MARVIX AI

SAMPLE PEDIATRIC GASTROENTEROLOGY SOAP NOTE

NEW CROHN DISEASE WITH GROWTH FAILURE

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1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Priya L. Ramanathan

DOB
11/02/2014

AGE / SEX
11 yrs / Female

MRN / PATIENT ID
PGI-52846

DATE OF SERVICE
08/05/2026

PROVIDER
Elena Kowalczyk, MD

CREDENTIALS
MD, MSc

PARENT / GUARDIAN PRESENT
Both parents — Sunita and Vikram Ramanathan

VISIT TYPE
Pediatric Gastroenterology Consultation — new patient, expedited

CARE SETTING
Outpatient pediatric GI clinic

INFORMANT / COLLATERAL SOURCE
Patient and both parents; school nurse log; primary care record

REFERRAL SOURCE
Primary care, 07/22/2026 — weight loss, anemia, faltering growth

PRIMARY CARE PROVIDER
Oakmont Pediatrics — Dr. A. Fernandes

CC CHIEF COMPLAINT

2 PRIMARY GASTROINTESTINAL CONCERN

"My stomach hurts most days and I get tired at school. I've stopped growing — I'm the shortest in my class now and I used to be in the middle." — patient. Parents report 14 months of intermittent abdominal pain, 4.6 kg of weight loss, and a mouth ulcer that keeps returning.

S SUBJECTIVE

3 REPORTED GI SYMPTOMS, NUTRITION & TREATMENT RESPONSE

3a REASON FOR EVALUATION & SYMPTOM PATTERN

Reason for Pediatric Gastroenterology Evaluation

Expedited new-patient assessment for suspected inflammatory bowel disease. Referral triggered by **growth failure with height velocity arrest, 4.6 kg weight loss, iron-deficiency anemia unresponsive to oral iron, and a faecal calprotectin of 1,240 µg/g** ordered by primary care.

Abdominal Pain

Fourteen months of periumbilical and right lower quadrant pain, initially once or twice weekly and now daily. Cramping in character, 5–7/10 at worst, lasting 30–90 minutes. **Worse 20–40 minutes after meals and often relieved partially by a bowel movement.** Wakes her from sleep two or three nights a week — a feature the family had not previously mentioned to anyone. No specific dietary trigger identified, though she has independently begun avoiding dairy and large meals because "it hurts less if I eat less." Missing school on pain days.

Nausea / Vomiting / Reflux

Intermittent nausea, particularly in the morning and with pain episodes. No vomiting in the past 3 months; three isolated episodes earlier in the year, non-bilious and non-bloody. No heartburn, no regurgitation, no dysphagia, no odynophagia, no choking or coughing with feeds.

Bowel Habits

Three to five loose stools daily, up from one formed stool daily 18 months ago. Bristol type 5–6. Urgency present with two episodes of soiling at school in the past month, which she found humiliating and has not told her parents about until today. **Nocturnal stools two or three nights weekly** — a red flag. Intermittent mucus. **Visible fresh blood on three occasions in the past 2 months**, small volume, mixed rather than purely on the surface. No melaena.

Constipation Symptoms

None currently. No stool withholding, no large or painful stools, no toilet clogging, no encopresis of retentive type, no prior cleanout. Toilet trained without difficulty at 2 years.

Diarrhea Symptoms

As above — 14 months of gradually worsening loose stools with urgency, nocturnal symptoms, mucus, and intermittent blood. No recent travel, no sick contacts, no antibiotic exposure in 2 years, no camping or untreated water, no pets with diarrhoea. Two negative stool cultures via primary care in 03/2026 and 06/2026.

3b FEEDING, GROWTH & HEPATOBILIARY SYMPTOMS

Feeding / Swallowing Symptoms

Appetite markedly reduced for 8 months — described by her mother as "picking at food and pushing the plate away." Self-imposed dairy and portion restriction driven by pain avoidance, not by taste preference. No dysphagia, no odynophagia, no food impaction, no texture aversion, no prolonged meals, no tube feeding, no feeding therapy history.

Growth / Nutrition

Weight 28.4 kg today, down from 33.0 kg in 05/2025 — a 4.6 kg loss (14% of body weight) over 14 months. **Height 137.5 cm, up only 1.2 cm in 14 months**, against an expected 6–7 cm. She has crossed from the 45th to below the 5th centile for weight and from the 40th to the 8th centile for height. Mid-parental height predicts the 50th centile. **No pubertal progression — Tanner 1 at 11 years 9 months**, with no breast development and no menarche. No supplements beyond the oral iron. No dietitian involvement to date.

Liver / Pancreatic / Biliary Symptoms

No jaundice, no scleral icterus, no dark urine, no pale stools, no pruritus. No right upper quadrant pain. No steatorrhoea. Liver enzymes and GGT normal on the 07/2026 primary care panel — relevant because primary sclerosing cholangitis association would change surveillance.

Inflammatory / Red-Flag GI Symptoms

Multiple red flags present: weight loss, growth failure with height velocity arrest, delayed puberty, nocturnal diarrhoea, blood in stool, recurrent aphthous oral ulceration (three episodes in 6 months, one present today), fatigue, intermittent low-grade fevers to 37.9°C reported by the school nurse on four occasions, and 6 weeks of intermittent right knee and ankle discomfort without swelling. No perianal pain, no drainage, no known fistula. No family history of inflammatory bowel disease.

3c TREATMENT, DIET & BACKGROUND HISTORY

Medication and Treatment History

Oral ferrous sulphate 3 mg/kg/day since 02/2026 with **no rise in hemoglobin over 6 months** — adherence confirmed by the mother, who administers it. Paracetamol and occasional ibuprofen for pain; **ibuprofen used roughly twice weekly for 8 months**, which needs to stop. Two courses of a probiotic without benefit. Peppermint oil capsules trialled by the family. Lactose-free milk for 4 months with partial and unconvincing benefit. No acid suppression, no laxatives, no antispasmodics, no steroids, no immunomodulators, no antibiotics.

Dietary History

Vegetarian household — lacto-vegetarian, no meat or fish, eggs occasionally. Now avoiding dairy by self-restriction, which has removed her main protein and calcium source. Estimated intake by 3-day recall roughly 1,150 kcal/day against an estimated requirement of 2,000–2,200, with protein around 0.7 g/kg/day. Fibre intake low since she began restricting. Fluid intake adequate. No gluten avoidance. No known food allergy, no eosinophilic disease history. No dietitian ever involved.

Past Medical / Surgical History

Term birth, 3.4 kg, no NICU stay. No congenital GI anomaly, no prior abdominal surgery, no feeding tube. Recurrent aphthous ulcers noted from age 9 and attributed to stress. Mild eczema in infancy, resolved. Fully immunised including varicella and MMR — important before any biologic therapy. No tuberculosis exposure. No drug allergies. Never hospitalised.

Family History

Paternal aunt with "bowel problems" requiring surgery in her twenties, details unknown and being sought — possibly Crohn disease. Maternal grandmother with hypothyroidism. Father with psoriasis. No known celiac disease, liver disease, pancreatitis, colon polyps, or GI malignancy. No consanguinity.

Social / School History

Year 6, previously academically strong and now described by her teacher as withdrawn and tired. **Twenty-two days of school missed this academic year** against three the year before. Withdrew from the swim team in 02/2026 because of fatigue and embarrassment about her size. Two soiling episodes at school, not disclosed to her parents until today, with associated avoidance of school toilets. Lives with both parents and two older brothers; supportive household, no food insecurity, no transport barrier. Both parents work full time; the mother has already reduced her hours.

Pertinent Negatives

No hematemesis, no melaena, no bilious vomiting. No severe or localised acute abdominal pain suggesting obstruction or perforation. No perianal pain, discharge, or known fistula. No jaundice or pruritus. No severe dehydration. No dysphagia. No rash beyond the oral ulcer, no eye pain or redness, no oral candidiasis. No recent travel, antibiotic exposure, or infectious contact.

ROS PEDIATRIC GASTROENTEROLOGY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Upper GI	**Positive — daily post-prandial abdominal pain, intermittent nausea. Negative for reflux, dysphagia, odynophagia, vomiting in 3 months**
Lower GI	**Positive — 3–5 loose stools/day, urgency, 2 soiling episodes, nocturnal stools, mucus, blood ×3. Negative for constipation, tenesmus without stool**
Growth / nutrition	**Positive — 4.6 kg loss, height velocity 1.2 cm/14 months, appetite loss, self-restricted diet. Negative for dehydration symptoms**

Hepatobiliary	**Negative for jaundice, dark urine, pale stools, pruritus, easy bruising, abdominal distension**
Extraintestinal	**Positive — recurrent aphthous ulcers, fatigue, low-grade fevers, intermittent knee and ankle arthralgia, delayed puberty. Negative for erythema nodosum, uveitis, perianal disease**
Feeding	**Negative for choking, coughing with feeds, texture aversion, tube-feeding concerns**
Medication / diet	**Positive — 6 months of oral iron without hemoglobin response; twice-weekly ibuprofen for 8 months. Negative for food allergy symptoms, adherence problems**

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE
37.4°C

BLOOD PRESSURE
98/60 mmHg

HEART RATE
96 bpm

RESPIRATORY RATE
18 / min

OXYGEN SATURATION
99% room air

HEIGHT
137.5 cm — 8th centile (40th in 05/2025)

WEIGHT
28.4 kg — below 5th centile (45th in 05/2025)

BMI
15.0 kg/m² — 6th centile

GROWTH PERCENTILES
Height velocity 1.0 cm/year (expected 6–7); weight z-score −1.9

PAIN SCORE
4/10 at rest, 6/10 post-prandial

5a AGE-APPROPRIATE PHYSICAL EXAMINATION

General Appearance

Alert, cooperative, and articulate but visibly thin and pale, with reduced subcutaneous fat over the upper arms and a prominent clavicular contour. Small for age and noticeably prepubertal for 11 years 9 months. Sits comfortably. Quiet in affect and defers to her parents initially, becoming more forthcoming when seen briefly on her own.

Head / Eyes / Ears / Nose / Throat

Conjunctival pallor. No scleral icterus. No uveitis or episcleral injection. **Two aphthous ulcers on the buccal mucosa, 4 mm and 6 mm, shallow with an erythematous halo.** Angular cheilosis present. Mucous membranes moist. Dentition intact with no enamel erosion. Tonsils and pharynx normal.

Neck

No lymphadenopathy. Thyroid not enlarged and non-tender. No masses.

Cardiovascular

Heart rate 96 with a regular rhythm. Soft grade 1/6 flow murmur at the left sternal border, consistent with anemia. Pulses full and symmetrical. Capillary refill under 2 seconds. No oedema. No signs of dehydration or hemodynamic compromise.

Pulmonary

Normal effort, clear breath sounds bilaterally, no wheeze or crackles. No aspiration concern.

Abdomen

Soft with normal bowel sounds and no distension. **Tenderness in the right lower quadrant with a vaguely palpable, mildly tender, thickened mass in the right iliac fossa** — likely inflamed terminal ileum. No guarding, no rebound, no peritonism. No hepatomegaly, no splenomegaly, no ascites, no hernia. No scars. No G-tube.

Perianal / Rectal Exam

Performed with consent and a chaperone, with careful explanation. **One 4 mm posterior midline skin tag and a shallow non-painful fissure at the 6 o'clock position.** No abscess, no fistula opening, no drainage, no significant perianal inflammation. Digital examination deferred deliberately — the diagnostic information will come from endoscopy, and an uncomfortable rectal examination in an 11-year-old adds nothing and costs trust.

Genitourinary

Tanner stage 1 — no breast development, no pubic hair, premenarchal. This is delayed for chronological age and is a growth-relevant finding rather than an incidental one. No other GU findings.

Musculoskeletal

Full range of motion at both knees and ankles with **no effusion, no warmth, and no synovitis today**, despite the reported arthralgia. No spinal tenderness. Gait normal. No clubbing. Reduced muscle bulk in the thighs and upper arms consistent with undernutrition.

Skin

Pale with cool extremities. **No erythema nodosum, no pyoderma gangrenosum.** Dry skin over the shins. No rash, no petechiae, no bruising. No surgical scars. Nails without koilonychia; hair somewhat thin and brittle.

Neurologic

Alert and fully oriented. Tone, power, reflexes, coordination, and gait all normal. Developmentally appropriate. No neurologic contributor to feeding, swallowing, or bowel function.

GN GROWTH / NUTRITION ASSESSMENT

6 GROWTH & NUTRITION STATUS

GROWTH CHART REVIEW

Crossing two major centile channels for both weight and height — the single most important objective finding in this consultation

WEIGHT, HEIGHT, BMI TREND

Weight 45th → below 5th centile; height 40th → 8th; BMI 6th centile

HEIGHT VELOCITY

1.0 cm/year against an expected 6–7 cm/year at this age — growth arrest, not slow growth

WEIGHT-FOR-LENGTH

Not applicable at 11 years; BMI z-score −1.6 used instead

WEIGHT LOSS / FAILURE TO THRIVE

4.6 kg (14% of body weight) over 14 months — moderate malnutrition by z-score criteria

DIETARY ADEQUACY

Approximately 1,150 kcal/day against 2,000–2,200 required; protein 0.7 g/kg/day against 1.0–1.2 needed

HYDRATION STATUS

Adequate — moist mucosa, capillary refill under 2 s, normal blood pressure

FEEDING ROUTE

Full oral. No enteral or parenteral support currently

SIGNS OF MALNUTRITION

Reduced subcutaneous fat and muscle bulk, angular

cheilosis, brittle hair, conjunctival pallor

MICRONUTRIENT DEFICIENCY

Iron deficiency confirmed; vitamin D 14 ng/mL (deficient); zinc, folate, B12 pending

BONE HEALTH

DEXA ordered — 14 months of inflammation, undernutrition, and delayed puberty put peak bone mass accrual at risk

DIETITIAN INVOLVEMENT

Urgent pediatric GI dietitian referral generated today — never previously involved despite 14 months of symptoms

DS DISEASE-SPECIFIC ASSESSMENT TOOLS / SCORES

7 STRUCTURED ASSESSMENTS USED

PEDIATRIC CROHN'S DISEASE ACTIVITY INDEX

wPCDAI 57.5 — moderate-to-severe disease (abdominal pain, stool pattern, well-being, weight loss, growth, perianal findings, and abnormal laboratory values all contributing)

PEDIATRIC ULCERATIVE COLITIS ACTIVITY INDEX

Not applied — the phenotype and terminal ileal findings are not consistent with ulcerative colitis

BRISTOL STOOL SCALE

Type 5–6, 3–5 times daily, with 2–3 nocturnal stools weekly

STOOL DIARY

2-week prospective diary issued today with frequency, consistency, blood, urgency, and nocturnal columns

REFLUX SYMPTOM SCORE

Not applicable — no reflux symptoms

NUTRITION / MALNUTRITION SCREENING

STRONGkids score 4 — high risk

QUALITY-OF-LIFE / SCHOOL IMPACT

22 school days missed this year; withdrew from swim team; 2 undisclosed soiling episodes — substantial functional impact

SCORE, INFORMANT, LIMITATIONS

Scores derived from parental and patient report plus today's examination and the 07/2026 laboratory panel. wPCDAI will be recalculated after induction. Limitation: symptom recall over 14 months is imprecise, and the prospective diary is intended to correct this

PD PROCEDURES / DEVICES

8 GI PROCEDURES & DEVICE-SITE FINDINGS

Feeding devices / ostomy

None — no G-tube, GJ-tube, NG-tube, or ostomy. No device-site findings.

Endoscopy / colonoscopy

None performed to date. Ileocolonoscopy and upper GI endoscopy with biopsies **booked for 08/12/2026** under general anaesthesia, with the plan discussed in detail with the family including sedation risk, bowel preparation, and the reason both upper and lower endoscopy are required in suspected pediatric Crohn disease.

Biopsy review

No prior histology exists. A minimum of two biopsies from each of the terminal ileum, caecum, ascending, transverse,

descending, sigmoid, rectum, oesophagus, stomach, and duodenum will be taken irrespective of macroscopic appearance.

Motility / functional testing

Not indicated. No pH probe, impedance, manometry, capsule endoscopy, or breath testing planned at this stage.

Procedure tolerance

Not applicable — no procedure performed yet. Anaesthetic pre-assessment booked 08/10; hemoglobin will be rechecked before the list.

L LABORATORY AND DIAGNOSTIC RESULTS

9 RESULTS REVIEWED OR ORDERED

Laboratory Studies — 07/18/2026 (primary care) and 08/05/2026

Hemoglobin 9.2 g/dL, MCV 68 fL, ferritin 6 ng/mL, transferrin saturation 7% — iron deficiency anemia unresponsive to 6 months of oral iron. Platelets 486, white cells 11.2. **ESR 48 mm/hr, CRP 34 mg/L. Albumin 2.9 g/dL** with total protein 5.8 — protein-losing enteropathy. Liver enzymes, bilirubin, and GGT normal. Lipase and amylase normal. Creatinine and electrolytes normal. **Celiac serology: tissue transglutaminase IgA negative with a normal total IgA** — celiac disease excluded. Thyroid function normal. **Vitamin D 14 ng/mL (deficient).** Zinc, folate, and B12 sent today, pending. Pre-biologic screening sent today: hepatitis B surface antigen and core antibody, hepatitis C, HIV, varicella IgG, and an interferon-gamma release assay for tuberculosis — all pending.

Stool Studies

Faecal calprotectin 1,240 µg/g (reference under 50) on 07/16/2026 — markedly elevated and the single most discriminating non-invasive result here. Faecal occult blood positive. Stool culture negative on two occasions (03/2026, 06/2026). Ova and parasites negative ×2. *Clostridioides difficile* toxin and GI pathogen panel negative on 07/16 — important to exclude before immunosuppression. Pancreatic elastase normal at 380 µg/g, excluding pancreatic insufficiency.

Imaging

Abdominal ultrasound 07/24/2026: **thickened terminal ileal wall at 5.8 mm over an 8 cm segment with increased mural vascularity and adjacent mesenteric fat echogenicity and reactive nodes.** No abscess, no free fluid, no obstruction. Liver, biliary tree, pancreas, spleen, and kidneys normal. **MR enterography booked 08/10/2026** to define proximal small bowel involvement, stricturing, and any penetrating disease before endoscopy — the answer changes the induction strategy. No plain radiograph indicated. DEXA ordered.

Endoscopy / Pathology

Pending — ileocolonoscopy and upper GI endoscopy 08/12/2026 with segmental biopsies as above. No prior histology.

Motility / Functional Testing

Not indicated at this stage.

Prior Records Reviewed

Primary care record from 02/2025 onward including all growth measurements plotted personally today; two prior stool culture results; the 07/2026 laboratory panel; abdominal ultrasound images reviewed with the radiologist; school nurse log documenting four low-grade fevers and 22 absence days; pharmacy record confirming continuous ferrous sulphate dispensing since 02/2026 and repeated ibuprofen purchases.

A ASSESSMENT

10 PEDIATRIC GASTROENTEROLOGY CLINICAL INTERPRETATION

- **Newly diagnosed, previously unrecognised Crohn disease of the terminal ileum with probable ileocolonic involvement, moderate-to-severe (wPCDAI 57.5), presenting with growth failure and delayed puberty.** Histological confirmation is pending, but the constellation — right lower quadrant mass, calprotectin 1,240, CRP 34, ESR 48, albumin 2.9, refractory iron deficiency, an 8 cm thickened terminal ileum on ultrasound, oral ulceration, a perianal skin tag with a fissure, and arthralgia — leaves little diagnostic doubt.
- **Growth failure is the defining feature of this case and the reason it is urgent.** A height velocity of 1.0 cm/year against an expected 6–7, with Tanner 1 at 11 years 9 months and two centile channels lost, means she has spent 14 months of her pubertal window under inflammatory suppression. **Growth potential lost during this period is not fully recoverable**, and the therapeutic target is therefore not just symptom control but mucosal healing, steroid avoidance, and pubertal progression.
- **Fourteen months of red flags were treated as functional abdominal pain.** Nocturnal diarrhoea, blood in stool, oral ulceration, weight loss, growth arrest, low-grade fevers, and iron deficiency that does not respond to iron are each individually incompatible with a functional diagnosis. This is not a criticism of any single consultation but a system pattern worth documenting: the growth chart was measured but never plotted, and plotting it would have made the diagnosis a year ago.
- **Refractory iron deficiency was the missed signal.** Six months of adherent oral ferrous sulphate with no hemoglobin rise means either ongoing loss, malabsorption, or inflammation-mediated hepcidin block — in this case all three. Iron deficiency that does not respond to iron is a gastrointestinal diagnosis, not a haematological one.
- **Ibuprofen twice weekly for 8 months is actively harmful here** and must stop today. NSAIDs both aggravate mucosal inflammation and precipitate flares in inflammatory bowel disease, and its use has almost certainly worsened her disease while treating its symptom.
- **Differential considerations and why they are less likely:** celiac disease excluded by negative serology with a normal total IgA; infectious colitis excluded by four negative stool studies including *C. difficile* and a pathogen panel; intestinal tuberculosis is being formally excluded with an interferon-gamma release assay before immunosuppression, which is mandatory rather than optional; ulcerative colitis does not fit terminal ileal thickening, oral ulceration, or a perianal tag; eosinophilic and functional disease do not produce this inflammatory burden or growth arrest. **Very-early-onset monogenic disease is not a consideration at 11 years.**
- **Nutritional state:** moderate malnutrition with an intake of roughly half her requirement, protein at 0.7 g/kg/day, hypoalbuminaemia partly from protein-losing enteropathy, vitamin D deficiency at 14 ng/mL, and a self-imposed dairy restriction that has removed her main protein and calcium source in a lacto-vegetarian diet. **Bone health is at genuine risk** from the combination of inflammation, undernutrition, vitamin D deficiency, and pubertal delay at the age of peak bone mass accrual.
- **Perianal findings are limited — a tag and a fissure, with no fistula or abscess — but they must be reassessed under anaesthesia**, because perianal fistulising disease changes the treatment algorithm decisively toward early anti-TNF therapy.
- **The psychosocial impact is being under-reported and needs naming.** Twenty-two school days lost, withdrawal from competitive swimming, being the shortest in her class, and two soiling episodes at school she felt unable to disclose to her parents. An 11-year-old who conceals soiling is carrying significant shame, and that will affect adherence to whatever we prescribe.
- **Immediate priorities are sequencing, not treatment intensity:** MR enterography and endoscopy must be completed within 7 days so that induction can be chosen on complete information, with the pre-biologic screen running in parallel so that no time is lost if early anti-TNF therapy is indicated. Starting steroids today would relieve symptoms, blunt the diagnostic yield of endoscopy, and further suppress growth — the wrong trade in a child whose principal problem is growth.

P PLAN

11 PEDIATRIC GASTROENTEROLOGY MANAGEMENT BY PROBLEM

- **Diagnostic sequence — compressed deliberately into 7 days:** MR enterography **08/10**; anaesthetic pre-assessment **08/10**; **ileocolonoscopy and upper GI endoscopy with segmental biopsies 08/12** including examination of the perianal region under anaesthesia. Pre-biologic screen (hepatitis B and C, HIV, varicella IgG, interferon-gamma release assay) already sent today so that therapy is not delayed by screening. DEXA within 4 weeks. Zinc, folate, and B12 pending.
- **Induction therapy — decision deferred to 08/13, with the strategy already agreed with the family:** if disease is confirmed as ileal or ileocolonic without penetrating or perianal fistulising features, **exclusive enteral nutrition for 8 weeks is the preferred induction**, at 100–120% of estimated energy requirement using a polymeric formula, because it induces remission at rates comparable with corticosteroids while *improving* rather than suppressing growth and bone health. If fistulising or extensive disease is found, **early anti-TNF therapy** will be recommended instead. **Corticosteroids are being deliberately avoided** in a child with growth arrest and pubertal delay unless nothing else is tolerated. Maintenance with an immunomodulator or biologic will be decided at the same visit, informed by histology and MR findings.
- **Stop ibuprofen today — a specific, non-negotiable instruction.** Explained to both parents and to the patient in terms she understood. Paracetamol 15 mg/kg up to four times daily for pain in the interim. No new antispasmodic while the diagnosis is being confirmed.
- **Nutrition and growth — urgent dietitian referral generated today, appointment 08/07:** aims are to restore intake toward 2,000–2,200 kcal/day and protein toward 1.2 g/kg/day, to **reintroduce dairy** since her self-restriction is pain-driven rather than lactose-driven and has cost her protein and calcium in a lacto-vegetarian diet, to prepare her practically and psychologically for possible exclusive enteral nutrition including taste trials of the formula this week, and to plan vegetarian protein sources. Weight and height at every visit with the same scales and stadiometer.
- **Iron and micronutrients: stop oral iron** — six adherent months without response makes it futile and it is aggravating her gut symptoms. **Intravenous ferric carboxymaltose arranged for 08/11**, dosed by weight and hemoglobin deficit, before the endoscopy list. Start vitamin D 2,000 IU daily for deficiency at 14 ng/mL with a recheck at 12 weeks. Calcium intake to be addressed through diet with the dietitian rather than a supplement in the first instance. Zinc and folate replaced on result.
- **Growth and puberty:** pediatric endocrinology **co-review requested**, not because a primary endocrine cause is suspected but because the pubertal delay and bone health need joint monitoring while inflammation is brought under control. Bone age film with the DEXA. Growth and Tanner staging documented at every visit — pubertal progression is a treatment endpoint in this case, not an observation.
- **Symptom and diary plan for the next 7 days:** 2-week prospective stool and pain diary issued. Low-residue eating for comfort in the interim, without formal restriction. Adequate hydration. Bowel preparation instructions given in writing with a nurse-led telephone check on 08/11.
- **Vaccination review before immunosuppression:** immunisations confirmed complete including varicella and MMR — documented today, since **live vaccines cannot be given once biologic or immunomodulator therapy starts**. Influenza vaccine to be given in September ahead of the season. Pneumococcal and hepatitis B status being confirmed serologically.
- **Referral and coordination:** pediatric GI dietitian 08/07; pediatric endocrinology co-review; inflammatory bowel disease clinical nurse specialist assigned today as the family's named contact with a direct telephone number; **pediatric psychology referral** for the soiling-related shame, school avoidance, and the impending burden of chronic disease and possible tube feeding; school liaison letter issued today granting unrestricted toilet access, a private facility, permission to leave lessons without asking, and a plan for catching up missed work; primary care informed by same-day letter. Paternal aunt's records being sought with consent to clarify the family history.

- **Family education:** the working diagnosis, the reason endoscopy is needed even though the diagnosis is already probable, the rationale for avoiding steroids, and the realistic goal of catch-up growth were all explained with a diagram of the terminal ileum and a plotted growth chart the parents could see for themselves. The parents asked whether the year of delay had caused permanent harm and were given an honest answer: some height potential has likely been lost, and how much depends on how quickly remission is achieved and how much of the pubertal window remains. Written information pack and the national patient organisation details provided. Teach-back completed.
- **Red flags given verbally and in writing:** severe or localised abdominal pain, persistent vomiting especially if bilious, abdominal distension with absent stool or flatus, large-volume rectal bleeding, fever above 38.5°C, new perianal pain or swelling, or inability to maintain fluids — contact the nurse specialist same day or attend the emergency department.

F FOLLOW-UP

12 REASSESSMENT PLAN

Follow-up timeframe and purpose

08/07 dietitian assessment with formula taste trials. **08/10** MR enterography and anaesthetic pre-assessment. **08/11** intravenous iron infusion and nurse-led bowel preparation check. **08/12** ileocolonoscopy, upper GI endoscopy, and perianal examination under anaesthesia. **08/13 consultant review — diagnosis confirmed and induction therapy started** with histology, MR findings, and the pre-biologic screen all available. Then clinic at 2, 4, and 8 weeks of induction with weight, height, Tanner staging, wPCDAI, CRP, albumin, and faecal calprotectin at each point; calprotectin is the objective marker of mucosal response and will drive escalation. Endocrinology co-review and DEXA within 4 weeks. Psychology within 3 weeks. Repeat endoscopy at 6–12 months to confirm mucosal healing. Named nurse specialist contactable between visits. **Same-day contact** for any red-flag symptom.

TB TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT
88 minutes

COUNSELING / CAREGIVER EDUCATION TIME
31 minutes — diagnosis, endoscopy rationale, steroid-avoidance strategy, growth prognosis, red flags

NUTRITION COUNSELING TIME
12 minutes — dietary recall, dairy reintroduction, preparation for exclusive enteral nutrition

CARE COORDINATION TIME
17 minutes — endoscopy and MR booking, iron infusion, dietitian, endocrinology, psychology, school letter

RECORDS REVIEW TIME
13 minutes — growth data plotted from 02/2025, prior stool studies, laboratory panel, school nurse log

PROCEDURE / TEST REVIEW TIME
9 minutes — abdominal ultrasound images reviewed directly with the radiologist

E/M LEVEL
99205 — new patient, high-complexity medical decision making: chronic illness with severe exacerbation and progression, extensive data review, and decision regarding immunosuppressive therapy

PROCEDURE CODE(S)
None today — endoscopy 08/12/2026 to be coded separately

DIAGNOSTIC TEST INTERPRETATION CODE(S)
Ultrasound images independently reviewed; interpretation by radiology

NUTRITION / COUNSELING CODE(S)
Dietitian referral generated; medical nutrition therapy to be billed by the dietitian

BASIS FOR BILLING
Medical Decision Making — high complexity, with a decision regarding hospitalisation-level intervention and immunosuppression; time also documented

PRIMARY ICD-10
K50.00 — Crohn disease of small intestine without complications (working diagnosis, histology pending)

SECONDARY ICD-10
R62.51 failure to thrive, child; E44.0 moderate protein-calorie malnutrition; D50.9 iron deficiency anemia; E55.9 vitamin D deficiency; E30.0 delayed puberty; K59.1 functional diarrhea; K62.6 ulcer of anus and rectum (fissure); K12.0 recurrent oral aphthae; M25.561 pain in right knee; Z79.899 other long-term drug therapy (NSAID use, discontinued)

SO PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY	DATE	TIME
Elena Kowalczyk, MD	MD, MSc	Pediatric Gastroenterology	08/05/2026	11:47 AM