



and occipital area with decreased myelination.

Adrenal insufficiency is common with this disorder and Matthew has had two Cortrosyn stimulation tests. The first one was done fasting. The fasting ACTH was elevated at 272 pg/mL. Baseline cortisol was 16.1 mcg/dl, and increased only to 18.8 mcg/dl. This is a marginal increase and quite borderline. The afternoon ACTH level was 86 pg/mL. The baseline cortisol was 6.7 mcg/dl with serum cortisol increased with using 150 mcg of Cortrosyn to 18.2 mcg/dl. This does suggest some marginal adrenal function.

Physical examination: On physical examination, Matthew is an obviously delayed child. His length is 102 cm, weight was 14.5 kg. Blood pressure was unable to be obtained. Matthew was not otherwise examined on this visit.

LABORATORY DATA:

Laboratory studies done on 02/08/02 revealed an AST of 125 iu/l, ALT of 72 IU/L, total protein = 8.5 mg/dl, alk phos = 257 IU/L. Calcium = 9.8, phosphorus 5.3. Sodium = 141 mEq/L, potassium 5.2 mEq/L, creatinine 0.4 mg/dl, glucose 79 mg/dl. Free T4 = .8 ng/dl, TSH 6.31 mIU/ml. Hemoglobin 11.2. Platelet count 268,000. White count = 9,000. Total cholesterol 57, triglycerides 52, HDL 13, LDL 33. Uric acid 3.0. Lactate 2.3 mmol/L. Ammonia is 40 mmol/L, PTT 34.5 seconds which is slightly elevated and PT 17.0 seconds, also slightly elevated.

Renin 1.8 ng/ml/hr n(mean=2.5 age 3-5 yrs.)

Assessment and plan: The TSH is again slightly elevated suggesting mild hypothyroidism. This is certainly a soft call. In my estimation, however, a small dose of thyroid hormone in order to bring the TSH in an acceptable range is quite reasonable. Matthew was doing well on Levoxyl 12.5 mcg daily and I would certainly suggest that it be started once again.

I do feel that Matthew should be on Hydrocortisone and I have discussed this with his mother. There is no doubt in my mind that he has an element of adrenal insufficiency from testing. Matthew's surface area at this time is 0.64 sqm. I have suggested Cortef 2.5 mg bid. In the event of a significant vomiting illness, the parenteral dose is 30 mg followed by 15 mg/sqm every six hours. In the event of a mild febrile illness with no vomiting, the dose is 5 mg three times a day. For a more significant febrile illness without vomiting, the dose is 10 mg three times a day.

I discussed the pituitary adrenal axis at great length with Mrs. Wulf for this 45 minute visit.

I have also faxed this information to Dr. Martinez. Certainly if she has any thoughts about supplementation, I would be interested in her comments.

RTC: June 24, 2002

Clinic note reviewed by attending. Original signed note in the office chart.

Nancy Friedman, M.D.
Pediatric Endocrinology
Box 3080 DUMC, Durham, NC 27710
Phone: 919-684-3772
Fax: 919-684-8613
NF/jpj
Dictated on: 02/14/2002