January 20, 1982

New York

Dear Doctor : RE: Paul Tubiana

This letter is to inform you about our aspect of the hospitalization of your patient, Paul Tubiana, à 7 year old white male whom you admitted for treatment of new onset juvenile diabetes mellitus.

Paul was admitted on 12/29/81. He was apparently well until September of 1981 when he developed increased thirst and urination. At that time a urinalysis was normal. About 3 weeks prior to admission he developed a viral illness with fever and vomiting which resolved, and in the past week, there has been a marked increase in drinking, eating and frequency of urination. Since September there has been a 7 lb. weight loss.

On December 29, 1981 a urinalysis revealed glycosuria and ketonuria and he was referred to the Hospital Emergency Room for evaluation. His blood sugar was 553 and his serum was acetone negative. Arrangements were made for admission.

Family history is positive for adult onset diabetes.

Paul was the 3 kg product of a full term uncomplicated pregnancy and delivery. Milestones were normal,

On physical examination his weight was 29 kg, height 130 cm, pulse 100/minute, blood pressure 110/70 mmHg, respirations 24/minute - no Kussmaul. HEENT - fundi normal, no otitis, pharyngitis, thyroid non-palpable; chest clear; heart normal; abdomen - no masses or hepatosplenomegaly; GU - prepubertal male; neuro - grossly normal.

Laboratory Data:

Hgb 13.5; Hct 38.5; WBC 7.7; U/A 4+ glucose, negative protein; Osmo, serum 266; glucose 556; serum pH 7.41, bi 25.

Our impression was, naturally, diabetes mellitus and that Paul presented in a non-acidotic, non-hyperosmolar, not excessively dehydrated hyperglycemic state. We elected to use the I.M. insulin protocol with I.V. and p.o. hydration. Paul received 0.1 u Regular insulin/kg q 1 hour IM x 3 which brought his blood sugar down to 128. At that point he was given a snack and begun on sliding scale.

On Day #4 (1/2/82) he was changed to one shot/day of an NPH and Regular combination. At this time it became apparent that Paul was having considerable difficulty in dealing with the hospital situation and the routines of diabetic care. Also his insulin dose quickly rose to greater than 1 unit/kg/day without evidence of Somogyi phenomenon.

Also on 1/6/82 the dose was split into a.m. and p.m. NPH and Regular doses. At the time of discharge his evaluation was still in progress.

Other studies undertaken in the hospital revealed:

1. normal a.m. cortisol (13.4)
2. normal thyroid functions - T_4 8.2; TSH 4.2; T_3 140
3. normal BUN (7) and creatinine (0.8)
4. no proteinuria

Also, Mrs. Tubiana was instructed by our nutritionist about a low concentrated sugar diet and our nurse clinician taught the use of 2 drop method urine testing and the use of Glucagon for emergencies.

At the time of discharge, Paul's dose was: 20 NPH and 9 Regular in a.m. and 9 NPH and 4 Regular in the p.m. We plan to see Paul in about 3 weeks in our diabetic center.

We thank you for allowing us to share in the care of this patient.

Sincerely,

M.D.

M.D.
Pediatric Endocrinology

QUEST DIAGNOSTICS INCORPORATED

PATIENT INFORMATION
TUBIANA, PAUL

REPORT STATUS **FINAL**

ORDERING PHYSICIAN

GENDER: M FASTING: N

COLLECTED: 03/19/2003 17:59
RECEIVED: 03/20/2003 00:28
REPORTED: 03/21/2003 09:02

Test Name	In Range	Out of Range	Reference Range	Lab
C-PEPTIDE		6.2 H	0.6-3.2 ng/mL	TBR

NOTE: Factors such as obesity, high carbohydrate diet, and inactivity tend to increase this value.

PERFORMING LABORATORY INFORMATION:

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