MEMO

BY: **Kenneth P. Morelli**
DATE: Wednesday, September 25, 2024
RE: FRANKLIN, MELISSA (HENDERSON, BRAYTEN J. INF DEC'D) (File #: F19135f)

This case involves a delivery on 7/16/2012 at 12:33 pm by scheduled repeat C-Section at Faxton St. Luke's Hospital in Utica NY. Apgars were 9/9. Infant was given ABX because the Mom tested positive for Group B Strep. Right after birth he was taken to the regular nursery. He was transferred to the special care nursery later that evening because he was noted to have petechiae on his back, trunk, buttocks and thighs. HC was 11-25 percentile.

Brayton's initial hematocrit and platelets were low at 66000 and maternal platelet count was 245,000. Faxton St. Luke's Hospital called for a consult with Crouse Hospital in Syracuse, NY. Crouse recommended a retest. 2nd test the platelets were at 11,000. Infant was transferred to Crouse for a transfusion and possible IVIG however he was never given transfusions- only was monitored.

He was admitted to Crouse at 2350 on the day of birth (7/16/2012). Petechiae noted in the chart. Retested at Crouse on 7/17/12 which was a 57,000; 7/18/12 which was 54,000 and then again on 7/18/12 at 58,000. He was tested again on 7/19/12 and it was 54,0000. He was considered stable except for platelets- no head studies done. At discharge, he was recommended for follow up blood drawn by the pediatrician. At Crouse he wasn't given transfusions or IvIg done- only was monitored and had his blood drawn. Not tested for TORCH or any viral infecrion.

From Discharge (7/18/12 until the child was 4 months)- the mother would complain to the pediatrician, Dr. Sharma that he wasn't moving like the other kids, not smiling, not grasping, staring spells- Pediatrician did nothing.

At 5 Months of life- the infant had his first convulsive seizure. Pediatrician referred him to a neurologist at Slocum Dixon. MRI was done at Faxton St. Luke's Hospital on 1/4/13.

MRI taken on 1/4/13 IMPRESSION:

1. 1. INCREASED T1 SIGNAL INTENSITY IN THE PERIVENTRICULAR SUBEPENDYMAL REGION SUSPICIOUS FOR CALCIFICATION.
2. VENTRICULAR DILATATION WITH GLIOTIC CHANGE AS DESCRIBED ABOVE. THERE IS THINNING OF THE CORPUS CALLOSUM SUSPECTED AS WELL AS SUSPECTED ABNORMALITY OF MYELINATION WITH THE GIVEN AGE OF THE PATIENT.
3. SUSPECTED PORENCEPHALIC CYST WITHIN THE RIGHT FRONTAL LOBE WITH A PERIVENTRICULAR PSEUDOCYST WITHIN THE LEFT FRONTAL LOBE.
4. THESE FINDINGS ARE SUSPICIOUS FOR POSSIBLE CONGENITAL CMV. A NONCONTRASTED CT STUDY MAY BE HELPFUL TO CONFIRM PERIVENTRICULAR CALCIFICATION.
5. NO DEFINITE FINDINGS TO SUGGEST CEREBELLAR HYPOPLASIA.

After this MRI, CMV is suspected as the cause of the seizures and delays. On 1/11/13 and EEG was done which was abnormal and child started on phenobarbital.

On February 22, 2013, Brayton was admitted to Faxton St. Luke's Hospital for seizures and then transferred to Upstate Children's Hospital and the pediatric Neurologist did more MRI's which showed damage to brain consistent with CMV infection. Records state that CMV is the likely cause of Infant's problems. Subsequent records all use a dx of congenital CMV.

Child eventually passed away on December 19, 2022 at the age of 10. Prior to his passing, he was diagnosed with right sided weakness, feeding tube dependence, epilepsy, non-verbal, Cerebral Palsy, wheelchair bound, totally dependent of his mother and siblings.

We are seeking an opinion as to whether antiviral medication would have improved the outcome for this child? We believe we have a case for failure to diagnose and treat CMV infection in a new born. Please review and advise if you would be on board with this case.

Additionally could diagnosis referral and treatment by the pediatrician beginning at two weeks after birth have made a difference in the outcome? Are you able to comment on the progression of the child's brain damage?

The infant was seem by multiple neonatologists during his stay at Crouse Hospital. The admitting neonatologist suspected CMV due to the thrombocytopenia and petechiae but nevertheless did not order any testing. The neonatologists who treated him subsequently through discharge were not concerned with the persistent thrombocytopenia and he was discharged to his pediatrician who also did nothing.