1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Amara N. Okoye

DOB
07/15/2026

AGE/SEX
12 weeks / Female

MRN / PATIENT ID
ANO-8820347

DATE OF SERVICE
10/07/2026

PROVIDER
Rebecca Hollis

CREDENTIALS
MD, FAAD, FAAP

VISIT TYPE
Pediatric Dermatology Consultation — Lesion Evaluation (urgent new patient)

CARE SETTING
Outpatient — Pediatric Dermatology Clinic

PARENT / GUARDIAN PRESENT
Mother (Chioma Okoye) and father (David Okoye)

INFORMANT / COLLATERAL SOURCE
Mother; pediatrician referral note; serial phone photos

PRIMARY CARE PROVIDER, IF APPLICABLE
Jason Whitfield, MD (pediatrics)

REFERRING PROVIDER, IF APPLICABLE
Jason Whitfield, MD

INTERPRETER USED, IF APPLICABLE
Not required — English

CHAPERONE PRESENT, IF APPLICABLE
Parents present throughout

CC CHIEF COMPLAINT

2 PRIMARY PEDIATRIC DERMATOLOGY CONCERN

Mother: “The red birthmark on her eyelid has doubled in the last three weeks and now her eye looks half closed.”

S SUBJECTIVE

3 PATIENT- & CAREGIVER-REPORTED HISTORY

3a PRESENTING CONCERN

Reason for Pediatric Dermatology Evaluation:

Urgent initial birthmark evaluation — rapidly growing vascular lesion of the right upper eyelid, referred for possible propranolol therapy.

History of Present Illness:

At 1 week of life parents noticed a faint pink, scratch-like patch on the R upper eyelid. From week 5 it became bright red and raised; over the past 3 weeks it has doubled in size and the eyelid now droops over part of the pupil when she is calm. Seen by pediatrician 10/02; urgent referral placed. No treatment tried. Parents worry about her vision and appearance.

Rash History:

Not applicable — no rash. Two small (3–4 mm) red bumps noted on the scalp and L thigh in the last month.

Eczema / Atopic Dermatitis History:

Mild dry cheeks; fragrance-free cream daily. No eczema diagnosis. Father has asthma.

Acne History, if applicable:

Transient neonatal acne at 3 weeks, resolved without treatment.

3b LESION-SPECIFIC HISTORY

Birthmark / Vascular Lesion History:

Precursor at 1 week; rapid proliferation weeks 5–12. Bright red, now with a bluish deeper part. No ulceration, bleeding, or apparent pain. Causes partial eyelid closure. No prior imaging or treatment. Not segmental; no other facial involvement — PHACE features not suspected.

Pigmentary Concern:

Congenital dermal melanocytosis over the sacrum (stable, bluish-grey). No café-au-lait macules.

Mole / Skin Lesion History:

Small red papules on the scalp and L thigh (likely additional hemangiomas). No moles.

Warts / Molluscum / Viral Lesions:

Not applicable.

Hair and Scalp Symptoms:

Mild occipital friction hair thinning (normal for age). Mild cradle cap.

Nail Symptoms:

None.

Diaper / Genital / Perianal Symptoms, if applicable:

Mild intermittent diaper dermatitis treated with zinc oxide. No lesions in the diaper area.

3c EXPOSURES, DEVELOPMENT & BACKGROUND

Medication / Product Exposure History:

Vitamin D 400 IU daily. Fragrance-free cream, zinc oxide paste, fragrance-free wipes, free-and-clear detergent. No other medications.

Infectious Exposure History:

Home with mother (on parental leave); 4-year-old brother attends preschool. No current illness at home.

Allergy / Atopy History:

No known drug allergies. Exclusively breastfed. No urticaria or food reactions.

Birth / Developmental History:

Born at 35+2 weeks by C-section for pre-eclampsia; birth weight 2.4 kg; 3-day NICU stay for feeding (no respiratory support). Feeding well; social smile at 7 weeks; tracks faces. 2-month vaccines up to date. No hypoglycemia after the NICU.

Treatment History and Response:

None for the hemangioma.

Past Dermatologic History:

Neonatal acne; congenital dermal melanocytosis. No prior procedures.

Family History:

Father — asthma. Maternal aunt had an infantile hemangioma that resolved. Mother — keloids. No cardiac arrhythmias or sudden death.

Social / Environmental History:

Lives with both parents and brother; no smokers; one dog. Mother returns to work as an accountant in January (infant to attend daycare). Insurance through father's employer; pharmacy 5 minutes away.

Pertinent Negatives:

Denies noisy breathing or stridor (airway hemangioma concern), feeding difficulty, bleeding or ulceration, eye discharge, wheeze, poor feeding, or sweating with feeds. Rapid change in lesion is positive (reason for visit).

ROS PEDIATRIC DERMATOLOGY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Rash, itching, pain, burning, swelling, drainage, scaling, crusting, blistering, or ulceration
Negative for ulceration or drainage; eyelid swelling from lesion.

New, changing, bleeding, painful, or non-healing skin lesion
Positive — rapidly growing eyelid lesion; 2 small new red papules.

Eczema flare, sleep disruption from itching, scratching, or skin infection symptoms
Negative.

Acne, scarring, pigment change, psychosocial impact, or treatment irritation
Negative; parental anxiety about appearance.

Hair loss, scalp scaling, scalp pain, nail changes, or mucosal lesions
Mild cradle cap only.

Fever, fatigue, weight loss, joint pain, photosensitivity, oral ulcers, or systemic symptoms
Negative; growing well.

Medication reaction symptoms, hives, swelling, respiratory symptoms, or mucosal involvement
Negative — no stridor or wheeze.

School/daycare exposure, household rash, insect bites, animal exposure, or infectious contacts
Sibling in preschool; no current illness.

O OBJECTIVE

5 OBSERVED FINDINGS

5a VITALS, IF OBTAINED

TEMPERATURE	BLOOD PRESSURE	HEART RATE
98.6 °F (axillary)	84/48 (cuff, R arm)	148 (awake)
RESPIRATORY RATE	**OXYGEN SATURATION**	**HEIGHT / LENGTH**
38	99% RA	57.5 cm
WEIGHT	**BMI**	**GROWTH PERCENTILES, IF APPLICABLE**
5.1 kg	—	

Wt 32nd, length 40th (corrected age)

PAIN SCORE, IF APPLICABLE

FLACC 0

5b EXAMINATION

General Appearance:

Alert, well-appearing, well-hydrated infant; interactive, smiles at mother, consolable. No respiratory distress. Pre-propranolol check: regular heart rhythm, no murmur, lungs clear, no stridor.

Skin Examination:

R upper eyelid: well-demarcated, bright red, lobulated, compressible plaque with deeper blue subcutaneous component. Scalp (vertex): 4 mm red dome-shaped papule. L anterior thigh: 3 mm red papule. Sacrum: 4 cm blue-grey patch (dermal melanocytosis). Mild seborrheic scale of the scalp. No ulceration, telangiectatic segmental patches, or midline lumbosacral hemangioma.

Lesion-Specific Examination:

R upper eyelid lesion 2.2 × 1.6 cm (superficial + deep), involving the medial two-thirds of the lid and extending to the lid margin. Elevation ~5 mm. Non-tender, no ulceration. Comparison with parental photos at 6 weeks (~1.0 cm) confirms rapid proliferation. Clinic photographs obtained with ruler.

Full-Body Skin Examination, if performed:

Complete skin exam with parents present, including scalp, oral cavity, and diaper area. Three hemangiomas total (eyelid, scalp, thigh) — fewer than 5, so liver ultrasound not required. Tolerated well.

Scalp / Hair:

Mild greasy scale (cradle cap); occipital friction thinning. Vertex hemangioma as above.

Nails:

Normal.

Mucosa, if examined:

Oral mucosa clear (no mucosal hemangioma). Conjunctiva quiet. When calm, upper lid margin covers ~one-third of the R pupil; R globe appears displaced slightly downward. Formal vision testing deferred to ophthalmology.

Lymph Nodes, if relevant:

Not relevant; none palpable.

Musculoskeletal, if relevant:

Normal tone and movement for age.

MD PEDIATRIC DERMATOLOGIC MORPHOLOGY / DISTRIBUTION ASSESSMENT

6 MORPHOLOGY & PATTERN

PRIMARY LESION TYPE

Vascular plaque with deep subcutaneous component

SECONDARY SKIN CHANGES

None — no ulceration or crust

DISTRIBUTION AND SYMMETRY

Focal, R upper eyelid; 2 small focal papules elsewhere

BODY SURFACE AREA AFFECTED WHEN RELEVANT

<1%

AGE-APPROPRIATE SEVERITY GRADING WHEN APPLICABLE

High-risk per IH risk stratification (periocular, causing ptosis)

PRESENCE OF INFECTION, EXCORIATION, LICHENIFICATION, SCARRING, PIGMENT CHANGE, ULCERATION, OR MUCOSAL

INVOLVEMENT

None

DERMOSCOPIC FINDINGS WHEN PERFORMED

Not performed

COMPARISON WITH PRIOR PHOTOGRAPHS OR MEASUREMENTS

Doubled since 6-week photos

GROWTH, DEVELOPMENT, SLEEP, SCHOOL, ACTIVITY, OR PSYCHOSOCIAL IMPACT

Risk of amblyopia (visual development); parental distress

PR PROCEDURES PERFORMED, IF APPLICABLE

7 IN-OFFICE PROCEDURES

No procedures performed. In-clinic propranolol first-dose observation (not a procedure): heart rate and blood pressure checked at 1 h and 2 h after first dose — see Plan.

ST SCREENING / ASSESSMENT TOOLS

8 SCORES & INTERPRETATION

Hemangioma Severity Scale (HSS) 14; Hemangioma Activity Score (HAS) 5.5 — actively proliferating. Infantile hemangioma risk stratification: high risk (periocular with visual-axis encroachment). FLACC 0. Informant: parents and photos. Baseline scores for tracking treatment response.

L LABORATORY AND DIAGNOSTIC RESULTS

9 REVIEWED & ORDERED

Pathology:

None — clinical diagnosis; biopsy not needed.

Microbiology:

None.

Laboratory Testing:

Not required before propranolol in a healthy infant with normal cardiac exam. Point-of-care glucose before first dose: 82 mg/dL.

Allergy / Contact Dermatitis Testing:

Not applicable.

Imaging:

Not ordered now. Orbital MRI to be decided by ophthalmology if retrobulbar extension is suspected. Liver ultrasound not indicated (<5 cutaneous lesions).

Prior Records Reviewed:

Pediatrician referral note 10/02; NICU discharge summary (no cardiac concerns; no hypoglycemia after day 2); growth chart; parental photo series at weeks 2, 6, 9, and 11.

A ASSESSMENT

10 PEDIATRIC DERMATOLOGIC INTERPRETATION

1) Infantile hemangioma, mixed (superficial and deep), R upper eyelid, high-risk — in the early proliferative phase (12 weeks; most growth happens before 5 months). Causing partial ptosis and possible globe displacement, with risk of deprivation or astigmatic amblyopia. Systemic propranolol indicated now. Prematurity (35 weeks) noted, but corrected age >5 weeks, weight >2 kg, and normal cardiac exam — suitable for outpatient start. 2) Two small focal infantile hemangiomas (scalp, thigh) — low risk; observe. 3) Differential: congenital hemangioma (RICH/NICH — excluded by postnatal onset and growth), pyogenic granuloma, kaposiform hemangioendothelioma (no purpura or firmness), venous malformation — clinical picture classic for IH. 4) Not segmental — PHACE work-up not required. 5) Seborrheic dermatitis and dermal melanocytosis — benign. Parents engaged and able to give doses with feeds.

P PLAN

11 PEDIATRIC DERMATOLOGY MANAGEMENT BY PROBLEM

Topical treatment plan

Scalp and thigh hemangiomas: observation (topical timolol optional if they grow). Cradle cap: baby oil to loosen scale, then soft brush; ketoconazole 2% cream 2×/week if persistent.

Systemic treatment plan

Propranolol oral solution 4.28 mg/mL. Start 1 mg/kg/day = 2.6 mg BID (0.6 mL BID) ×1 week, then 2 mg/kg/day = 5.1 mg BID (1.2 mL BID), weight-adjusted monthly. Give during or right after feeds, ≥6 h apart; never to a baby who is not feeding. First dose given in clinic: HR 148 → 132 (1 h) → 128 (2 h); BP 84/48 → 80/46 → 82/48; no wheeze; glucose stable. Planned duration ~6–12 months, then taper.

Eczema/dermatitis plan

Continue fragrance-free emollient daily; short lukewarm baths.

Acne plan

Not applicable.

Wart/molluscum plan

Not applicable.

Infection plan

Hold propranolol during illness with poor feeding, vomiting, or wheezing; call clinic before restarting.

Birthmark/vascular lesion plan

Propranolol as above. Serial standardized photographs at each visit. Pulsed-dye laser for residual redness after involution if needed (age 2–4). Watch for ulceration — call for any open area or bleeding.

Hair/nail plan

Cradle cap care as above.

Procedure plan

None planned.

Medication monitoring plan

HR and BP recheck 1 week after dose increase. Weight-based dose adjustment monthly. Continue routine vaccines on schedule (no interaction). Signs of hypoglycemia (sweating, lethargy, poor feeding, cold/clammy skin) and bronchospasm reviewed.

Sun protection and skin cancer prevention plan

Shade and protective clothing under 6 months; mineral sunscreen to small areas only if unavoidable.

Referral and care coordination plan

Urgent pediatric ophthalmology within 1 week (amblyopia, astigmatism, ptosis; decide on orbital MRI). Letter to pediatrician with the dosing plan. Vascular anomalies clinic if response is poor.

Patient and caregiver education

Natural history explained (growth to ~5 months, slow involution over years). Written propranolol sheet: dose with feeds, skip the dose if not eating, never double up, use the oral syringe provided. Daycare plan for January to be reviewed. Teach-back with both parents.

F FOLLOW-UP

12 REASSESSMENT PLAN

Nurse phone check in 48 h. Return in 1 week (10/14) for HR/BP and dose increase to 2 mg/kg/day. Then monthly for weight-based dosing, photographs, and HAS/HSS. Ophthalmology within 1 week. Seek urgent care for wheezing, breathing difficulty, lethargy, poor feeding, cold/clammy skin, or ulceration with bleeding.

TB TIME DOCUMENTATION & BILLING

13 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT
75 minutes (incl. 2-h observation, separately staffed)

CAREGIVER COUNSELING TIME
30 minutes

MEDICATION / SKIN CARE EDUCATION TIME
15 minutes

PROCEDURE TIME, IF APPLICABLE
—

MEDICATION MONITORING TIME, IF APPLICABLE
15 minutes (post-dose checks)

CARE COORDINATION TIME
10 minutes (ophthalmology, PCP)

RECORDS REVIEW TIME, IF APPLICABLE
5 minutes

13a BILLING CONSIDERATIONS — E/M / PEDIATRIC DERMATOLOGY CODING

E/M LEVEL
99205

BIOPSY CODE(S), IF APPLICABLE
—

DESTRUCTION / CRYOTHERAPY CODE(S), IF APPLICABLE
—

INJECTION CODE(S), IF APPLICABLE

—

CULTURE / KOH / DIAGNOSTIC TEST CODE(S), IF APPLICABLE

82962 (POC glucose)

PROCEDURE CODE(S), IF APPLICABLE

—

BASIS FOR BILLING

Medical Decision Making (high — drug therapy requiring intensive monitoring)

ICD-10 DIAGNOSIS CODES

D18.01 — Hemangioma of skin and subcutaneous tissue

[SECONDARY DIAGNOSIS / LESION / SYMPTOM CODE(S), IF APPLICABLE]

H02.401 — Unspecified ptosis of right eyelid; L21.0 — Seborrhea capitis; Q82.5 — Congenital non-neoplastic nevus (dermal melanocytosis)

SO SIGNATURE

14 PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY
Rebecca Hollis	MD, FAAD, FAAP	Pediatric Dermatology

DATE	TIME
10/07/2026	16:50