Pt: Haya Al-Yasin
DOB: 6/9/03
DOA: 7/7/08

Resident Admission H&P

CC: Reevaluation of developmental delay and seizure d/o

HPI: Haya is a 5 y/o with history of an astrocytoma s/p resection 9/05, VP shunt 2/06, and seizure disorder who is brought to KKI by her parents for evaluation of her developmental delay. Per Mom, Haya was a healthy child in her first year, but after after 12mos, developed gradual and progressive loss of her motor skills (unsteadiness leading to inability to walk or grasp objects). She was seen in Freiburg, Germany, where she was diagnosed with a cystic right sided cerebellar mass by MRI, and subsequently had resection of a grade I pilocytic astrocytoma 9/2005. Her post-op course was complicated by malabsorptive hydrocephalus, managed by serial lumbar punctures and eventual VP shunt 2/2006.

Following the surgery, Haya had significant loss of skills, and was unable to walk, verbalize, and displayed little interaction with others. Haya had extensive physical and language therapy with gradual gains, and can now sit unsupported, reach for items, is able to feed herself, and makes sounds to indicate wants.

Also of note, in January 2008, she had onset of seizure, the first of which was prolonged (15 minutes), consisting of generalized tonic/clonic movement with breath holding. She was seen a local hospital, and had an additional seizure and was given IV valium and a phenytoin loading dose. A head CT showed stably dilated ventricles with no bleeding. She was subsequently started on Tegretol. Mom reports that thereafter, she had gradually more frequent seizures, despite an increase in the tegretol to 200mg BID. She now has 3-5minute seizures up to twice weekly (irregular) at baseline; last was 2 weeks ago.

Haya's mother reports that developmental screening overseas suggested that her delay will likely be persistent, which prompted her parents to seek reevaluation.

PMH:
1) Astrocytoma s/p resection and VP shunting per HPI
2) Seizure d/o per HPI
3) Adenoidectomy 5/05
4) Developmental delay

ROS: Otherwise negative except per HPI

FH: No neurological diseases known in family

Medications:
1) Tegretol 200mg PO BID
2) Diastat PRN

Allergies: NKDA
Diet: Regular, no restrictions

Development:
Normal development until 12 months; thereafter lost coordination and ambulation per mom. Presently is non-verbal, makes sounds, able to support her head and sit unassisted, but can only ambulate with assistance.

Soc: Lives with her parents and two sisters in Kuwait. She attends a special needs school.

PE:
Wt: 22.4 kg (90th % for age), Ht 106cm (25-50%), BMI 20 (>97%).
VS: T 37, P 101, RR 22, BP 103/61
PE: General: well-nourished child, poorly interactive but alert and NAD
HEENT: NC, clear conj, PERRL, neck supple, MMM, good dentition.
CV: RRR, no m/r/g, 2+ pulses, WWP
Resp: CTA bilaterally, unlabored.
Abd: NT, ND, NBS, soft
GU: Tanner stage 2 female genitalia with light hair growth.
Ext: WWP, normal muscle mass.
Neuro: Non verbal at baseline, regards well, no facial asymmetry, slightly low tone in extremities. DTRs 2+ and symmetric throughout.

A: 5 year old with history of brain tumor resection, hydrocephalus s/p VP shunt, seizure disorder, now presenting for reevaluation of global developmental delay and seizure disorder. In addition to her surgical history as an etiology for her delay, her ongoing seizure disorder may be affecting her cognitive function. Given her poor control on tegretol, an EEG may be worthwhile in order to further define her disorder and guide therapy. Further developmental testing will also be in order to guide her outpatient therapy.

P:
1) Neuro: Monitor exam and for any seizure activity. Continue tegretol, consider obtaining trough level to check for therapeutic range. Plan for EEG to further evaluate seizure activity, neurology c/s. Plan for developmental testing (neuropsych evaluation) for further treatment and prognosis.
2) HM: PT/OT consults while inpatient.
3) Respiratory: Stable on RA, will keep on CPOX while in bed given seizure activity.
4) Dispo: Pending workup.

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