Baby A
DOB: 00/00/00

MEDICAL CHRONOLOGY

??/??/94	113	**Ultrasound scan *(undertaken in Egypt)* =** 14 weeks & 4 days. Viable fetus. Placenta fundal
??/??/94	114	**Ultrasound scan *(undertaken in Egypt)* =** 31 weeks & 4 days. Viable fetus. Placenta fundal**. No abnormality detected. Cephalic presentation**
24/11/94	82 - 85	**18.50pm -**CTG performed. **(CLINICAL NOTES OF ADMISSION MISSING).** Baseline is 140bpm with accelerations & excellent variability. Contracting 2 in 10 minutes **19.30pm –** Vaginal examination performed **.(CLINICAL NOTES MISSING)**
24/11/94	106	**FBC = Neutrophils high at 8.20 (normal range is 2.0 – 7.5); Hct abnormal at 0.338 & MCH abnormal at 31.1**
25/11/94	49	**10am – BP high at 130/105 & urine - + protein**
25/11/94	46	**14.45pm -** Admitted at 41 + 3 weeks gestation. NBM - For c/s today for previous c/s. Not contracting. No PV loss. BP/90 & urine – NAD. Has pregnancy induced hypertension. CTG reactive
25/11/94	109	**Biochemistry Results = Bicarbonate low at 21 (normal range is 22-32); Creatinine low at 55 (normal range is 65 – 101); ALP high at 200 (normal range is 38 – 126) & Albumin is 34 (normal range is 37 – 47)**
25/11/94	107 – 108	**FBC = Hct abnormal at 0.344 & MCH abnormal at 31.2. APTT low at 0.80 (normal range is 0.85 – 1.16) & Fibrinogen high at 4.54 (normal range is 1.7 – 4.0)**
25/11/94	86 - 90	**17.42pm –** CTG commenced. Baseline 120bpm with accelerations & good variability. CTG discontinued at 18.18pm. No uterine activity noted on monitor
25/11/94	46	**21.00-pm –** Dr C to review – can take diet **23.40pm –** BP/85. FHHR with transducer
26/11/94	91	**07.22am –** CTG commenced. Baseline appears 120bpm but poor copy. Fair variability with some accelerations. Discontinued at 08.15am.
26/11/94	46 & 49	**10.00am –** CTG reactive. BP/90 & urine -+ protein. Awaiting transfer to V Ward
27/11/94	47	**01.00am – BP high at 120/110.** Advised to rest on bed. Urine – NAD. No blurred vision or epigastric pain. **01.30pm** – CTG reactive & discontinued at 02.10pm
27/11/94	47	**06.30pm** – BP-116/90. Fetal movements felt +++. For c/s tomorrow.
27/11/94	47	**20.30pm** – **C/o slight headache**. BP/85 – 90. FHHR with pinard. Seen by anaesthetist

28/11/94	99 – 101	**09.34am -** CTG commenced. Baseline 110 - 120bpm with accelerations noted & good variability. Contracting regularly 1 in 7 minutes. **10am** – CTG discontinued
28/11/94	48	42 weeks gestation. For c/s at 11am. CTG reactive.
28/11/94	53	**17.00pm -** Anaesthetic chart states caesarean is elective. **Operation performed of Caesarean Section under GA. (OPERATION & CLINICAL NOTES MISSING)**
28/11/94	59 & 71	**17.30pm –** Baby delivered. Weight = 3620g **17.35pm –** Placenta delivered EBL = 500mls. Apgars of 7 & 9. **Oxygen given for 1 minute**. Baby appeared normal. Delivered by Obstetric SHO EM.
28/11/94	69 & 71	Neonatal summary states vertex presented at delivery in occipito-anterior position at 5 minutes old trunk was pink & response to stimuli was good with good tone. Heart rate >100bpm & regular respirations. Cord PH not known. No other procedures given. IM Vitamin K given & baby examined by Midwife Majekodumni. Temperature was 36.8 degrees. States mother had been seen antenatally on labour ward. **(NOTES MISSING).** Baby resuscitated by Paediatric SHO G.
28/11/94	72	17.30pm – Neonatal clinical notes indicate difficult delivery but cried within 30 seconds of delivery. Heart rate always >100bpm. **Intermittently needed bag & mask for 3 minutes**
??/11/94	74	Baby check showed normal behaviour & tone. Fit for discharge
30/11/94	60 & 79 & 102 & 115	Baby jaundiced. For SBR at 18.00 – 208umol/l (below treatment line). **20.00pm -** Breast feeding 4 hourly
01/12/94	80 & 116	**03.10am – Jaundice more pronounced**, SBR repeated – insufficient sample. Fed well x 3 times overnight
01/12/94	60	Baby has changing stool. Weighed – 3420g. Breast feeding
01/12/94	80	13.00PM – **Baby more alert this morning**. Feeding well. SBR not required at present
02/12/94	60 & 117 & 102	Jaundice. SBR taken – 209 umol/l - below treatment line
03/12/94	60	Jaundice. SBR taken. Weighed – 3520g.
03/12/94	55 – 57 & 75 – 77	Mother & baby discharged home. Baby has no feeding problems & no problems prior to discharge.
06/12/94	1270	Discharged from Hospital after admission for gastroenteritis. No intravenous fluids required.
09/12/94	1682	**PKU & Hypothyroid Result** = Normal
17/12/94	1627	*(Difficult to read GP notes)* Reviewed by GP. Feeding less. Bowels& passing urine normally. O/e no dehydration , fontanelles normal
11/12/95	1629	Seen by GP. Diagnosed with epilepsy in Egypt. Not crawling or walking. Refer to paediatric clinic.
01/01/96	1567	GP notes indicate global delay& epilepsy
16/01/96	1275	Letter to Neurologist at Hospital 2 having repeated CT scan of brain & EEG **(REPORTS MISSING)**

13/02/96	1227	**EEG Report = Prominent abnormality with marked excess of continuous low & intermediate slow activity. Changes reminiscent of Angelman's syndrome. Chromosome studies may assist with this diagnosis.**
22/01/96	847 – 848	Developmental Assessment at Hospital 3 **(NOTES MISSING).** Health Visitor, Ms R H present **(HEALTH VISITOR NOTES MISSING).** States at 7 months developed seizure disorder & EEG was performed in Egypt **(REPORT MISSING)** & he was started on sodium valporate which was stopped due to a rash. Now on Phenytoin of 4.1mls BD (this was increased by Hospital to 8.2mls BD (a high dose) **(NOTES MISSING)** CT scan in Egypt showed normal cortical sulci , posterior fossa & no mid line shift or deformity **(REPORT MISSING).** Now 14 months old & central hypotonia with peripheral hypertonia suggestive of a cerebral lesion with seizures. Developmental age of 2-3 months old. For further EEG from Hospital 4 **(REPORT MISSING)**
27/02/96	1262	**Cytogenetic Report = Chromosome 15 not deleted, but does not rule out possibility of uni – parental disomy.**
10/04/96	851	Letter handing care over to Hospital 2 from Hospital 3, **EEG at Y was grossly abnormal & suggestive of Angelman's syndrome (REPORT MISSING)**. Chromosome analysis did not reveal chromosome 15 deletion & congenital infection screen at Hospital 3 showed no antibodies to CMV or toxoplasmosis. Serum lactate results not available **(ALL RESULTS MISSING)**
29/04/96	853	Letter to GP after review at Hospital 3 **(NOTES MISSING).** Likely to have ongoing developmental problems
05/06/96	1297 – 1299	Letter to Dr S from R H. States from 2 months old until 8 months old (Jan 1995 – July 1995) lived in Egypt
19/01/97	1228	**ERG Report =** Normal. **VER shows a formed but delayed response**
30/01/97	1326	Admitted to Hospital 4 for routine MRI (**REPORT MISSING)**, Lumbar Puncture & bloods to identify cause of problems
30/01/97	1229	**EEG Report = Grossly abnormal record devoid of normal rhythm. High voltage slow activity**
31/01/97	1326	Discharged home & review in clinic.
17/03/97	1328	Letter to paediatrician at S **(NOTES MISSING).** Suffers from Global developmental delay, severe motor disorder, seizure disorder & feeding problems. . No clear documentation in first few months of life, thus difficult to ascertain if had acute illness with loss of skills or is an underlying degenerative process. For nerve conduction studies.
08/05/97	1332 – 1333	Letter to Neurologist at Hospital 2. States has been seen at S G Hospital by Audiology Physician. **(NOTES MISSING).** Has microcephaly with global developmental delay
04/06/97	1021 – 1027	**Operation performed of Gastrostomy Tube insertion**
30/06/97	1232	**EMG Report =** No evidence of peripheral neuropathy

05/06/98	1230	**EEG Report = Severely abnormal. Indicate severe multifocal or symptomatic generalised epilepsy with brunt of the abnormality being right sided**
18/06/98	1567	GP notes indicate learning difficulties with severe cerebral palsy
26/06/98	928	Letter from Neurologist states has had several emergency hospital admissions for airways obstruction
25/01/99	935	Letter to whom it may concern from Consultant Neurologist. Frequent life threatening chest infections & needs one to one supervision
17/12/02	1531 – 1534	Multidisciplinary meeting indicates has severe motor disorder with marked truncal hypotonia , scoliosis , no unifying diagnosis , severe learning & feeding difficulties
27/07/03	1564	Discharge summary from Hospital 3, indicates spastic quadriplegia, recurrent chest infection & increasing oxygen requirement
29/04/05	186 – 187	Discharge summary from Hospital 3 indicates increased frequency of seizures. EEG showed no background changes **(REPORT MISSING)**