WakeMed
WakeMed Health & Hospitals
Raleigh, North Carolina 27610

PATIENT	DOVER, MICAH XAVIER
DOB	03/24/2014
PROVIDER	KAREN NEFF CHILTON, MD
MED REC NO	[redacted]
ADMIT DATE	07/19/2014
DISCHARGE	07/22/2014

DISCHARGE SUMMARY

DIAGNOSES:
1. Nonaccidental trauma.
2. Acute fractures of left ribs and right acromion.
3. Healing fractures of right ribs and left acromion.

ATTENDING PHYSICIAN: Dr. Karen Chilton.

CONSULTATIONS: Speech and Ophthalmology.

HISTORY AND PHYSICAL: Briefly, this is a previously healthy 16-week-old male who presented to the ED with mom for left rib pain. Mom reported that she kept trying to stand him up and nurse him, however he was very uncomfortable. She noticed that when she touched his rib he would start whimpering.

HOSPITAL COURSE:
1. Nonaccidental trauma. After being seen in the ED and having imaging, the patient was noted to have multiple fractures of varying ages, many in a distribution consistent with a squeezing injury. The patient received a full skeletal survey, and was noted to have an acute fracture of the left ribs 1, 3, 4, 5, and 6, as well as an acute right acromial fracture. It was also noted that he had healing fractures of the right ribs 6-10, with several having multiple fractures, as well as a healing left acromial fracture and possible periosteal reaction in the left ulna and radius, suggesting another healing fracture. On external exam, he was also noted to have multiple healing scapular puncture wounds in a distribution suggesting that they resulted from a bite over the left shoulder area, as well as bruising the size of a fingertip on the right midlateral chest wall, and palpable crepitus over the left ribs. On initial admission, the patient was very irritable with picking up or any changes in position. On initial exam, he did not have any evidence of blue sclera on exam, or other radiologic findings suggestive of osteogenesis imperfecta or rickets. Complete review of the skeletal survey with Pediatric Radiology and overall physical exam indicated unquestionable injuries inflicted by an adult. He was admitted to the floor and treated with Tylenol and Motrin as needed for pain. He also received a head CT and MRI that were negative for fracture or other bleeding. Ophthalmology was consulted and completed an exam, with no signs of retinal hemorrhage or any globe trauma. At the time of admission, the family gave no explanation for the inflicted injuries. Social Work, as well as Child Protective Services, were notified. Of note, mom did report 8 miscarriages prior to the delivery of this patient. Other labs were collected to rule out other metabolic conditions, including a phosphorus, PTH, calcium, alkaline phosphatase, and vitamin D. These labs did not indicate

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any other underlying process. CPS and Social Work secured placement for the patient in foster care prior to discharge. He was discharged to a foster care family.

2. Transaminitis. Upon admission, the patient was noted to also have an elevated AST and ALT. These were repeated on the second day of admission and were downtrending. He also had an abdominal ultrasound, which was normal, and raised no concern for any other injuries. These elevated liver enzymes were likely secondary to the associated trauma.
3. Fever on presentation, with increased white blood cell count. On admission, the patient was noted to have an increased white blood cell count and fever of 101.0 degrees Fahrenheit. Initially, a blood culture and urinalysis were obtained. The urinalysis was only positive for a small hemoglobin. However, this was further evaluated with the abdominal ultrasound. The blood cultures were negative, with no growth at the time of discharge. Urine culture was also final no growth. He was monitored throughout his admission, and remained afebrile, with no other clinical signs of infection. It is likely that these findings on presentation were secondary to the associated trauma.
4. Nutrition. Prior to admission, mom reported only breastfeeding for the patient. While he was in the hospital, he received a combination of pumped breast milk, as well as some formula feeding. He was also seen by Speech Therapy to address any difficulties with bottle feeding. Prior to discharge, he was feeding well, taking about 4 ounces every 2-3 hours.

PROCEDURES: None.

IMAGING: A pediatric skeletal survey with the following findings:
1. Acute fractures of the left 1st, 3rd, 4th, 5th, 6th ribs, slight offset.
2. Healing fractures of the right 6th, 7th, 8th, 9th, 10th ribs, with several ribs having multiple fractures.
3. Acute-appearing right acromial fracture.
4. Healed left acromial/glenoid fracture.
5. Possible periosteal reaction involving the left ulna and radius.
6. Pleural thickening versus a small amount of pleural fluid on the left, with no pneumothorax detected.

CT head with no intracranial hemorrhage, hydrocephalus, or mass effect. No other abnormalities noted.

An ultrasound of the abdomen with the following impression:
1. A small amount of simple free fluid, possibly at the right liver tip. No parenchymal injury was seen.
2. Debris in the bladder is a nonspecific finding. Correlation with urinalysis may be helpful.
3. Small left pleural effusion, consistent with left-sided rib injuries.

MRI head that showed no focal intracerebral abnormality. No abnormal signal intensity, mass effect, hemorrhage, or extracerebral fluid. No other acute abnormalities seen. Overall, negative brain MRI.

ANCILLARY DATA: On admission, a CBC with a white blood cell count of 15.4, hemoglobin 11.3, hematocrit 31, platelet count 470. Differential: 48 neutrophils, 48 lymphocytes, 2 monocytes, and 1 basophil.

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Electrolytes: Sodium 134, potassium 4.2, chloride 103, CO2 of 20, BUN 5, creatinine 0.27, glucose 71, calcium 10.2. Osmolality 264. Hepatic function tests: AST 197, ALT 157, alkaline phosphatase 330, direct bilirubin 0.1, total bilirubin 0.7. Those were from 07/19.

Labs from 07/20 include repeat LFTs with an AST of 120, ALT 131, alkaline phosphatase 343, an amylase of 15, a lipase of 9.

A urinalysis that was negative for urine albumin, negative for urine glucose, negative for urine ketones, negative for urine bilirubin, small urine hemoglobin, negative for leukocyte esterase, negative for nitrites, less than 3 RBCs, less than 5 WBCs, and trace bacteria. A phosphorus of 5.3, and intact PTH of 28, and a 25-hydroxyvitamin D of 19.6. A urine toxicology that was negative for amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, methadone, opiates, oxycodone, and propoxyphene. A urine culture that was no growth, with a final status, and a blood culture that was no growth after 2 days of incubation. This will be followed up for 5 days after discharge.

DISCHARGE MEDICATIONS:
1. Vitamin D drops.
2. Acetaminophen at 50 milligrams per kilogram per dose every 4 hours as needed for pain.
3. Ibuprofen at 10 milligrams per kilograms per dose every 6 hours as needed for pain.

FOLLOWUPS: Primary care physician. The patient is to follow up with the primary care physician at Sunrise Pediatrics 2-3 days after discharge.

DISCHARGE EXAMINATION: Please see exam from the daily progress note on the day of discharge.

DISCHARGE INSTRUCTIONS: Please seek medical attention if the patient has a fever greater than 100.4 degrees Fahrenheit, has difficulty breathing, is fussy and inconsolable, has difficulty feeding or decreased urine output, or any other concerning symptoms.

DISPOSITION:
Good/improved.

DISCHARGE WEIGHT: 6.135 kilograms.

Of note, greater than 30 minutes was spent on the day of discharge for discharge planning and care coordination for this patient.

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Electronically Signed By
KAREN NEFF CHILTON, MD 07/24/2014 02:25 P

KAREN NEFF CHILTON, MD
Dictated by: CHRISTOPHER NASSEF, MD-R

ttt/Job: 101234008/Doc: 2337772/DD: 07/22/2014 02:34 P /DT: 07/23/2014 01:32 A

cc: KAREN NEFF CHILTON, MD
BADIE CLARK, MD