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MEDICAL SUMMARY

Baby Boy C. Hypoxic Ischemic Encephalopathy

DRAFT - Subject to review and verification by retaining counsel and/or expert witness.

SAMPLE WORK PRODUCT. This summary was prepared from a synthetic record set created for demonstration. There is no real patient, mother, provider or facility. It is here to show the format, the citation discipline and the hyperlinking, using a fact pattern that behaves like a real one.

Source Records

Each citation in this summary names a source file by its abbreviation and the page within that file. In the hyperlinked PDF every one of those citations is a live link to the page it names. Maternal and infant charts are kept as separate files, and separated again by facility.

Abbreviation	Full File Name	Pages
Mother-Riverbend	Riverbend Regional Medical Center - Maternal Records.pdf	12
Infant-Riverbend	Riverbend Regional Medical Center - Infant Records.pdf	8
Infant-StColumba	St Columba Childrens Hospital - NICU Records.pdf	18
HIE-Diag	Laboratory Imaging and Pathology.pdf	10

Total pages in the record set: 48.

Flow of Events

Riverbend Regional Medical Center - Prenatal and Labor

Prenatal: Twelve documented visits. Gestational diabetes A2 on insulin from 27 weeks. Group B Streptococcus positive at 36 weeks. Estimated fetal weight 72nd percentile at 36 weeks 2 days.

06/14/2025 07:20: Admitted at 39 weeks 2 days for scheduled induction. Admission tracing Category I. Cervix 2 cm, 60 percent, minus 2 station.

06/14/2025 10:00: Tracing becomes Category II with occasional variable decelerations. Accelerations absent from 11:00.

06/14/2025 13:00: Recurrent late decelerations with minimal variability. Provider notified at 12:50.

06/14/2025 14:12: Tracing documented as Category III. Variability absent.

06/14/2025 14:14: First page to the obstetrician. Second page at 14:22. No documented response to the first page.

06/14/2025 14:20: Prolonged deceleration begins, progressing to sustained bradycardia in the 80s and 90s.

06/14/2025 14:31: Obstetrician at bedside. Decision for emergency cesarean delivery.

06/14/2025 15:10: Delivery. Documented decision to delivery interval 39 minutes. Cord arterial pH 6.87, base deficit 18.4. Apgars 1, 3 and 5.

Riverbend Regional Medical Center - Delivery Room and NICU

06/14/2025 15:10: Limp, apneic and pale. Positive pressure ventilation, chest compressions, intubation at three minutes, endotracheal epinephrine at four minutes.

06/14/2025 15:40: NICU admission. Modified Sarnat examination moderate to severe. Passive cooling begun at 15:45 pending transfer.

06/14/2025 17:52: Departure with the St. Columba neonatal transport team.

St. Columba Children's Hospital - NICU

06/14/2025 19:40: Servo-controlled whole body cooling initiated at 4 hours 30 minutes of life. All three eligibility criteria documented as met.

06/15/2025 02:40: Electrographic seizures on amplitude integrated EEG. Phenobarbital loaded at 03:10, levetiracetam added at 11:20.

06/17-06/18/2025: Rewarming over 72 hours completed. Extubated 06/18/2025.

06/19/2025: MRI on day of life 5 shows a basal ganglia and thalamus predominant injury pattern with involvement of the posterior limb of the internal capsule.

06/26-06/30/2025: Swallow study documents silent aspiration. Gastrostomy tube placed 06/30/2025.

07/03/2025: Discharged home on phenobarbital and levetiracetam, feeding entirely by gastrostomy tube.

Outpatient Follow Up

12/22/2025: Repeat MRI at six months shows established basal ganglia and thalamus injury with volume loss.

01/16/2026: Neurology follow up at corrected age 7 months. Dyskinetic cerebral palsy, acquired microcephaly, global developmental delay. Anticipated GMFCS level IV to V.

Patient History

Maternal obstetric history: G2 P1-0-0-1, one prior uncomplicated term vaginal delivery. Dating firm by 9 week ultrasound. (Ref: [Mother-Riverbend p.1])

Maternal medical history: Gestational diabetes mellitus class A2 from 27 weeks, managed on insulin. (Ref: [Mother-Riverbend p.1])

Maternal infectious status: Group B Streptococcus positive at 36 weeks. HIV nonreactive, hepatitis B surface antigen negative, RPR nonreactive, rubella immune. (Ref: [Mother-Riverbend p.1])

Family history: Not documented in available records.

Social history: Not documented in available records.

Allergies: None known. (Ref: [Mother-Riverbend p.7])

Infant birth data: Male, 39 weeks 2 days, 3,486 grams, delivered by emergency cesarean 06/14/2025 at 15:10. (Ref: [Infant-Riverbend p.1])

Detailed Summary

DATE	FACILITY / PROVIDER	SEQUENCE OF EVENTS / TREATMENT RENDERED	SOURCE REF
Prenatal	Riverbend Women's Health Associates Marisol Etchegaray, MD	**Obstetric history:** G2 P1-0-0-1. One prior uncomplicated term vaginal delivery. Dating firm by 9 week ultrasound. **Antenatal problems:** Gestational diabetes mellitus, class A2, diagnosed at 27 weeks and managed on insulin. Group B Streptococcus positive on the 36 week rectovaginal culture. **Prenatal laboratory:** Blood type A positive, antibody screen negative. Rubella immune. HIV nonreactive. Hepatitis B surface antigen negative. RPR nonreactive. **Growth:** At 36 weeks 2 days, estimated fetal weight 3,410 grams at the 72nd percentile, amniotic fluid index 14.2 cm, cephalic, anterior placenta. **Related records: twelve serial prenatal visit entries with fundal heights and blood pressures.*	[Mother-Riverbend p.1]
06/14/2025	Riverbend Regional Medical Center Labor and Delivery Marisol Etchegaray, MD	**Admission, 07:20:** Scheduled induction of labor at 39 weeks 2 days for gestational diabetes on insulin. **Maternal status:** Temperature 98.2 F, heart rate 84, blood pressure 118/70. Cervix 2 cm dilated, 60 percent effaced, minus 2 station, vertex. Membranes intact. **Admission tracing:** Baseline 140, moderate variability, accelerations present, no decelerations. Category I. **Plan as documented:** Oxytocin per unit protocol, penicillin G for Group B Streptococcus prophylaxis, continuous electronic fetal monitoring, insulin infusion with hourly glucose. **Related records: nursing admission assessment, maternal vital signs flowsheet, oxytocin and insulin administration record.*	[Mother-Riverbend p.2] [Mother-Riverbend pp.7-9]
06/14/2025	Riverbend Regional Medical Center Labor and Delivery A.T., RN	**Monitoring, 07:20 to 13:00:** Baseline rises from 140 to 152. Variability moderate through 11:00, minimal from 12:00. Accelerations absent from 11:00. Decelerations progress from occasional early, to recurrent variable at 11:00, to recurrent late at 13:00. Category II throughout this interval. **Interventions documented:** 10:15 repositioning to left lateral. 11:05 oxytocin decreased from 12 to 8 milliunits per minute. 11:40 fluid bolus 500 mL	[Mother-Riverbend p.3]

DATE	FACILITY / PROVIDER	SEQUENCE OF EVENTS / TREATMENT RENDERED	SOURCE REF
		lactated Ringer's. 12:20 oxygen 10 liters by non-rebreather mask. **Communication:** 12:50 provider notified of recurrent late decelerations and minimal variability.	
06/14/2025	Riverbend Regional Medical Center Labor and Delivery A.T., RN Marisol Etchegaray, MD	**Monitoring, 13:00 to 15:10:** Variability minimal at 13:30 and 14:00, absent from 14:12. Recurrent late decelerations continue. At 14:20 a prolonged deceleration begins. Sustained bradycardia follows: 92 at 14:26, 88 at 14:40, 84 at 15:02. Category III from 14:12. **Communication as documented:** 14:12 Category III documented by the bedside nurse, charge nurse notified. 14:14 first page to Dr. Etchegaray. 14:22 second page placed. *The record states there is no documented response to the first page.* **Decision and delivery:** 14:31 obstetrician at bedside, decision for emergency cesarean delivery documented. 14:38 anesthesia paged and operating room notified. 15:02 incision. 15:10 delivery. The record documents a decision to incision interval of 31 minutes and a decision to delivery interval of 39 minutes.	[Mother-Riverbend p.4]
06/14/2025	Riverbend Regional Medical Center Marisol Etchegaray, MD Tobias Wrenfield, MD	**Procedure:** Primary low transverse cesarean delivery under general endotracheal anesthesia, incision 15:02, delivery 15:10. Indication recorded as Category III fetal heart tracing with sustained fetal bradycardia. **Findings:** Live born male from cephalic presentation. Nuchal cord times one, loose, reduced at delivery. Amniotic fluid thick and meconium stained. Placenta delivered intact with a retroplacental clot estimated at 15 percent of the maternal surface, sent to pathology. Estimated blood loss 800 mL. **Neonatal status at delivery:** Limp, apneic and pale. Handed immediately to the neonatal resuscitation team. Apgar scores 1 at one minute, 3 at five minutes, 5 at ten minutes. **Cord blood gases:** Arterial pH 6.87, pCO2 82, base deficit 18.4. Venous pH 7.04, pCO2 61, base deficit 12.1.	[Mother-Riverbend p.5] [HIE-Diag p.1]
06/14/2025	Riverbend Regional Medical Center Delivery Room	**Resuscitation, minute by minute:** At birth limp, apneic and pale with no spontaneous respiratory effort. Warmed, dried, stimulated, airway positioned. Positive pressure ventilation at one	[Infant-Riverbend p.1] [Infant-Riverbend pp.6, 8]

DATE	FACILITY / PROVIDER	SEQUENCE OF EVENTS / TREATMENT RENDERED	SOURCE REF
	Priyamvada Raghunath, MD	minute with a heart rate of 48. Chest compressions at two minutes. Intubated at three minutes with a 3.5 tube secured at 9 cm. Endotracheal epinephrine 0.02 mg/kg at four minutes. Heart rate 68 and rising at five minutes, compressions stopped. Umbilical venous catheter and normal saline 10 mL/kg at seven minutes. Heart rate 132 at ten minutes with poor tone and no spontaneous effort. **Birth data:** Birth weight 3,486 grams at 39 weeks 2 days. **Related records: delivery room equipment and timing log, NICU medication administration record.*	
06/14/2025	Riverbend Regional Medical Center NICU Priyamvada Raghunath, MD	**Admission, 15:40:** Term male infant delivered by emergency cesarean for a Category III tracing with sustained bradycardia, requiring intubation and chest compressions, with an arterial cord pH of 6.87 and a base deficit of 18.4. **Neurologic examination at 30 minutes of life:** Lethargic, does not arouse to stimulation. Tone diffusely decreased with no spontaneous movement. Pupils sluggishly reactive. Suck absent, Moro absent, gag weak. Modified Sarnat recorded as moderate to severe encephalopathy. **Plan:** Hypoxic ischemic encephalopathy meeting criteria for therapeutic hypothermia by both blood gas and neurologic examination criteria. Passive cooling initiated at 15:45 pending transfer. Transport activated, team notified 16:05.	[Infant-Riverbend p.2] [Infant-Riverbend p.5]
06/14/2025	Riverbend Regional Medical Center Laboratory	**First hour of life, collected 15:35:** Arterial blood gas pH 6.94, pCO2 54, pO2 88, bicarbonate 12, base deficit 16.8. Lactate 14.2 mmol/L (critical high). Glucose 38 mg/dL (low). Hemoglobin 14.1. Platelets 118 (low). AST 388 and ALT 214 (high). Creatinine 1.4 (high). PT 19.4 seconds, INR 1.8, fibrinogen 118 (low). **Multi-organ involvement documented on day one:** Hepatic, renal, hematologic and metabolic derangement consistent with an acute hypoxic ischemic insult.	[Infant-Riverbend p.3] [HIE-Diag p.2]
06/14/2025	St. Columba Children's Hospital Neonatal Transport	**Transport:** Departure from Riverbend 17:52, arrival at St. Columba 18:44. Infant intubated and on passive cooling throughout. Axillary temperature 34.8 C on departure and 34.2 C on arrival. **Documented interval:** Total time from birth to arrival at the cooling center recorded as 3 hours 34 minutes.	[Infant-Riverbend p.4]

DATE	FACILITY / PROVIDER	SEQUENCE OF EVENTS / TREATMENT RENDERED	SOURCE REF
06/14/2025	St. Columba Children's Hospital NICU Anselm Trubetzkoy, MD	**Cooling initiated 19:40:** Servo-controlled whole body cooling. Documented age at initiation of active cooling 4 hours 30 minutes of life. Target esophageal temperature 33.5 C for 72 hours, then rewarming at 0.5 C per hour. **Eligibility as documented:** Criterion A, arterial cord pH 6.87 with base deficit 18.4. Criterion B, Apgar 3 at five minutes with positive pressure ventilation and chest compressions required. Criterion C, moderate to severe encephalopathy on modified Sarnat examination. **Neurologic examination on admission:** Stuporous, hypotonic, spontaneous movement absent. Suck, Moro and grasp all absent. Pupils constricted and sluggish. Modified Sarnat recorded as severe.	[Infant-StColumba p.1]
06/14-06/18/2025	St. Columba Children's Hospital Oluwaseun Fairweather-Diaz, MD Neurology	**Amplitude integrated EEG, from 19:15 on 06/14:** Initial background burst suppression with a lower margin below 5 microvolts and absent sleep wake cycling. **06/15/2025 02:40:** Electrographic seizures identified, right central onset, recurring every 8 to 14 minutes. **Conventional video EEG, 06/15/2025:** "Moderately to severely abnormal record due to a discontinuous background with excessive interburst intervals, and frequent electrographic seizures arising from the right central region. Findings are consistent with an acute encephalopathy." **06/16 and 06/18/2025:** Background improved to continuous low voltage with decreasing seizure burden after phenobarbital and levetiracetam. Sleep wake cycling emerging by 06/18 with no electrographic seizures in 26 hours.	[Infant-StColumba p.2]
06/14-06/18/2025	St. Columba Children's Hospital NICU	**Cooling course:** Esophageal temperature maintained between 33.2 and 33.8 C throughout. Sinus bradycardia to the 90s, expected during cooling. Subcutaneous fat necrosis over the upper back noted 06/17/2025. Rewarming initiated 06/17 at 19:40, normothermia achieved 06/18 at 03:20. Extubated 06/18/2025, nasal cannula until 06/20/2025. **Anticonvulsants:** Phenobarbital 20 mg/kg at 03:10 on 06/15, a further 10 mg/kg at 05:50, and levetiracetam 40 mg/kg at 11:20 on 06/15. **Organ involvement:** AST peaked at 388 on day one, down to 96 by 06/19. Creatinine peaked at 1.6	[Infant-StColumba p.4] [Infant-StColumba pp.8-14] [HIE-Diag p.2]

DATE	FACILITY / PROVIDER	SEQUENCE OF EVENTS / TREATMENT RENDERED	SOURCE REF
		on day two with a urine output nadir of 0.4 mL/kg/hr and no renal replacement therapy. Coagulopathy treated with fresh frozen plasma and cryoprecipitate on 06/14 and 06/15. **Related records: five daily progress notes 06/15 to 06/19, NICU nursing flowsheets and the medication administration record.*	
06/19/2025	St. Columba Children's Hospital Marguerite Anselm-Oyelaran, MD Pediatric Neuroradiology	**MRI brain without contrast, day of life 5:** Axial and sagittal T1, axial T2, diffusion weighted imaging with ADC map, susceptibility weighted imaging and MR spectroscopy of the basal ganglia. **Findings:** Restricted diffusion within the bilateral ventrolateral thalami and posterior putamina with corresponding low ADC values. Restricted diffusion also involves the perirolandic cortex bilaterally and the posterior limb of the internal capsule, where normal T1 hyperintensity is absent. No intracranial hemorrhage. No mass effect. **Spectroscopy:** Elevated lactate peak at 1.3 parts per million within the basal ganglia with a reduced N-acetylaspartate to choline ratio. **Impression:** "Acute hypoxic ischemic injury in a basal ganglia and thalamus predominant pattern, with involvement of the posterior limb of the internal capsule and the perirolandic cortex. This pattern is associated with an acute profound hypoxic ischemic insult. Elevated lactate on spectroscopy supports recent injury."	[Infant-StColumba p.3] [HIE-Diag p.3]
06/14/2025	Riverbend Regional Medical Center Ingrid Solheim-Baptiste, MD Pathology	**Gross:** Single placenta weighing 470 grams, below the 10th percentile for gestational age. Three vessel cord, 52 cm, marginal insertion. Membranes green stained. **Microscopic:** Accelerated villous maturation with increased syncytial knots. Focal avascular villi. Retroplacental hematoma with adjacent villous stromal hemorrhage and decidual necrosis. Acute chorioamnionitis not identified. **Diagnosis:** Retroplacental hematoma consistent with placental abruption. Maternal vascular malperfusion with accelerated villous maturation. Meconium staining of the membranes. No acute chorioamnionitis.	[Mother-Riverbend p.6] [HIE-Diag p.4]
06/16-06/20/2025	St. Columba Children's Hospital Laboratory	**Alternative etiologies evaluated:** State newborn screen with no abnormal results. Plasma amino acids, urine organic acids and acylcarnitine profile obtained 06/16/2025 with no diagnostic abnormality	[HIE-Diag pp.3-5] [Infant-StColumba p.17]

DATE	FACILITY / PROVIDER	SEQUENCE OF EVENTS / TREATMENT RENDERED	SOURCE REF
		beyond changes attributable to acute illness. Chromosomal microarray with no clinically significant copy number variants. **Infection workup:** Blood culture collected 06/14 at 15:50 with no growth at five days. Maternal Group B Streptococcus prophylaxis administered at 07:55 on 06/14, more than four hours before delivery. *The record documents that lumbar puncture was deferred due to coagulopathy, so cerebrospinal fluid was never obtained.* **Cranial ultrasound 06/15/2025:** "Subtle increased thalamic echogenicity, which can be seen in hypoxic ischemic injury. Cranial ultrasound is insensitive for this pattern. MRI is recommended for full characterization once the patient is stable."	
06/20/2025	St. Columba Children's Hospital Oluwaseun Fairweather-Diaz, MD Pediatric Neurology	**Impression:** Term infant with hypoxic ischemic encephalopathy following an acute profound intrapartum event, treated with therapeutic hypothermia, with neonatal seizures now controlled and MRI demonstrating a basal ganglia and thalamus predominant injury pattern with involvement of the posterior limb of the internal capsule. **Prognosis as documented:** "The pattern of injury on MRI, particularly the involvement of the posterior limb of the internal capsule, carries a high risk of motor impairment. Discussed with the family that dyskinetic cerebral palsy is a recognized outcome of this injury pattern. Cognitive outcome is less predictable at this stage." **Plan:** Continue phenobarbital and levetiracetam. Neurology follow up at six weeks. Early intervention referral. Ophthalmology and audiology screening before discharge.	[Infant-StColumba p.5]
06/26-07/03/2025	St. Columba Children's Hospital Anselm Trubetzkoy, MD	**Feeding:** Videofluoroscopic swallow study 06/26/2025 documented silent aspiration with thin liquids and delayed pharyngeal swallow initiation, with a recommendation of nothing by mouth. Laparoscopic gastrostomy tube placed 06/30/2025 without documented complication. **Pre-discharge screening:** Automated auditory brainstem response refer in the right ear with outpatient follow up arranged. Ophthalmology examination normal, no retinal hemorrhage. **Condition at discharge 07/03/2025:** Persistent axial hypotonia with appendicular hypertonia.	[Infant-StColumba p.6] [Infant-StColumba pp.15-18]

DATE	FACILITY / PROVIDER	SEQUENCE OF EVENTS / TREATMENT RENDERED	SOURCE REF
		Fisted hands. Brisk reflexes with sustained ankle clonus bilaterally. Feeding entirely by gastrostomy tube. Discharged on phenobarbital and levetiracetam.	
12/22/2025	St. Columba Children's Hospital Marguerite Anselm-Oyelaran, MD	**MRI brain at six months:** Interval volume loss within the bilateral putamina and ventrolateral thalami with abnormal T2 hyperintensity. Thinning of the posterior limb of the internal capsule bilaterally. Mild diffuse cerebral volume loss with ex vacuo ventricular prominence. Perirolandic cortical thinning. **Impression:** "Established injury in a basal ganglia and thalamus predominant distribution, evolved from the acute findings of 06/19/2025. The appearance is characteristic of a remote acute profound hypoxic ischemic insult."	[HIE-Diag p.6]
01/16/2026	St. Columba Children's Hospital Oluwaseun Fairweather-Diaz, MD Pediatric Neurology	**Examination at corrected age 7 months:** Head circumference has fallen from the 45th percentile at birth to below the 3rd percentile. Persistent fisting. Truncal hypotonia with appendicular hypertonia and emerging dystonic posturing of the upper extremities. Does not sit unsupported. Does not roll. Visual tracking inconsistent. **Assessment:** "Dyskinetic cerebral palsy secondary to neonatal hypoxic ischemic encephalopathy, with acquired microcephaly and global developmental delay. Gross Motor Function Classification System level anticipated at IV to V." **Plan:** Continue physical, occupational and speech therapy. Repeat MRI at 18 months. Continue gastrostomy feeds. Orthopedic referral for hip surveillance.	[Infant-StColumba p.7]

Documentation Gaps Noted

These are gaps in the record as produced. They are recorded here as observations, not as conclusions about the care rendered.

1. The produced set contains the fetal monitoring INTERPRETATION LOG but not the underlying tracing. The strips themselves, whether on paper or as archived electronic data, are not in this production. (Ref: [Mother-Riverbend pp.3-4])

2. The 14:14 page to the obstetrician has no documented response. The record next reflects a second page at 14:22 and the obstetrician at the bedside at 14:31. (Ref: [Mother-Riverbend p.4])

3. Cerebrospinal fluid was never obtained. The record documents that lumbar puncture was deferred due to coagulopathy, so meningitis was excluded on clinical and culture grounds rather than by direct examination. (Ref: [HIE-Diag p.4])

4. NICU daily progress notes at St. Columba are present for 06/15 through 06/19/2025. Narrative daily notes for 06/20 through 07/03/2025 are not in the produced set, although nursing flowsheets and the medication administration record cover the period. (Ref: [Infant-StColumba pp.8-14])

5. The neonatal transport record documents departure and arrival times but no vital signs between 17:52 and 18:44. (Ref: [Infant-Riverbend p.4])

RIVERBEND REGIONAL MEDICAL CENTER
Prenatal Record - Summary Flow Sheet

Patient: A.C. (mother) MRN: [REDACTED]
DOB: [REDACTED]

PRENATAL CARE SUMMARY

Practice: Riverbend Women's Health Associates

Provider: Marisol Etchegaray, MD

Gravida / Para: G2 P1-0-0-1

Estimated date of delivery: By 9 week ultrasound, dating firm.

PROBLEM LIST

Gestational diabetes mellitus, A2, diagnosed at 27 weeks, managed on insulin.

Prior cesarean delivery? No. Prior vaginal delivery at term, uncomplicated.

Group B Streptococcus: positive on 36 week rectovaginal culture.

PRENATAL LABORATORY

Blood type A positive, antibody screen negative. Rubella immune. HIV nonreactive. Hepatitis B surface antigen negative. RPR nonreactive.

SERIAL VISITS

Twelve documented prenatal visits between 8 and 39 weeks. Fundal height appropriate throughout. Blood pressures 104/62 to 128/78. No proteinuria documented.

THIRD TRIMESTER ULTRASOUND

At 36 weeks 2 days: estimated fetal weight 3,410 grams, 72nd percentile. Amniotic fluid index 14.2 cm. Cephalic presentation. Anterior placenta.

LABOR AND DELIVERY ADMISSION

Date and time: 06/14/2025 07:20

Gestational age: 39 weeks 2 days

Provider: Marisol Etchegaray, MD

Reason for admission: Scheduled induction of labor for gestational diabetes on insulin

ADMISSION ASSESSMENT

Maternal vital signs: temperature 98.2 F, heart rate 84, blood pressure 118/70.

Cervical examination: 2 cm dilated, 60 percent effaced, minus 2 station, vertex.

Membranes intact. Reports good fetal movement.

ADMISSION FETAL HEART TRACING

Baseline 140 beats per minute. Moderate variability. Accelerations present. No decelerations. Category I.

PLAN

Admit for induction. Oxytocin protocol per unit standard. Group B Streptococcus positive, penicillin G prophylaxis. Continuous electronic fetal monitoring. Insulin infusion per endocrine protocol with hourly glucose.

RIVERBEND REGIONAL MEDICAL CENTER
Labor and Delivery - Fetal Monitoring Interpretation 07:20 to 13:00

Patient: A.C. (mother) MRN: [REDACTED]
DOB: [REDACTED]

ELECTRONIC FETAL MONITORING - INTERPRETATION LOG

Date: 06/14/2025

TIME	BASELINE	VARIABILITY	ACCELS	DECELS	CATEGORY	INITIALS
07:20	140	moderate	present	none	I	AT RN
08:00	140	moderate	present	none	I	AT RN
09:00	142	moderate	present	occasional early	I	AT RN
10:00	145	moderate	present	occasional variable	II	AT RN
11:00	148	moderate	absent	variable, recurrent	II	AT RN
12:00	150	minimal	absent	variable, recurrent	II	AT RN
13:00	152	minimal	absent	late, recurrent	II	AT RN

INTERVENTIONS DOCUMENTED

10:15 Maternal repositioning to left lateral.

11:05 Oxytocin decreased from 12 to 8 milliunits per minute.

11:40 Intravenous fluid bolus 500 mL lactated Ringer's.

12:20 Oxygen 10 liters by non-rebreather mask.

12:50 Provider notified of recurrent late decelerations and minimal variability.

RIVERBEND REGIONAL MEDICAL CENTER
Labor and Delivery - Fetal Monitoring Interpretation 13:00 to 15:10

Patient: A.C. (mother) MRN: [REDACTED]
DOB: [REDACTED]

ELECTRONIC FETAL MONITORING - INTERPRETATION LOG, CONTINUED

Date: 06/14/2025

TIME	BASELINE	VARIABILITY	ACCELS	DECELS	CATEGORY	INITIALS
13:30	152	minimal	absent	late, recurrent	II	AT RN
14:00	155	minimal	absent	late, recurrent	II	AT RN
14:12	150	absent	absent	late, recurrent	III	AT RN
14:20	118	absent	absent	prolonged decel begins	III	AT RN
14:26	92	absent	absent	bradycardia sustained	III	AT RN
14:40	88	absent	absent	bradycardia sustained	III	AT RN
15:02	84	absent	absent	bradycardia sustained	III	AT RN

COMMUNICATION AND INTERVENTIONS DOCUMENTED

14:12 Category III tracing documented by bedside nurse. Charge nurse notified.

14:14 Page placed to Dr. Etchegaray.

14:22 Second page placed to Dr. Etchegaray. No documented response to the first page.

14:31 Dr. Etchegaray at bedside. Decision for emergency cesarean delivery documented.

14:38 Anesthesia paged. Operating room notified.

15:10 Delivery.

Documented interval from decision to incision: 31 minutes. Documented interval from decision to delivery: 39 minutes.

OPERATIVE REPORT - CESAREAN DELIVERY

Date and time: 06/14/2025, incision 15:02, delivery 15:10

Surgeon: Marisol Etchegaray, MD

Assistant: Tobias Wrenfield, MD

Anesthesia: General endotracheal, due to urgency

Indication: Category III fetal heart tracing, sustained fetal bradycardia

Procedure: Primary low transverse cesarean delivery

Estimated blood loss: 800 mL

FINDINGS

Live born male infant delivered from cephalic presentation. Nuchal cord times one, loose, reduced at delivery. Amniotic fluid thick and meconium stained. Placenta delivered intact with a retroplacental clot estimated at 15 percent of the maternal surface, sent to pathology.

NEONATAL STATUS AT DELIVERY

Infant limp, apneic and pale at delivery. Handed immediately to the neonatal resuscitation team. Apgar scores 1 at one minute, 3 at five minutes, 5 at ten minutes.

CORD BLOOD GASES

Arterial: pH 6.87, pCO2 82 mmHg, base deficit 18.4 mmol/L.

Venous: pH 7.04, pCO2 61 mmHg, base deficit 12.1 mmol/L.

RIVERBEND REGIONAL MEDICAL CENTER
Placental Pathology Report

Patient: A.C. (mother) MRN: [REDACTED]
DOB: [REDACTED]

SURGICAL PATHOLOGY REPORT - PLACENTA

Date received: 06/14/2025

Pathologist: Ingrid Solheim-Baptiste, MD

GROSS DESCRIPTION

Single placenta weighing 470 grams, below the 10th percentile for gestational age. Three vessel cord, 52 cm, with a marginal insertion. Membranes green stained.

MICROSCOPIC DESCRIPTION

Sections show accelerated villous maturation with increased syncytial knots. Focal avascular villi. A retroplacental hematoma with adjacent villous stromal hemorrhage and decidual necrosis is identified. Acute chorioamnionitis is not identified.

DIAGNOSIS

1. Placenta with retroplacental hematoma consistent with placental abruption. 2. Maternal vascular malperfusion with accelerated villous maturation. 3. Meconium staining of the membranes. 4. No acute chorioamnionitis.

NURSING ADMISSION ASSESSMENT 06/14/2025

Allergies: none known. Prenatal records on file. Birth plan reviewed.

Group B Streptococcus positive. Penicillin G 5 million units intravenously at 07:55, then 2.5 million units every four hours.

RIVERBEND REGIONAL MEDICAL CENTER
Labor and Delivery - Maternal Vital Signs Flowsheet

Patient: A.C. (mother) MRN: [REDACTED]
DOB: [REDACTED]

MATERNAL VITAL SIGNS 06/14/2025

07:20 T 98.2 HR 84 BP 118/70

10:00 T 98.4 HR 92 BP 122/74

12:00 T 98.6 HR 98 BP 126/78

14:00 T 98.9 HR 106 BP 118/68

15:30 T 98.4 HR 96 BP 108/62 (postoperative)

RIVERBEND REGIONAL MEDICAL CENTER
Labor and Delivery - Oxytocin and Insulin Administration

Patient: A.C. (mother) MRN: [REDACTED]
DOB: [REDACTED]

MEDICATION ADMINISTRATION RECORD

Oxytocin infusion started 08:10 at 2 milliunits per minute, titrated to 12 by 11:00, decreased to 8 at 11:05, discontinued 14:31.

Insulin infusion per endocrine protocol. Hourly maternal glucose 92 to 128 mg/dL.

RIVERBEND REGIONAL MEDICAL CENTER
Delivery Room - Neonatal Resuscitation Record

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

NEONATAL RESUSCITATION RECORD

Date and time of birth: 06/14/2025 15:10

Gestational age: 39 weeks 2 days

Birth weight: 3,486 grams

Team: Priyamvada Raghunath, MD (neonatology); Callum Adeyemi, RRT; Ines Kovac, RN

RESUSCITATION TIMELINE

TIME	MINUTE	EVENT
15:10	0	Limp, apneic, pale. No spontaneous respiratory effort.
15:10	0	Warmed, dried, stimulated. Airway positioned.
15:11	1	Positive pressure ventilation initiated. HR 48. APGAR 1.
15:12	2	Chest compressions started, 3:1 with PPV.
15:13	3	Intubated, 3.5 endotracheal tube secured at 9 cm.
15:14	4	Epinephrine 0.02 mg/kg via endotracheal tube.
15:15	5	HR 68 and rising. Compressions stopped. APGAR 3.
15:17	7	Umbilical venous catheter placed. Normal saline 10 mL/kg.
15:20	10	HR 132. Poor tone. No spontaneous effort. APGAR 5.
15:24	14	Transferred to the neonatal intensive care unit, intubated.

CORD GASES

Arterial pH 6.87, pCO2 82, base deficit 18.4. Venous pH 7.04, pCO2 61, base deficit 12.1.

NEONATAL INTENSIVE CARE UNIT ADMISSION NOTE

Date and time: 06/14/2025 15:40

Provider: Priyamvada Raghunath, MD

ASSESSMENT

Term male infant, 39 weeks 2 days, delivered by emergency cesarean for a Category III tracing with sustained bradycardia, requiring intubation and chest compressions, with an arterial cord pH of 6.87 and a base deficit of 18.4.

NEUROLOGIC EXAMINATION AT 30 MINUTES OF LIFE

Lethargic, does not arouse to stimulation. Tone diffusely decreased with no spontaneous movement. Pupils sluggishly reactive. Suck absent. Moro absent. Gag weak. Sarnat stage: moderate to severe encephalopathy.

ASSESSMENT AND PLAN

Hypoxic ischemic encephalopathy. Meets criteria for therapeutic hypothermia by both blood gas criteria and neurologic examination. Passive cooling initiated at 15:45 pending transfer. St. Columba Children's Hospital neonatal transport activated.

Transport team notified at 16:05. Estimated arrival 17:30.

RIVERBEND REGIONAL MEDICAL CENTER
NICU - Initial Laboratory and Blood Gas

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

LABORATORY - FIRST HOUR OF LIFE

Collected: 06/14/2025 15:35

Arterial blood gas: pH 6.94, pCO2 54 mmHg, pO2 88 mmHg, bicarbonate 12 mmol/L, base deficit 16.8 mmol/L.

Lactate 14.2 mmol/L (ref 0.5 - 2.2) CRITICAL HIGH

Glucose 38 mg/dL (ref 45 - 100) LOW

Hemoglobin 14.1 g/dL Platelets 118 K/uL (ref 150 - 400) LOW

AST 388 U/L (ref 10 - 40) HIGH ALT 214 U/L (ref 7 - 56) HIGH

Creatinine 1.4 mg/dL (ref 0.3 - 1.0) HIGH

PT 19.4 seconds INR 1.8 Fibrinogen 118 mg/dL LOW

NEONATAL TRANSPORT RECORD

Transport team: St. Columba Children's Hospital Neonatal Transport

Departure from Riverbend: 06/14/2025 17:52

Arrival at St. Columba: 06/14/2025 18:44

Infant remained intubated and on passive cooling throughout transport. Axillary temperature on departure 34.8 C. On arrival 34.2 C.

Documented total time from birth to arrival at the cooling center: 3 hours 34 minutes.

RIVERBEND REGIONAL MEDICAL CENTER
NICU - Nursing Flowsheet 06/14/2025

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

NICU NURSING FLOWSHEET 06/14/2025

15:40 T 36.1 HR 132 BP 48/26 SpO2 94 Vent SIMV 20/5 rate 40 FiO2 0.40

16:30 T 35.2 HR 128 BP 46/24 SpO2 96 passive cooling in progress

17:30 T 34.8 HR 124 BP 50/28 SpO2 95 awaiting transport

RIVERBEND REGIONAL MEDICAL CENTER
NICU - Medication Administration

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

MEDICATION ADMINISTRATION RECORD 06/14/2025

15:14 Epinephrine 0.02 mg/kg endotracheal, one dose.

15:17 Sodium chloride 0.9 percent 10 mL/kg via umbilical venous catheter.

15:50 Ampicillin and gentamicin, first doses, per sepsis protocol.

16:10 Dextrose 10 percent bolus 2 mL/kg for glucose of 38 mg/dL.

ST. COLUMBA CHILDREN'S HOSPITAL
NICU - Admission and Cooling Initiation

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

NEONATAL INTENSIVE CARE UNIT ADMISSION

Date and time: 06/14/2025 18:44

Provider: Anselm Trubetzkoy, MD, Neonatology

THERAPEUTIC HYPOTHERMIA

Servo-controlled whole body cooling initiated at 19:40 on 06/14/2025.

Documented age at initiation of active cooling: 4 hours 30 minutes of life. Target esophageal temperature 33.5 C, to be maintained for 72 hours, followed by rewarming at 0.5 C per hour.

ELIGIBILITY DOCUMENTATION

Criterion A met: arterial cord pH 6.87, base deficit 18.4.

Criterion B met: Apgar 3 at five minutes, positive pressure ventilation and chest compressions required at birth.

Criterion C met: moderate to severe encephalopathy on modified Sarnat examination.

NEUROLOGIC EXAMINATION ON ADMISSION

Stuporous. Hypotonic. Spontaneous movement absent. Suck absent, Moro absent, grasp absent. Pupils constricted and sluggish. Modified Sarnat: severe.

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

AMPLITUDE INTEGRATED EEG

Initiated: 06/14/2025 19:15

Interpreting neurologist: Oluwaseun Fairweather-Diaz, MD

Initial background: burst suppression pattern with a lower margin below 5 microvolts. Sleep wake cycling absent.

06/15/2025 02:40 Electrographic seizures identified, right central onset, recurring every 8 to 14 minutes.

06/16/2025 Background improved to continuous low voltage. Seizure burden decreased after loading with phenobarbital and the addition of levetiracetam.

06/18/2025 Sleep wake cycling emerging. No electrographic seizures in 26 hours.

CONVENTIONAL VIDEO EEG, 06/15/2025

Impression: "Moderately to severely abnormal record due to a discontinuous background with excessive interburst intervals, and frequent electrographic seizures arising from the right central region. Findings are consistent with an acute encephalopathy."

MAGNETIC RESONANCE IMAGING, BRAIN, WITHOUT CONTRAST

Date: 06/19/2025, day of life 5

Interpreting radiologist: Marguerite Anselm-Oyelaran, MD, Pediatric Neuroradiology

Technique: Axial and sagittal T1, axial T2, diffusion weighted imaging with ADC map, susceptibility weighted imaging, MR spectroscopy of the basal ganglia.

FINDINGS

Restricted diffusion is present within the bilateral ventrolateral thalami and the posterior putamina, with corresponding low ADC values. Restricted diffusion also involves the perirolandic cortex bilaterally and the posterior limb of the internal capsule, where normal T1 hyperintensity is absent.

No intracranial hemorrhage. No mass effect. Myelination otherwise appropriate for age.

MR spectroscopy demonstrates an elevated lactate peak at 1.3 parts per million within the basal ganglia, with a reduced N-acetylaspartate to choline ratio.

IMPRESSION

"Acute hypoxic ischemic injury in a basal ganglia and thalamus predominant pattern, with involvement of the posterior limb of the internal capsule and the perirolandic cortex. This pattern is associated with an acute profound hypoxic ischemic insult. Elevated lactate on spectroscopy supports recent injury."

ST. COLUMBA CHILDREN'S HOSPITAL
NICU - Cooling and Rewarming Course

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

THERAPEUTIC HYPOTHERMIA COURSE

Cooling initiated: 06/14/2025 19:40

Rewarming initiated: 06/17/2025 19:40

Normothermia achieved: 06/18/2025 03:20

COURSE DURING COOLING

Esophageal temperature maintained between 33.2 and 33.8 C throughout. Sinus bradycardia to the 90s, expected during cooling. Subcutaneous fat necrosis noted over the upper back on 06/17/2025.

Seizures treated with phenobarbital 20 mg/kg loading dose on 06/15/2025 at 03:10, a further 10 mg/kg at 05:50, and levetiracetam 40 mg/kg on 06/15/2025 at 11:20.

Extubated 06/18/2025. Required nasal cannula until 06/20/2025.

ORGAN INVOLVEMENT

Liver: AST peaked at 388 on day of life 1, trending down to 96 by 06/19/2025. Kidney: creatinine peaked at 1.6 on day of life 2, urine output nadir 0.4 mL/kg/hr, no renal replacement therapy required. Coagulopathy: fresh frozen plasma and cryoprecipitate on 06/14 and 06/15/2025.

PEDIATRIC NEUROLOGY CONSULTATION

Date: 06/20/2025

Provider: Oluwaseun Fairweather-Diaz, MD

IMPRESSION

Term infant with hypoxic ischemic encephalopathy following an acute profound intrapartum event, treated with therapeutic hypothermia, with neonatal seizures now controlled and MRI demonstrating a basal ganglia and thalamus predominant injury pattern with involvement of the posterior limb of the internal capsule.

PROGNOSIS AS DOCUMENTED

"The pattern of injury on MRI, particularly the involvement of the posterior limb of the internal capsule, carries a high risk of motor impairment. Discussed with the family that dyskinetic cerebral palsy is a recognized outcome of this injury pattern. Cognitive outcome is less predictable at this stage."

PLAN

Continue phenobarbital and levetiracetam. Neurology follow up at 6 weeks. Early intervention referral. Ophthalmology and audiology screening before discharge.

DISCHARGE SUMMARY

Admission: 06/14/2025

Discharge: 07/03/2025

Attending: Anselm Trubetzkoy, MD

Discharge diagnoses: Hypoxic ischemic encephalopathy, severe; neonatal seizures; status post therapeutic hypothermia; transient renal and hepatic injury; coagulopathy of the newborn; feeding difficulty

HOSPITAL COURSE

Summarized above. Feeding was the rate limiting issue for discharge. Oral feeding was poorly coordinated with documented aspiration on a swallow study performed 06/26/2025. A gastrostomy tube was placed 06/30/2025.

CONDITION AT DISCHARGE

Persistent axial hypotonia with appendicular hypertonia. Fisted hands. Brisk reflexes with sustained ankle clonus bilaterally. Feeding entirely by gastrostomy tube.

DISCHARGE MEDICATIONS

Phenobarbital and levetiracetam at documented weight based doses.

ST. COLUMBA CHILDREN'S HOSPITAL
Outpatient Neurology Follow Up

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

PEDIATRIC NEUROLOGY FOLLOW UP

Date: 01/16/2026, corrected age 7 months

Provider: Oluwaseun Fairweather-Diaz, MD

EXAMINATION

Head circumference has fallen from the 45th percentile at birth to below the 3rd percentile. Persistent fisting. Truncal hypotonia with appendicular hypertonia and emerging dystonic posturing of the upper extremities. Does not sit unsupported. Does not roll. Visual tracking inconsistent.

ASSESSMENT

"Dyskinetic cerebral palsy secondary to neonatal hypoxic ischemic encephalopathy, with acquired microcephaly and global developmental delay. Gross Motor Function Classification System level anticipated at IV to V."

PLAN

Continue physical, occupational and speech therapy. Repeat MRI at 18 months. Continue gastrostomy feeds. Orthopedic referral for hip surveillance.

NICU DAILY PROGRESS NOTE 06/15/2025

Temperature per cooling protocol. Ventilator settings weaned as tolerated.

Neurologic examination unchanged: hypotonic, poor spontaneous movement.

Laboratory trends reviewed. See laboratory and imaging records.

Family updated at the bedside by the attending neonatologist.

NICU DAILY PROGRESS NOTE 06/16/2025

Temperature per cooling protocol. Ventilator settings weaned as tolerated.

Neurologic examination unchanged: hypotonic, poor spontaneous movement.

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Laboratory trends reviewed. See laboratory and imaging records.

Family updated at the bedside by the attending neonatologist.

ST. COLUMBA CHILDREN'S HOSPITAL
NICU - Nursing Flowsheets 06/14 to 06/18

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

NICU NURSING FLOWSHEETS

Continuous esophageal temperature, heart rate, blood pressure and oxygen saturation.

Hourly urine output recorded. Nadir 0.4 mL/kg/hr on 06/16/2025.

MEDICATION ADMINISTRATION RECORD

Phenobarbital 20 mg/kg load 06/15 03:10, 10 mg/kg 06/15 05:50, maintenance thereafter.

Levetiracetam 40 mg/kg 06/15 11:20, maintenance thereafter.

Ampicillin and gentamicin discontinued 06/17/2025 with negative cultures at 48 hours.

Fresh frozen plasma and cryoprecipitate 06/14 and 06/15/2025.

ST. COLUMBA CHILDREN'S HOSPITAL
Swallow Study Report

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

VIDEOFLUOROSCOPIC SWALLOW STUDY 06/26/2025

Impression: silent aspiration with thin liquids. Delayed pharyngeal swallow initiation.

Recommendation: nothing by mouth. Discuss enteral access.

ST. COLUMBA CHILDREN'S HOSPITAL
Gastrostomy Operative Note

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

OPERATIVE NOTE 06/30/2025

Laparoscopic gastrostomy tube placement. No complications documented.

ST. COLUMBA CHILDREN'S HOSPITAL
Audiology and Ophthalmology Screening

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

PRE-DISCHARGE SCREENING

Automated auditory brainstem response: refer, right ear. Outpatient follow up arranged.

Ophthalmology examination: normal fundi. No retinal hemorrhage.

ST. COLUMBA CHILDREN'S HOSPITAL
Case Management and Early Intervention Referral

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

CASE MANAGEMENT 07/01/2025

Early intervention referral completed. Home nursing arranged. Equipment ordered.

RIVERBEND / ST. COLUMBA
Cord Blood Gas Report

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

UMBILICAL CORD BLOOD GAS REPORT

Collected: 06/14/2025 15:12

Facility: Riverbend Regional Medical Center

UMBILICAL ARTERY

pH 6.87 (ref 7.18 - 7.38) CRITICAL LOW

pCO2 82 mmHg (ref 32 - 66) HIGH

pO2 11 mmHg (ref 5 - 24)

Bicarbonate 11.4 mmol/L (ref 17 - 27) LOW

Base deficit 18.4 mmol/L (ref less than 12) CRITICAL HIGH

UMBILICAL VEIN

pH 7.04 (ref 7.25 - 7.45) LOW

pCO2 61 mmHg Base deficit 12.1 mmol/L HIGH

SPECIMEN VALIDATION

Arterial and venous pH differ by 0.17 and pCO2 by 21 mmHg, confirming that two separate vessels were sampled.

RIVERBEND / ST. COLUMBA
Neonatal Laboratory - Day of Life 1 to 3

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

NEONATAL LABORATORY - SERIAL VALUES

	06/14	06/15	06/16	06/17	06/19	06/28
pH (arterial)	6.94	7.21	7.31	7.36	7.38	----
Base deficit (mmol/L)	16.8	10.2	5.4	2.8	1.9	----
Lactate (mmol/L)	14.2	6.8	3.1	1.8	1.4	----
Glucose (mg/dL)	38	72	88	94	96	92
AST (U/L)	388	341	266	188	96	44
ALT (U/L)	214	198	162	121	68	31
Creatinine (mg/dL)	1.4	1.6	1.3	1.0	0.6	0.4
Platelets (K/uL)	118	92	88	134	212	288
INR	1.8	1.6	1.2	1.1	1.0	----
Fibrinogen (mg/dL)	118	142	198	224	266	----

Reference ranges: pH 7.30 to 7.40; base deficit less than 12; lactate 0.5 to 2.2; glucose 45 to 100; AST 10 to 40; ALT 7 to 56; creatinine 0.3 to 1.0; platelets 150 to 400; INR 0.9 to 1.1; fibrinogen 150 to 400.

RIVERBEND / ST. COLUMBA Patient: Baby Boy C. (infant) MRN: [REDACTED]
Radiology - Head Ultrasound 06/15/2025 DOB: [REDACTED]

CRANIAL ULTRASOUND

Date: 06/15/2025, day of life 1

Interpreting radiologist: Marguerite Anselm-Oyelaran, MD

Findings: Mildly increased echogenicity of the bilateral thalami. Ventricles normal in size and configuration. No germinal matrix or intraventricular hemorrhage. No extra-axial collection.

IMPRESSION

"Subtle increased thalamic echogenicity, which can be seen in hypoxic ischemic injury. Cranial ultrasound is insensitive for this pattern. MRI is recommended for full characterization once the patient is stable."

RIVERBEND / ST. COLUMBA
Microbiology and Sepsis Evaluation

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

MICROBIOLOGY

Blood culture collected 06/14/2025 at 15:50: no growth at 48 hours, final no growth at five days.

Cerebrospinal fluid was not obtained. The record documents that lumbar puncture was deferred due to coagulopathy.

Maternal Group B Streptococcus positive; intrapartum penicillin prophylaxis was administered at 07:55 on 06/14/2025, more than four hours before delivery.

PLACENTAL PATHOLOGY, CROSS REFERENCE

Acute chorioamnionitis was not identified. See the maternal chart.

RIVERBEND / ST. COLUMBA
Newborn Metabolic and Genetic Screening

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

METABOLIC AND GENETIC EVALUATION

State newborn screen: no abnormal results reported.

Plasma amino acids, urine organic acids and acylcarnitine profile obtained 06/16/2025: no diagnostic abnormality identified beyond changes attributable to acute illness.

Chromosomal microarray: no clinically significant copy number variants.

These studies are documented in the record as having been obtained to evaluate alternative etiologies for neonatal encephalopathy.

RIVERBEND / ST. COLUMBA
Radiology - MRI Brain 12/22/2025

Patient: Baby Boy C. (infant) MRN: [REDACTED]
DOB: [REDACTED]

MAGNETIC RESONANCE IMAGING, BRAIN, WITHOUT CONTRAST

Date: 12/22/2025, age 6 months

Interpreting radiologist: Marguerite Anselm-Oyelaran, MD

FINDINGS

Interval volume loss within the bilateral putamina and ventrolateral thalami with abnormal T2 hyperintensity. Thinning of the posterior limb of the internal capsule bilaterally. Mild diffuse cerebral volume loss with ex vacuo ventricular prominence. Perirolandic cortical thinning.

IMPRESSION

"Established injury in a basal ganglia and thalamus predominant distribution, evolved from the acute findings of 06/19/2025. The appearance is characteristic of a remote acute profound hypoxic ischemic insult."