Jane Doe
DOB: 08/28/1952

Patient is a 56-year-old female.

Past Medical History: Hypertension, Heart disease, Non-Q wave myocardial infarction, Diabetes (since 1995), Chronic Obstructive Pulmonary Disease, Acute Respiratory Disease Syndrome, Chronic Renal Insufficiency, Right Upper Extremity Deep Vein Thrombosis, Chronic urinary track infections, Gall Bladder Disease

Surgical History: Laparoscopic Cholecystectomy in August 2007, Thoracocentesis of Left Lung, Heart Bypass Surgery in 2007, Pleurodesis in November 2007, Appendectomy and Tubal Ligation in 1968, Tennis Elbow Surgery in 1983.

Family History: Not significant.

Social History: Patient had history of smoking but quit in August 2007. Does not drink or use drugs. She is married.

Medications: Aspirin, Metoprolol, Lasix, Lisinopril, Protonix, Lantus, Simvastatin, Levemir, Bacitracin, Lactinex, Zofran, Morphine, Lortab, Haldol, Zyvox

Allergy: Coded Allergies: Amiodarone, Codeine, Hydrocodone, Metronidazole, Penicillin and Quinolones. **Uncoded Allergies:** EGGS, Lortab

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REFERENCE
11/25/2007	General Medical Center Peter David, M.D.	**Admission for Shortness of Breath and Back Pain** Patient complained of pain in the right lower chest and upper abdomen. She had shortness of breath which had worsened over the last week. She also had episodes of nausea and vomiting. She also had right-sided back pain, dry cough and some dizziness. Over the last week she had increased swelling of her lower extremities, which was right greater than left. Vein was taken out from the right leg for the previous coronary artery bypass grafting. The previous day she treated herself by taking 80mg of Lasix and said that there had been at least 5 pounds of weight loss since with some improvement in the swelling. Her baseline dose is 40 mg of Lasix every other day **Physical Examination:** Blood pressure 178/95. On auscultation breath sounds are decreased at bilateral bases particularly at the left base. Chest X-ray showed chronic changes. There was left-sided pleural effusion which appeared to be smaller since she had the video assisted thoracoscopy performed last week. **Labs** showed increased WBC and blood glucose. Creatinine was highly elevated. **Chest X-ray** showed extensive infiltrates throughout the left lung with a small left hydropneumothorax. Left pleural-based mass may reflect loculated pleural fluid.	**71, 73-74** **2166-2169**

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REFERENCE
		Vascular congestion and small bilateral effusions reflect superimposed CHF **CT of chest, abdomen, and pelvis showed** moderate to large right pleural effusion. Left upper lobe soft tissue density probably reflect hematoma. Bibasilar infiltrates with moderate mediastinal adenopathy. Right lung nodule adjacent to major fissure. Mild right perinephric stranding. Mild increased size of right kidney. To correlate with urinalysis to exclude pyelonephritis Left thyroid nodule. Recommended correlation with thyroid sonogram **Bilateral Upper Extremity venous Doppler** demonstrate no definite findings or thrombus involving either upper extremity **Bilateral Lower Extremity Venous Doppler** There is some degree of possible chronic thrombus formation involving the left lesser saphenous vein and possible short segment of thrombus formation involving the right greater saphenous vein **Assessment/Plan** Acute Renal Failure: Plan was to temporarily hold her diuretics and ACE inhibitor and to use alternative medications to control blood pressure. To check her urine electrolyte and creatinine Increasing shortness of breath and cough: Treatment with Zithromax History of subhepatic hematoma and right sided chest pain: CT scan of the chest, abdomen and pelvis without contrast ordered History of right upper extremity deep vein thrombosis and asymmetrical lower extremity edema: Venous Doppler of all four extremities ordered. Coronary artery disease and history of congestive heart failure: The patient's blood pressure was elevated. Changed Lisinopril to Hydralazine. Diabetes mellitus: Patient to continue her home insulin regimen with no changes Assessment of postoperative ejection fraction: Echocardiogram ordered Mild chronic obstructive pulmonary disease: Will start patient on Spiriva Nausea and vomiting – Zofran as needed. Gastrointestinal prophylaxis with Protonix Deep vein thrombosis prophylaxis with subcutaneous Heparin	
11/26/2007	General Medical Center John Smith, M.D. Peter David,	**Progress Note:** The patient felt better. **Chest x-ray** revealed some persistent cardiomegaly, vascular congestion and bilateral effusion. Loculated pleural effusion noted in left upper thorax. **Transthoracic 2-Dimentional Echocardiogram showed** Global hypokinesis with borderline LV systolic	**2072, 2171, 2177**

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REFERENCE
	M.D. Harry R. smith, M.D. William Lee, M.D.	function, ejection fraction 50 to 55% Mitral valve leaflet thickening, moderate mitral regurgitation without mitral stenosis Normal aortic valve, without evidence of aortic insufficiency and stenosis Left atrial enlargement, diameter 4.3 cm Normal right ventricular size and systolic function Moderate tricuspid regurgitation with Doppler derived estimated pulmonary artery pressures Interatrial septum grossly intact No evidence of intracardiac masses and thrombus Small pericardial effusion **Assessment and Plan** Acute renal failure: Planned to hold off her ACE inhibitor, creatinine elevated to 2.1 Chronic obstructive pulmonary disease: patient received supplemental oxygen at 2 litres per nasal cannula and was monitored closely Increased shortness of breath and cough: given Zithromax, and would increase Ceftriaxone 1 gm daily History of subhepatic hematoma and right sided chest pain: CT of abdomen and pelvis showed mild perinephric stranding. Continued to monitor Lower extremity superficial thrombosis: Bilateral lower venous Doppler revealed some degree of chronic thrombus formation Coronary artery disease and history of congestive heart failure: renal function remained elevated and appear to be slightly fluid volume overloaded, continued to monitor Diabetes mellitus: to continue current insulin regimen Nausea and vomiting: the patient was given Zofran Gastrointestinal prophylaxis with Protonix Deep venous thrombosis prophylaxis with subcutaneous heparin C-diff prophylaxis with Lactinex Patient reported itching in various places of her body on administration of Rocephin. Benadryl ordered and to continue with current regimen.	
11/27/2007	General Medical Center Peter David, M.D. Harry R. smith, M.D.	**Progress Note:** The patient had hypoglycemia. Blood glucose was mildly elevated. She had some swelling in lower extremities. **Lab** revealed elevated creatinine. **Chest X-ray showed** bilateral atelectasis or infiltrate and CHF. No change in the left upper lateral thoracic pleural based mass probably reflect resolving hematoma **Assessment/Plan** Acute renal failure: Etiology unclear. The patient had developed renal failure around the time of last admission. Not known the patient had significant hypotension.	**2217**

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REFERENCE
		Bilateral pulmonary infiltrates and pleural effusions status post left-sided pleurodesis. The patient's CT scan showed extensive infiltrates bilaterally particularly on the left side. Planned to keep the patient on broad-spectrum antibiotics. Considered performing a thoracentesis on the right side and remove some fluid from her chest and bronchoscopy. Chronic Obstructive pulmonary disease. History of subhepatic hematoma and right-sided chest pain. Lower extremity superficial thrombosis. Coronary artery disease and history of congestive heart failure. Plan to consider removal of right-sided pleural effusion. Gastrointestinal prophylaxis with Protonix Deep vein thrombosis prophylaxis with subcutaneous Heparin **Nutritional Recommendations:** 1800 ADA 2 gram NA diet with additional protein source with each meal	
11/28/2007	General Medical Center John Smith, M.D. Peter David, M.D. Michael Warren, M.D.	**Progress Note:** The patient felt better. **Procedure:** Thoracentesis under local anesthesia Thoracentesis was performed by Dr. Mark, and 1100cc of reddish and yellow-colored fluid was removed. The patient tolerated the procedure and did not have any complications. Specimen were collected and sent to lab **Lab** report was normal **Chest X-ray after status post thoracentesis** revealed decrease in left pleural effusion. No pneumothorax **Non-Gyn Cytology Report** Collected fluid from pleural fluid. A PCP stain ordered. Atypical cells present	**2067, 2136, 2173**
11/29/2007	General Medical Center Peter David, M.D.	**Progress Note: Procedure:** Bronchoscopy Specimen were collected and sent to laboratory. Subsequent to bronchoscopy, she had some drowsiness and needed 1-2 litres of oxygen to maintain O2 saturations. **Lab** showed hemoglobin slightly drifted downward, creatinine elevated. Noted mild hyperglycemia **Chest x-ray** showed improved right-sided pleural effusion. Stable appearance of chest **Assessment and Plan** Pulmonary infiltrates with pleural effusion, status post left-sided pleurodesis with suspicion of left-sided lung mass. Continued to follow reports of bronchoscopy and thoracentesis Acute renal failure Lower extremity superficial thrombosis Coronary artery disease and history of congestive heart failure Diabetes mellitus Gastrointestinal prophylaxis Deep vein thrombosis prophylaxis	**2065, 2078-2079**

DATE	PROVIDER	OCCURRENCE/TREATMENT	PDF REFERENCE
		Mycobacteriology showed no mycobacteria recovered, no acid-fast bacilli found **Non-Gyn Cytology Report :**Specimen Type: Bronchial Washing Result: Negative for malignancy	
11/30/2007	General Medical Center John Smith, M.D. Peter David, M.D.	**Discharge Summary:** Throughout her hospitalization, the patient was supportive. Her electrolytes were managed. Her creatinine came down to 2. She underwent thoracentesis on 11/28/2007 and bronchoscopy and some bronchoalveolar lavage on 11/29/2007. Findings showed copious amount of clear sputum and mucosa was not erythematous but only mildly edematous and friable. ACE inhibitor was discontinued due to her renal failure. She had mild chronic obstructive pulmonary disease and she was on Spiriva. Overall, the patient remained hemodynamically stable and stable from a respiratory standpoint. By the date of discharge she maintained proper saturation in the low 90s on room air. She was afebrile at discharge and was stable for discharge home **Lab reports** were normal. Sputum culture and urine culture were all normal **Venous Doppler** revealed some degree of chronic thrombus formation in the lesser saphenous vein and possible short segment thrombus in the right greater saphenous vein, but no definite deep venous thrombosis **CT of chest, abdomen, pelvis** revealed large pleural effusion. **Discharge Diagnoses** Acute renal failure Shortness of breath with bilateral pulmonary infiltrates Coronary artery disease Congestive heart failure Type II diabetes mellitus Mild chronic obstructive pulmonary disease Right-sided pleural effusion Left upper lobe lung mass **Plan:** Advised patient to follow up with Dr. James in 2 weeks. The patient would require a CT of chest on the day of office visit. Ordered CBC, basic metabolic panel and magnesium. To monitor the patient closely as she may need percutaneous biopsy in future.	**2050-2052**

History & Physical

Patient:

DATE OF ADMISSION
11/25/2007

CHIEF COMPLAINT
Increasing shortness of breath with nausea and right-sided back pain.

HISTORY OF PRESENT ILLNESS
This is a 55-year-old female that has had two admissions to this hospital in the recent past. The first one was in August with Adult respiratory distress syndrome and pneumonia following laparoscopic cholecystectomy. The patient also had a subhepatic hematoma at that time. The patient was in our ICU for a while on the ventilator. Eventually she recovered. Subsequently came back in October electively for coronary artery bypass grafting. This was performed by Dr. Baseline ejection fraction is around 30%. The patient subsequently recovered from this. Her only major postoperative complication was paroxysmal atrial fibrillation. However she subsequently had a persistent left-sided pleural effusion. The patient was again admitted a third time about a week ago at which point Dr. proceeded to performing video-assisted thoracoscopy and drainage of the left pleural effusion.

The patient states that on and off throughout she has been having right-sided pain. The site of pain that she points is in the right lower chest and upper abdomen. She has also had persistent shortness of breath and states that since August she has not been able to lie flat in bed due to shortness of breath. The patient has also had significant shortness of breath on minor exertion. Over the last week or so she has noticed worsening of her shortness of breath to the point that she was short of breath even at rest. The patient also has been nauseated for the last week and at least has had two or three episodes of vomiting, which contained ingested food. Also again she has been complaining of right-sided back pain. She says that it had become less significant for her after she had the chest tube placed about a week ago, which was hurting her but over the last couple of days pain in the right side of her chest has returned. The patient has also been coughing. Cough is however mostly dry or accompanied by clear sputum. She denies having any recent fever, sore throat or runny nose but does say that she has some postnasal drip, which has been persistent for a long period of time. She also denies having any diarrhea or constipation recently. She does not complain of burning micturition or frequency or micturition and there is no focal weakness. She denies having any headaches although may have had some dizziness. She also states that over the last week there has been progressively increasing swelling of her lower extremities, which is right greater than left. The right leg is the one that she had the vein taken out from when she had coronary artery bypass grafting. Yesterday she treated her self by taking 80mg of Lasix and says that there has been at least five pounds of weight loss on her scale at home since with some improvement in her swelling of lower extremities. Her baseline dose is 40mg of Lasix every other day.

PAST MEDICAL HISTORY
1. Status post laparoscopic cholecystectomy performed in August 2007 and subsequent subhepatic hematoma.
2. Adult respiratory distress syndrome and pneumonia in August 2007.
3. Status post coronary artery bypass grafting performed October 2007. The patient had a preop ejection fraction of 30% and postop ejection fraction is not available to me.
4. Paroxysmal atrial fibrillation in the postoperative period.
5. Diabetes mellitus.
6. Chronic obstructive pulmonary disease. The patient had pulmonary function testing performed in October of this year, which showed mild decrease in FEV 1 to 78% of the reference range at 2.16. DLCO was also decreased to 65%. These were otherwise unremarkable.
7. The patient had a right upper extremity deep vein thrombosis. The patient was subsequently anticoagulated. The last venous Doppler shows resolution of this right upper extremity deep vein thrombosis.

8. The patient is status post left-sided pleurodesis performed on 11/18/2007, only about a week ago.
9. Hyperlipidemia.

SOCIAL HISTORY
She is a smoker. She smoked more than two packs per day and smoked for several decades. Discontinued in August of this year. No known history of heavy alcohol intake or drug use.

ALLERGIES
The patient claims to be allergic to
1. Penicillin.
2. Levaquin.
3. Metronidazole.
4. In addition to some narcotics.
5. Amiodarone.

It is however noted that the patient was given Carbapenem antibiotics during her visit in August without any adverse reactions. The patient states that her only reactions to Penicillins and Levaquin was a rash. Use of Cephalosporins gave her a yeast infection in the past but no other adverse reaction.

HOME MEDICATIONS
1. Aspirin 81mg p.o. every day.
2. Metoprolol 50mg p.o. b.i.d.
3. Lasix 40mg every other day.
4. Lisinopril 10mg every day.
5. Protonix 40mg every day.
6. Potassium 10meq daily.
7. NovoLog 7 units subcutaneously before each meal.
8. Lantus 12 units at bedtime.
9. Simvastatin 20mg p.o. every day.

PHYSICAL EXAMINATION
The patient is alert, awake and oriented. She appeared to be comfortable.
VITAL SIGNS: Had a pulse rate of 87 and blood pressure of 178/95. She was saturating in the high 90s on two liters of oxygen. She was breathing in the teens and was afebrile.
HEENT: Pupils equal, round, reactive to light and accommodation. There was no significant throat erythema. Her airway did appear to be narrow.
NECK: Shows no raised JVP, asymmetry, masses or lymph nodes.
CHEST: Shows bilateral equal expansion on inspection and palpation. On auscultation breath sounds are decreased at bilateral bases particularly at the left base. All surgical scars were seen. I looked at the incision from the last chest tube, which appeared to be unremarkable.
HEART: Regular. Minimal systolic murmur.
ABDOMEN: Soft and nontender with positive bowel sounds.
EXT: Show 2+ edema on the right side and 1+ on the left. There was no calf tenderness.
NEUROLOGICAL: Nonfocal.

IMAGING

The patient had a chest x-ray performed today, which shows chronic changes. There is also a left-sided pleural effusion, which appears to be smaller since she had the video-assisted thoracoscopy performed last week however since the postoperative chest x-ray there appears to be no significant changes.

LABORATORY
The patient did have an increase in her white blood cell count to 12.6 today. On 11/19/2007 it was 9.7. Her hemoglobin is 10.2 with a platelet count of 317. The patient's electrolytes are unremarkable however I do not have a magnesium or phosphorus available.

Blood glucose was mildly elevated to 127. There is however an elevation of her creatinine to 2.2 postoperatively she was up to 2.3 but it is noted that her baseline creatinine is only 0.9. The patient is in acute renal failure.

The patient's PCO2 about a week ago was 37 and we have not repeated an arterial blood gas since then. Her INR about two weeks ago was 1.1.

ASSESSMENT/PLAN
1. Acute renal failure. I understand that the patient is volume overloaded however at this time she is in no major respiratory distress and I feel that protecting her renal function takes priority. I am therefore going to temporarily hold her diuretics. In fact I am temporarily also going to take her off her ACE inhibitor and will use alternative medications to control her blood pressure. Will also check her urine electrolytes and creatinine.

2. Increasing shortness of breath and cough. There is no definite sign of infection however the patient does appear to be more symptomatic now and there is some increase in the white blood cell count. I would only be treating her with Zithromax for now and will follow.

3. History of subhepatic hematoma and right sided chest pain. I would obtain a CT scan of the chest, abdomen and pelvis without contrast. IV contrast cannot be given as the patient is in acute renal failure.

4. History of right upper extremity deep vein thrombosis and asymmetrical lower extremity edema. Will obtain venous Doppler of all four extremities.

5. Coronary artery disease and history of congestive heart failure. I am changing her Lisinopril temporarily to Hydralazine. The patient's blood pressure does appear to be elevated at this time. I will continue with Metoprolol. Hopefully once her renal function normalizes we can start her back on her Lisinopril and Lasix again.

6. Diabetes mellitus will continue her home insulin regimen with no changes at this time.

7. Assessment of postoperative ejection fraction. Will obtain an echocardiogram tomorrow morning.

8. Mild chronic obstructive pulmonary disease. Will start her on some Spiriva.

9. Nausea and vomiting. Will give her Zofran as needed.

10. Gastrointestinal prophylaxis with Protonix.

11. Deep vein thrombosis prophylaxis with subcutaneous Heparin.

Discharge Summary

Patient:

DATE OF ADMISSION
11/25/2007

DATE OF DISCHARGE
11/30/2007

HOSPITAL COURSE
For details of admission, please see the History and Physical dated 11/25/2007. In brief, the patient is a pleasant, 55-year-old Caucasian female who was admitted for right-sided chest pain and increasing shortness of breath. She has had a complicated hospital history over the last few months. In 08/2007 she was admitted with adult respiratory distress syndrome and pneumonia after a laparoscopic cholecystectomy. She was back in 10/2007 for an elective coronary artery bypass, which was complicated by a persistent left-sided pleural effusion and subsequently had to have a video assisted thoracoscopy procedure to resolve that. She also had some paroxysmal atrial fibrillation postoperatively. She eventually recovered and went home.

During this admission, she was complaining of some right-sided chest pain. She had some nausea/vomiting as well as lower extremity edema over the last few days. She was found to have acute renal failure with a creatinine of 2.2 on admission. Etiology of this renal failure remains unclear. She did not receive any type of intravenous contrast or nephrotoxic agents. She does not have any known episodes of hypotension. Throughout the hospitalization, she was just treated supportively. Her electrolytes were managed appropriately. Creatinine only came down to about 2 on the day of discharge.

She underwent a CT of the chest, abdomen, and pelvis because she had a history of a subhepatic hematoma. The CT of the abdomen and pelvis revealed the subhepatic hematoma had resolved. CT of the chest did reveal a large round lesion in the left upper lobe. It also showed that she had a fairly large right-sided pleural effusion. On 11/28/2007, patient underwent thoracentesis for removal of fluid on that right side. She tolerated this well and the effusion appeared to be transudative. They removed a total of 11,000 cc of straw colored fluid. There were no complications from this. On 11/29/2007 patient underwent bronchoscopy and some bronchoalveolar lavage. Findings included copious amounts of clear sputum and mucosa was not erythematous but only mildly edematous and friable. Laboratory data is still pending from that procedure.Patient was started on Zithromax and Rocephin for complaitns of shortness of breath and cough. She initially had some minor itching reaction to the Rocephin and was pretreated with Benadryl and famotidine, and did quite well after that. We plam to continue for a full course of antibiotics with both of these. Due to her renal failure, we discontinued the patient's ACE inhibitor and started her on hydralazine and kept her on her beta blocker, which was metoprolol for her hypertension. We plan to continue this. Patient has known mild chronic obstructive pulmonary disease and she was started on Spiriva.

Overall, patient remained hemodynamically stable and stable from a respiratory standpoint. She required supplemental oxygen initially. By the date of discharge she was maintaining proper saturations in the low 90s on room air. She had an ambulatory pulse oximetry, did not drop below 88%. She was feeling much better. She has been afebrile and doing well on the day of discharge and she was stable for discharge home.

DISCHARGE PHYSICAL EXAMINATION
VITAL SIGNS: Her temperature is 98.2, blood pressure is 139/67, pulse is 78, respiratory rate is 22, pulse oximetry is 92% on room air.
HEENT: Pupils are equally round and reactive to light. Oropharynx is clear. Nose and throat – erythema.
NECK: There is no raised jugular venous pressure, masses, or asymmetry.

CHEST: There is bilateral equal expansion on inspection and palpation. Auscultation reveals clear breath sounds.
HEART: Regular rate and rhythm. No murmurs, rubs, or gallops.
ABDOMEN: Soft, nontender, nondistended. Bowel sounds are positive.
EXTREMITIES: There is trace edema in the lower extremities bilaterally. No calf tenderness.
NEUROLOGICAL: Examination is nonfocal. Patient is alert and oriented, conversing appropriately. She did move all extremities equally and spontaneously.

LABORATORY DATA
Upon admission to the hospital, patient's white count was 10.4, on discharge it was 11.5. Hemoglobin and hematocrit remain stable.

Chemistry panel on admission revealed a creatinine of 2.2. On the date of discharge creatinine was 2. Glucose throughout the hospitalization was fairly labile. She even had times of hypoglycemia, down into the 30s. On discharge, blood glucoses were in the high normal limits.

Culture from the pleural fluid was negative. Sputum culture as well as urine culture were all negative.

IMAGING
Patient had venous Dopplers performed on 11/25/2007, revealed some degree of chronic thrombus formation in the lesser saphenous vein and possible short segment thrombus involving the right greater saphenous vein but no definite findings of a deep venous thrombosis.

CT of the chest, abdomen, and pelvis was performed on 11/25/2007, reveals a large right pleural effusion. There is a nodular opacity noted in the right major fissure. There is some extensive left basilar atelectasis or infiltrate noted. There is no hepatic mass detected. There is also a soft tissue density noted in the left pleural space.

Echocardiogram performed on 11/26/2007 revealed global hypokinesis with ejection fraction of 50 to 55%. There was moderate mitral regurgitation without stenosis. She had a normal aortic valve, moderate tricuspid regurgitation with pulmonary artery pressure of 42.

DISCHARGE DIAGNOSES
1. Acute renal failure.
2. Shortness of breath with bilateral pulmonary infiltrates.
3. Coronary artery disease.
4. Congestive heart failure.
5. Type 2 diabetes mellitus.
6. Mild chronic obstructive pulmonary disease.
7. Right-sided pleural effusion.
8. Left upper lobe lung mass.

DISCHARGE MEDICATIONS
1. Aspirin 81 mg p.o. daily.
2. Simvastatin 20 mg p.o. at bedtime.
3. Hydralazine 25 mg p.o. 4 times daily.
4. Metoprolol 50 gm p.o. twice daily.
5. Spiriva 18 mcg 1 inhalation daily.
6. Omnicef 300 mg p.o. twice daily x 5 days.
7. Zithromax 500 mg p.o. daily x 2 days.

DIET
A heart healthy ADA diet.

ACTIVITY
Activity as tolerated. Encouraged walking.

OXYGEN
The patient does not require any daytime oxygen, ambulatory oxygen saturation showed oxygen saturations greater than 88%.

FOLLOW-UP PLAN
1. Patient will need to follow up with Dr. in approximately 2 weeks in the office.
2. Patient will need a CT of the chest without contrast the day of office visit to follow up pulmonary infiltrates as well as left upper lobe mass.
3. Patient will need a CBC, basic metabolic panel, and magnesium 2 days prior to her office visit.
4. Patient has a left upper lobe pleural based mass. Will continue to monitor it closely and she may need percutaneous biopsy in the future.

NOTE: I am acting as a scribe for Dr.

Report Not Authenticated Until Signing Doctor Signature is in Place

Procedure Note

Patient:

DATE OF PROCEDURE
11/29/2007

PROCEDURE
Bronchoscopy.

PHYSICIAN

INDICATIONS FOR PROCEDURE
Shortness of breath with pulmonary infiltrates and suspicion of lung mass.

CONSENT
Informed consent was obtained personally by myself after a detailed discussion with the patient.

SEDATION
The patient was sedated with a total of 1 mg of versed and 50 mcg of fentanyl in addition to administration of various amounts of local anesthetic solution throughout the bronchial tree.

ROUTE
This procedure was performed through the right nostril.

DESCRIPTION OF PROCEDURE
Informed consent was obtained, as mentioned above, after which the patient was transferred to the bronchoscopy suite where the back of her throat was sprayed with local anesthetic solution and her right nostril was also filled with Xylocaine gel. After this, a lubricated bronchoscope was advance through her right nostril and advanced to visualize the vocal cords without difficulty. Vocal cords were sprayed with a total of 9 mL of 4% Xylocaine solution after which the bronchoscope was advanced into the trachea where an additional 3 mL of 4% Xylocaine solution was instilled. Further 3 mL of 1% Xylocaine solution was instilled in the left mainstem. I subsequently proceeded to examining the entire right and left bronchial tree. Throughout the entire bronchial tree, I found copious amounts of clear secretions. While the mucosa was not grossly erythematous, it was somewhat edematous and was friable and bled easily upon touch. I examined the left upper lobe, lingula, left lower lobe, right upper lobe, and right middle lobe as well as the right lower lobe including the superior segment of the right lower lobe and did not have any additional findings. Bronchioalveolar lavage was performed in the left upper lobe, instilling a total of 120 mL of saline. We got back a return in excess of 60 mL. The return was not clear as opposed to the secretions seen in the lumen of the bronchial tree. It, in fact, was a slightly brownish-yellow color. After the bronchioalveolar lavage had been performed in the left upper lobe, a minor mucosal hemorrhage was seen which however was tending to subside spontaneously. Bronchioalveolar lavage was also performed in the superior segment of the right lower lobe instilling 60 mL of saline and we got back a return greater than 30 mL. Toward the end of this procedure, the patient appeared to be stable. There were no desaturations, no hemoptysis and no hypotension reported. Specimens have been collected and will be sent to the appropriate laboratory. The patient at this time appears to be stable to be transferred to the recovery room and subsequently to the floor per protocol.

Procedure Note

Patient:

DATE OF PROCEDURE
11/28/2007

PROCEDURE
Thoracentesis.

PHYSICIAN

INDICATION
Persistent large right-sided pleural effusion.

The procedure was taken for both diagnostic as well as well as therapeutic reasons.

CONSENT
Informed consent was obtained from the patient. I reviewed with her the risks and benefits.

ANESTHESIA
Local anesthesia with 1% Xylocaine was used.

DESCRIPTION OF PROCEDURE
Informed consent was obtained after which observing aseptic precautions and after administration of local anesthesia as mentioned above and using ultrasound guidance the pleural effusion on the right side of the patient's chest was visualized and then a Cook-Yueh centesis catheter was inserted with only 1 single stick and without any difficulty after which via a 3-way stop cork, it was connected to a vacuum bottle and we removed a total of 1100 mL of straw-colored fluid. Towards the end of this procedure, no further fluid was seen coming into the vacuum bottle. Subsequent postprocedure ultrasound of the chest as well as chest x-ray did not show any significant residual pleural effusion present on the right side nor was there any pneumothorax. The patient tolerated this procedure well and did not have any complications. Specimens collected have been sent to the lab and will be followed.

Progress Note

Patient:

DATE
11/26/2007

SUBJECTIVE
Patient states she is feeling better this morning. She slept well overnight. She is offering no new complaints this morning.

OBJECTIVE
VITAL SIGNS: T-max overnight was 98.4, current temperature 97.9, blood pressure 131/72, pulse 61, respiratory rate 20, pulse oximetry 97% on 2 liters per nasal cannula.
NEUROLOGICAL: Exam is nonfocal. Patient is alert, oriented and converses appropriately. She is able to move all extremities equally and spontaneously.
HEENT: Pupils equal, round and reactive to light. Oropharynx is clear with no erythema.
NECK: Supple. No raised JVP, masses, or asymmetry.
CHEST: There is bilateral equal expansion on inspection and palpation. Auscultation reveals fairly clear breath sounds throughout. Slightly diminished in the left base.
HEART: Regular rate and rhythm. No murmurs, rubs, or gallops.
ABDOMEN: Soft, nontender, nondistended. Bowel sounds are positive.
EXTREMITIES: There is trace lower extremity edema bilaterally with the right slightly greater than the left.

LABORATORY
CBC with a white count of 10.4, hemoglobin 9.7, hematocrit 31, platelet count 235. Chemistry panel reveals a sodium of 140, potassium of 4.5, BUN 17, creatinine 2.1, glucose 118, calcium 8.5, phosphorous 4.9, magnesium 2.1. ABG performed at 2 liters per nasal cannula revealed a pH of 7.36, pCO2 49, bicarb 26, base excess 1, capillary pO2 of 32.

Urine culture remains negative at this time.

IMAGING
Chest x-ray performed this morning reveals some persistent cardiomegaly, vascular congestion and bilateral effusion. The loculated pleural effusion in the left upper thorax is again noted. These findings are compatible with congestive heart failure. There has been no significant change since her prior exam.

ASSESSMENT AND PLAN
1. Acute renal failure: Will go ahead and continue holding her diuretics at this time and continue to leave her off her ACE inhibitor. Electrolytes remain within normal limits at this time. Her creatinine remains elevated at 2.1.

2. Chronic obstructive pulmonary disease: Patient remains on a regimen including Xopenex as needed and Spiriva. She is receiving supplemental oxygen at 2 liters per nasal cannula and doing well with that. Will continue to monitor closely.

3. Increased shortness of breath and cough: Will leave the patient on Zithromax, but will increase her coverage by adding ceftriaxone 1 gm daily.

4. History of subhepatic hematoma and right sided chest pain: CT of the abdomen and pelvis was performed and revealed no obvious subcapsular hepatic hematoma. There is some mild right perinephric stranding. Patient is not complaining of any abdominal pain at this time and will just continue to monitor closely.

Progress Note

Patient:

DATE
11/29/2007

SUBJECTIVE
The patient underwent thoracentesis yesterday as well as bronchoscopy today. Both of these are dictated separately. There were no new reported overnight issues as would be expected. Subsequent to the bronchoscopy, the patient has been somewhat drowsy and has needed 1-2 liters of oxygen to maintain her O2 saturations. However, at this time she remains comfortable.

OBJECTIVE
GENERAL: She is drowsy, but arousable.
VITAL SIGNS: She has a pulse of 76 and blood pressure of 137/72. She is afebrile and saturating in the high 90s on 2 liters oxygen.
HEENT: Shows pupils are equal and reactive. There was no significant throat erythema.
NECK: Shows no raised JVP, asymmetry, masses or lymph nodes.
CHEST: Shows bilateral equal expansion on inspection and palpation. On auscultation, chest was essentially clear. There is improvement in breath sounds at both bases, particularly at the right base since thoracentesis was performed yesterday.
HEART: Regular. No murmur.
ABDOMEN: Soft and nontender with positive bowel sounds.
EXTREMITIES: Show minimal edema only with no calf tenderness.
NEUROLOGICAL: The patient was moving all extremities.

LABORATORY DATA
Lab work from today shows hemoglobin is slightly drifting downward to 8.9 today. The rest of the CBC was essentially unremarkable. The patient's creatinine remains elevated at 2.1 with no major change since admission. Mild hyperglycemia is also noted again. The other electrolytes are unremarkable.

X-RAY DATA
The patient's chest x-ray from today shows improvement in right-sided pleural effusion with no other new changes.

ASSESSMENT & PLAN
1. Pulmonary infiltrates with pleural effusion, status post left-sided pleurodesis with suspicion of left-sided lung mass: At this time, the patient is status post thoracentesis yesterday and I also performed a bronchoscopy today. The initial reports from the thoracentesis show that the patient's pleural effusion was transudative. We will continue to follow further reports from both the thoracentesis as well as the bronchoscopy and will keep her on antibiotics for a total of one week. We will subsequently repeat a CT chest in around 2 weeks and if improvement of the suspicious lesion on the left side is not seen by then, perhaps consideration could be given to performing a lung biopsy.

2. Acute renal failure: The patient's creatinine is stable at around 2. Etiology of acute renal failure still remains uncertain to me. We will continue with supportive care and management of her electrolytes.

3. Lower extremity superficial thrombosis: The patient is off subcutaneous heparin for the procedures. The thrombosis is superficial so the patient has not been fully anticoagulated. I will likely, however, obtain venous Dopplers again in a couple of weeks to follow up.

4. Coronary artery disease and history of congestive heart failure: We are holding off on diuretics and ACE inhibitors because of her acute renal failure. We are adjusting her beta-blocker and hydralazine according to her blood pressure.

5. Diabetes mellitus: Blood glucoses were low and therefore her insulin has been held. This may have been because of development of acute renal failure. At this time, the patient has developed mild hyperglycemia. I do not, however, want to risk hypoglycemia and therefore I am still not administering any scheduled insulin for now and we will continue to follow.

6. Gastrointestinal prophylaxis with Protonix.

7. Deep vein thrombosis prophylaxis: We will only encourage ambulation for now. I would not suggest sequential compression devices because of superficial thrombosis. If the patient still needs to be in the hospital tomorrow, perhaps subcutaneous heparin could be restarted.

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PATIENT:		**CLIENT:**	
MR#:		**PRINTED:**	12/6/2007
DOB / AGE:	8/28/1952 (Age: 55)	**CLINICIAN:**	
SEX:	F	**ADD'L CLINICIAN(S):**	
COLLECTED:	11/28/2007		
RECEIVED:	11/29/2007		

NON - GYN CYTOLOGY REPORT

AMENDED

AMENDMENTS
Amended: 12/5/2007 15:52 CST
Reason: Additional Procedures Performed
Previous Signout Date: 12/3/2007 17:28 CST

SPECIMEN TYPE
Pleural Fluid

DIAGNOSIS

Pleural Fluid:
Satisfactory for evaluation.
Atypical cells present.
See below.

COMMENT
Prepared specimen received in the laboratory on 12-3-2007. Direct smears and cell block show predominantly reactive mesothelial cells, macrophages, and cellular debris. There are a few scattered groups of atypical cells with slightly hyperchromatic nuclei having irregular nuclear borders, and some with prominent nucleoli. Clinical history, clinical impression, and radiologic description are not given. Further investigation is recommended. Correlation with the clinical history, clinical impression, and radiologic images is suggested. Please notify the lab if there is pertinent clinical information that would be helpful in the evaluation of future specimens. A PCP stain is ordered and the interpretation will be given in an amended report.

Supplemental Comment 12-5-2007: The PCP stain is negative for Pneumocystis organisms (control is adequate). Rare weakly stained fungal hyphae are seen and probably represent contamination. Correlation with cultures is suggested.

Cytotechnologist:
Electronically Signed By:
Verified: 12/3/2007 17:28 CST
Performing Location:

CLINICAL HISTORY

Specimen Submitted: Pleural fluid.
Clinical History: Cytology and PCP stain in one bottle.

GROSS

The specimen is labeled with the patient's name. Received unfixed is 900 ml of opaque amber fluid. Two direct smears and a cell block are prepared and examined.

IMAGING CONSULTATION

Pt Name:
Procedure: US Venous Duplex Upper Ext Bil
Order #:
Location Performed:

DOB: 08/28/1952
Ordering Provider:
Exam Date: 11/25/07

Signs and Symptoms: HXT DVT RUE F/U, SOA

PATIENT NAME:

BILATERAL UPPER EXTREMITY VENOUS DOPPLER:

Doppler evaluation of both upper extremities was performed. Comparison is made to the previous right upper extremity venous Doppler study of 10/18/2007. There has also been previous upper extremity Doppler evaluation with findings of previous thrombus formation involving the right upper extremity.

The current study demonstrates no definite findings of thrombus involving either upper extremity.

Electronically Signed By:

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IMAGING CONSULTATION

Pt Name:
Procedure: CT Abdomen WO; CT Chest WO; CT Pelvis WO
Order #:
Location Performed:

DOB: 08/28/1952
Ordering Provider:
Exam Date: 11/25/07

Signs and Symptoms: H/O SUB HEPATIC HEMATOMA AND BACK PAIN

CT CHEST, ABDOMEN AND PELVIS WITHOUT CONTRAST

Clinical History:

Subhepatic hematoma, pain

No films are available for comparison.

CT chest findings:

A left thyroid nodule measures 1.4 cm.

There is extensive mediastinal adenopathy. There is marked coronary calcification. Right paratracheal node measures 1.4 x 1.5 cm. AP window lymph node measures 2 x 1.5 cm.

There appears to have been a pleurodesis. There is a large right pleural effusion. There appears to be loculated left pleural fluid posteriorly and a tiny left hydropneumothorax as gas is noted in the pleural space anteriorly on image 33. Adjacent to this there is gas in the left anterior chest wall on image 35. More cephalad in the left pleural space, there is a soft tissue density in left anterior pleura which measures 2.5 x 1.9 cm. Nodular opacity is noted near the right major fissure, measures 1.2 cm. Extensive left basilar atelectasis or infiltrate is noted. There is extensive subcutaneous edema. There is a small to moderate pericardial effusion.

No hepatic mass is detected. Gallbladder is absent. Spleen is unremarkable. Unopacified pancreas, adrenal glands are grossly unremarkable. Right kidney appears mildly enlarged. There is also mild right perinephric stranding.

No uterine abnormality is detected. The bladder is partially decompressed. Visualized large bowel is grossly unremarkable.

IMPRESSION:

Exam is limited due to lack of IV contrast.

Moderate to large right pleural effusion. There appears to be loculated left posterior pleural fluid with a small amount of gas which is probably iatrogenic. Left upper lobe soft tissue density probably reflects hematoma.

Bibasilar infiltrates with moderate mediastinal adenopathy which is probably reactive.

Right lung nodule adjacent to the major fissure. This may reflect focal infiltrate. However, followup is recommended in one month to ensure its stability.

No obvious subscapular hepatic hematoma.

Mild right perinephric stranding. There is mild increased size of the right kidney in part likely reflects a horizontal lie. Please correlate with urinalysis to exclude pyelonephritis.

Left thyroid nodule. Correlation with thyroid sonogram is recommended.

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IMAGING CONSULTATION

Pt Name:
Procedure: Chest Single View
Order #:
Location Performed:

DOB: 08/28/1952
Ordering Provider:
Exam Date: 11/26/07

Signs and Symptoms: LT PLEURAL EFFUSION

CHEST SINGLE VIEW:

COMPARISON:
This exam is compared to the study done one day prior.

FINDINGS:
There is persistent cardiomegaly, vascular congestion and bilateral effusions. Probable loculated pleural fluid is again noted in the left upper thorax.

IMPRESSION:
Findings compatible with CHF. Bilateral pleural effusions greater on the left, not significantly changed since the prior exam. No pneumothorax is detected.

Probable loculated pleural fluid in left upper hemithorax laterally.

Electronically Signed By:

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IMAGING CONSULTATION

Pt Name:
Procedure: US Thoracentesis-RT
Order #:
Location Performed:

DOB: 08/28/1952
Ordering Provider:
Exam Date: 11/28/07

Signs and Symptoms: SOA

PATIENT NAME

ULTRASOUND GUIDED FOR RIGHT SIDED THORACENTESIS

Ultrasound guidance was provided for right-sided thoracentesis. Thoracentesis was performed by Dr. Approximately 1100 cc of reddish and yellow-colored fluid were removed.

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IMAGING CONSULTATION

Pt Name:
Procedure: Echo Order
Order #:
Location Performed:

DOB: 08/28/1952
Ordering Provider:
Exam Date: 11/26/07

Signs and Symptoms: CHF

Transthoracic 2-dimensional echocardiogram, M-mode, views obtained the parasternal long and short axis, apical 2-chamber and 4-chamber, subcostal, color-flow and spectral Doppler.

Indication: Heart failure

Measurements/dimensions:
LV IDd 4.6, LV IDs 3.3, interventricular septal wall thickness 0.9, posterior wall thickness 1.3, aortic root diameter 2.8, and left atrial diameter 4.3.

Conclusion:
1. Global hypokinesis with borderline LV systolic function, ejection fraction 50 to 55%.
2. Mitral valve leaflet thickening, moderate mitral regurgitation without mitral stenosis.
3. Normal aortic valve, without evidence of aortic insufficiency and stenosis. Maximum instantaneous velocity 1.1 m/sec.
4. Left atrial enlargement, diameter 4.3 cm
5. Normal right ventricular size and systolic function.
6. Moderate tricuspid regurgitation with Doppler derived estimated pulmonary artery pressures 42 mmHg.
7. Interatrial septum grossly intact.
8. No evidence of intracardiac masses and thrombus.
9. Small pericardial effusion.

Electronically Signed By:

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Patient:	**DOB: Aug 28, 1952**	**Age/Sex: 55/F**
Unit#:	**Account#:**	**Room/Bed: /**
User:	**Date: 11/27/07 14:15**	**Type: Nutrition Notes**

Nutritional Recommendations
Date: 11/27/07

Recommendations: RECOMMEND 1800 ADA 2 GRAM NA DIET WITH ADDITIONAL PROTEIN SOURCE WITH EACH MEAL.