

Name: |
 MR#: |
 Acct. #: |
 Age: |
 Attending: |

ADMISSION HISTORY & PHYSICAL

Admission Date/Time: 4/25/2009 11:33

Admitting MD:

Chief Complaint: NST with persistent variable decelerations of Baby B

HPI: ; a 34 y.o. Caucasian /female G:1 P: 0 @ 28.2 weeks EGA
 34yo G1 @ 27 2/7 wks by conception dating with mono/di twins and known lumbosacral neural tube defect of twin B presents for a routine NST to triage. On NST Baby B had concerning recurrent variable decelerations but good moderate variability. Per recent admission and USN; Baby A has EFW 4% from 11%. B has EFW 8%, but umbilical artery doppler has intermittently absent EDF. Patient is s/p BMZ 4/20-4/21. In addition has already had a discussion with NICU and do not feel the need to have an additional discussion with this admission.

Dating Criteria: EDC: by LMP of: Revised EDC: 07/23/09 by

Pregnancy Complicated by:

1. Mono/di twins
2. Breech/breech presentation
3. Fetus B with lumbosacral meningocele (L1 to sacrum) and Arnold Chiari malformation
4. IUGR of both twins
5. Clomid/IUI pregnancy
6. Hypothyroidism, s/p total thyroidectomy
7. h/o physical and sexual abuse, not to have pelvic exams without anesthesia

Past Obstetric History: See Prenatal for additional pregnancies

Delivery Date	Delivery Mode	Sex	Weight	Complications
1)			lb oz	
2)				
3)				
4)				

Past OB Ultrasounds:

- 4/1/09: 23 6/7, posterior placenta
 A: breech, maternal right; normal fluid, 418g
 B: breech, maternal left; normal fluid, 400g; S/D 5.75 (>95%)
- 4/6/09: 24 4/7, post placenta
 A: normal fluid, S/D 4.19 (66%)
 B: normal fluid, S/D 5.25 (92%)
- 4/13/09: 25 4/7, post placenta
 A: normal fluid, S/D 4.77 (86%)
 B: normal fluid, S/D 5.31 (>95%)
- 4/20/09: 26 4/7, post placenta
 A: breech mat R, normal fluid, EFW 527g (4%), S/D 4.2
 B: breech mat L, normal fluid, EFW 598g (8%), absent and reversed EDF
- 4/23/09: 27 0/7
 A: breech mat R, normal fluid, S/D 5.6
 B: breech mat L, normal fluid, intermittent REDF seen for twin B, with forward EDF in the ductus venosus

Past Gynecologic History:

Menarche Onset: 13 Monthly Menses? No Frequency:
 Pap Smear: Normal STD:
 On BCP at conception: No
 Past GYN History:

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unable to tolerate exams secondary to h/o physical and sexual abuse
no h/o STI or abn paps

Past Medical/Surgical History:

Med Hx:

Hypothyroidism s/p thyroidectomy

Surg Hx:

Total thyroidectomy 2007

Meds:

Levothyroxine

Allergies:

PCN

Sulfa

Drug resistant infection? **NO** If YES, which one(s)?

Cultures:

Allergies: See Allergy/Medication Form

Social History:

Alcohol Use: No

Drug Use: No

Tobacco Use: No

Partner Violence: No

Is an emotional or behavioral disorder an active problem?

If Yes, does the patient express suicide ideation?

Does the patient have a history of suicide attempts?

Social/Family History: Family Hx: Diabetes

Social Hx:

- no tobacco, alcohol, or drug use

- h/o physical and sexual abuse, pt does not tolerate pelvic exams

Physical Examination:

HEENT: Normocephalic; Atraumatic

Vital Signs: BP:118 /62 P:87 R20 T36.7 O2 SAT:

Lungs: Clear to auscultation

Heart: Regular Rate & Rhythm with No Murmur

Abdomen: Gravida Non-tender @ S+ cm

Neurologic:

Extremities/Skin: No edema noted

Comments:

Fetal Assessment:

Baseline FHR: 140

Variability: Moderate

Accels: Present

Decels: None

FHR Strip: Reassure

Presentation: Frank

Baby B:

Baseline FHR: 140

Variability: Moderate

Accels: Absent

Decels: Variable

FHR Strip: Reassure

Presentation: Frank

Baby C:

Baseline FHR:

Variability:

Accels:

Decels:

FHR Strip:

Presentation:

Presentation determined by: Ultrasound

Admission Ultrasound Info:

Uterine Contractions:

Toco: occasional

Labor Assessment:

Estimated Fetal Weight:

Birth Certificate Report - For Period

Baby's Name:

Mothers Name:

Birth Date:

BirthWeight: 0.73

GestAge: 28

Antibiotics: Yes

Surfactant: Yes

NICU Ventilation: ventilator

HepB: None

DR ventilation: No

HBIg: None

Seizures: No

DR Treatment:

Apgar 1: 6

Apgar 5: 9

Apgar10:

Diagnoses:

hypotension

meningomyelocele

neutropenia

pain/sedation

respiratory distress syndrome

sepsis, presumed (culture negative)

vertebra anomaly

Note:

Baby Boy **A** is the 790 gram product and Baby **B** is the 730 gram product of a 28-2/7 week gestation pregnancy born to a 34 year old Caucasian 34 year old woman. Pregnancy was complicated by monochorionic-diamniotic twins, clomid/IUI pregnancy, Twin B with lumbosacral myelomeningocele and Arnold Chiari Malformation, hypothyroidism for which mother is on *Leyothyroxine*, IUGR of both twins. Mother presented to **ER** on 4/25/09 after Twin B was noted to have a poor fetal heart rate tracing with reverse and diastolic flow. Babies were in breech presentation. Mother was monitored on **ECG**; then **ECG**, then back to **ECG** for poor strip. She received betamethasone on 4/20/09 through 04/21/09. There was no labor, no antibiotics, no rupture of membranes. The decision was made to deliver for non-improvement of Twin B's strip. Cesarean Section was done under general anesthesia due to inability to get full spinal anesthesia.