperature 97.7. Alert, irritable, hydrated, looks undernourished. **Skin**: 2 cm hyperpigmented macule on left thigh. **Abdomen**: Distended, tympanic, very tender to palpation. Abdominal girth: 40 cm (1 cm above umbilicus). *Otherwise, unremarkable*. **Perinatal history:** Full-term female born at 37 weeks of gestation via c-section to a 33-years-old G7P6016 mother. Perinatal exposure to HIV: She received treatment during pregnancy and the baby has been on Zidovudine since birth. Her initial screen was negative. Mom states her CD4 count (around 800) has been good with low/undetectable viral load. The mother was diagnosed in 2003, all her other children are negative. According to the mother no other complications during pregnancy or delivery, the baby went home with her. She does not remember the birth weight. NBS: HIV antibody positive. Sickle cell trait. **Assessment:** 40-days-old female with perinatal exposure to HIV and history of constipation since birth admitted for management of intestinal obstruction At the moment she is hemodynamically stable, but requires input/output monitoring, monitoring of abdominal distention and NG tube decompression, so we will transfer to Pediatric Intensive Care Unit (PICU). Intestinal obstruction and constipation might be secondary to Hirschsprung disease given the presence of symptoms since birth. Failure to thrive questionable. Weight for age at 4th percentile (unknown. birth weight). Inappropriate feeding. Low alkaline phosphatase, total protein, and albumin. **Plan:** Admit to PICU under Pediatrics Surgery. Vitals every 2 hours. Continuous monitoring. Respiratory - Room air. Fluid Electrolyte Nutrition (FEN)/Gastrointestinal (GI) – NPO. D5 1/3 NS + 10 mEq potassium chloride (KCl) 14 cc/hour (1M). Sucrose for pacifying. Abdominal girth measurements. NG tube decompression. ID - Zidovudine 4mg/kg/dose twice daily. Repeat chemistry. Consider HIV viral load. Follow-up with Pediatrics Surgery. **Consultant diagnosis**: Other intestinal obstruction. Other constipation. Contact with and (suspected) exposure to HIV.	

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XX/XX/2016	XXXX XXXX	**Barium enema:** **Clinical history**: Large bowel obstruction, evaluate for Hirschsprung's disease. **Findings**: There is a focal area of narrowing (marked by the arrow) seen at the upper rectum/sigmoid colon junction consistent with a transition zone. The rectum appears small compared to the sigmoid colon with a rectosigmoid ratio less than 1. These findings are suspicious for short segment Hirschsprung disease. **Impression**: Focal area of narrowing at the upper rectum/sigmoid colon junction consistent with a transition zone. Rectosigmoid ratio less than 1. These findings are suspicious for short segment Hirschsprung disease	757-758
XX/XX/2016	XXXX XXXX	**Labs:** **High**: Phosphorus (6.7) **Low:** Glucose (29)	161-162
XX/XX/2016	XXXX XXXX	**Pediatric notes:** PICU#1. 40-day-old infant admitted for constipation, vomiting and abdominal distension. Born full term to a disease well controlled HIV positive mother. Both had undetectable viral load. Passed meconium on day#2 and noted to have only one hard stool per day. Mother has been feeding the infant with diluted juice and formula. Followed by PMD at Bellevue. On AZT treatment dose. Current presentation to YYYYY hospital with 3 days of constipation, increasing abdominal distension and 5-6 episodes of NBNB vomiting. **Examination: Vitals**: Temperature 98.3, RR 40, HR 145, BP 105/60, oxygen saturation 98%. Weight and height below 4th percentile. **Abdomen** distended, tense. Hyperactive bowel sounds positive. *Otherwise, unremarkable.* **All treated Diagnoses**: Other constipation. Contact with and (suspected) exposure to HIV. Other intestinal obstruction. Moderate protein-calorie malnutrition. **Impression**: Acute intestinal obstruction- Hirschsprung disease to be ruled out. To rule out vertical transmission of HIV. Failure to thrive. Dehydration. **Plan**: Place NGT 8fr and intermittent suction. Continue NPO status. Barium enema as planned by Pediatric Surgery showed a focal area of narrowing at the upper rectum/sigmoid colon junction consistent with a transition zone. Rectosigmoid ratio less than 1. These findings are suspicious for short segment Hirschsprung disease. For rectal biopsy in the OR in morning. Follow up with ID team regarding AZT dose. Chem 10 in morning. Mother by bedside and updated on current treatment plans.	799-801

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XX/XX/2016	XXXX XXXX	**Labs:** **Normal**: WBC (11), neutrophil % (24.1), glucose (81), CRP (<0.2) **High**: Platelet (541), phosphorus (5.5) **Low**: BUN (2), creatinine (<0.1), total protein (5.1), albumin (3)	163-167
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** 41-day-old baby girl admitted with constipation underwent barium enema yesterday which showed a transition point and the recto-sigmoid junction and a rectosigmoid ration of less than 1. She is full mucosal possible full thickness rectal biopsy today. She is on maintenance fluid. Did not pass gas or stool yet. Her urine output is 184 cc in the past 24 hours. Consent was taken from the mother. **Examination**: Vital Signs Stable (VSS). Sleeping. Abdomen is distended. **Assessment and plan**: 41-day-old baby girl with possible Hirschsprung for mucosal possible full thickness rectal biopsy today. Mother is consented. **Attending notes**: With suspected Hirschsprung's disease. Abdominal distension. Plan full thickness rectal biopsy.	812-813
XX/XX/2016	XXXX XXXX	**Operative report of rectal biopsy:** **Preoperative and postoperative diagnosis**: Chronic constipation, rule out Hirschsprung's disease. **Procedure**: Full thickness rectal biopsy. **Specimen**: Full thickness rectal biopsy **Anesthesia**: General via ETT. **Indications**: 41-day-old female baby with severe chronic constipation. The benefits, risks, and alternatives to the procedure were explained to the mother who verbally confirmed her understanding and gave her informed consent. **Findings**: Patent anal opening. Full thickness rectal biopsy taken including the muscle. **Description**: After successful timeout, patient was anesthetized and intubated and was made to lie in a lithotomy position. The anus and the perianal region were cleaned with gauze and then Digital Rectal Examination (DRE) was done. Semisolid stool was found gushing out. A red rubber catheter was introduced through the anus and saline was used to flush the rectosigmoid. About 100 ml of feces mixed with saline was evacuated. After this, the anus and the perianal region were scrubbed with Betadine scrub. Following that, the patient was draped in the usual way. Silk stay sutures were placed at the 1, 3, 5, 7, 9 and 11 o' clock positions to expose the anal canal. After retraction, the dentate line was visualized, and a stay suture was placed about 1 cm above the	734-736

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		dentate line in the posterior midline. Another stay suture was placed about 1.5 cm above the previously mentioned suture. The patch of tissue between the two sutures was excised using Metzenbaum scissors. The defect in the rectum was closed in a continuous locking fashion using a 4-0 chromic catgut suture. Hemostasis was secured. The stay sutures in the perianal region were removed. Final sponge, needle, and instrument counts were reported as correct. The specimen was sent for histopathology. The patient was kept intubated and transported to the PICU in stable condition having tolerated the procedure well. The attending surgeon, Dr. XXXX, was present and scrubbed for the duration of the procedure.	
XX/XX/2016	XXXX XXXX	**Nutritional assessment:** **Dietary pattern**: As per diet history, patient consumes Enfamil formula, 4 oz every 4 hours, no breastfeeding. No diet restrictions. **Meal intake**: NPO. **Height:** 57 cm. **Weight:** 3.53 kg. Body Mass Index (BMI): 10.8 (<5th percentile/age). Patient is under-weight per growth curve. **Nutrition diagnosis**: Predicted suboptimal energy intake related to planned medical therapy/diet order as evidenced by patient currently NPO x 1 day in house, pending diet advancement. Diagnosis status: New. **Plan:** Estimated nutrient need using current weight with considerations for catch up growth – 486 Kcals/day, protein 10 gm/day, fluids 353 ml/day.	814-816
XX/XX/2016	XXXX XXXX	**PICU notes:** PICU # 2. 41-day-old female who presented with constipation admitted for management of intestinal obstruction secondary to Hirschsprung's disease. Had stool evacuated yesterday during barium enema. This morning abdomen is distended and tense. Abdominal Girth (AG) is 40cm, up from 38 cm yesterday. She has been taken to OR for a rectal biopsy. **Examination: Vitals**: BP 90/52, pulse 128, RR 41, temperature 98.2. **Abdomen** distended, tense. Hypoactive bowel sounds positive. *Otherwise, unremarkable*. **System-wise management**: Respiratory – Room Air (RA). FEN/GI – NPO. D5 1/3 NS + 10 KCl. Intake/Output (I/O) – 336/240. NG on Low Intermittent Suction (LIS) with no significant drainage. ID – Zidovudine 4g/kg dose twice daily.	831-834, 840-844

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Impression: Acute intestinal obstruction-most likely Hirschsprung's disease. To rule out vertical transmission of HIV. Failure to thrive. Hypoalbuminemia. Dehydration resolved. **Plan**: Will follow up biopsy. Surgery planned for possibly XX/XX/2016. Will need weight monitoring before discharge. Daily weight. Will stop Zidovudine at 6 weeks of life and start Bactrim 5mg/kg/day in 2 divided doses 3times a week as per CDC guidelines and ID specialist recommendation. Continue NPO status. PPN tomorrow. Surgery planned for next week.	
XX/XX/2016	XXXX XXXX	**Labs:** **Normal**: Glucose (85) **High**: Phosphorus (6) **Low**: BUN (4), creatinine (<0.1)	170-171
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** Status post full thickness rectal biopsy. Passing stool and the abdomen is less distended. Started on Total Parenteral Nutrition (TPN). She is on IVF and sucrose **Examination**: **Vitals**: BP 99/62, temperature 97.8, pulse 150, RR 38. Sleeping. Abdomen is less distended. **Assessment and plan**: 41-day-old baby girl with possible Hirschsprung disease. Follow-up rectal biopsy results.	854-855
XX/XX/2016	XXXX XXXX	**PICU notes:** PICU #3. Still has abdominal distension but less tense than yesterday. Started on TPN today. **Examination: Vitals**: BP 99/62, pulse 135, RR 48, temperature 98.1. **Abdomen** distended, AG 40cm, hypoactive bowel sounds. **System-wise management**: FEN/GI – Weight 3.59 kg (+65 g from yesterday). Started on 30ml Pedialyte as needed for pacification, otherwise NPO. Intake/Output – 336/282. NG on LIS with no significant drainage. **Assessment and plan:** *Remain unchanged except for* Peripherally Inserted Central Catheter (PICC) line. Will stop Zidovudine tomorrow and start Bactrim 5mg/kg/day in 2 divided doses 3times a week as per CDC guidelines and ID specialist recommendation. Peripheral Parenteral Nutrition (PPN)/Intralipid (IL). Per Oral (PO) Pedialyte 5cc/ feed for comfort.	856-863
XX/XX/2016	XXXX XXXX	**Labs:** **Normal**: Glucose (79), BUN (9), phosphorus (4.6) **Low**: Creatinine (0.2)	172-173
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:**	872-873

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Passing stool and the abdomen is less distended. Started on TPN. She is on IVF and sucrose. **Examination**: **Vitals**: BP 92/52, temperature 98.4, pulse 136, RR 40. Sleeping. Abdomen is less distended. **Assessment and plan**: *Remains same.*	
XX/XX/2016	XXXX XXXX	**PICU notes:** PICU #4. PICC line done today. Abdomen still distended. Placed under radiant warmer for hypothermia. **Examination: Vitals**: BP 118/78, pulse 171, RR 50, temperature 97.9. **Abdomen** distended, tense, AG 40cm, hypoactive bowel sounds. **System-wise management**: Cardiovascular System (CVS) – Peripheral Intravenous (PIV). PICC in internal jugular. FEN/GI – Weight 3.7 kg (+11 g from yesterday). Intake/Output – 336/282. Smear of stool last night. NG on LIS with no significant drainage. **Assessment and plan:** *Remain unchanged except for* Continue TPN max protein 4g, max IL 3.5g, no manganese and no iron as recommended by Neonatologist.	883-886, 876-880
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** Preliminary report showed decreased ganglionic cells. Passing stool and the abdomen is less distended. Started on TPN. She is on IVF. **Examination**: **Vitals**: BP 93/51, temperature 98.6, pulse 153, RR 38. Sleeping. Abdomen is less distended. **Assessment and plan**: *Remains same except for* Biopsy highly suggestive of Hirschsprung disease. OR Monday afternoon.	893-894
XX/XX/2016	XXXX XXXX	**PICU notes:** PICU #5. No significant interval events. AG remains 40 cm. **Examination: Vitals**: BP 112/58, pulse 151, RR 51, temperature 98. **Abdomen** distended, tense, AG 40cm, normal bowel sounds. **System-wise management**: FEN/GI – Weight 3.52 kg (-18 g from yesterday). Intake/Output – 406/38. Smear of stool last night. NG on LIS with no significant drainage. **Assessment and plan:** *Remain unchanged.*	900-903
XX/XX/2016	XXXX XXXX	**Labs:** **Normal**: WBC (8.3), neutrophil % (30), glucose (98), BUN (13)	174-177

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		High: Platelet (467) **Low**: RBC (3.75), hemoglobin (11.7), hematocrit (34.8), creatinine (<0.1), total protein (4.5), albumin (2.6)	
XX/XX/2016	XXXX XXXX	**PICU notes:** PICU #6. No significant interval events. AG varying between 38 - 40cm. One smear of stool in between with no intervention. **Examination: Vitals**: BP 103/55, pulse 147, RR 45, temperature 98.3. **Abdomen:** Normal appearance, distended to 38 cm, shiny, sluggish bowel sounds, no hepatosplenomegaly. **System-wise management**: CVS –PICC in internal jugular day 3, dressing is clean, dry, and intact. FEN/GI – Weight 3.5 kg (-25 g from yesterday). NG on LIS with no significant drainage. **Assessment and plan:** *Remain unchanged except for* Abdominal girth every shift. Surgery for XX/2016.	919-923
XX/XX/2016	XXXX XXXX	**Pathology report:** **Collected date:** XX/2016. **Final report:** Rectal biopsy - Multiple sections of colonic mucosa reveal few abnormal ganglion cells. No mature ganglion cells identified. Findings are suggestive of Hirschsprung's disease. Clinical correlation is suggested.	168-169
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** Status post full thickness rectal biopsy, the report of the biopsy showed decreased number of the ganglion cells, most likely Hirschsprung disease. Seen at the bedside today. Doing well. Passing flatus. She is for OR today. **Examination**: **Vitals**: BP 94/55, temperature 98.6, pulse 140, RR 40. Abdomen is less distended, no tenderness. **Assessment and plan**: Patient with Hirschsprung disease. OR today. She is NPO. Obtain consent. **Attending notes**: Patient is XX-day old infant with suspected Hirschsprung's. Pathology consistent with Hirschsprung's. Plan correction. Consent discussed with mother.	934-935
XX/XX/2016	XXXX XXXX	**PICU notes:** PICU #7. **Examination: Vitals**: BP 92/51, pulse 140, RR 32, temperature 97.9. **Abdomen:** AG 37 cm, protruded abdomen consistent for age, minimal tension, no tenderness. **System-wise management**: FEN/GI – Weight 3.425 kg (-75 g from yesterday). Strict NPO. TPN	939-946

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		+IL @1M. NG on LIS with no significant drainage. **Assessment and plan:** *Remain unchanged except for* For colostomy today. Packed Red Blood Cells (PRBCs) ready. To OR for corrective surgery.	
XX/XX/2016	XXXX XXXX	**Consent for diagnostic laparoscopy and possible transanal pull through:** Risks, benefits, side effects and alternatives of the diagnostic laparoscopy and possible transanal pull through explained. Risks and side effects of the proposed care – Bleeding, infection, injury to the surrounding structures, intestinal perforation, bowel obstruction, rectovesical/rectovaginal fistula, and enterocolitis.	27-28
XX/XX/2016	XXXX XXXX	**Operative report of transanal pullthrough:** **Preoperative and postoperative diagnosis**: Hirschsprung's disease. **Procedure**: Diagnostic laparoscopy, transanal pullthrough. **Anesthesia**: General endotracheal. **Indications**: 46-day-old baby girl with Hirschsprung's disease. The benefits, risks, and alternatives to the procedure were explained to the mother who agreed to it. **Findings**: Narrowed rectum, dilated hypertrophic colon proximally. **Description**: The patient was taken to the operating room and after proper identification of the patient's name, medical record number, and procedure to be done, general anesthesia was established via Endotracheal Tube (ETT). The abdomen was prepped in the usual standard fashion, a 0.5 cm supraumbilical incision was made, using Versa-Step veress needle the abdominal cavity was entered the abdomen was filled with CO2 and the trocar was inserted. The camera was introduced, and the distal colon was noticed to be hypertrophied and going down to the pelvis. The decision was made to proceed with transanal pull through. The hips and knees were flexes and the feet were secured on the ether screen. The perianal area was then prepped and draped in a standard surgical fashion. Using 4-0 neurolon retraction sutures between the anal verge and the perianal skin, the mucosa was retracted circumferentially until the dentate line was observed. The mucosa was then incised circumferentially above the dentate line. Stay sutures of 4-0 neurolon were then placed circumferentially in the proximal rectal mucosa to aid in dissection, and a submucosal dissection was carried proximally using electrocautery. When the apparent transition zone was reached, a biopsy was obtained to confirm ganglion cells by frozen section, but none were present. Dissection was therefore continued proximally entering the abdominal cavity for approximately 5 cm whereupon the muscle was then incised circumferentially just proximal to the peritoneal reflection. The distal sigmoid colon was then transected at this level,	484-486

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		and a ring of distal sigmoid colon was excised immediately proximal to the line of transection, then submitted for biopsy to confirm ganglion cells by frozen section, which now confirmed their presence. Hemostasis was then obtained using electrocautery. The distal rectal cuff was then incised through its posterior midline using electrocautery. Subsequently the distal sigmoid colon was pulled through the two halves of the divided rectal cuff and an anastomosis was performed using 4-0 Vicryl sutures between the full thickness of the distal sigmoid colon and the distal rectal mucosa just above the dentate line. The perianal retraction sutures were then removed. The patient tolerated the procedure well, was extubated, and transferred to the PACU in stable condition. Sponge, needle, and instrument counts were correct at the end of the case. The attending surgeon, Dr. XXXX, were present and scrubbed throughout the entire procedure.	
XX/XX/2016	XXXX XXXX	**Labs:** **Normal**: BUN (17) **High**: WBC (21.2-22.9), neutrophil % (64), band % (27), glucose (101), platelet (471), CRP (5.1) **Low**: RBC (2.99-3.55), hemoglobin (9.3-11.2), hematocrit (27.6-32.9), creatinine (0.2)	182-187
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** Status post transanal pull through for Hirschsprung Disease. Post-Operative Day (POD) 1. The procedure went well. We sent 2 frozen sections intraoperatively. We confirmed the presence of ganglion cells at the level we reached. The baby was extubated and transferred to PICU in a stable condition. Last night she spiked fever to 101.5. She is passing flatus. No other issues. She is on Clindamycin and Gentamicin. **Examination**: **Vitals**: BP 87/52, temperature 100.6, pulse 168, RR 36. Abdomen is less distended, soft, and lax. **Assessment and plan**: 47-day-old baby girl status post transanal pull through for Hirschsprung Disease. POD 1. She can be started on clears. Continue with antibiotics. Vital signs monitoring as per ICU. Follow up final pathology report. **Attending notes**: 47-day-old girl personally seen by me POD#1 status post transanal pull-through for Hirschsprung's disease. Spiked temperature last night, partial sepsis work up done, now afebrile. Exam unremarkable. Starting Pedialyte. Otherwise Continue Present Management (CPM). Agree with resident's findings and plans.	980-981
XX/XX/2016	XXXX XXXX	**PICU notes:** PICU #8. Status post resection of aganglionic segment and transanal pull through with end-to-end anastomosis. Extubated in the OR.	983-987, 989-993

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		Passing stools. Fever spikes overnight. **Examination: Vitals**: BP 103/53, pulse 165, RR 34, temperature 100.1. **Heart**: S1, S2 present, rate and rhythm regular, II/VI systolic murmur. **Abdomen:** AG 35 cm, hypoactive bowel sounds, soft, non-tender and less tense. **System-wise management**: CVS – New onset, 2/6 murmur heard today. Otherwise, stable. PICC in internal jugular day 6. FEN/GI – Weight 3.5 kg (+10 g from yesterday). ID – Patient started having fever since midnight, 5 hours after coming back to the unit. She was stable otherwise and with dual antibiotics. Bactrim 5mg/kg/day in 2 divided doses 3x a week; missed her 2nd Bactrim dose yesterday. Status post Zidovudine 4mg/kg dose twice daily. **Assessment and plan:** *Remain unchanged except for* Continue daily weight and abdominal girth every shift. Continue TPN – currently max protein 4g, max IL 3.5g, no Manganese or iron in TPN as recommended by Neonatologist. Patient on clear, limited to Pedialyte 30cc every 3 hours. NGT to be removed. Discontinued Famotidine. Started Zosyn today, Gentamicin continued, and Clindamycin discontinued. Ordered blood culture for fevers. Tylenol every 4 hours as needed for fever. Will closely monitor heart murmur. **Attending notes**: **Impression**: Hirschsprung's disease causing intestinal obstruction, status post-surgery. Fever spikes with new onset murmur and leukocytosis with bandemia in a patient with central PICC line. Differential diagnosis – post operative stress, abdominal sepsis, to rule out endocarditis. Clinical anemia. Maternal exposure to HIV. Failure to thrive, hypoalbuminemia. **Plan**: Peripheral blood culture. Discontinue Clindamycin. Will start Zosyn 80mg/kg/dose every 6 hours. Follow C-Reactive Protein (CRP). Repeat CBC tonight. EKG today, echo tomorrow. Will continue TPN/IL. PO clears as requested by Surgery. Pedialyte 30cc every 3 hours. Viral load to be repeated.	
XX/XX/2016	XXXX XXXX	**Labs**: **Normal**: BUN (11), prealbumin (8) **High**: Glucose (155), **Low**: Creatinine (0.2), total protein (5.1), albumin (2.5)	189-191
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** Running low grade fever to 100.6 last was at 0200 hours. She is on Zosyn and Gentamicin. Tolerated clears. She is passing stools and flatus. **Examination**: **Vitals**: BP 103/59, temperature 98.4, pulse 149, RR	1004-1005

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		39. Abdomen is less distended, soft, and lax. **Assessment and plan**: Patient status post transanal pull through for Hirschsprung disease. Doing well. Running low grade fever early this morning at 0200 hours. Repeat CBC. Continue with antibiotics.	
XX/XX/2016	XXXX XXXX	**PICU notes:** PICU #9. Decreased fever spike. Tolerating per oral clears well. Passing stools 4-5 times. Decreased bandemia in repeat CBC. **Examination: Vitals**: BP 81/48, pulse 153, RR 42, temperature 99.8. **Abdomen:** AG 35 cm, soft, non-tender, normoactive bowel sounds. **System-wise management**: CVS – Still with 2/6 murmur heard today. Otherwise, stable. EKG sinus tachycardia with RA deviation. Partial echo so far is normal. FEN/GI – Weight 3.62 kg. Stooling more. **Assessment and plan:** *Remain unchanged except for* Continue Zosyn and Gentamicin. If patient spikes fever, do urinalysis. **Attending notes:** Abdominal sepsis – low suspicion based on clinical and lab findings To rule out endocarditis- unlikely with negative culture. Mild anemia- combination of poor nutrition, blood loss and physiological nadir. Failure to thrive from protein calorie malnutrition. Maternal exposure to HIV – negative results so far. Well controlled disease in mother.	1006-1015
XX/XX/2016	XXXX XXXX	**PICU notes:** PICU #10. **Examination: Vitals**: BP 98/53, pulse 165, RR 40, temperature 98.1. **Abdomen:** AG 36 cm, good bowel sounds, soft and non-tender. **System-wise management**: FEN/GI – Weight 3.68 kg (-75 g from yesterday). Good stools. ID – Fever free for 24 hours. Blood culture no growth for 48 hours. **Assessment and plan:** *Remain unchanged except for* Regular diet, half strength, 30 cc every 6 hours for now. Discontinued Zosyn, restarted Clindamycin. Continue Gentamicin. **Attending notes:** PO feeds of formula as requested by Pediatric Surgery. Will start with strength feeds 30cc every 6 hourly. Follow pre albumin. Will decrease TPN/IL if tolerating PO feeds well. Will discontinue Zosyn and continue Clindamycin prophylaxis dose.	1027-1037
XX/XX/2016	XXXX	**Pediatric Surgery notes:**	1038-1039

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	XXXX	She is on Clindamycin and Gentamicin. On TPN. Tolerated clears. She is passing stools and flatus. **Vitals**: BP 98/53, temperature 98.1, pulse 165, RR 40. *Examination, assessment, and plan remains same.*	
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** POD 4. Doing well. Passing gas and stool. On Similac half strength every 6 hours. **Examination**: **Vitals**: BP 89/42, temperature 99.5, pulse 143, RR 40. Abdomen is soft, lax, non-tender. *Assessment and plan remains same.* **Attending notes**: 50-day-old girl POD#4 status post transanal pull-through for Hirschsprung's disease. Afebrile, VSS. Abdomen soft, flat, nontender. Tolerating diet. Stooling normally. Repeat WBC in morning. Discharge planning.	1050-1051
XX/XX/2016	XXXX XXXX	**Pediatric notes:** Transferred to floor. Afebrile. **Examination: Vitals**: BP 82/47, pulse 154, RR 40, temperature 98. **Abdomen:** AG 36 cm, non-distended, no masses, soft. **System-wise management**: FEN/GI – Weight 3.71 kg. good stools. **Assessment and plan:** *Remain unchanged except for* Advance per oral formula feeds to 30 cc every 4 hourly. Will decrease TPN to 10 cc/hour.	1212-1221
XX/XX/2016	XXXX XXXX	**Nutritional assessment:** **Nutrition diagnosis**: Predicted suboptimal energy intake related to planned medical therapy/diet order as evidenced by patient currently NPO x 8 days in house, pending diet advancement. Diagnosis status: Ongoing. Malnutrition related to acute illness/decreased ability to consume sufficient energy as evidenced by patient meeting <\=50% of estimated needs in >\=5 days, weight loss of 2% of weight since admission. Diagnosis status: Ongoing. **Dietician assessment risk**: High **Assessment**: A 50-day-old female who presented with constipation admitted for management of intestinal obstruction secondary to Hirschsprung's disease status post transanal pull through surgery. Patient's mother reports to be tolerating strength feeds every 6 hours. TPN +IL @ 10cc/kg/hour (Total fluid goal 120m1/kg/day, 12.5% dextrose, 4 g protein and 3.5g IL).	1059-1060

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		Recommendation: Continue with current nutritional therapy as tolerated by patient.	
XX/XX/2016	XXXX XXXX	**Labs**: **Normal**: WBC (13.8), neutrophil % (32.4) **High**: Platelet (566), monocyte % (21.7) **Low**: RBC (3.5), hemoglobin (10.8), hematocrit (32.2)	192-193
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** **Examination**: **Vitals**: BP 90/40, temperature 98.1, pulse 150, RR 40. Abdomen normal. AG 36 cm. Weight 3.81 kg. Intake/output 510/315. **Assessment:** 51-days-old female with prenatal exposure to HIV with FTT presented with Hirschsprung's disease status post transanal pull through and is better. **Plan:** Plan to stop TPN today and remove PICC line. **Attending notes**: 51-days-old girl personally seen by me POD#5 status post transanal pull through for Hirschsprung's disease. Afebrile, VSS. Abdomen soft, flat, non-tender. Tolerating diet. May be discharged home once PICC is removed. Follow-up with Pediatric Surgery Clinic on XX/XX/2016.	1222-1224
XX/XX/2016	XXXX XXXX	**Procedure note of PICC line removal:** **Procedure**: Uncomplicated removal of PICC line.	1225-1226
XX/XX/2016	XXXX XXXX	**Discharge summary:** **Hospital course:** XX-day-old female status post transanal pull through for Hirschsprung disease POD 5. Patient was seen at bedside, patient is doing well, patient is moving bowels and passing gas. Patient was seen at the bedside, tolerating diet. Denies nausea/vomiting and ready to be discharged. Follow up in the Pediatric Surgery clinic XX/XX/2016. **Examination**: **Vitals**: BP 90/40, temperature 98.4, pulse 168, RR 40. Abdomen soft, non-tender, non-distended, positive bowel sounds. **Discharge status:** Stable. **Diet and oral supplement:** Regular	1072-1073
XX/XX/2016	XXXX XXXX	**Other related record:** Anesthesia Record *(Ref 1117-1118, 33-36, 1170-1172, 15)* Checklist/Verification List *(Ref 13-14, 31-32, 21-26)* Consent *(Ref 9-12, 16-20, 27-30)* Discharge Instructions *(Ref 4)* Echocardiogram *(Ref 473-477)* EKG *(Ref 472)* ER nursing notes *(Ref 763-767, 1095-1101)* Flow Sheet *(Ref 55-76, 138-160, 1227-1269)* Medication Sheets *(Ref 1270-1287)*	

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		Nursing Notes/Records *(Ref 339-471, 487-501, 620-628, 777-798, 807-811, 628-636, 726-733, 817-830, 835-839, 501-619, 636-702, 845-853, 864-875, 881-882, 886-892, 894-899, 904-918, 924-930, 737-751, 931-933, 935-938, 947-979, 982, 988, 702-725, 994-1003, 1010, 1016-1026, 1040-1049, 1052-1053, 1065-1066, 194-329, 1070-1071, 1076-1078, 1084)* Nutritional Assessments *(Ref 1102)* Orders *(Ref 37-54, 78-133)* Plan of Care *(Ref 1079-1081)* Social Service Records *(Ref 802-807, 330-338, 1085)* Transfer Report *(Ref 775-776)* **Reviewer's Comment: There are no significant details related to the case focus in these records hence not summarized; can be elaborated if required.*	
XX/XX/2016	XXXX XXXX	**Culture report**: **Collected date**: XX/XX/2016 **Blood culture report**: No growth at 5 days.	185
XX/XX/2016	XXXX XXXX	**Pediatric Surgery follow-up visit:** Mother complaints of the patient is having pain, and straining with BMs, eating well. Path reveals: A, B and C: Colon resection with frozen section: Aganglionic colonic segment consistent with Hirschsprung disease. The dilated resection segment is positive for ganglion cells. Abdomen soft, non-tender with normal bowel sounds, no erythema/edema; tight anus was appreciated, XXXX XXXX performed digital dilatation. **Assessment and plan**: Status post diagnostic laparoscopy, transanal pull through, baby has discomfort with tight anal sphincter, so mother was taught how to perform digital rectal dilatation. Return to clinic in 1 week.	4164-4165
		XXXXX Hospital Center (XX/2016-XX/2016)	
XX/XX/2016	XXXX XXXX	**@ 1427 hours ER visit for vaginal stool output:** **Chief complaint**: Poop is coming from vagina. Mother states "She has surgery last week and now her stool is coming out of her vagina." **History of present illness**: 58-day-old female patient brought in by mom after she saw poop coming from her vagina. Mom noticed this just last night. History of Hirschsprung disease status post-surgical procedure (transanal pull through) on October 24th. She had a follow-up appointment yesterday at the Peds Surgery Clinic, but they did not notice any abnormality and was sent home with plan to be followed-up next week. **Review of systems**: Negative for fever, decreased appetite, decreased urine output, decreased stooling. She has been feeding	2181-2185

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		continuously without issues. **Examination**: **Abdomen:** Soft, non-tender, no organomegaly, bowel sounds present in all quadrants. **Genitalia:** A yellow mustar discharge coming out from the vaginal orifice was noted, at the same time she was pooping. The stools had the same color and consistency as the vaginal discharge. *Otherwise, remarkable*. **Assessment:** 58-day-old female with Hirschsprung disease with a most likely rectovaginal fistula. **Plan:** Pediatric Surgery consultation. **Disposition**: Admitted as an inpatient. Pediatric Surgery was consulted and saw the patient in the ER. Admitted for social reasons, as mom is concerned about her condition.	
XX/XX/2016	XXXX XXXX	**@ 1739 hours: Pediatric consultation for vaginal discharge:** **Reason for consult**: Vaginal discharge after surgical procedure on the anorectal region. Today mother brought her to the ER for evaluation as last night she noticed stool coming from baby's vagina. No nausea/vomiting. Tolerating feeds. No other acute complaints. **Exam:** Alert, awake. **Abdomen:** Soft/non-distended. **Rectal:** Couldn't appreciate stool from vagina. Sphincter tight. **Assessment:** Status post transanal pull through for Hirschsprung's disease. **Plan**: Admit to Pediatric Surgery. Will dilate. Feeds. **Attending notes**: Patient with stool seen in vagina. Question is this from rectum washing up in diaper or fistula questionable. Plan admit and start antibiotics.	2608-2609
XX/XX/2016	XXXX XXXX	**@ 1830 hours Pediatric consultation report:** **Reason for consult**: Status post transanal pull through. Please evaluate. *History reviewed.* Baby is feeding well (formula) and voiding normally. No blood or mucus in the stool. Baby was admitted last night, and Clindamycin was initiated by Pediatric Surgery for anaerobic coverage. House staff was unable to obtain IV access, so baby has been receiving PO Clindamycin. **Examination: Vitals**: BP 109/50, pulse 150, RR 40, temperature 98.3. **Abdomen**: Non-distended/Non-tender, soft, positive bowel sounds, no masses. **Genitourinary (GU)**: Female genitalia, Tanner I, stool is present in front upper part of diaper and on the vaginal area.	2610-2613

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		Assessment: Rule out rectum-vagina fistula. Perinatal HIV exposure. **Plan**: Imaging study with contrast to confirm fistula. Continue Clindamycin as per Pediatric Surgery. Start Bactrim for PCP prophylaxis. Exclusive formula feeding.	
XX/XX/2016	XXXX XXXX	**@ 2052 hours Admission for ano-vaginal fistula:** Patient is a 58-day-old female with a history of Hirschsprung's status post transanal pull through surgery presenting with recto-vaginal fistula. Mother noticed stool in parts of the diaper that she found abnormal and said the baby strains with passing stool. She followed up with surgery day prior to admission who did not find anything concerning on examination. However, mother then noticed stool passing through the vaginal opening, so she came to the ER. Patient has been feeding well, urine output unchanged, stooling adequately without blood or mucus in the stool. No fevers or any other concerns on exam today. **Examination: Vitals:** Temperature 98.8, pulse 148, RR 40, BP 90/48. **Skin:** 2 cm hyperpigmented macule on left thigh, milia on face. **CVS**: Normal rhythmic cardiac sounds, S1 and S2 present, Grade III/VI holosystolic murmur loudest at right upper sternal border. **Abdomen**: Soft, mildly distended, nontender, no masses. *Otherwise, unremarkable*. **Assessment**: 58-day-old female status post transanal pull through surgery for Hirschsprung's presenting with ano-vaginal fistula admitted for observation. Moderate protein calorie malnutrition. **Plan**: Vitals every 4 hours. Follow up with surgery for plan. Respiratory: Room air CVS: no PIV FEN/GI: Breastfeeding/formula ad lib every 3 hours. Daily weights. **Attending notes**: Now seen for stool coming from vagina. Plan admit and antibiotics.	2197-2202
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** Admitted to Pediatric Surgery for rectal dilation (Dilatation performed with Hager dilator 9). Patient seen and examined this morning. Doing well. No nausea/vomiting. Tolerating feeds. No other acute complaints. **Exam: Abdomen**: Soft, non-distended. **Rectal:** Stool coming from vagina. Weight 3.935 kg. On diaper change, stool deposited near the vaginal area was noticed, foul smelling discharge from vaginal region, no redness or swelling at anal or vaginal region.	2205-2206, 2208-2210

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REF
		Assessment: Status post transanal pull through for Hirschsprung disease. Status post rectal dilation. Rule out recto-vaginal fistula. **Plan**: IV antibiotics. Feeds. **Attending note**: Dilated rectum, no difficulty. Plan X-ray in morning. Enema. Continue medications.	
XX/XX/2016	XXXX XXXX	**Barium enema:** **Clinical history:** 60-day-old patient. Status post-surgical repair for reversible disease. Fecal material is visualized within the vagina. **Findings**: Contrast is visualized to communicate with the vagina/uterus on cross-table lateral view. **Impression**: Abnormal communication between the distal rectum/anus and the vagina/uterus.	2167-2168
XX/XX/2016	XXXX XXXX	**Pediatrics notes**: Feeding well. Passing urine adequately. Active, alert. Irritable and crying after bowel movements, mother said Tylenol yesterday helped, so Tylenol order made as needed every 4 hours to allow for pacification given the extent of diaper rash. Vaginal area covered in zinc oxide and notable redness in vaginal region. Stool fragments noted in vaginal opening, no active stooling, no foul discharge. Anus patent. **Examination: Vitals**: BP 90/46, pulse 138, RR 40, temperature 98.3. **Abdomen:** Normal bowel sounds, soft, non-tender, no masses. **Genitalia:** Normal female external genitalia, diaper rash surrounding vagina covered in zinc oxide, stool fragments noted in the vaginal opening. **Assessment**: Admitted for possible ano-vaginal fistula. **Plan:** Follow up with Pediatric Surgery for plan after contrast enema studies today. Respiratory: RA CVS: No PIV FEN/GI: Formula ad lib. Daily weights ID: Clindamycin 60mg every 8 hours day 2. Bactrim 9.5mg twice daily on Monday, Wednesday, and Friday. Neuro: Tylenol as needed every 4 hours.	2216-2218
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** Contrast enema done today showing abnormal communication between the distal rectum/anus and the vagina/uterus. **Assessment and plan**: *Remain same except for* Possible recto-vaginal fistula. OR on Wednesday. IV antibiotics. **Attending note**: Patient had fistula seen on enema study, exam showed major leak in stooling. Plan bowel prep and exploration and revision of anastomosis.	2228-2229

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XX/XX/2016	XXXX XXXX	**Pediatrics notes**: **Examination: Vitals**: BP 88/48, pulse 138, RR 40, temperature 98.5. **Abdomen:** Normal bowel sounds, soft, non-tender, no masses. **Genitalia:** Normal female external genitalia with stool exiting from vaginal introitus. **Assessment**: Admitted for ano-vaginal fistula, awaiting perineal exploration. *Plan remains same*	2242-2245
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** Patient now has recto-vaginal fistula. Stool seen coming from vagina. Plan bowel prep and repair.	2246-2247
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** Patient status post transanal pull through now has recto-vaginal fistula. Stool seen coming from vagina. Plan bowel prep and repair today under general anesthesia.	2252-2253
XX/XX/2016	XXXX XXXX	**Pediatrics notes**: **Vitals**: BP 100/46, pulse 168, RR 32, temperature 98.7. weight 3.040 kg. *Examination, assessment, and plan remains unchanged.* No acute events overnight. Mother reports sharp decrease in stool per vagina. For EUA, possible repair rectovaginal fistula later today. Otherwise, CPM.	2257-2260
XX/XX/2016	XXXX XXXX	**Operative report of Examination Under Anesthesia (EUA)**: **Preoperative and postoperative diagnosis**: Possible rectovaginal fistula status post transanal pull through for Hirschsprung's disease. **Procedure**: Examination under anesthesia, including urethral catheterization, vaginoscopy, anoscopy and proctoscopy. **Anesthesia**: GET. **Indications**: 2-months-old girl underwent transanal pull through for Hirschsprung's disease on XX/XX/2016. She recovered uneventfully and was discharged home. Subsequently her mother reported that she saw stool emanating from the vagina. This finding was confirmed by Dr. XXXX on personal examination. Contrast enema was thereupon performed which was highly suggestive of rectovaginal fistula. Accordingly, examination under anesthesia was recommended, with plans to perform perineal exploration and repair of possible rectovaginal fistula if found. The benefits, risks, and alternatives to the procedure were discussed with the mother who had her questions answered, verbally confirmed her understanding, and provided her written informed consent. **Findings**: No evidence of rectovaginal fistula.	2144-2146, 1314-1317

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		Description: All preoperative verifications were performed in accordance with hospital protocol. The infant was transported to the operating room and placed on the operating table in a supine position. General anesthesia was established via ETT. The infant was thereupon replaced in a dorso-lithotomy position. The perineum was prepped with a povidone iodine solution and draped in a sterile surgical fashion. Time-out was successfully completed. Visual examination of the perineum and vulva revealed no obvious abnormality and no evidence of stool in the vagina. A #5Fr feeding tube was inserted into the urethra yielding a scant amount of clear light-yellow fluid. A #18Fr rectal tube was inserted into the rectum via the anus following which the rectum was irrigated with normal saline solution warmed to body temperature. No irrigation fluid or stool was seen to emanate from the vagina. Direct vaginoscopy was then performed which revealed no evidence of a rectovaginal fistula. Direct anoscopy and proctoscopy were also performed with the same findings. A 30- 5mm telescope was then serially placed into the vagina and anorectum again showing no evidence of a rectovaginal fistula. As no additional procedures were found to be indicated on examination, the procedure was terminated. The infant was then returned to a supine position, awakened, extubated, and transported to the PICU in stable condition having tolerated the procedure well. The attending co-surgeons, Drs. XXXX XXXX and Arthur Cooper, were both present and scrubbed for the duration of the procedure.	
XX/XX/2016	XXXX XXXX	**Nutritional assessment:** **Dietary pattern**: As per mother, patient consumes Enfamil formula 4 oz every 3 hours, unable to breastfeed. No diet restrictions. **Meal intake**: Per oral intake 50-75% intake. **Height:** 60 cm. **Weight:** 3.935 kg. BMI: 10.8 (<5th percentile/age). Patient is under-weight per growth curve. **Nutrition diagnosis**: Malnutrition related to chronic illness/decreased ability to consume sufficient energy as evidenced by patient suspected to be meeting <\=75% of estimated needs in >\=1 month, failure to gain adequate weight. Diagnosis status: new. **Plan:** Estimated nutrient need using current weight with considerations for catch up growth – 486 Kcals/day, protein 8 gm/day, fluids 486 ml/day. **Malnutrition code**: Severe malnutrition (chronic illness) <75% of nutrition needs in >=1 month. **Plan**: Consider a more calorically dense, elemental formula (24 Kcals/oz) as needed to meet catch up growth needs.	2295-2299

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XX/XX/2016	XXXX XXXX	**PICU notes**: Patient was admitted to the PICU for post-OR monitoring. **Vitals**: BP 108/62, pulse 151, RR 30, temperature 97.7. weight 3.935 kg. **Assessment:** 2-month-old baby girl with perinatal HIV exposure but negative for HIV at this time, status post transanal pull through for Hirschsprung's disease, admitted for management of suspected ano-vaginal fistula status post perineal exploration, all findings normal. **Plans**: Shift to regular diet. Discontinue IVF. Daily weights. Strict I&O. Continue Clindamycin. Continue Bactrim MWF. Continue Zinc Oxide. May transfer to the floors once tolerating regular diet.	2289-2292
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** Patient seen and examined this morning. No nausea/vomiting. Tolerating clears. **Exam: Abdomen**: Soft, non-distended, non-tender. **Assessment and plan**: *Remain same except for* Status post EUA for possible recto-vaginal fistula. No evidence of fistula. Plan feeds and IV antibiotics. **Attending note**: POD#1 Status post negative EUA rule out rectovaginal fistula. Afebrile, VSS. Abdomen soft, flat, nontender. Tolerating diet. No stool yet. To CPM.	2293-2294
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** *(XX, M.D.; XX, M.D.) (Ref 2308)* Mother was highly concerned about the progress. She was extremely frustrated and felt her care would be better served elsewhere or to simply take her child home. The plan was again explained that we at this time, could not find any evidence of a fistula, but our evaluations were on-going. Dr. XXXX was informed of the above, and assessed the baby, and re-assured the mother. We will continue to care for the infant and attempt to formulate plans to ensure safe care of the infant. Evaluating rectovaginal fistula and on antibiotics. **Surgery notes**: *(XX ZZ, M.D.; XX XX, M.D.) (Ref 2316-2317)* Once again, patient had stool coming from vagina. **Assessment and plan**: *Remain same except for* Stool still coming from vagina. OR for revision and repair of recto-vaginal fistula. Pedialyte on Sunday.	2308, 2316-2317
XX/XX/2016	XXXX XXXX	**Pediatrics notes**: Placed catheter and closed off vaginal opening with tight Opsite. Placed urine bag over anal opening. Plan to return to evaluate for any stool on examination of gauze covering vaginal opening. Told mom plan to discuss treatment plan pending outcome of this evaluation. Child has been stable, afebrile, feeding and urinating well.	2312-2314

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		Examination: Vitals: BP 119/46, pulse 124, RR 38, temperature 98.2. **Genitalia:** Superficial skin irritation on labia majora, stool seen passing through vaginal opening during preparation. **Assessment and plan:** *Remain unchanged except for* Follow up with stool output.	
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** Re-examined patient. Unable to prove that there was no communication, for recto-vaginal fistula. Plan repair.	2321-2322
XX/XX/2016	XXXX XXXX	**Pediatrics notes**: The patient had a benign overnight course. In view of objective findings of stool in the vaginal area, patient will undergo adjustment of transanal pull through Surgery by Monday morning. **Examination: Vitals**: BP 93/43, pulse 154, RR 26, temperature 98.4. **Genitalia:** Noted some small stool on the vaginal area. **Assessment and plan:** *Remains unchanged except for* For OR on Monday (XX/2016). To start bowel prep tomorrow, Pedialyte clears by 0600. NPO by Sunday midnight, IVF care of night team. Do partial sepsis work up and change antibiotic to Zosyn.	2323-2326
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** Afebrile. Tolerating feeds. Knows the plan for OR tomorrow. **Exam: Abdomen**: Full, soft, non-tender, no masses, positive bowel sounds. **Assessment and plan**: *Remain same except for* Will keep NPO for OR tomorrow. Golytely to continue. **Attending note**: 2-month-old female. No change in status. Stool from vagina. Plan repair.	2331-2332
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** Scheduled for redo procedure today. **Assessment and plan**: *Remain same except for* Stool still coming from vagina. OR for revision and repair of recto-vaginal fistula.	2337-2338
XX/XX/2016	XXXX XXXX	**Operative report of diverting colostomy:** **Preoperative and postoperative diagnosis**: Rectovaginal fistula status post transanal pull through for Hirschsprung's disease. **Procedure**: Examination under anesthesia, diverting loop colostomy. **Anesthesia**: GET. **Indication**: While on the Pediatric inpatient unit, the patient again	2154-2157, 1321-1326

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		was observed having stool emanating from the vagina. The patient was scheduled for repeat examination under anesthesia, possible revision of transanal pull through with repair of rectovaginal fistula, and possible diverting colostomy. The benefits, risks, and alternatives to the procedure were discussed with the mother who had her questions answered, verbally confirmed her understanding, and provided her written informed consent. **Findings**: Rectovaginal fistula approximately 1.5 cm proximal to the site of the coloanal anastomosis. **Description**: All preoperative verifications were performed in accordance with hospital protocol. The infant was transported to the operating room and placed on the operating table in a supine position. General anesthesia was established via ETT. The infant was placed in a prone jackknife position with a soft bolster beneath her hips. The perineum was prepped with a povidone iodine solution and draped in a sterile surgical fashion. Time-out was successfully completed. Using 4-0 braided nylon eversion sutures between the anal verge and the perianal skin, the mucosa was everted circumferentially. Visual inspection of the perineum and vulva was then performed. The anterior wall of the coloanal anastomosis was found to have focally disrupted in the midline although the coloanal sutures appeared intact. Gentle probing of the rectovaginal septum then revealed the presence of a rectovaginal fistula between the anterior wall of the rectal submucosa and the posterior wall of the vagina approximately 1.5 cm proximal to the site of the disrupted coloanal anastomosis. Consideration was given at this point to suture repair of the rectovaginal fistula, but it was deemed safer to perform diverting loop colostomy to allow the fistula to heal spontaneously in anticipation of interval colostomy closure. The eversion sutures were therefore removed, and the patient was rotated to a supine position. The abdomen was prepped and draped in the standard surgical sterile fashion. A transverse incision was made in the upper part of left lower quadrant approximately 3 cm from the umbilicus and carried out down to the anterior abdominal wall. The anterior rectus sheath, rectus muscle, and peritoneum were separately identified and opened. A loop of proximal sigmoid colon was gently grasped and brought out through the incision. A 16 Fr red rubber catheter was placed through the mesocolon immediately adjacent to the mesenteric border to function as a bridge. Gentle traction on this bridge permitted interrupted suture closure of the abdominal wall beneath this bridge using interrupted sutures of 3.0 Vicryl. The resulting colostomy was then secured to the fascia	

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		circumferentially with interrupted sutures of 3.0 Vicryl. It was then primarily matured proximally using electrocautery and additionally secured to skin using interrupted sutures of 5.0 Vicryl after which a colostomy bag was placed. Final sponge, needle, and instrument counts were reported as correct. The infant was then awakened, extubated, and transported to the PICU in stable condition having tolerated the procedure well. The attending co-surgeons, Drs. XXXX XXXX and Arthur Cooper, were both present and scrubbed for the duration of the procedure.	
XX/XX/2016	XXXX XXXX	**PICU notes**: Upon arrival to the PICU, the patient was not intubated, comfortable and not in distress. On examination, colostomy bag was noted. **Vitals**: BP 97/48, pulse 138, RR 44, temperature 98.5. **Assessment and plan:** *Remain unchanged except for* Clear liquids for now. Continue IV Clindamycin. Continue Bactrim.	2361-2363
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** No acute events overnight. Tolerating clears. Doing well. **Exam: Abdomen**: Soft, non-distended, non-tender. Colostomy functional, stool and gas. **Assessment and plan**: *Remain same except for* 2-months-old female status post diversion colostomy for rectovaginal fistula. Plan clears, ostomy care.	2372-2373
XX/XX/2016	XXXX XXXX	**PICU notes**: Tolerated clear fluids well. Stool noted on the colostomy bag. No fever for the patient. **Vitals**: BP 106/59, pulse 138, RR 49, temperature 98.8. **Assessment and plan:** *Remain unchanged except for* Doing well, tolerating clear fluids well, for transfer to the floors.	2376-2378
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** Tolerating feeds. No fevers. Residual rectal discharge. Doing well. **Assessment and plan**: *Remain same except for* Plan feeds and ostomy care.	2397-2398
XX/XX/2016	XXXX XXXX	**Pediatrics notes**: Stool is noted on diaper which was explained to mom and nurses is normal finding due to retained fecal material in the distal portion of the colon. Colostomy base was replaced due to loosening of the adhesive. Stool in bag is without blood or mucus. Baby otherwise comfortable and tolerating per oral well. Has not required Tylenol for pain/fussiness.	2401-2403

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		Examination: Vitals: BP 84/42, pulse 124, RR 30, temperature 98.4. **Abdomen:** Colostomy bag in place filled with stool, no signs of infection. **Assessment and plan:** *Remain unchanged except for* Monitor for fever. Do partial sepsis work up and change antibiotic to Zosyn.	
XX/XX/2016	XXXX XXXX	**Pediatrics notes**: Patient has not had stool in the diaper since yesterday evening. Child was stable overnight. Mother reports decreased per oral intake this morning, with decreased activity as well. Mom denies any emesis. **Examination: Vitals**: BP 90/47, pulse 147, RR 40, temperature 98.2. **Abdomen:** Normal bowel sounds, soft, non-tender, no masses, no hepatosplenomegaly; colostomy bag in place on left side, colostomy base is clean, dry, and intact, bag with stool, no blood or mucus. **Assessment and plan:** *Remain unchanged.*	2416-2418
XX/XX/2016	XXXX XXXX	**Pediatric Surgery notes:** Tolerating feeds. No fevers. Doing well. *Examination, assessment, and plan remains same.* **Attending note**: Colostomy functioning but has retracted somewhat and appears slightly dusky. Continuing to follow closely. Tolerating diet. Otherwise, CPM.	2419-2420
XX/XX/2016	XXXX XXXX	**Operative report of colostomy revision:** **Preoperative diagnosis**: Possible retraction of colostomy. **Postoperative diagnosis**: Insufficient retraction of colostomy to justify revision. **Procedure**: Examination under monitored anesthesia care. **Anesthesia**: Monitored anesthesia care. **Findings**: Slight retraction and duskiness of colostomy insufficient to justify revision of colostomy. **Description**: The colostomy bag was removed, and the colostomy and adjacent skin were cleaned. Examination under monitored anesthesia care was performed with findings as noted above. The procedure was terminated. The patient was transported to the PACU in satisfactory condition having tolerated the procedure well. Drs. Arthur Cooper and XXXX XXXX were present and scrubbed for the entire procedure.	2162-2163, 1333-1334
XX/XX/2016	XXXX XXXX	**Reviewer's Comment: Patient was followed up by the specialties Pediatric and Surgery until her discharge on XX/XX/2016 and showed gradual improvement in her clinical condition. Hence the progress notes of the rest of the hospitalization along with*	

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		significant diagnostics are summarized in a combined manner to avoid repetition of details.	
XX/XX/2016	XXXX XXXX	**Combined progress notes:** **XX/XX/2016: Pediatric Surgery notes:** *(XX XX, M.D.; XXXX, M.D.) (Ref 2429-2430)* Exam reveals slight duskiness and retraction of colostomy. Otherwise, CPM. **XX/XX/2016:** **Pediatric Surgery notes**: *(XXXX, M.D.) (Ref 2464-2465)* Temperature spike overnight, otherwise VSS. Partial sepsis work up undertaken. Colostomy continues functioning well. Tolerating diet. Otherwise, CPM. **Pediatrics notes**: *(XXXX, M.D.) (Ref 2470-2472)* Patient was noted to be slightly dehydrated this morning, and mother reported decreased per oral intake. Patient was also spiking fevers since 2330 hours last night. In light of persistent fever spikes, patient got a chest X-ray, CBC, CRP, blood culture, Urine Analysis (UA) and urine culture done. During the time spent obtaining these labs, patient had shown significant improvement in per oral intake therefore Intravenous Fluids (IVF) were not started.	2429-2430, 2447-2451, 2455-2458, 2464-2465, 2470-2472
XX/XX/2016	XXXX XXXX	**Labs:** **Normal**: WBC (7.1), neutrophil % (38.8), RBC (3.59), hemoglobin (10.3) **High**: Monocyte % (27), band % (11), CRP (0.42), glucose (104), potassium (5.26), phosphorus (6.8) **Low**: Hematocrit (31.2), BUN (2), creatinine (0.2) **Urine analysis:** Abnormal – Specific gravity (<=1.005)	1459-1461, 1464-1465
XX/XX/2016	XXXX XXXX	**Combined progress notes** **Pediatrics notes**: *(XXX, M.D.; XXX, M.D.) (Ref 2484-2486)* Patient is spiking fevers. Twice during this day. Once early morning and one in the afternoon. Partial sepsis workup was done yesterday and is unremarkable till now. Good per oral intake and good urinary output. Whitish discharge was noted twice. Surgery were contacted and they do not see any need for starting antibiotics.	2484-2486, 2476-2477
XX/XX/2016	XXXX XXXX	**Labs**: **Normal**: WBC (9.4), neutrophil % (24.1), band % (4), RBC (3.73), hemoglobin (10.9), hematocrit (32.6), platelet (283), CRP (<0.2)	1466-1468
XX/XX/2016	XXXX XXXX	**Pelvis ultrasound:** **Indication:** Rectal fistula; evaluate for abscess. **Findings**: No obvious loculated fluid collection is identified to suggest abscess. There is no free fluid. Multiple bowel loops are seen. The uterus is not clearly delineated. **Impression**: No obvious abscess collection identified.	2171
XX/XX/2016	XXXX	**Culture report:**	1462-1463

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	XXXX	**Collected date**: XX/2016. **Urine culture**: >100,000 (org/ml) Klebsiella pneumoniae. **Sensitivity**: Resistant to Ampicillin, Ampicillin/Sulbactam, Nalidixic acid, Nitrofurantoin, Piperacillin, Tetracycline, Ticarcillin. Sensitive to Amikacin, Amoxicillin/Clavulanic acid, Aztreonam, Cefazolin, Cefepime, Cefotaxime, Cefotetan, Cefpodoxime, Ceftazidime, Ceftriaxone, Ciprofloxacin, Doripenem, Ertapenem, Gentamicin, Imipenem, Levofloxacin, Meropenem, Moxifloxacin, Norfloxacin, Piperacillin/Tazobactam, Tobramycin, Trimethoprim-Sulfamethoxazole.	
XX/XX/2016	XXXX XXXX	**Combined progress notes:** **11/23/2016: Pediatrics notes**: *(XX, M.D.; XX, M.D.) (Ref 2506-2508)* Patient is spiking fevers. Twice during night max 100.5. Coughing but clear breath sounds. Decreased per oral intake one ounce of Sim19 every two hours but good urinary output. Pelvic ultrasound was normal. CBC and CRP were drawn at 1800 hours once she had fever. Urine culture grew Klebsiella Pneumonia >100000. One dose of Ceftriaxone IM 50mg/kg and will start on Bactrim treatment dose from tomorrow. **Pediatric Surgery notes**: *(XXX, M.D.) (Ref 2516-2517)* Low grade temperature spikes still continue, otherwise VSS. Partial sepsis work up reveals Klebsiella UTI. Colostomy continues functioning well. Tolerating diet. Otherwise, CPM. **11/25/2016: Renal ultrasound:** *(XXX, M.D.) (Ref 2174-2175)* **Clinical Indication:** Urinary tract infection. **Findings**: Both kidneys are normal in size. The right kidney measures approximately 5.0 cm in length and the left kidney measures approximately 5.4 cm in length. There is no hydronephrosis. No cystic or solid masses are demonstrated. There is no evidence of shadowing renal calculi. The cortex is of normal thickness and echogenicity bilaterally. Limited views of the urinary bladder demonstrate no mural or intraluminal abnormalities. **Impression**: Normal renal ultrasound. **11/26/2016: Pediatric Surgery notes**: *(XXX, M.D.) (Ref 2554-2555)* Hospital course complicated by UTI and possible bronchiolitis. Plan – Ostomy care, antibiotics.	2494-2495, 2497-2499, 2506-2508, 2516-2517, 2174-2175, 2523-2528, 2535-2536, 2541-2543, 2550-2552, 2554-2555
XX/XX/2016	XXXX XXXX	**Culture report:** **Collected date**: 11/20/2016. **Blood culture**: No growth at 5 days	1458
XX/XX/2016	XXXX XXXX	**Labs**: **Normal**: WBC (11.5), segmental % (19), RBC (4.05), hemoglobin (11.4), hematocrit (34.8) **High**: Platelet (582)	1469-1470
XX/XX/2016	XXXX	**Labs**:	1471-1472

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	XXXX	**Normal**: WBC (15.9), neutrophil % (25.3), band % (3), RBC (4.12), hemoglobin (12.2), hematocrit (36.1) **High**: Platelet (822)	
XX/XX/2016	XXXX XXXX	**Nutritional assessment:** **Diet tolerance:** No GI distress reported. **Intake adequacy:** 100% meal intake. **Weight evaluation**: Admission weight (11/10/2016) – 3.935 kg → (XX/XX/2016) – 4.187 kg increasing trend noted. **Dietitian assessment risk**: Moderate. **Nutrition diagnosis**: Malnutrition related to chronic illness/decreased ability to consume sufficient energy as evidenced by patient suspected to be meeting <\=75% of estimated needs in >\=1 month, failure to gain adequate weight. Diagnosis status: ongoing. **Prescribed regimen**: Similac with iron 19 calories.	2573-2574
XX/XX/2016	XXXX XXXX	**Combined progress notes:** **11/27/2016: Pediatrics notes**: *(XXXX, M.D.) (Ref 2564-2567)* Afebrile for more than 48 hours. Coughing but clear breath sounds. Improved per oral intake one ounce and a half of Sim19 every two hours but good urinary output. **11/28/2016: Pediatrics notes**: *(XXXX, M.D.) (Ref 2577-2579)* Afebrile for the last three days. Coughing but clear breath sounds. Good per oral intake and urinary output. Mother is not comfortable dealing the colostomy bag so a VHS to be arranged for the patient tomorrow.	2564-2567, 2575-2579
XX/XX/2016	XXXX XXXX	**Discharge summary:** **Hospital course**: Exam at the time of admission - Alert, in no acute distress. Stool from vaginal opening. XXXX: Admitted to Pediatric Surgery. Started on Clindamycin. Rectal dilation was performed. XXXX /2016: Stool still evident from vagina. Contrast enema was performed which showed abnormal communication between the distal rectum/anus and the vagina/uterus. XXXX /2016: Patient was taken to the OR for examination under anesthesia, including urethral catheterization, vaginoscopy, anoscopy, and proctoscopy with no evidence of rectovaginal fistula. XXXX /2016: On exam, once again stool noticed passing through vagina. Patient was prepped for the OR again. XXXX /2016: Underwent diversion colostomy for rectovaginal fistula. Tolerated the procedure well. XXXX /2016-11/18/2016: Patient did well. No acute events. Colostomy remained functional. XXXX /2016: Patient was taken to the OR for colostomy evaluation to make surgery colostomy is functional and viable. XXXX /2016-11/28/2016: Remained on the Pediatric Surgery service for treatment of UTI (Klebsiella) and bronchiolitis.	2584-2587

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		XXXX /2016: Patient seen and examined this morning. Afebrile. No cough. Tolerating feeds. No vomiting. **Plan**: Needs ostomy care. Colostomy bag. Bactrim as prophylaxis. Follow up Pediatric Surgery clinic 12/02/2016. Follow up PMD.	
XX/XX/2016	XXXX XXXX	**Other related records:** Anesthesia Record *(Ref 1320, 2652-2654, 1331-1332, 2677-2679, 1339, 2700-2702)* Checklist/Verification List *(Ref 1318-1319, 1327-1330, 1337-1338)* Consent *(Ref 1314-1317, 1321-1326, 1333-1336)* Discharge Instructions *(Ref 1311-1313)* ER nursing notes *(Ref 2176-2180, 2614-2621)* Flow Sheet *(Ref 2131-2143, 2147-2153, 2158-2161, 2164-2166, 1340-1365, 1409-1457)* Medication Sheets *(Ref 2736-2737)* Nursing Notes/Records *(Ref 2186-2196, 2203-2204, 2206-2207, 2211-2215, 2219-2227, 2230-2241, 2245, 2248-2251, 2254-2256, 2261-2288, 2300-2307, 2309-2311, 2315, 2318-2320, 2326-2336, 2339-2357, 2364-2371, 2374-2375, 2379-2396, 2399-2400, 2404-2410, 2415, 2420-2428, 2430-2432, 2434-2446, 2451-2454, 2458-2463, 2465-2466, 2469, 2473-2475, 2477-2483, 2487-2493, 2496, 2500-2505, 2509-2515, 2517-2522, 2524, 2528-2534, 2537-2540, 2544-2549, 2553, 2555-2563, 2567-2572, 2574, 2580-2583, 1473-1637, 1653-1815, 1831-2130, 2587-2590, 2606-2607)* Nutritional Assessments *(Ref 2358-2360, 2411-2413, 2467-2469)* Orders *(Ref 1367-1408)* Plan of Care *(Ref 2593-2601)* Social Service Records *(Ref 2414, 1638-1651, 2591-2592)* **Reviewer's Comment: There are no significant details related to the case focus in these records hence not summarized; can be elaborated if required.*	
XX/XX/2016	XXXX XXXX	**Pediatric Surgery follow-up visit:** Patient without complaints eating well moving bowels without problems, voiding without problems, no fevers or night sweats, no wound drainage. Wound clean & dry. Wound healing well. Abdomen soft, non-tender with normal bowel sounds. Other colostomy pink and functioning. **Assessment and plan:** Status post diversion colostomy for rectovaginal fistula; doing well, pink functioning colostomy. Return to clinic in 2 weeks.	4162-4163
XX/XX/2016	XXXX XXXX	**Labs**: **Normal**: RBC (4.49), hemoglobin (12.3), hematocrit (38.3), creatinine (0.3), total protein (6.8), albumin (4.5), CRP (0.74) **High**: WBC (12.3), platelet (745), lymphocyte % (59), monocyte % (11.1), glucose (111), potassium (5.8) **Low**: Neutrophil % (26.1), BUN (<5), sodium (136)	2921-2925

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XX/XX/2016	XXXX XXXX	**Pediatric ID follow-up visit:** *History reviewed.* As per mother, patient scheduled for appt with Surgery at OSH later this month (12/19/2016) to determine when colostomy bag can be removed, and additional surgery performed. Patient currently taking Sulfatrim 1.2ml twice daily (MWF) as prophylaxis. Mother reports no issues since taking child home. Changes colostomy bag every 2-3 days: no issues. Stopped taking AZT sometime in October. Nutrition: Feeds on Enfamil. Takes 4 ounces every 2-3 hours. Elimination: frequent wet diapers. Sleeps: sleeps in her crib in mom's room on her back. Wakes up 2-3 times a night to feed. Naps throughout the day. **Examination:** Weight: 5 kg (8^{th} percentile), 54 cm (0^{th} percentile). Abdomen: Positive colostomy bag with watery yellowish fluid, positive bowel sounds, non-tender, non-distended, no organomegaly, no masses. GU: Normal female, positive diaper rash (improved from before as per mother). Skin: Hyperpigmented patch on left inner thigh around knee. *Otherwise, unremarkable.* **Assessment and plan:** 3-month perinatally exposed female who presents for a follow up. Patient dropping on both weight and height curves; will continue to monitor. 1. 2-month vaccines given (Pediarix, PCV-13, Hep B, and Rotavirus) 2. Labs obtained (CBC, BMP, LFT, CRP) 3. Zinc Oxide cream given for diaper rash. 4. Return to Peds ID clinic in 2 months (February) for follow up and 4-month vaccines.	2934-2937
XX/XX/2016	XXXX XXXX	**Pediatric Surgery follow-up visit:** 3-month-old female patient status post transanal pull through for Hirschsprung's disease and subsequent diverting colostomy for rectovaginal fistula. Colostomy pink continues to function well. No new problems reported. She presents for refill of ostomy pouch. **Assessment:** Status post diversion colostomy for rectovaginal fistula; doing well, pink functioning colostomy. **Plan:** Return to clinic in 3 weeks.	4160-4161
XX/XX/2017	XXXX XXXX	**Pediatric Surgery follow-up visit:** Colostomy functioning well. She is tolerating diet. Barium enema done today - **Impression**: Previously seen abnormal	4154-4158

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		communication between the distal rectum and vagina is not visualized. No evidence for contrast extravasation outside the confines of the rectum. **Examination: Abdomen**: Soft, colostomy bag with fecal matter, colostomy viable and well-vascularized. **Assessment:** Pre-operative diagnosis - Colostomy status, resolved rectovaginal fistula, Hirschsprung's disease. **Plan of treatment/procedure planned**: Colostomy reversal, coloanal anastomosis, proctoscopy. Reversal of colostomy with coloanal anastomosis on Friday, 02/10/2017. Admit on Thursday for surgery. Bowel prep with normal saline through the ostomy. Can drink Pedialyte at midnight. Dilators for OR. Speak to Dr. XXXX to find out if he will able available on Friday.	
		XXXX Center (XXXX/2017-XXXX2017)	
		**Reviewer's Comment: Patient was hospitalized for colostomy reversal from 02/09/2017 to 03/06/2017. Hence this hospitalization is summarized briefly including the admission history and physical, operative report, significant radiological reports, and discharge summary alone; can be elaborated if required.*	
XX/XX/2017	XXXX XXXX	**Admission for colostomy status:** 5 months old female with history of Hirschsprung's disease status post transanal pull through procedure (XXXX/2016) complicated by rectovaginal fistula status post colostomy (XXXX/2016) admitted for colostomy reversal tomorrow. Colostomy functioning well. She is tolerating diet. She has no fever or chills. **Examination**: Baby girl, alert to surrounding. Afebrile, not pale, anicteric. Cardiopulmonary stable. **Abdomen**: Soft, non-distended, non-tender, colostomy bag with solid form fecal matter. Colostomy viable and well-vascularized. **All treatment diagnosis**: Colostomy status. Admitted for reversal of colostomy with coloanal anastomosis. **Plan**: Regular diet now. Pedialyte only from 2200 hours till 0400 hours. Bowel prep with normal saline through the ostomy tonight. OR for tomorrow.	3385-3388
XX/XX/2017	XXXX XXXX	**Consent for reversal of colostomy:** Risks, benefits, side effects and alternatives of the reversal of colostomy with colo-anal anastomosis and related procedures. Risks and side effects of the proposed care – Bleeding, infection, scarring, injury to internal organs, anastomotic leakage and failure, anesthetic complications.	3072-3073
XX/XX/2017	XXXX XXXX	**Operative report of closure of colostomy:** **Preoperative diagnosis**: Hirschsprung's disease, colostomy status. **Postoperative diagnosis**: Hirschsprung's disease.	3311-3313

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		Procedure: Closure of colostomy **Anesthesia**: General anesthesia via ETT and local anesthesia with 0.25% Bupivacaine. **Indications**: 5-months-old female with history of Hirschsprung's disease status post transanal pull through complicated by rectovaginal fistula necessitating diverting loop colostomy. The benefits, risks, and alternatives were explained to the mother who had her questions answered, verbally confirmed her understanding, and provided her written informed consent. **Findings**: Loop colostomy, viable colon, negative leak test at the anastomotic site. **Description**: All preoperative verifications were performed in accordance with hospital protocol. The patient was placed on the operating room table in the supine position and general anesthesia via ETT was provided. The anal region was dilated with a dilator. Bowel irrigation with saline/betadine solution was undertaken. There was no drainage of solution from the vagina introitus. The anterior abdominal was washed and prepped with Betadine and draped in sterile fashion. Time-out was successfully completed. An elliptical incision was made in the skin approximately 1 mm from the margin of the colostomy stoma. The incision was carried down to the peritoneum. Serosal adhesions to the rectus fascia were taken down. The two ends of the loop colostomy were identified, serially clamped with straight clamps, and divided. There free ends were passed as specimen for HPE. The bowel ends were anastomosed using a single-layer through-and-through anastomosis, starting from the mesenteric border. Leak test was done and was negative. Hemostasis was secured. The peritoneum was closed together with the fascia with 3-0 Vicryl using simple interrupted technique. The subcutaneous region was irrigated with saline and closed with 4-0 Vicryl 4-0 using simple interrupted technique. The skin was then closed with 5-0 nylon using simple Interrupted technique. Xeroform, dry gauze and Opsite were applied to skin. The sponge, needle, and instrument counts were correct at the end of the procedure. The patient tolerated the procedure well and was taken to the PICU in satisfactory condition. The attending surgeons, Drs. XXXX, were present and scrubbed throughout the entire procedure.	
XX/XX/2017	XXXX XXXX	**X-ray abdomen:** **History**: NG tube placement; status post reversal of colostomy on 02/10/2017. **Findings**: An NG tube is seen, with the tip projecting over the left upper quadrant and which may be positioned in the stomach. There	3337-3338

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		are several dilated bowel loops, which may be a combination of small and large bowel. No air is seen in the sigmoid or rectum. There is radiolucency over both upper quadrants consistent with free air. The osseous structures are intact. **Impression**: NG tube tip probably in the stomach. Bowel gas pattern as described above which may represent postoperative ileus rather than obstruction. Radiolucency over both upper quadrants consistent with free air, postoperative (patient status post reversal of colostomy on the previous day).	
XX/XX/2017	XXXX XXXX	**X-ray abdomen:** **Clinical history:** Abdominal distention. Status post bowel re-anastomosis. **Findings**: The feeding catheter courses into the gastric cavity. The heart is mildly enlarged with normal pulmonary vasculature. The lungs are clear, without pleural effusion or pneumothorax. There is extensive free intra-abdominal air. There is no evidence for soft tissue mass or mass effect. **Impression**: Extensive free intra-abdominal air, likely increased. Prominent heart size with clear lungs.	3339-3340
XX/XX/2017	XXXX XXXX	**Operative report of closure of anastomotic leak:** **Preoperative and postoperative diagnosis:** Anastomotic leak **Procedure**: Exploratory laparotomy, T-tube placement, closure of anastomotic leak. **Anesthesia**: General via ETT. **Drains**: 14 Fr T-tube placed into colonic lumen via anterolateral aspect of colocolonic anastomotic site. **Indications**: 5-month-old girl with Hirschsprung's disease status post transanal pull through during the neonatal period complicated by rectovaginal fistula, necessitating diverting loop colostomy. Patient underwent colostomy closure two days ago but developed pneumoperitoneum earlier today. The benefits, risks, and alternatives to the procedure were explained to the mother who had her questions answered, verbally confirmed her understanding, and provided her written informed consent. **Findings**: Leak at the anterolateral aspect of the colocolonic anastomotic site. **Description**: After consent was obtained from the mother, the patient was brought to the operating suite and timeout was conducted and documented by the circulating nurse. The patient was	3322-3324, 4190-4191

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		then placed on operating room table in the supine position. After induction of general anesthesia and endotracheal intubation, the patient's abdomen was prepped and draped in the usual sterile fashion. The previous incision site was reopened. The incision was deepened through the subcutaneous tissue and hemostasis was achieved with electrocautery. The incision was lengthened on both sides. The colocolonic anastomosis site was examined and a leak was found at the anterolateral aspect of the anastomosis. The left lower quadrant was then irrigated with normal saline which was then aspirated. After thorough aspiration of the operative site, it was decided to place a T-tube via the leak site to create a controlled fistula rather than a new colostomy. The T-tube was appropriately trimmed and placed through the leak site. After placement of the T-tube, multiple simple sutures of 4-0 Vicryl were placed adjacent to the leak site so as to fashion a watertight seal. The T-tube was exteriorized to the skin. Four additional simple sutures of 4-0 Vicryl were placed to secure the anastomotic site against the abdominal wall to function as a patch. The left lower quadrant was the again irrigated with normal saline which was again aspirated. The fascial layer was then closed with 2-0 Vicryl sutures. The subcutaneous tissue was closed with 4-0 Vicryl sutures and the skin was closed with 5-0 nylon sutures. The T-tube drain was fixed to the skin with interlocking 5-0 nylon sutures. A bag was attached to the T-tube and a sterile dressing was applied at the wound site. The patient tolerated the procedure without complication. Sponge, needle, and instrument counts were correct at the end of the case. The patient was then transported intubated to the PICU in stable condition. The attending surgeons, Dr. XXXX and Dr. XXXX, were present and scrubbed for the duration of the procedure.	
XX/XX/2017	XXXX XXXX	**X-ray chest and abdomen:** **History**: Post surgery. Bowel perforation. **Findings**: The endotracheal tube tip is at the thoracic inlet. The feeding catheter courses into the gastric cavity. The right-sided central venous catheter tip courses into the right atrium. There is a Foley catheter in place. The heart is mildly enlarged with normal pulmonary vasculature. There is an opacification within the right apex with elevation of the minor fissure. There is no evidence for pleural effusion or pneumothorax. There are air-filled loops of mildly distended small bowel. Air and fecal material are visualized within normal caliber colon. There is no evidence for free intra-abdominal air. There is no evidence for soft tissue mass or mass effect. **Impression**: Prominent cardiac silhouette with normal pulmonary	3351-3352

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		vasculature. Newly developed right upper lobe atelectasis. Mild small bowel distention, possibly ileus. No evidence for free intra-abdominal air.	
XX/XX/2017	XXXX XXXX	**X-ray abdomen:** **History**: Post surgery **Findings**: Enteric tubes course into the gastric cavity. The endotracheal tube is approximately 2.0 cm above the carina. There is right central venous catheter whose tip is overlies the cavoatrial junction. A rectal tube is visualized. Interval resolution of pneumoperitoneum. Again, visualized are multiple dilated loops of bowel. There is right upper lobe atelectasis. Granular opacities are seen in the lung on the right. There is no large pleural effusion or discernible pneumothorax. The cardiothymic silhouette is unremarkable. The bones are intact. **Impression**: 1. Enteric tube courses into gastric cavity. Endotracheal tube tip is 2.0 cm above the carina. Right central venous catheter tip in the cavoatrial junction. Interval placement of rectal tube. 2. Interval resolution of pneumoperitoneum. 3. Multiple dilated loops of bowel, unchanged. 4. Right upper lobe atelectasis. Granular opacities seen in the lung, mainly on the right.	3354-3355
XX/XX/2017	XXXX XXXX	**Operative report of end colostomy:** **Preoperative diagnosis**: Pneumoperitoneum status post colostomy closure, T-tube placement. **Postoperative diagnosis:** Colostomy status **Procedure**: Exploratory laparotomy, construction of end colostomy. **Anesthesia**: General anesthesia via ETT. **Indications**: 5-months-old girl with history of Hirschsprung's disease status post transanal pull through procedure, status post loop colostomy on account of rectovaginal fistula, status post colostomy closure, status post exploratory lap for T-tube placement, now with recurrent pneumoperitoneum. The benefits, risks, and alternatives were explained to the parents who had their questions answered, verbally confirmed understanding, and provided written informed consent. **Findings**: Viable colon, anastomotic leak. **Description**: All preoperative verifications were performed in accordance with hospital protocol. The patient was placed on the operating room table in the supine position. General anesthesia via ETT was provided. Rectal tube connected to betadine filled bulb was placed in the patient’s rectum for leak test. The anterior abdominal wall was prepped and draped in the usual sterile fashion. Time-out	3334-3336, 3076-3077

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		was successfully completed. Sutures over the left paraumbilical incisions were removed and dissection carried down to the peritoneum. There was no purulent fluid from the peritoneum. However, peritoneal swabs were taken for aerobic and anaerobic cultures. The peritoneum was lavaged with warm saline. The anastomotic site was identified, and test was positive. The T-tube was intact. Hemostasis was secured. End colostomy was undertaken with transection of the bowel proximal to the anastomotic site using endo white 45 mm GIA stapler. The distal bowel was tucked into the peritoneal cavity after inspection of the stapling edge. The proximal bowel was opposed to the fascia using 3-0 Vicryl sutures. The remainder of the abdominal wound was closed in layers using 2-0 Vicryl for the fascia, 4-0 Vicryl for subcutaneous layer, and 5-0 nylon for the skin. The colostomy was matured using 4-0 Vicryl sutures. Xeroform, dry gauze and Opsite were applied to the medial incision while a colostomy bag was placed over the stoma. The sponge, needle, and instrument counts were correct at the end of the procedure. The patient tolerated the procedure well and was taken to PICU in satisfactory condition. The attending surgeons, Drs. XXXX and YYYY, were present and scrubbed throughout the entire procedure.	
XX/XX/2017	XXXX XXXX	**X-ray abdomen:** **History**: Rule out pneumoperitoneum. **Findings**: The enteric tube and T-tube are in stable position. Again, noted is a large area of lucency overlying the liver, likely due to pneumoperitoneum. There is gas-filled, distended bowel loop in the mid abdomen measuring approximately 3.7 cm. The lung bases are clear. The bones are intact. **Impression**: Persistent large area of lucency overlying the liver, likely due to pneumoperitoneum.	3366-3367
XX/XX/2017	XXXX XXXX	**Procedure report of arterial line insertion:** *(XXXX M.D.)* **Indication**: Hemodynamic monitoring.	3640-3641
XX/XX/2017	XXXX XXXX	**X-ray abdomen:** **Clinical history**: Tachycardia. Vomiting. **Findings**: The heart size and pulmonary vasculature are normal. There is no evidence for focal parenchymal opacification, pleural effusion, or pneumothorax. There are air-filled loops of normal caliber bowel throughout the abdomen. There is an ostomy apparatus at the left lower abdomen. **Impression**: Unremarkable chest. Unremarkable bowel gas pattern. Left lower abdominal colostomy.	3380-3381

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XX/XX/2017	XXXX XXXX	**Discharge summary:** **Hospital course:** X-month-old female child with Hirschsprung's disease status post transanal pull through (10/24/2016) complicated by rectovaginal fistula status post colostomy (11/14/2016), status post colostomy closure (02/10/2017), status post exploratory lap and T-tube placement for pneumoperitoneum for repair of anastomotic leak (02/12/2017) and now status post exploratory lap with end colostomy for pneumoperitoneum (02/16/2017). Patient was stable overnight, hemodynamically stable, afebrile and is tolerating feeds. No other complaints. 6-month-old girl underwent unsuccessful reversal of descending loop colostomy requiring creation of a new end descending colostomy. **Discharge status**: Stable. **Next appointment**: Return to Pediatric Surgery clinic on 03/08/2017.	4028-4030
XX/XX/2017	XXXX XXXX	**Other related records:** Anesthesia Record *(Ref 4075-4076, 5210-5211, 3060-3063, 4086-4088, 4196-4199, 5221-5223, 3084-3085, 4220-4221, 4094-4099, 4105, 5229-5234, 5240)* Assessment *(Ref 3384, 4519)* Checklist/Verification List *(Ref 3074-3075, 4210-4211, 3068-3069, 4204-4205, 3082-3083, 4218-4219, 3086-3091, 4222-4226)* Consent *(Ref 3047, 4185, 3072-3073, 4206-4209, 3053-3059, 3064-3067, 4190-4195, 4200-4203, 3070-3071, 3076-3081, 4212-4217)* Discharge Instructions *(Ref 3052, 4188-4189)* Flow Sheet *(Ref 3301-3310, 4436-4445, 3314-3321, 3325-3333, 4449-4456, 4460-4468, 3110-3149, 4245-4284, 4050-4074, 5185-5209)* Labs *(Ref 3244-3300, 4379-4435)* Medication Sheets *(Ref 4106-4148, 5241-5283)* Nursing Notes/Records *(Ref 3389-3427, 3427-3434, 3438-3439, 3442-3450, 3452-3456, 3459, 3462-3480, 3486-3495, 3499-3508, 3513, 3516-3517, 3524-3538, 3543-3548, 3555-3562, 3565-3571, 3583-3594, 3599-3600, 3604, 3608-3609, 3618-3639, 3641-3649, 3655-3656, 3665-3678, 3681-3682, 3692-3710, 3715-3719, 3722-3730, 3742-3743, 3747-3751, 3754-3758, 3767-3771, 3774-3782, 3785, 3793, 3798-3810, 3819, 3824-3835, 3843, 3854-3862, 3864-3865, 3877-3885, 3892-3893, 3896-3902, 3905-3907, 3922-3926, 3929-3932, 3937, 3945-3954, 3958, 3971-3979, 3987-3992, 3995-4001, 4004, 4008-4009, 4016-4027, 4033-4036, 4048, 4524-4569, 4573-4574, 4578-4582, 5168-5171, 5183)* Nutritional Assessments *(Ref 3440-3442, 4575-4577, 3514-3516, 4167, 5302, 3605-3607, 3679-3681, 3772-3774, 3852-3854, 3908-3910, 3993-3995)* Orders *(Ref 3094-3109, 4229-4244, 3150-3240, 4285-4375)*	

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		Patient's Information *(Ref 3043-3044, 4182)* Plan of Care *(Ref 3051, 4187, 4037-4045, 5172-5180)* Progress Notes *(Ref 4081-4083, 5216-5218, 3435-3437, 4570-4572, 3451-3452, 3457-3458, 3460-3461, 3481-3485, 4089-4090, 5224-5225, 3496-3498, 3509-3512, 3518-3524, 3539-3543, 3549-3554, 3563-3565, 3572-3583, 3595-3599, 3601-3603, 3610-3617, 4100, 5235, 3650-3654, 3657-3664, 4101, 5236, 3683-3692, 3711-3715, 3720-3721, 3731-3741, 3744-3746, 3752-3754, 3759-3766, 3783-3798, 3811-3818, 3820-3824, 3836-3842, 3844-3851, 3863-3864, 3866-3877, 3886-3892, 3894-3895, 3903-3905, 3911-3921, 3927-3929, 3933-3936, 3938-3944, 4582-5083, 3955-3971, 3980-3986, 4002-4003, 4005-4007, 4010--4015, 5084-5162)* Referral Report *(Ref 3045, 4184)* Social Service Records *(Ref 4031-4032, 4049, 5166-5167, 5184)* Transfusion Record *(Ref 3092-3093, 4227-4228)* X-Ray Reports *(Ref 3341-3350, 3351-3383, 4486-4518)* **Reviewer's Comment: There are no significant details related to the case focus in these records hence not summarized; can be elaborated if required.*	
XX/XX/2017	XXXX XXXX	**Pediatric Surgery follow-up visit:** Patient has been doing well since discharge. Current weight 7.10 kg. Weight on discharge 6.73 kg. No fever, nausea, vomiting. Stoma is functioning. Mother was instructed to return to the clinic on Wednesday or Friday next week. **Attending note:** 6-month-old girl well known to and personally seen by me in follow-up of diverting colostomy performed for rectovaginal fistula status post transanal pull through for Hirschsprung's disease. Abdomen soft, flat, nontender. Colostomy pink and functioning. Minimal drainage from T-tube. Gaining weight. Return to clinic 03/22/2017 to see Dr. XXXX.	4152-4153
XX/XX/2017	XXXX XXXX	**Pediatric Surgery follow-up visit:** She has been doing well since then, gaining weight. Stiches were removed. Referred to general Pediatrics for oral rash. No fever, nausea, vomiting. Stoma is functioning. Return to clinic in 2 weeks. **Attending note:** Patient here for E&M whitish discharge from mouth. Seen with Dr. XXXX, exam confirms likely thrush. It has been puzzling why she developed the rectovaginal fistula and sustained anastomotic disruption at the site of her previous colostomy closure. Given her history of perinatal HIV exposure, and despite negative HIV tests thus far, I have asked Dr. XXXX to see her on XX/XX/2017. Of note, her colostomy is pink and functional, while her few remaining sutures were also incidentally removed during her visit. Return to clinic after visit with Dr. XXXXX. Otherwise, CPM.	4149-4151
XX/XX/2017	XXXX	**ER visit for displaced colostomy tubing:**	4174-4178

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	XXXX	*History reviewed.* Patient has been eating and drinking well, normal behavior pattern. As per mother she had given baby a bath and was about to dress her when she dislodged the catheter from the colostomy site. **Examination: Vitals**: Pulse 130, RR 38, temperature 98.8, oxygen saturation 100%. **Abdomen:** Colostomy on left lower quadrant, colostomy tube displaced. Drainage from colostomy site. *Otherwise, unremarkable*. **Assessment**: 6-month-old female with displaced colostomy. **Plan**: Surgery consult. **In-house notes**: 6-months-old female with dislodged colostomy tubing. Patient was scheduled for follow up in Pediatric surgery on 03/29/2017. Consultation with Pediatric Resident who corresponded with Dr. XXX. He recommended that the catheter should not be replaced, and patient should follow up in Pediatric Surgery as scheduled. **Disposition**: Discharged to home. **Discharge instructions**: Do not replace tube. Cover with colostomy bag. Keep area clean and dry. Follow-up in Pediatric Surgery clinic on 03/29/2017. **Reviewer's Comment: The Pediatric Surgery visit notes are not available for review.*	
XX/XX/2017	XXXX XXXX	**Cardiology consultation for tachycardia:** The patient has Hirschsprung's and has undergone numerous surgical interventions. The mother was informed that during the last series of surgical interventions the patient's heart rate was fast. She is about to undergo further anesthesia it was recommended that a cardiac evaluation be done. **Examination: Cardiac**: Point of Maximal Impulse (PMI) is not displaced. The precordium is quiet with no thrills or abnormal pulsations. The first and second heart sounds are normal. No systolic or diastolic murmurs. There are no rubs, clicks or gallops, there are no dominant or cranial bruits. **EKG**: Normal sinus rhythm. Normal ECG. **Echocardiogram**: 1. Patent foramen ovale, multiple fenestrations present. 2. Atrial septal aneurysm 3. Normal left ventricular cavity size and systolic function. **Visit diagnosis:** Patent foramen ovale. **Impression and plan:** The clinical evaluation is entirely normal. The echocardiogram doss demonstrates a small left-to-right shunt	3030-3032

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		through what appeals to be a fenestrated patent foramen ovale. While this does not have any hemodynamic significance, I would recommend the use of appropriate air and particle filters in the IV system at the time of anesthesia and surgical intervention. There are no contraindications to the use of general anesthesia, I have explained this to the patient's mother and have asked her to return in one far follow-up.	
XX/XX/2017	XXXX XXXX	**Follow-up visit:** Patient now presenting for follow up after colostomy closure on XXXX/2017 at XXX Hospital. Patient was discharged from the hospital on XXXX/2017. Hospital course was complicated by hypertension to 100s/60s. Nephrology service was consulted while in the hospital and patient was started on Amlodipine 1 mg daily with good response in pressure control. Hospital stay was otherwise uncomplicated, and patient was discharged tolerating feeds with pain well controlled. **Reviewer's Comment: The hospital records are not available for review.* Per mother, patient has been doing well since discharge but continues having 1-2 episodes of emesis a day. She reports that patient was having these episodes of emesis since prior to discharge from the hospital. Emesis NBNB, consisting of undigested formula, non-projectile and varying in volume. Patient drinks 8 oz of Enfamil 4-5x/day as well as varied baby food. Per mom, emesis only occurs when patient drinks formula and not when eating solid foods. Also, emesis does not occur immediately after feed and does not occur after every feed. Patient is having 3-4 soft, brown bowel movements a day and 7WD/day. Mom denies blood in the diaper after bowel movements, fever, shortness of breath, abdominal pain, dysuria, constipation, diarrhea or seeing stool coming out from vagina. Of note, patient has a history of fenestrated PFO and atrial septal aneurysm which has been evaluated by echocardiogram and has no hemodynamic significance. Patient also was born to HIV positive mother and is followed at Immunology clinic. She was last seen there on XX/2017 where she was catching up on vaccines (received 4-month vaccines at 6 month of age). Patient had 3 HIV PCRs reportedly negative, with last one done at XXXXX hospital. AZT was discontinued in 10/2016. **Examination: Vitals**: Temperature 98.1, HR 145, BP 99/53, oxygen saturation 100%. Weight 9.035 kg. **Cardiovascular**: Regular Rate Rhythm (RRR), normal S1/S2, I/VI systolic murmur. **Abdomen**: Soft, non-distended, surgical scar noted on Left Lower Quadrant (LLQ) with indurated tissue around it and minimal tenderness, no erythema or discharge noted from incision site, remainder of abdomen without tenderness, no hepatosplenomegaly. *Otherwise, unremarkable*.	2957-2961

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		Assessment and plan: XX-month-old with history of Hirschsprung's disease status post repair and numerous surgical interventions secondary to complications from initial surgery resulting in colostomy placement on 02/2017, now presenting for follow up status post ostomy closure on 07/14/2017. Hospital course complicated by hypertension managed with Amlodipine. Patient continues having daily NBNB emesis since discharge from hospital, although is well appearing and in no distress. Physical exam significant for benign abdominal exam with no distention or other signs of obstruction. Mild induration and tender to palpation on incision site are expected post-op changes. Site appears clean, dry and without discharge. Vital signs stable and within normal limits. Unclear as to reason for emesis, but given patient is well appearing with benign physical exam, obstruction, infection, or other acute intraabdominal pathology is unlikely. 1. Emesis: Pediatric surgery was contacted and given benign exam in office they will see patient on Wednesday 07/26/2017. Mom is to call them and make appointment. Return precautions given to mother. 2. Hypertension: Nephrology attending Dr. XXXX was contacted as per discharge instructions. Given normal BP Amlodipine will be decreased to 0.5mg daily. Patient will be seen for follow up in 1 week. 3. Well Child Care (WCC): Patient primarily seen at Immunology clinic. Will refer patient back to Immunology for continuing care and 6-month vaccines.	
XX/XX/2017	XXXX XXXX	**Pediatric follow-up visit:** *History reviewed.* More liquids were added to her diet, and her food and her constipation has improved greatly, and she has only spit up a small amount of milk recently. She continues to follow with Immunology and Pediatric Surgery at XXX. No noted issues per mother or available notes in record. **Assessment:** 10-month-old with history of Hirschsprung's disease status post repair and numerous surgical interventions secondary to complications from initial surgery resulting in colostomy placement on 02/2017, now presenting for follow up status post ostomy closure on 07/14/2017. Hospital course complicated by hypertension managed with amlodipine, with recent vomiting that has improved with improved bowel regimen. **Plan**: Continue with bowel regimen, consider adding laxative if she becomes constipated in future. Follow up in 1 month for vomiting and BP measurement in brief clinic. Continue Amlodipine 0.5mg. Contacted Dr. XXX who was not concerned by the blood pressure,	2972-2975

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		thinking that she is likely much lower while at home and not in distress. Will continue same dose of Amlodipine until normal pressures can be documented, plan to follow up in Nephro clinic on 10/18. HIV+ mother: Continue to follow in ID clinic, 12-month appointment to be made at next brief visit as she receives her PCP care there.	
XX/XX/2017	XXXX XXXX	**Other related records:** Assessment *(Ref 2943-2945, 2962-2966, 2977)* ER Record *(Ref 4168-4175, 5303-5308)* Flow Sheet *(Ref 2956)* Labs *(Ref 2984-2990)* Nursing Notes/Records *(Ref 2983)* Office Visit/Follow-up Visit *(Ref 2981-2982, 2991-2993, 2946-2948)* Orders *(Ref 2953-2955, 2994-2998)* Prescription Record *(Ref 2970-2971)* Social Service Records *(Ref 2980)* Telephone Conversation *(Ref 2967)* X-Ray Reports *(Ref 2978-2979)* **Reviewer's Comment: There are no significant details related to the case focus in these records hence not summarized; can be elaborated if required.*	
XX/XX/2017	XXXX XXXX	**Pediatric follow-up visit for well-childcare:** 13-month-old brought in by mother for vaccines/Well XXX. Concerns: Nodes on chest - being followed by Immunology; no change in size; no other symptoms. Diet: Patient drinks milk, eats baby food, apple sauce, eats everything. Stool 4-5x day; soft, no blood; colostomy site healing well Emesis: Resolved; no more vomiting with feeds or randomly. No longer on amlodipine for hypertension. Upper Respiratory Infection (URI): Congestion; denies fevers, vomiting, diarrhea, change in activity from baseline. **Development**: Stands 2 seconds, bangs 2 cubes, mama/dada specifically, waves bye-bye. Imitates activities. Stands alone, puts block in cup; one-word joint attention (points for interest and needs), turns and responds to name. **Physical exam:** **Growth curve assessment**: Weight- 70th percentile; height - 95th percentile. **General**: Alert, interactive **Chest**: Rhonchi and occasional wheezes; +4 small nodules palpated at midclavicular line over ribs. **Abdomen**: Soft, non-distended, no hepatosplenomegaly; colostomy	2891-2894

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		scar over left abdomen; healed; no signs of leakage or infection. **GU**: Normal Tanner I *Otherwise, unremarkable.* **Assessment and plan**: 1. Well child – 13-month-old growing and developing well. Vaccines today: MMR, VZV, Hep A #1, flu. Discussed risks, benefits and alternatives of all vaccines received. No immediate adverse reactions. Discussed: Dental care / referral. Reading together encouraged / ROR book given. Appetite may decrease, do not force feed. Wean to cup, transition from baby food to all table foods; Recommend 16-24oz milk/day. Avoid nuts/hard candies. Return to clinic as per Immunology (1 month). 2. Rib nodules - Stable; followed by Immunology.	
		**Reviewer's Comment: Further records are not available for review.*	