

**Situation**

**Chief Complaint / Diagnosis:** bloody diarrhea and dehydration

**Allergy:** NKDA      **Code status:** Full code

**Background**

**Latest Vital Signs:** T 99 F, P 124 , R 28 , BP 88/58 , SaO<sub>2</sub> – 99% on 2 liters NC,

weight 10.8 kg

**Medical History:** immunizations UTD

**Home Medications:** none

**RECENT History:** 2 day history of fever and diarrhea. Over the past 24 hrs, the patient has had blood noted in the diarrhea. It is reported that the child has had stools approximately every 30 minutes to 1 hour for the past 12 hours. Oral intake has been poor for that time period as well. Fever was as high as 102 F at home. In ED patient was initially noted as lethargic, poor skin turgor, capillary refill greater than 3 seconds. P 162, BP 74/70, R 54.

IV started, labs drawn, 2 IV boluses of 210 ml of NS given. After second bolus the patient was noted to have improved vital signs and less lethargy.

Lab results were consistent with dehydration. IV D5 ¼ NS + 20 meq KCL/liter @ 50 ml/hr.

Intake 420 + 15 ml po

Output – 3 diarrheal stools (no blood) 120ml

Last diaper change 1 hour ago – diarrheal stool, no blood noted

**Surgical History:** none

**Assessment**

**Assessment:** Currently resting quietly, easily awakened, mucous membranes pink, dry. Skin warm, dry with fair turgor, capillary refill 3 seconds. Lungs clear bilaterally. Heart with no murmur, normal S1 S2. Abdomen soft with bowel sounds in all quadrants. No edema of extremities with pulses 2+.

**Recommendation**

Orders sent to pharmacy. Waiting on antibiotic.

May have Ibuprofen as needed. None given

Strict I&O, encourage clear liquids as tolerated.

Notify MD of frank blood in stool, temps > 102, or signs of worsening dehydration.

Date/Time	Note progress of case, complications, change in diagnosis on discharge, instructions to patient.
Today	<i>11-month-old male admitted through ED with dehydration and bloody diarrhea. Parent reports 2 day Hx of fever/diarrhea. Poor oral intake.</i>
	<i>PMH: term gestation. No hospitalizations. Immunizations UTD.</i>
	<i>Social: lives at home with parent.</i>
	<i>PE: T 101 F P 130 R 30 BP 92/50 O2 sats 98% on 2l/NC</i>
	<i>Gen: lethargic</i>
	<i>Lungs: CTA bilat.</i>
	<i>CARD: RRR, normal S1 S2</i>
	<i>ABD: soft, nontender, no masses, + bowel sounds</i>
	<i>EXT: no edema, cap refill 3-4 secs, pulses equal X 4</i>
	<i>Skin: warm, dry, poor turgor. Mucous membranes tacky, pink</i>
	<i>DX: Dehydration/diarrhea (Bacterial)</i>
	<i>PLAN: fluid bolus in ED, admit pedi, VS q 4 , strict I &amp; O, IVF</i>
	<i>Labs drawn - CBC, BMP, UA, stool culture, blood culture</i>
	<i>Meds: Claforan, Ibuprofen</i>
	<i>Clear liquids</i>

Lab	Patient	Ref. Range (Hockenberry Essentials 8 <sup>th</sup> ed.)
Glucose	107 *	60 – 100 mg/dL
Calcium	10.0	8.2 – 10.8 mg/dL
Sodium	147*	138 – 146 mEq/L
Potassium	3.3 *	3.5 – 5.0 mEq/L
CO <sub>2</sub>	17*	20 – 28 mEq/L
Chloride	101	98 – 106 mEq/L

Dustin Matthews

11 mo. M

BUN	21	5 – 18 mg/dL
Creatinine	0.9*	0.3 – 0.7 mg/dL
<b>Lab</b>	<b>Patient</b>	<b>Ref.</b> <b>Range</b> ((Hockenberry Essentials 8 <sup>th</sup> ed.)
WBC	18	5.5 – 15.5 x 10 <sup>9</sup> /L
RBC	7.2	3.9 -5.3 – RBC x 10 <sup>6</sup> /μL
Hgb	15.3	11.5 – 15.5 g/dL
Hct	53	35 - 45%
Platelets	251	150 – 400 x 10 <sup>9</sup> /L
Neut.	60	54 – 62%
Lymphs	33	25 – 33%
Mono	6.7	3% – 7%
Eos	0.2	1 – 3%
Baso	0.1	0.0 – 0.75%